FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #11-111-OPE

REVISIONS TO THE REFERRAL TO TREATMENT PROGRAM (M-687r)

Date: November 30, 2011	Subtopic(s): Form
🖥 This procedure can now be accessed on the FIAweb.	This policy bulletin is to inform Substance Abuse Service Center (SASC) staff as well as staff of the Comprehensive Services Model (CSM) vendors that the Referral to Treatment Program (**M-687r**) form has been revised. Form **M-687r** is to be used by staff of the SASC as well as CSM vendors when referring applicants/participants to substance abuse treatment programs. In addition to updating the logo and formatting to match current agency standards, the **M-687r** form has undergone the following revisions: • Check boxes for Credentialed Alcohol Substance Abuse Counselor (CASAC) either at SASC or at a CSM Vendor to indicate the level of treatment required, either intensive or non-intensive, have been added. • The check boxes for "New Referral" and "Already in Program" have been relocated to the top of the form. • The MTA's information number has been included so that applicants/participants may contact MTA for specific directions to the treatment program. • The requirements for the manual reporting of compliance with the treatment program have been removed as this is now completed using the Substance Abuse Tracking and Reporting System (STARS). **Note:** The **M-687r** form is designed as a fill and print form available at the FIA Forms page. Once the form is printed, it must be scanned and indexed into the electronic case record. *Effective Immediately*

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: *(917) 639-0298*

Distribution: X

Attachment:

⌨ Please use Print on Demand to obtain copies of forms.

M-687r	Referral to Treatment Program (Rev. 11/30/11)
M-687r (S)	Referral to Treatment Program (Spanish) (Rev. 11/30/11)

NYC Human Resources | Family Independence
Administration | Administration
Department of
Social Services

Date: _____

Case Number: _____

Case Name: _____

Program Code: _____

Referral to Treatment Program

Please check one: ☐ New Referral ☐ Already in Program

Please check one: ☐ Intensive Tx Required ☐ Non-intensive Tx Required

Section I: Applicant/Participant Information(to be completed by referring Worker)

First Name _____ M. I. _____ Last Name _____

Suffix Number: _____ Line Number _____

Section II: Instructions to Applicant/Participant

You are being referred to a drug/alcohol program for treatment to help you become employable. You must report to the program with this Referral form and your signed Consent for Disclosure form. You must report to this mandatory appointment on time. You cannot change this appointment unless you have a legal or medical emergency, which must be documented. If you are unable to keep this appointment, you must call:
_____ before the scheduled appointment date.

Appointment Date: _____ Time: _____

Treatment Program: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

For travel directions please contact the MTA at **(718) 330-1234**.

As a cash assistance Applicant/Participant with a substance abuse problem, I understand that I must comply with the requirements of both HRA and the Treatment Program. I understand that failure to report to or comply with the above mandated appointment may jeopardize my eligibility for or continued receipt of cash assistance, food stamps, and medical assistance benefits.

_____ _____
Applicant/Participant Signature   Date

_____ _____ _____
Worker Name (print)   Date   Telephone Number

(See Reverse)

Section III: To Treatment Program

Referral outcome information must be reported in the Substance Abuse Tracking and Reporting System (STARS) within two business days of applicant/participant's appointment date. **Please refer back to the location on top of the form, on the next day, clients who were given an inappropriate referral.**

☐ **Inappropriate Referral - Applicant/Participant must report back to the referring site on** _____

(Enter referral recommendation below, including service type and, if applicable, specific programs.) (Next Business Day)

_____

_____

_____
Preparer Name (print)

_____
Preparer Signature

_____
Title (print)

_____
Date

_____
Telephone Number

SAMPLE

NYC **Human Resources Administration** | Family Independence
Department of | Administration
Social Services

Fecha: _____

Número de Caso: _____

Nombre del Caso: _____

Código del Programa: _____

Envío a Programa de Tratamiento

Favor de marcar una casilla: ☐ Nuevo Envío ☐ Ya en el Programa

Favor de marcar una casilla: ☐ Se Requiere Tx Intensivo ☐ Se Requiere Tx No Intensivo

Sección I: Información del Solicitante/Participante (a ser llenada por el Trabajador que corresponda)

Nombre _____ I. _____ Apellido _____

Número de Sufijo: _____ Número de la Línea _____

Sección II: Instrucciones al Solicitante/Participante

Usted está siendo enviado(a) a un programa de tratamiento para drogas/alcohol para ayudarle a poder trabajar. Debe presentarse al programa con este formulario de Envío y el formulario firmado de Autorización para Revelar Información. Debe presentarse a esta cita obligatoria a tiempo. Usted no puede cambiar esta cita a menos que tenga una emergencia legal o médica, la cual debe ser documentada. Si no puede cumplir esta cita, debe llamar a: _____ antes de la fecha de la cita programada.

Fecha de la Cita: _____ Hora: _____

Programa de Tratamiento: _____ Teléfono: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Para indicaciones de viaje favor de comunicarse con la MTA al **(718) 330-1234.**

Como Solicitante/Participante del programa de asistencia en efectivo con un problema de adicción a drogas, entiendo que debo cumplir con los requisitos ambos, de la HRA y del Programa de Tratamiento. Entiendo que si no cumplo o no me presento a la cita obligatoria mencionada arriba, podría poner en peligro mi elegibilidad para asistencia en efectivo, cupones para alimentos, y beneficios de asistencia médica.

_____   _____
Firma del Participante/Solicitante   Fecha

_____   _____   _____
Nombre del Trabajador (letra legible)   Fecha   Número de Teléfono

(Vea al Reverso)

Section III: To Treatment Program

Referral outcome information must be reported in the Substance Abuse Tracking and Reporting System (STARS) within two business days of applicant/participant's appointment date. **Please refer back to the location on top of the form, on the next day, clients who were given an inappropriate referral.**

☐ **Inappropriate Referral - Applicant/Participant must report back to the referring site on** _____

(Enter referral recommendation below, including service type and, if applicable, specific programs.)   (Next Business Day)

_____

_____

_____   _____
Preparer Name (print)   Preparer Signature

_____   _____   _____
Title (print)   Date   Telephone Number

_____   _____
Nombre del Empleado del Programa   Firma del Empleado del Programa
(con letra legible)

_____   _____   _____
Título (letra legible)   Fecha   Número de Teléfono