

## Introduction

Welcome to the Access to American Indian Recovery (AAIR) Program. To participate as an AAIR client, each provider must complete the client enrollment application process on behalf of the applicant, before the client will be eligible to receive services. This will involve a two-step enrollment process.

**Step One:** As a provider, you will be asked to complete the paper copy client enrollment application on behalf of the applicant to determine client eligibility and to obtain the necessary signatures. This form will be for your personal records and should be stored at your place of business. At any time you may be asked by an AAIR program representative to produce this record for client verification purposes.

**Step Two:** You will next be asked to enter the client information into the Voucher Management System (VMS) to formally enroll your client into the program. The online VMS form duplicates some of the information from the hard-copy form. It also will ask you for additional personal information about the client, such as their age and race/ethnic identification, whether or not the address they have provided is a permanent residence, whether they have insurance and what type, how they were referred to the program, and their tribal affiliation. You should complete this online information either with the client present, or should request this information from the client prior to completing the enrollment process, so that the information will be as accurate as possible.

The hard copy version of the client enrollment form contains Parts 1 through 3 that must be completed by you and your client. We have provided you with an application checklist, a set of detailed instructions to guide you through each part of the enrollment form, and applicable forms.

If you have any questions or you need help completing any part of the application, please contact the AAIR Call Center at:

### **AAIR Call Center – Client Enrollment**

3130 Kilgore Road, Suite 100  
Rancho Cordova, CA 95670  
Toll-free telephone: (866) 350-8772  
Fax: (916) 679-4600

## Client Enrollment Application Checklist

To participate as an AAIR client, each applicant must complete a client enrollment application. The following parts of the application must be completed and should be maintained in the client's AAIR file located at the provider's place of business:

### Enrollment

#### Part 1 – General Applicant Information (Sections A – G)

- All applicable questions are answered. If an item is not applicable, write N/A.
- The application is signed and dated by the applicant.
- The application is signed and dated by the provider.

#### Part 2 – Authorization for Use and Disclosure of Client Information

- The authorization for use and disclosure of client information is signed and dated by the applicant.

#### Part 3 – Consent to Participate in Alcohol/Other Drug Abuse Treatment Evaluation and Follow-up

- The client signed and dated the consent to participate in alcohol or other drug abuse treatment studies, evaluations, and follow-up.
- Health study locator Information is complete.

### Forms

#### Tribal Enrollment, Indian Descedant, or Indian Household Verification Form

- Use this form only if the client does not have a tribal enrollment or Bureau of Indian Affairs card.

#### Statement Guaranteeing Client Choice of Treatment (required)

- The provider, after completing an assessment, completed the provider options form, and the client and provider signed and dated the form certifying the client's choice of provider.

**If you have any questions or you need help completing any part of the application, please contact the AAIR Call Center at:**

#### AAIR Call Center – Client Enrollment

3130 Kilgore Road, Suite 100, Rancho Cordova, CA 95670  
Toll-free telephone: (866) 350-8772, Fax: (916) 679-4600

**Or**

#### AAIR Administration

4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841  
916-929-9761

## Instructions for Completing Part 1 of the General Application Information

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### Section A – Administration Information

1. **Applicant Name** – Provide the first, middle, and last name of the applicant.
2. **Physical Address** – Provide the street, city, state, and ZIP code of the applicant.
3. **Mailing Address** – If different from the physical address, provide the street or post office box, city, state, and ZIP code where mail is received by the applicant.
4. **Date of Birth** – Provide the month, date, year of birth, and age of the applicant.
5. **Client Identifier** – Last six digits of the client’s social security number, followed by the first three letters of their last name.
6. **Telephone Number** – Provide the area code and telephone number where the applicant can be reached.
7. **Telephone Number (Alternate)** – Provide an alternate area code and telephone number where the applicant can be reached.

### Section B – Applicant’s Legal Guardian Name/Contact Information

1. **Name** – If applicable, provide the first, middle, and last name of the applicant’s authorized representative. If not applicable, write N/A.
2. **Physical Address** – Provide the street, city, state, and ZIP code of the applicant’s authorized representative.
3. **Mailing Address** – If different from the physical address, provide the street or post office box, city, state, and ZIP code where mail is received by the applicant’s authorized representative.
4. **Telephone Number** – Provide the area code and telephone number where the applicant’s authorized representative can be reached.
5. **Telephone Number (Alternate)** – Provide an alternate area code and telephone number where the applicant’s authorized representative can be reached.
6. **Relationship to the Applicant** – Provide the relationship between the applicant and the applicant’s authorized representative.

## **Instructions for Completing Part 1 of the General Application Information**

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### **Section C – Tribal Enrollment, Indian Descendant, or Indian Household Verification**

1. Check one that applies to certify the applicant's tribal enrollment, Indian descendant, or Indian household status. If NONE applies, stop and do not continue to complete the application. The applicant is not eligible to enroll in AAIR.
2. Indicate which form of written verification the applicant has provided to prove enrolled tribal membership, Indian descendant, or Indian household status.

