

RAS-Col – Application for Assistance

Phone: 970-826-8010 / Email: PopHealth@memorialrh.org



RAS-Col

Rural Alliance Addressing
Substance Use Disorder
COLORADO

Client Name _____ County of Residence _____

Date of Birth _____ Monthly Income _____

Client Email _____ Client Phone # _____

Referred by _____ Referred by Agency _____

Referred by email _____ Referred by Phone # _____

Community members may be assisted with a variety of social needs in support of their substance use disorder (SUD) and/or mental health treatment and recovery through the RAS-Col Consortium. Please indicate below what support is needed and in what amount. *(If you don't know the exact amount, provide an estimate.)*

☐ Housing \$ _____ ☐ Transportation \$ _____

☐ Childcare \$ _____ ☐ Counseling* \$ _____ ☐ Dental* \$ _____

**Counseling and dental assistance is only available for Moffat, Routt, and Grand county residents.*

Provide additional details for how the funding will be used if awarded (Ex. rent, car insurance, utility bill, etc.).

How will this funding support your treatment or recovery process? _____

List the agencies, contact person, and contact information (phone/email) of who you are working with for treatment / recovery services. By providing this information, you are giving permission for us to verify you are actively and consistently engaged in services.

Agency/Organization	Contact Person	Phone	Email

Provide your plan to support yourself and achieve financial independence. _____

I agree to participate in the Brief Assessment of Recovery Capital (BARC-10) survey prior to receiving funding and 3 months after receiving funding. (Participation in the survey is required to receive funding.) ☐ Yes ☐ No

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Attestation of Participation in Services

By signing this form, I attest that I am accessing Substance Use Disorder or Mental Health treatment or recovery services and a Care Plan is in place to support my health and well-being.

Applicant (signature & date) _____

Referral Source (signature & date) _____

Legal Residency Disclosure Statement

I hereby affirm that I am a citizen or legal resident of the United States of America. I understand that providing false or misleading information regarding my residency status may result in disqualification from eligibility for services, benefits, or participation in programs for which U.S. legal residency is a requirement. I certify, under penalty of perjury, that the information provided in this statement is true and accurate to the best of my knowledge.

Applicant Printed Name _____

Applicant Signature _____

Date _____

Applications will not be reviewed until the application is completed in its entirety (Application, Release of Information, and BARC-10 Survey). Based on the information provided, RAS-Col will assess what resources are available to respond to the needs described and will follow-up with the applicant. Additional paperwork (rental agreement, childcare invoice, bank statement, cancelled check, etc.) may be required upon approval of funding.



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Authorization to Communicate / Release of Information

A. Agency Information

Memorial Regional Health (MRH) on behalf of the Rural Alliance Addressing Substance Use Disorder – Colorado (RAS-Col)

Agency Representative: Memorial Regional Health
Attn: Population Health Department
750 Hospital Loop
Craig, CO 81625
Phone: 970-826-8010
Email: PopHealth@memorialrh.org

B. Client Information

Name (First MI Last):	DOB:	SSN ***-**-_____
Address:		
City:	State:	ZIP:
Email:	Phone:	

C. MRH/RAS-Col is Authorized to DISCLOSE

INFORMATION TO and RECEIVE INFORMATION FROM:

☐ ALL agencies listed below, as applicable.

☐ ONLY the agencies as indicated below.

<input type="checkbox"/> Advocates Crisis Trauma & Survivor Services (ACTSS)	<input type="checkbox"/> Bridges of Colorado	<input type="checkbox"/> Grand County Rural Health Network	<input type="checkbox"/> Integrated Communities
<input type="checkbox"/> Jackson County Public Health	<input type="checkbox"/> Memorial Regional Health	<input type="checkbox"/> Middle Park Health	<input type="checkbox"/> Mind Springs Health
<input type="checkbox"/> Moffat County Public Health	<input type="checkbox"/> Northwest Colorado Health	<input type="checkbox"/> Oxford House	<input type="checkbox"/> Pioneers Medical Center
<input type="checkbox"/> Porch Light Health (formerly Providence / Front Range Clinic)	<input type="checkbox"/> Rio Blanco Public Health	<input type="checkbox"/> Routt County Public Health	<input type="checkbox"/> The Foundry
<input type="checkbox"/> The Health Partnership	<input type="checkbox"/> Travis House	<input type="checkbox"/> UCHealth / Yampa Valley Medical Center	<input type="checkbox"/> Yampa Valley Psychotherapy

