Wings- Support & Recovery

Peer Recovery Support Participant Agreement

Contact Information

_____ _____ ____/____/_____

Name SSN (Last 4 Only) Date of Birth

_____

Address

_____

City State Zip Code

_____ Is this a ☐ Home Phone or ☐ Cell Phone

Phone

_____

Email

Guardianship

Do you have a guardian? ☐ Yes ☐ No,

If you checked Yes, fill in the information below:

_____

Name

_____

Address

_____

City State Zip Code

_____ Is This a ☐ Home Phone or ☐ Cell Phone

Number

EMERGENCY CONTACT NUMBER

_____

Name

_____

Relationship to you

_____ Is This a ☐ Home Phone or ☐ Cell Phone

Phone

The person listed above will be contacted in the event of an emergency, and/or if fifteen days (15) or more have passed since our last contact with you.

PERMISSION TO CONTACT

I, _____ authorize a Wings- Support & Recovery Peer Supporter to

Your Name

Wings- Support & Recovery

contact me using the following methods (please check all that apply and fill in current information):

☐ Phone

_____ _____

Phone Number Alternate Phone Number

☐ Texting

_____

Phone Number

☐ Email

_____

Email Address

☐ Other (please describe and list contact information below)

_____

Best time to be contacted (check all that apply)?

☐ Morning (7-12) ☐ Afternoon (12-5) ☐ Evening (5-10) ☐ Anytime

Is it OK to leave a message? ☐ Yes ☐ No

_____ Initialing here, I agree to keep current contact information on file at Wings- Support & Recovery. If I need to update my information I will contact my Peer Supporter and/or the Peer Support Supervisor as soon as possible.

Current Services

We want you to be successful and achieve your recovery goals. It would be helpful for us to know if you are working with other Wings programs or with another area agency. Having this information will help us serve you better. Disclosure of this information is strictly voluntary but is helpful nonetheless. Please check all the agencies you are currently receiving services from below:

☐ Maryhaven

☐ Union County Job and Family Services

☐ Wings Vocational Program

☐ Wings Recovery Housing

☐ Social Security Admin. (SSI, SSDI)

☐ Logan County Metropolitan Housing (for Union County Subsidized Housing)

☐ Other agencies (Please list below)

_____

_____

Are you currently involved with the Union County Criminal Justice System? (If "Yes", please specify in what area: e.g.: Felony Drug Court, Family Treatment Drug Court, Probation, etc.)

In what capacity would you like to make use of the Wings- Support & Recovery Peer Support Services? *(Mark all that apply)*

- ☐ Wings-sponsored Support Groups
- ☐ Individual Peer Support
- ☐ Other: _____

PEER RECOVERY SUPPORT SPECIALTIES

We want to provide you with the most appropriate service and support possible for your needs. To this end, we want to try to provide you with a recovery supporter that most closely matches your recovery needs. Peer recovery support is based on the idea that people helping people with shared or similar life experiences can be mutually beneficial. The peer recovery supporter is a person committed to their own recovery. Peer recovery supporters are certified in three areas of specialty: please indicate which type of peer recovery supporter best fits your needs.
(If Marked, Please indicate what type of Mental Health Diagnosis or Substance Abuse you are currently dealing with)

- ☐ Mental Health Recovery: _____
- ☐ Drug and/or Alcohol Recovery _____
- ☐ Dual Diagnosis (You have both) _____

If you marked yes for either "Drug and/or Alcohol Recovery" and/or "Dual Diagnosis"

Please list any and all drugs you have used:

_____

_____

_____

_____

Office Use Only-

_____ _____

Peer Recovery Supporter Assigned Date

Wings- Support & Recovery

Program Expectations

Please review this document and sign below to acknowledge your willingness to enter the Peer Recovery Support program. To be matched with a Peer Recovery Supporter you must first sign this agreement.

Here is what you can expect from us:

- We will work to inspire hope of recovery from mental illness, addiction or co-occurring disorders.
- We will share lived experience in an appropriate way to foster connectedness and relationship building with peers.
- We will listen and empathize with the peer's pain and isolation while encouraging growth in recovery.
- We will assist in exploring options to overcome barriers to recovery.
- We will provide a person-centered approach to peer support that taps into a peer's strengths to build recovery capital.
- We will help develop strategies for improved communication skills and self-advocacy: encouraging a proactive role in their own behavior and physical health.
- We will support the peer in developing a relapse prevention plan.
- We will keep our relationship with you confidential. We will not monitor any participant's abstinence or report on any participant's use of substances. We will only recognize participation in the program, and regularity of contact with your Peer Recovery Supporter, if you request this information be released.
- We are ethically obligated to report a participant's disclosure of personal involvement with child abuse or neglect, elder abuse or neglect, threatened self-harm, or threatened harm to others.