### **Section D – State Resident Verification**

1. Check YES or NO to certify the applicant is a resident of the State of California, Oregon, Washington, or Idaho. If no, stop and do not continue to complete the application. The applicant is not eligible to enroll in AAIR.
2. Indicate what form of written verification the applicant has provided to prove their residency.

### **Section E – Substance Abuse Screening/Recovery Support Evaluation**

1. Indicate if the applicant is requesting clinical treatment or recovery support services.

### **Section F – Provider Certification**

1. The provider who submits this application to AAIR must certify that he/she has documentation on file verifying the applicant is eligible for services under Sections C, D, and E.

### **Section G – Applicant Certification**

1. The applicant who completes this application at the enrollment site must certify that the information provided in the application is correct to the best of their knowledge. AAIR requires that the applicant sign the enrollment application regardless of age.
2. If an applicant is not authorized by state law to self-consent to substance abuse treatment services, his/her legal representative must co-sign the enrollment application at section G.

**Part 1-General Application**

**Section A - Applicant Information**

Date \_\_\_\_\_

1. Applicant Name (First, Middle, Last) \_\_\_\_\_

2. Physical Address (Street, City, State, ZIP Code) \_\_\_\_\_

3. Mailing Address (If different [Street/P.O. Box, City, State, ZIP Code]) \_\_\_\_\_

4. Date of Birth (mm/dd/yyyy)      5. Age \_\_\_\_\_

6. Client Identifier (last six digits of the client's social security number, followed by the first three letters of their last name) \_\_\_\_\_

7. Telephone Number \_\_\_\_\_ 8. Telephone Number (Alternate) \_\_\_\_\_

**Section B - Applicant's Legal Guardian Name or Contact Information**

For minors under the age of 18 or adult dependents.

1. Name (First, Middle, Last) \_\_\_\_\_

2. Physical Address (Street, City, State, ZIP Code) \_\_\_\_\_

3. Mailing Address (If different [Street/P.O. Box, City, State, ZIP Code]) \_\_\_\_\_

4. Telephone Number \_\_\_\_\_ 5. Telephone Number (Alternate) \_\_\_\_\_

6. Relationship to the Applicant (i.e., parent, guardian, etc.) \_\_\_\_\_

\_\_\_\_\_

**Part 1-General Application - Continued**

**Section C - Tribal Enrollment, Indian Descendant,  
or Indian Household Verification**

1. The applicant must meet one of the following to be eligible for the AAIR program.

Check one that applies.

- 1. Enrolled member of a federally recognized tribe.
- 2. Descendant of an Indian person
- 3. An Native American resident of California who;
  - a. holds trust interests in public domain, national forest, or Indian reservation allotments in California, or
  - b. is listed on the plans for distribution of the assets or California descendant of such an Indian person, or
  - c. is a descendant of an Indian person who resided in California on June 1, 1852, and is regarded as an Indian by the community in which he/she lives.
- 4. A non-Indian minor (under the age of 19 years) who is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an enrolled member of a federally recognized Indian tribe.
- 5. A non-Indian spouse who is currently married to an AI/AN person. The Indian spouse must meet the Indian eligibility requirements of the AAIR program for the non-Indian spouse to be eligible. (a legal certificate of marriage must be provided as well)

2. I (the provider) certify that I have one (1) of the following forms of written verification on file that proves that the applicant is an enrolled tribal member, Indian descendant, or a member of an Indian household:

- Copy of a tribal enrollment card issued by the tribe
- Copy of an Indian identification card issued by the Bureau of Indian Affairs
- Copy of an appropriate document verifying descent from an Indian person
- Completed and signed AAIR form c2.a2 – Tribal Enrollment, Indian Descendant, and Indian Household Verification Form (if needed, the form is enclosed on page 16)
- Copy of a legal certificate of marriage if applying as a non-Indian spouse





## Part 2 - Authorization for Use and Disclosure of Client Information

### Section A Client Identification

1. I, (name of client) \_\_\_\_\_,  
hereby voluntarily authorize the disclosure of information from my record.

### Section B Disclosure by

The information is to be disclosed by:

1. Name of Person/Facility/Organization

2. Telephone

3. Address (Street/P.O. Box, City, State, ZIP)

### Section C - Disclosure to

The information is to be disclosed to:

**Access to American Indian Recovery (AAIR)**

4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841

916-929-9761, FAX: 916-929-7246

### Section D - Information to be Disclosed

The information to be disclosed is any information relating to services paid for by the AAIR Program. I understand this information will be used to,

- evaluate services received;
- prepare required reports for AAIR's funding agency used in determining AAIR's responsibility to pay for these services;
- perform audits of providers records for their compliance with AAIR program requirements

*This authorization expires 12/31/2010*

### Section E - Client Bill of Rights

I may refuse to sign this authorization. However, I understand that AAIR cannot pay for services delivered unless it has authorization from me to collect this required information. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the Access to American Indian Recovery (AAIR) program at 4400 Auburn Boulevard, 2nd Floor, Sacramento, CA 95841. My revocation will take effect on the date the revocation is received by AAIR, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. In some cases, such re-disclosure is not protected by state law and may no longer be protected by the federal confidentiality law (HIPAA).

Signature, Client Name

Date

Signature, Authorized Representative Name (state relationship to client)



**Part 3 - Consent to Participate in Alcohol or Other Drug Abuse Treatment Studies, Evaluations, and Follow-Up - Continued**

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14. Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ 15. Pager: (\_\_\_\_\_) \_\_\_\_\_

16. E-mail address: \_\_\_\_\_

17. Work phone? (\_\_\_\_\_) \_\_\_\_\_  
(Name of Company)

18. Other phone? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

19. Do you have a message number? (\_\_\_\_\_) \_\_\_\_\_

20. Who lives there? Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

21. Address: \_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

22. Best mailing address: \_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

23. Phone: (\_\_\_\_\_) \_\_\_\_\_

24. Who lives there? Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

25. Best Contacts: Do you have friends or relatives who usually know how to reach you if you should move or leave the program?

(1) Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

Address: \_\_\_\_\_

Phone? (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Pager: (\_\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Work phone? (\_\_\_\_\_) \_\_\_\_\_  
(Name of Company)

(2) Full Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

Address: \_\_\_\_\_

Phone? (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Pager: (\_\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Work phone? (\_\_\_\_\_) \_\_\_\_\_  
(Name of Company)

**Part 3 - Consent to Participate in Alcohol or Other Drug Abuse Treatment Studies, Evaluations, and Follow-Up - Continued**

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**Family** (Complete entire family; use extra space if necessary. Don't forget brothers, sisters, spouse, ex-spouse, girlfriend, boyfriend, baby's father/mother, grandparents, cousins, aunts, uncles, foster parents, etc. Persons who know how to reach you. Include cell phone and pager numbers.)

27. Mother: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

28. Father: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

29. Relative: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

30. Relative: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

31. Relative: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

32. Relative: \_\_\_\_\_  
(Full Name: First, Middle, Last)  
\_\_\_\_\_  
(Street address) (Apt. # or P.O. Box) (City) (Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ In touch? \_\_\_\_\_

Other phone/contact info? (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

**Part 3 - Consent to Participate in Alcohol or Other Drug Abuse Treatment Studies, Evaluations, and Follow-Up - Continued**

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**33. Is there a case worker, doctor, community clinic, religious institution or other contact that you see regularly?**

Name: \_\_\_\_\_  
(First, Middle, Last) (Relationship)

Address: \_\_\_\_\_

Phone? (\_\_\_\_\_) \_\_\_\_\_ Agency \_\_\_\_\_

Pager: (\_\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Other phone/contact info (\_\_\_\_\_) \_\_\_\_\_  
(Whose phone is this?)

**34. Do you receive money or food stamps regularly from an agency? \_\_\_\_\_ Yes \_\_\_\_\_ No**

(If yes) Agency \_\_\_\_\_

When is it paid? \_\_\_\_\_

Where is the check sent? \_\_\_\_\_

Where do you cash the check? \_\_\_\_\_

Caseworker: \_\_\_\_\_ File #: \_\_\_\_\_

Who is your representative payee? \_\_\_\_\_

Address: \_\_\_\_\_

Phone? (\_\_\_\_\_) \_\_\_\_\_ Agency: \_\_\_\_\_

**35. Is there any place you go regularly to hang out or to meet with friends?**

Place: \_\_\_\_\_

Address or Intersection: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Times you might be there: \_\_\_\_\_

**36. Are you on probation, parole, or have an active court case? \_\_\_\_\_ Yes \_\_\_\_\_ No**

(If yes) Agency \_\_\_\_\_

I.D. Number: \_\_\_\_\_  
(Department of Probation/Corrections, Case Number)

Probation/Parole Officer Name \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

**Part 3 - Consent to Participate in Alcohol or Other Drug Abuse Treatment Studies, Evaluations, and Follow-Up - *Continued***

**Section B - Consent for the Release of Confidential Information**

I, (name of Client) \_\_\_\_\_ consent to participate in alcohol or other drug abuse treatment evaluation and follow-up. I understand that I will be interviewed by a AAIR provider or independent evaluator about my problems and the services I received through AAIR at the time of assessment and upon discharge from the AAIR program. I also understand that I will also be contacted and interviewed five to eight months after my initial intake into AAIR by a provider or independent evaluator regarding my progress since treatment.

I have provided contact information where I believe I can be located in the future, and the names, addresses, and phone numbers of others who may be of help in locating me.

I understand that these persons will only be contacted concerning my whereabouts and that nothing about my treatment or my condition or the fact that I was in treatment will be disclosed to them or anyone else.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

\_\_\_\_\_  
Signature, Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Authorized Representative (if applicable)

\_\_\_\_\_  
Date

**Statement Guaranteeing Client Choice of Treatment** (after assessment)

**Section A - Client Information**

1. