Appendix B

State Opioid Response 3 - Grant Intake Form

Date of Session: _____ Client Name: _____

Client DOB: _____ Client ID: _____

Client Address: _____

Client Phones: _____

Care Coordination Provider: _____

Section I - The client is eligible for SOR services if questions 1 through 4 are answered Yes and the agency has obtained the required documentation that the individual meets the federal poverty guidelines.

Treatment and Recovery Support Services Eligibility

1. The client is 18 years of age or older. YES _____ NO _____

2. The client has a diagnosis of an opioid use disorder and/or stimulant use disorder or has a history of an opioid or stimulant overdose.

   YES _____ NO _____

3. The client demonstrates the need for SOR3 covered services.

   YES _____ NO _____

4. The client does not have adequate insurance or personal financial resources to pay for requested SOR3 covered services documented in Section II.

   YES _____ NO _____

Section II - Document client needs and requests for specific SOR3 covered services. Document lack of insurance or other financial resources for requested SOR3 covered services

All SOR clients receive the following covered services:

- SOR3 Grant Intake with GPRA Intake Interview
- Care Coordination
- Care Coordination with GPRA Discharge Interview
- Care Coordination with GPRA Follow-up Interview

Intake form: Treatment Related Covered Services

- ☐ Contingency Management
- ☐ SUD & MH Counseling Assessment, Individual, and/or Group Sessions
- ☐ Medical/Behavioral Health Copays
- ☐ MOUD Medical Care
- ☐ MOUD Medical Evaluation
- ☐ MOUD Injectable Naltrexone
- ☐ MOUD Injectable Buprenorphine
- ☐ MOUD Methadone (daily or weekly)
- ☐ MOUD Oral Buprenorphine
- ☐ MOUD Drug Testing
- ☐ Rapid HCV Testing
- ☐ Rapid HIV Testing
- ☐ HIV and Viral Hepatitis Confirmatory Testing

Intake form: Recovery Support Services

- ☐ Recovery Peer Coaching
- ☐ Dental Services
- ☐ Housing Assistance
- ☐ Recovery Calls
- ☐ Clothing/Personal Hygiene Assistance
- ☐ Education Assistance
- ☐ Wellness
- ☐ Transportation
- ☐ Employment Supports
- ☐ Recovery Housing
- ☐ Survivor Advocacy in Recovery

*For more information, see *Appendix A State Opioid Response 3- Service Descriptions, Rates, and Qualifications.*

Client Signature:_____ Date: _____

Provider / Witness Signature:_____ Date: _____

Appendix C

State Opioid Response 3 - Voluntary Consent Form

Introduction: SOR3 is a two-year grant that has been awarded to the Iowa Department of Public Health (Iowa HHS) by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that helps to increase access to quality treatment and recovery services from providers across the state of Iowa.

Goals of SOR3: SOR3 is a grant that helps participants pay for evidence-based treatment for a substance use disorder when they might otherwise not be able to afford it. This grant helps to pay for Medications for Addiction Treatment for people with opioid use disorder, Contingency Management for people with a stimulant use disorder, care coordination to help participants get the care services they need and other recovery support services that might help participants on their recovery path. During the grant, information is gathered that helps local, state, and federal agencies and funding authorities improve both substance use treatment and recovery services and access to those services and treatment for you and others in your community and across the country.

SOR3 services are based on client needs, agency policy, and current available SOR3 voucher funding, and are subject to change.

Welcome to SOR3! You are being asked to participate in SOR3 because of an opioid or stimulant overdose or because a treatment provider has identified that you have an opioid or stimulant use disorder.

Data Interviews: If you consent to participate in SOR3, you will be asked to take part in **three GPRA data interviews** that take 15 to 45 minutes each. GPRA (Government Performance Results Act) interviews ask questions about alcohol and drug use, education and employment, family and living conditions, involvement in the criminal justice system, and participation in social support and recovery groups. You will receive a $30 dollar gift card for completing the GPRA Follow-up interview. In the event that during the attempted completion of the GPRA Follow-up Interview you're residing in a restricted setting, by signing this consent you grant your Care Coordination provider the ability to attempt contact with you which may include disclosure to the facility at which you reside of your involvement in SOR3.

Release of Information: As part of your involvement in SOR3, you are authorizing contact between Iowa HHS and SAMHSA and each provider you're receiving services from, to obtain information necessary for SOR3 project management. This may include, but is not limited to, information related to fiscal reporting, quality improvement, client progress, and data collection. By signing this form you are authorizing release of information between you and Iowa HHS and SAMHSA. You may revoke your release of information at any time except to the extent that action has already been taken. This consent expires automatically 6 months after your final GPRA interview. All identifying information is required by law to be kept confidential.