Here is what we expect from you:

- Your recovery is your responsibility. The Peer Recovery Supporter will help you find your own pathway of recovery, but the choices and decisions you make are your own responsibility.
- Please keep your appointments with your Peer Recovery Supporter and strive to be on time. If you are unable to meet at the appointed time, contact your Peer Recovery Supporter as soon as you can.
- You understand and agree that you will not seek to hold your Peer Recovery Supporter or Wings Enrichment Center legally responsible for your decisions or actions.
- You may contact the supervisor who signs below with any questions or concerns you have about your experience in the Peer Recovery Support Program or, if you feel you may benefit from a different Peer Recovery Supporter you have the right to asked if you can be switched to another one.

We are here to help you establish or maintain long-term recovery. We are here to help you be successful and explore what recovery can bring to your life.

_____ _____

(Participant's Printed Name) (Peer Supervisor's Printed Name)

_____ _____

(Participant's Signature) (Date) (Supervisor's Signature) (Date)

Wings- Support & Recovery

MISCELLANEOUS

To help us match you with a Recovery Guide, please complete the form below:

Activity	Do You Currently participate in this activity? (Check all that apply)	Would you like to pursue this in the future? (Check all that apply)	Activity	Do You Currently participate in this activity? (Check all that apply)	Would you like to pursue this in the future? (Check all that apply)
Gardening/Yardwork			Home/Decorating		
Sewing/needlework			Crafts		
Playing cards/table games			Cycling		
Foreign languages			Attending Plays		
Church activities			Bird watching		
Walking			Home Repair		
Car repair			Exercise		
Writing			Hunting		
Dancing			Woodworking		
Listening to music/concerts			Pool/Billiards		
Puzzles			Child Care		
Pets/ Livestock			Cooking/Baking		
Movies			History		
Swimming			Collecting		
Bowling			Fishing		
Checker/Chess			Science		
Reading			Leatherwork		
Traveling			Shopping		
Housecleaning/Laundry			Photography		
Model Building			Painting/Drawing		
Television			Sports (please specify)	Specify:	Specify:
Poetry			Playing Instruments	Specify:	Specify:
Camping			Other (please specify)		
Politics					

Do you have any skills, interests, or hobbies? Would you be willing to share or teach to another individual? Please list them here:

Wings- Support & Recovery

Please briefly tell your recovery journey (*To your comfort level*). You may include things that have helped and especially those things that have not helped so that we may better help guide you on your path towards your continued recovery.

* = Required Field

SmartCareMCO New Member Enrollment/ClientID Request Form

PartnerSolutions
PartnerSolutions.org

*OhioMHAS Board Consortium	ClientID No.	*Form Type
Mental Health and Recovery Board of Union County		New Member

Provider Information

*Submitting Provider	*UPI	Requested Date	*Fax No.	*Phone No.
Wings Support and Recovery	14389		(937) 738-7326	(937) 642-9555

Client Information

*First Name	Middle Name	*Last Name	Suffix

*SSN	*DOB	*Sex	*Primary Language
☐ Client doesn't have an SSN.			

*Ethnicity

*Race ("X" all that apply)

☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ Asian ☐ Client Refused/Doesn't Know

*Marital Status

Residency and Contact Information

*Address 1	Address 2

*City	*State	*ZIP	*County of Residence	*County of Financial Responsibility

Primary Phone No.	Secondary Phone No.	Aff. Code	Aff. Code Start Date	Aff. Code End Date

Additional Information

Gender Identity	Sexual Orientation	Amish/Hutterite/Mennonite ("X" if yes)	House Bill 131
		☐	○ Yes ○ No ○ N/A

Coverage and Financial Information

*Effective Date	*Household Size	*Adjusted Gross Monthly Income	Medicaid ID	Medicaid Managed Care Plan
		$0.00		

Verifications

1.) *Disclosure of enrollment? ◉ Yes ○ No
2.) *Authorization for billing? ◉ Yes ○ No
3.) *Consent for treatment/services signed? ◉ Yes ○ No
4.) *Client refused to sign consent for treatment (MH only)? ○ Yes ◉ No ○ N/A
5.) *SUD release of information signed (SUD only)? ○ Yes ○ No ◉ N/A
6.) *In crisis at enrollment? ○ Yes ◉ No
7.) Client is potentially SPMI/SED? ○ Yes ○ No ○ N/A
8.) Residency verification form signed? ○ Yes ○ No ○ N/A
9.) Proof of household income? ○ Yes ○ No ○ N/A
10.) Proof of identity? ○ Yes ○ No ○ N/A

Prohibition on Redisclosure: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse and/or mental health treatment. State and Federal law prohibit redisclosure of this information without the client's consent. With respect to clients receiving alcohol and other drug addiction treatment, this information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Items Completed by Enrollment Staff

Client Copay	Client Plan	Staff Entering Data	Date Entered

Version 1.1

SmartCareMCO Residency Verification Form

PartnerSolutions
PartnerSolutions.org

The purpose of this form is to clarify which PartnerSolutions board is responsible for adjudicating claims for behavioral health services provided to the client being enrolled in SmartCareMCO. The form should be completed at the time the client first presents for treatment/services at the submitting agency and whenever a change in the client's residency occurs. The form should be presented to the appropriate PartnerSolutions board enrollment contact when:

1.) The county of the submitting agency does not match the legal county of residence of the client as noted on the enrollment form.