☐ Other _____

D. Information MRH/RAS-Col is Authorized to Discuss

☐ Childcare expense ☐ Housing rental / mortgage expense ☐ Transportation expense ☐ Utility expense

☐ Other _____

E. How information may be communicated

☐ Email ☐ Telephone ☐ In-Person ☐ Other _____

F. DISCLOSURES

REVOCATION	I understand I may revoke this authorization at any time by providing written notice to the agency noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.
AUTHORIZATION	<ul style="list-style-type: none">• I hereby authorize the above agencies to disclose social need information concerning the above-named client to the parties identified in the section entitled "Authorized to Disclose Information TO and Receive Information FROM."• A photocopy/fax of this authorization will be treated in the same manner as an original.
CONSENT	<div><div>_____ Applicant Signature</div><div>_____ Date</div><p>I understand my ability to receive services may be limited if a Release of Information is not signed, allowing agencies to communicate on my behalf. This authorization will expire one year from the date of consent.</p></div>

Brief Assessment of Recovery Capital (BARC-10)

Name: _____ **Date:** _____

Instructions: On a scale of 1 (**Strongly disagree**) to 6 (**Strongly agree**), please indicate your level of agreement with the following statements.

<p>1. There are more important things to me in life than using substances.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>	<p>6. I regard my life as both challenging and fulfilling without the need for using drugs or alcohol.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>
<p>2. In general I am happy with my life.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>	<p>7. My living space has helped to drive my recovery journey.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>
<p>3. I have enough energy to complete the tasks I set for myself.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>	<p>8. I take full responsibility for my actions.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>
<p>4. I am proud of the community I live in and feel part of it.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>	<p>9. I am happy dealing with a range of professional people.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>
<p>5. I get lots of support from friends.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>	<p>10. I am making good progress on my recovery journey.</p> <p><input type="checkbox"/> 1. Strongly disagree</p> <p><input type="checkbox"/> 2. Disagree</p> <p><input type="checkbox"/> 3. Somewhat disagree</p> <p><input type="checkbox"/> 4. Somewhat agree</p> <p><input type="checkbox"/> 5. Agree</p> <p><input type="checkbox"/> 6. Strongly agree</p>

Scoring and Indicator Note:

Total scores can range from a minimum of 10 to a maximum of 60. A Recovery Capital Curve Analysis showed the BARC-10 had predictive validity with sustained remission (i.e., 1 year or more) using a cut-off score of 47 in a sample whose average length of recovery time was 7 years. The lower the score, the more likely for relapse; the higher the score, the more likely for sustained recovery.

Reference: Vilsaint, Corrie L, Kelly, John F, Bergman, Brandon G, Groshkova, Teodora, Best, David, & White, William. (2017). Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. *Drug and Alcohol Dependence*, 177, 71–76.

<https://doi.org/10.1016/j.drugalcdep.2017.03.022>

Copyright Information: The Brief Assessment of Recovery Capital (BARC-10) is Copyrighted. According to this link: <https://shura.shu.ac.uk/information.html>, BARC-10, can be used without permissions or fees for personal research or study, educational, or not-for-profit purposes.

Please keep this information for your records. We also request your cooperation in citing this measure accordingly.



RAS-Col AND MRH FINANCIAL ASSISTANCE PROGRAM CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement (Agreement) is entered into on this _____ day of _____ 20__ between _____ (Recipient) and Rural Alliance Addressing Substance Use Disorder-Colorado (RAS-Col) and The Memorial Hospital dba Memorial Regional Health (MRH) and their officers, directors, employees, agents, volunteers, affiliates, and representatives.

Purpose of RAS-Col Voucher Program:

RAS-Col and MRH provide limited financial assistance through its Voucher program to eligible individuals to support access to housing, childcare, transportation, medical, dental, and behavioral health services. In order to ensure fairness, privacy, and financial assistance program integrity, Recipients are required under the terms of this Agreement to maintain confidentiality regarding the amount of voucher funding they receive.

1. Confidentiality and Non-Disclosure of Voucher Amount

Recipient agrees not to disclose, discuss, or share-verbally, in writing, electronically, or through any other means the specific amount of funding they received through the RAS-Col voucher program with any third party, including but not limited to other applicants, recipients, friends, family members, or service providers, unless required by law. RAS-Col and MRH acknowledge and agree that Recipients are authorized to disclose voucher funding to their legal representative and that such disclosure of confidential information does not constitute a breach of this Agreement.

2. Purpose of Confidentiality Agreement

The Recipient understands that voucher amounts may vary based on individual financial needs and personal circumstances. Disclosure of funding amounts may lead to confusion, dissatisfaction, or false expectations among other applicants or members of the community.

3. Consequences of Violation of this Confidentiality Agreement

The Recipient acknowledges that failure to comply with this confidentiality requirement may result in the **forfeiture of current voucher funding** and/or **ineligibility** for future RAS-Col financial assistance. RAS-Col and MRH reserves the right to take any appropriate action under the law in response to a breach of this Agreement.

4. Severability

If any provision of this agreement is determined by a court to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

5. Governing Law

The Agreement shall be governed by and construed in accordance with the laws of the State of Colorado.

6. Entire Agreement

This document constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes all prior or contemporaneous communications.

7. Acknowledgment

By signing below, the Recipient acknowledges that they have read, understood, and agree to the terms of this confidentiality Agreement. The Recipient further affirms that they will not disclose the amount of RAS-Col financial assistance received under any circumstances **not** authorized by RAS-Col or MRH.

Recipient Printed Name:_____

Signature:_____

Date:_____



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RAS-Col AND MRH FINANCIAL ASSISTANCE PROGRAM

WAIVER AND RELEASE OF LIABILITY AGREEMENT

This Waiver and Release of Liability Agreement (Agreement) is entered into on this _____ day of _____ 20__ between _____ (Recipient) and Rural Alliance Addressing Substance Use Disorder-Colorado (RAS-Col) and The Memorial Hospital dba Memorial Regional Health (MRH) and their officers, directors, employees, agents, volunteers, affiliates, and representatives.

Purpose of RAS-Col Voucher Program:

RAS-Col and MRH provide limited financial assistance through its Voucher program to eligible individuals to support access to housing, childcare, transportation, medical, dental, and behavioral health services. In order to ensure fairness, privacy, and financial assistance program integrity, Recipients are also required under the terms of RAS-Col and MRH Financial Assistance Program to maintain confidentiality regarding the amount of voucher funding they receive.

1. Purpose

The Recipient has applied for and been awarded voucher funding from RAS-Col administered by MRH to support access to medical, dental, and/or behavioral health care services (Services) from MRH and/or third-party healthcare providers. RAS-Col does **not** provide medical, dental, or behavioral health care directly and is **not** involved in the delivery of such Services.

2. Voluntary Participation

The Recipient acknowledges and agrees that use of the voucher funding and participation in any Services funded by RAS-Col and MRH is voluntary.

3. RAS-Col and MRH Financial Assistance Program: No Medical and/or other Services Responsibility

The Recipient acknowledges and agrees that RAS-Col and MRH is **not** responsible for the quality, appropriateness, outcomes, or results of any medical, dental, or behavioral health care provided by any third-party provider. RAS-Col and MRH make no express or implied warranties or guarantees regarding any care or Services received by the Recipient.

4. Assumption of Risk

The Recipient acknowledges that receiving medical, dental, or behavioral health care involves certain inherent risks, including by not limited to the risk of physical and/or emotional injury, illness, or care-related complications. The Recipient voluntarily assumes all such risks associated with any Services funded by RAS-Col and MRH.

5. Release and Waiver of Liability

In consideration of receiving voucher funding, the Recipient voluntarily releases, waives, and forever discharges RAS-Col, MRH, and its affiliates from any and all claims, demands, actions, causes of action, liabilities, damages costs, or expenses, whether known or unknown, arising out of or in connection with the Services received using such funding, including by not limited to any acts or omissions of third-party care providers.

6. Indemnification

The Recipient agrees to indemnify, defend, and hold harmless RAS-Col and MRH from and against any and all claims, liabilities, losses, or expenses (including attorneys' fees) arising out of or in connection with the Recipient's use of voucher funding or participation in Services funded by RAS-Col and MRH.

7. Severability

If any provision of this agreement is determined by a court to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

8. Governing Law

The Agreement shall be governed by and construed in accordance with the laws of the State of Colorado.

9. Entire Agreement

This document constitutes the entire agreement and understanding between the parties with respect to its subject matter and supersedes all prior or contemporaneous communications.

Recipient Printed Name:_____

Signature:_____

Date:_____