Risks and Confidentiality: IPN and SOR3 providers take the privacy of your information seriously. SOR3 providers, Iowa HHS and SAMHSA must comply with confidentiality and protected health information requirements as set forth in Federal and State Confidentiality Regulations (42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, 160 & 164). Your records are protected and cannot be disclosed without your written consent. HIV and/or HCV viral status information will be kept strictly confidential, pursuant to Iowa Code Chapter 141A.

Because SOR3 involves coordination of services you want, providers will ask you to sign a release of information to allow them to talk with other providers. You may revoke your release of information at any time except to the extent that action has already been taken. Generally, a program may not condition your services on whether you sign a release of information, however, in the special circumstances of the voluntary SOR3 project, you cannot participate if you do not sign the Voluntary Consent Form.

A unique identification number will be assigned to you as a SOR3 participant. Authorized representatives from Iowa HHS may have access to records that identify you by name. Any information you provide that is part of aggregate data given to SAMHSA will not include your name or other identifying data. If any publications or presentations result from the SOR3 project, you will not be identified.

SOR3 is voluntary: You can refuse to participate in SOR3 at any time. Refusal to participate in SOR3 will not affect any current or future substance use disorder treatment you may receive. You may refuse to answer certain questions and still participate in SOR3. If you refuse to answer a question, no one associated with SOR3 will seek the information you did not provide from some other source. If you participate in SOR3 and later choose not to participate, information you have already given will remain in the project.

As part of your involvement in SOR3 you will receive services from a Care Coordination provider. To assist you with your involvement in SOR3 and utilization of services in your recovery, Care Coordination providers establish policies and determine the appropriate use of funding (i.e. amounts, frequency, services or vendors), up to the available limits, as it pertains to your goals in recovery. Services you receive will be from a community provider as arranged by your care coordinator and shall not represent a conflict of interest.

Client Rights:
You have the right to:

- appropriate and considerate care and protection
- recognition and consideration of your cultural and spiritual values
- be told of all available SOR3 covered services and providers
- choose the services and providers you want from the list of available SOR3 covered services
- refuse a recommended service or plan of care
- review records and information about your services
- expect providers, Iowa HHS, and SAMHSA to keep all communications and records confidential

Maintaining Involvement: If you do not receive at least one SOR3 service or participate in scheduled Care Coordination every 30 days, you will be discharged from the SOR3 program. It is your responsibility to make contact with your Care Coordination provider during this timeframe. In addition, if you do not return required documentation for services provided, ongoing services may be reduced or discontinued entirely. By signing this form, you agree to these conditions in order to maintain involvement.

Questions: If you have questions or concerns about the SOR3 project, contact sor@idph.iowa.gov.

I have received, read, and understand the State Opioid Response - Voluntary Consent Form and all its contents. I agree to the conditions outlined above and choose to participate in the SOR3 program.

Client Signature:_____Date: _____

Provider / Witness Signature:_____Date: _____

Appendix D

State Opioid Response 3 - Collateral Contacts Form

The State Opioid Response 3 project requires a GPRA Follow Up interview be completed for each client. To assist with this requirement, obtain at least three collateral contacts from the client to help in locating the client six months after intake. Collateral contacts can be individuals that have regular contact with the client (e.g. probation officers, family members, or case workers). *Obtain a release of information from the client for each collateral contact.*

Documentation of collateral contacts may be completed in IBHRS in lieu of completing this form.

Contact #1

Name: _____

Address: _____

Phones: _____

E-mail:_____

Relationship:_____

Contact #2

Name: _____

Address: _____

Phones: _____

E-mail:_____

Relationship:_____

Contact #3

Name: _____

Address:_____

Phones: _____

E-mail:_____

Relationship:_____

Appendix E

State Opioid Response 3 - Release of Information

I, _____ authorize _____
(Client) (Care Coordination Provider)

to exchange information verbally and/or in writing with:

_____
(Provider/Individual)

The nature and amount of the information shared will be as limited as possible, but may include:

☐ personal identifying information
☐ participation and status in SOR3 covered services
☐ drug test results
☐ collateral contacts for follow-up
☐ other (specify): _____

This consent is specific to my participation in the State Opioid Response 3 project and will be used for care coordination, to monitor and evaluate services, and to submit claims to the Iowa Department of Public Health.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. Federal rules prohibit 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 in writing. 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 patient.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically on the date on which all billing and reporting requirements related to my participation in the State Opioid Response 3 project have been completely processed.

I understand that, generally, a program may not condition my services on whether I sign a release of information, however, in the special circumstances of the voluntary SOR3 project, I understand that I cannot participate if I do not sign a release of information.

Client Signature: _____ Date: _____

Provider / Witness Signature _____ Date: _____