2.) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client.

3.) The minor's physical address as noted on the enrollment form does not match the legal custodian's address.

4.) The board staff person responsible for processing the enrollment requests the form, such as in cases when a client needs to be transferred from one PartnerSolutions board's coverage plan to another's in SmartCareMCO.

A client or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Instructions: Fill out only the "Adult" section and the associated signature and date fields if the client is a legal adult or emancipated minor. Fill out only the "Minor" section and the associated signature and date fields if the client is a legal minor. If the form is completed by hand rather than electronically, please print legibly.

Adult

Client Name

Enter the client's street address, city, state, and ZIP for residency determination purposes.

Address 1

Address 2

City

State

ZIP

County of Residence

Minor

Indicate if minor is in legal custody of the following:

( ) Parent ( ) CSB ( ) DYS ( ) Court ( ) Other (specify):

Client Name

Legal Custodian Name

If legal custodian is Parent, enter the Parent's street address, city, state, and ZIP if different from the client's physical address on the enrollment form.

Address 1

Address 2

City

State

ZIP

County of Residence

Signatures

Signatures must be handwritten rather than electronically signed.

Client Signature (if Legal Adult or Emancipated Minor)

Date

Legal Custodian Signature (if Legal Minor)

Date

* For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Version 1.0

Authorization for Release/Exchange of Information

Consumer name _____

Consumer Address _____

Date of Birth _____ Social Security Number _____ Phone Number _____

I, _____ Authorize the following:

Wings Support and Recovery located at 729 S. Walnut St., Marysville, Ohio 43040
(Please choose only one)

And ☐ **Memorial Hospital of Union County** located at 500 London Avenue, Marysville, Ohio 43040

And ☐ **Maryhaven at the Mills Center** located at 715 S Plum St, Marysville, Ohio 43040

And ☐ **Lower Lights Unionstar** located at 773 Walnut St. Marysville, Ohio 43040

And ☐ **Lighthouse Behavioral Health Solutions** located at 104 North Main St. Marysville, OH 43040

And ☐ **New Vision a Memorial Hospital** located at 500 London Avenue Marysville, OH 43040

to communicate and exchange the below checked confidential information, including diagnostic information. (Select all that apply) Psychiatric Records☐, Medical Records☐, Substance Use Disorder Records☐, Behavioral Health Records☐, and/or other (please specify)._____

The Purpose of this Release of Information is as follows: _____

The Consumer or the Consumer's Representative must read and initial the following statements:

1. I understand that this authorization will expire on_____. (180 days from my signature below, unless an earlier expiration date is specified) Initials:_____
2. I understand that except to the extent that action has been taken upon my authorization, I may withdraw/revoke this authorization at any time by written notification to this agency. Initials:_____
3. I understand that this agency reserves the right to withhold information authorized to be released from the record that is determined to create a risk of physical harm to you or others, or will make effective treatment impossible. In such instance, you will be provided notification, an explanation and an opportunity to meet with the appropriate agency staff person to review the record. **Initials:**_____
4. If the signature below is not that of the Consumer, explanations will be provided below, and documentation may be required to accompany this authorization. Initials:_____
5. I understand that I will receive a copy of this form after I sign it. Initials:_____

Printed name of consumer or authorized representative_____
Date _____

Signature of Consumer or Authorized Representative _____

Authority of Authorized Representative _____

Signature of Staff or Witness_____ Date _____

Wings
support & recovery

********** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**********

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

IF YOU RECEIVE INFORMATION RELEASED WITH THISFORM THE FOLLOWING FEDERAL LAW APPLIES TO YOU: This information has been disclosed to you from records protected by Federal Confidentiality Rule (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is other-wise permitted by 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use if the information to criminally investigate or prosecute any alcohol or drug abuse consumer. "These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

REVOCATION OF AUTHORIZATION OF EXCHANGE OF INFORMATION

This authorization is subject to revocation at any time to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I,_____ herby revoke my authorization for release/exchange of information relating to my care and to the parties named above. Further release of information shall cease immediately.

Signature of Consumer or Authorized Representative _____
Date _____

Printed name of consumer or authorized representative _____

Authority of Authorized Representative _____