HACC, Inc. C.A.R.E. Assessment Request

Please send completed forms to:
FAX 310-831-0004

CLIENT INFORMATION

Client ID#________________

Name____

Street Address____

City___________________________ Zip Code__________________

Phone _____________________

D.O.B_____________________

SSN______________________

☐ Male ☐ Female Transgender

Ethnicity____________________

Veteran ☐

Referral Source____

____

Case Manager_____________________________________

Date of Assessment_________________________________

California Access to Recovery Effort

(CARE 3)

Revised September 2010

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I ______________________________ authorize HACC., Inc. ______________________________
(Client name) (Provider name)

to disclose to the California Department of Alcohol and Drug Programs (ADP), MAXIMUS (ADP's voucher services contractor), and the California State Controller's Office (SCO), information regarding my enrollment and services provided in the CARE voucher program.

The purpose of the disclosure authorized herein is to verify my eligibility and participation in the CARE voucher program and to pay the program for services provided.

I understand that my records are protected under the federal confidentiality regulations (42 Code of Federal Regulations, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent automatically expires six months after I discontinue all CARE services.

I have been provided a copy of this form.

Client Signature: ________________________________ Date: __________________

____ Date: __________________
Parent, guardian or authorized representative signature (if required)

Program Name: HACC, Inc. ____

Program Address: 599 W. 9th Street San Pedro, CA 90731 __________________

CARE Provider # 100537

Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

- O NO
- O YES, ONLY ONE
- O YES, MORE THAN ONE
- O REFUSED
- O DON'T KNOW

[IF YES, ANSWER FOR UP TO 6 PEOPLE] **What is the relationship of that person (Service Member) to you?** ***[WRITE RELATIONSHIP IN COLUMN HEADING]***

1 = Mother 5 = Spouse
2 = Father 6 = Partner
3 = Brother 7 = Child
4 = Sister 8 =Other (Specify)____________________

Has the Service Member experienced any of the following? [*CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]*	__________ **(Relationship) 1.**	__________ **(Relationship) 2.**	__________ **(Relationship) 3.**	__________ **(Relationship) 4.**	__________ **(Relationship) 5.**	__________ **(Relationship) 6.**
6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW
6b. Was physically injured during combat operations?	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW
6c. Developed combat stress symptoms/ difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts?	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW
6d. Died or was killed?	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW	O YES O NO O REFUSED O DON'T KNOW