Restored Citizens Network
(Reentry Coalition)
Referral Application

Current Date

Client ID

First Name: Last Name:

Emergency Mailing Address: City: Returning County:

Emergency Phone or Contact Number(s):

Date of Birth: Race: Male ❑ Female ❑ Offender#:

Release Date: Release Type: Institution:

Contact Information of someone not living with you: Name:

Phone# Address: Email

In What Areas Do You Need Help (Please check all that apply)

EMPLOYMENT:
❑ Need a job
EDUCATION: Education and vocational skills wanted.
❑ Need a GED ❑ Vocational Training ❑ College
MARITAL / FAMILY:
❑ Counseling ❑ Childcare ❑ Child Support ❑ Parenting Classes
SUBSTANCE ABUSE:
❑ AA / NA / CA ❑ Substance Abuse Counseling ❑ Residential Treatment
COMMUNITY FUNCTIONING:
❑ Housing ❑ Medical ❑ Budgeting ❑ Transportation / Drivers License ❑ Family Healing
PERSONAL / EMOTIONAL:
❑ Mental Health Referral ❑ Sex Offender Treatment
Assistance / Direction:
❑ Pending Legal Issues ❑ Faith-Based Involvement

What do you do best? Auto repair / Construction / Painting / Welding / Wood Working Cleaning / Clerical / Computers / Cooking / Factory / Farming / Landscaping / Sales /
Start my own business in: Other ?
What kind of work do you like? ?
What training programs have you taken and what experience do you have?
(Please List all training)

Agency / Organization Date

Phone# Email Address

Restored Citizens Network
Authorization for Information Sharing

Last_____ **First**_____ **Middle**_____ **Date of Birth**_____

I authorize the Restored Citizen Network to exchange, give receive, share or disclose information in their records, from whatever source derived, and related to my participation.
I authorize the release of the identified confidential information to members of the Restored Citizen Network. (Please Initial for all those that apply.)

YES_____ Ohio Department of Rehabilitation and Correction
YES_____ Local Law Enforcement
YES_____ Muskingum Behavioral Health
YES_____ Six County, Inc
YES_____ Ohio Means Jobs
YES_____ Muskingum County Job and Family Services
YES_____ ForeverDads
YES_____ Other _____

I understand the following:

1. **The purpose of this information sharing is to improve communications between Circle members and me, so that proper suggested services and referrals can be given.**
2. **I may revoke this Authorization at any time during the duration of this agreement.**
3. **Only members of the Circle will use information disclosed. However, I understand that disclosure of information in Circle meetings can and will be used in monitoring compliance with sobriety and release conditions agreed to, or ordered by affiliate agencies or authorities. I further understand that affiliate agencies or authorities have the right to adjust services or provide sanctions in response to information disclosed at the Circle meetings.**
4. **Future crimes or threats to commit crime are not protected under this authorization.**
5. **Suspicion of child abuse or neglect is not protected.**
6. **Non-identifying information from the referral form and project will be used for research and evaluation purposes by Dr. Morris Jenkins, the staff at the University of Toledo, and the Ohio Department of Rehabilitation and Correction.**
7. **This authorization will automatically expire on _____.**

I authorize the release of the following information;
(Please Initial for all those that apply.)

YES_____ Substance Abuse diagnosis and treatment information
YES_____ Criminal history
YES_____ Medical and mental history
YES_____ Educational, vocational, and employment records
YES_____ Attendance records, progress reports
YES_____ Other_____
YES_____ Other_____

I also understand that any disclosure is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of drug and alcohol abuse patient records. These rules prohibit any further disclose of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any us of information to criminally investigate or prosecute any alcohol or drug abuse client.

Executed this date: _____ **Participant:** _____
Witness: _____

CONFIDENTIAL CLIENT INFORMATION ANY UNAUTHORIZED DISCLOSURE IS A STATE OF OHIO AND FEDERAL OFFENSE
Revised 5/18/2016