SAN BERNARDINO COUNTY
Behavioral Health
621 East Carnegie Drive, Suite 210, San Bernardino | Phone: 800-968-2636 • Fax: 909-381-2172
www.SBCounty.gov

Reset

Consent for SUD Care Coordination Services

Date:	Time:	☐ AM ☐ PM

Last Name:	First Name:	
DOB:	Telephone (Home):	(Cell):

A. CARE COORDINATION SERVICES

I agree to participate in care coordination services administered by the Department of Behavioral Health (DBH) Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan. Care coordination services may include:

- A comprehensive assessment and periodic reassessment of my individual needs to determine the need for and/or the continuation of care coordination services
- Assistance in transitioning to a higher or lower level of substance use disorder (SUD) treatment, if necessary
- Development of a care coordination plan that may include service activities
- Communication, coordination and referrals and activities that relate to my care coordination plan
- Monitoring services and activities related to my care coordination plan
- Advocacy and linkage to physical and mental health services, transportation and assistance in retaining primary care services
- My care coordination services will not violate my privacy as an individual receiving substance use disorder treatment as set forth in 42 CFR Part 2 and California Law.

B. CARE COORDINATION PROGRAM GUIDELINES

I agree to the following care coordination guidelines:

- I will keep in touch with my care coordinator. If the care coordinator is unable to contact me after 30 days my care coordination services will be closed.
- If I cannot keep a scheduled appointment with my care coordinator I will contact them as soon as possible to change or cancel the appointment
- Care coordination services are subject to termination if you possess a weapon at a SUD clinic, during a care coordination visit or if you threaten or assault a SUD clinic staff member.

C. CARE COORDINATION AUTHORIZATION

1. I consent to being contacted by telephone, in writing and in person by the SUD Care Coordinator

Client Name:
DOB:
Phone Number:
Client ID #:

2. I understand that:
    - Care coordination services are voluntary, and I may withdrawal from the program at any time upon notification to my care coordinator
    - This consent for care coordination is not a condition for receiving SUD treatment
    - This consent is to remain in effect as long as I remain in my SUD care coordination program
    - This consent may be revoked in writing at any time by notifying your care coordinator
    - I understand that I am bound by the care coordination program guidelines
    - I understand that if I am dissatisfied with the care coordination program services, for any reason, I can call the Department of Behavioral Health – Substance Use Disorder and Recovery Services at 800-968-2636, for assistance

3. I understand that my confidential information will only be released as I permit, as indicated upon a signed consent to release information

Please check one option:

☐ I consent to care coordination program services ☐ I decline care coordination program services

Print Patient Name:	
Patient Signature:	Date:

If Applicable

Guardian Name:	
Guardian Signature:	Date:

----------SUD Administration Use Only----------

In the event that verbal consent was received by telephone or tele-health contact, please indicate the date and time of the contact and check the appropriate box below:

☐ Client listed consents to care coordination services ☐ Client listed declines care coordination services

Date:	**Time:**	☐ **AM** ☐ **PM**

SUD Care Coordinator Signature

Client Name:
DOB:
Phone Number:
Client ID #: