RAS-Col – Application for Assistance

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

Application Introduction:

RAS-Col voucher funding is meant to help people with substance use, behavioral health, or mental health challenges work toward being more financially independent and self-sufficient in their daily lives. Financial assistance through the RAS-Col Voucher Program is not a lasting substitute for your normal income to pay cost of living expenses. ***Applying for funding is no guarantee of receiving funding.***

I understand and agree with the intent of this funding. ☐ Yes ☐ No

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 #**______________________

Applicants may be assisted with a variety of social needs in support of their substance use disorder (SUD), behavioral health, and/or mental health treatment and recovery through the RAS-Col Consortium. 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 $** ________________ ☐ **Medication* $** ________________

☐ **Technology* $** ________________ ☐ **Other $** ________________

****Due to funding restrictions, medication and technology assistance is only available for those engaged in SUD treatment and recovery services.***

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

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If you are requesting assistance with counseling, dental, or medication, indicate if you have insurance coverage (mark all that apply):

☐ **Uninsured** ☐ **Medicaid** ☐ **Medicare** ☐ **Private/Other Insurance (specify**________________________**)**

Will insurance be used to pay for these services? ☐ Yes ☐ No ☐ Partial coverage

If insurance will not be covering the cost of health-care related services, explain why.______________________

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Assistance is provided by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $5,000,000 with 0% financed with non-governmental sources. The associated policies and procedures are those of the assistance facilitator(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, visit HRSA.gov. Rev. 04/2026 v9

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RAS-Col
Rural Alliance Addressing Substance Use Disorder COLORADO

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

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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 and self-sufficiency. ______________

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Have you or anyone in your household previously received Voucher assistance? ☐ Yes ☐ No

If applicable, provide the name of the household member who previously received Voucher assistance:

____

If yes, the following information is required to process your application:

To receive additional financial assistance through the RAS-Col Voucher Program, you must demonstrate continued participation in treatment or recovery services *and* identify the steps you have taken to achieve financial independence since your previous funding request(s).

- **Do you consider yourself to be in the treatment or recovery phase of your health journey?**
  ☐ Treatment ☐ Recovery

- **What barriers have you/are you facing that are preventing you from achieving financial independence and self-sufficiency?**

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Survey Participation

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

Consent for Review

I hereby consent to allow the RAS-Col Voucher Program Review Team to access and review all components of my RAS-Col Voucher Application for Assistance.

Applicant Printed Name ______________________________

Applicant 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 ______________________________

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. Participation in services must be verified before funding can be awarded.

Applicant (signature & date) ______________________________

Referral Source (signature & date) ______________________________

Applications will not be reviewed until the application in 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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RAS-Col
Rural Alliance Addressing Substance Use Disorder COLORADO

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.**

☐ Bridges of Colorado	☐ Grand County Rural Health Network	☐ Health Solutions West	☐ Integrated Communities
☐ Jackson County Public Health	☐ Memorial Regional Health	☐ Middle Park Health	☐ Moffat County Public Health
☐ Northwest Colorado Health	☐ Northwest Colorado Survivor Services	☐ Oxford House	☐ Pioneers Medical Center
☐ Porch Light Health	☐ Rio Blanco Public Health	☐ Routt County Public Health	☐ The Foundry
☐ The Health Partnership	☐ Travis House & Love Life	☐ UCHealth / Yampa Valley Medical Center	☐ Yampa Valley Psychotherapy

☐ **Other** ____

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

☐ Childcare expense ☐ Housing expense ☐ Transportation expense ☐ Counseling expense
☐ Dental expense ☐ Medication 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	I hereby authorize the above agencies to exchange information concerning the above-named client to the parties identified in the section entitled “Authorized to Disclose Information TO and Receive Information FROM” as it relates to the individual’s application for financial assistance through the RAS-Col Voucher program. **A photocopy/fax of this authorization will be treated in the same manner as an original.**
CONSENT	____ *Applicant Signature* *Date* ***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.***

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.

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

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 to 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:____

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:____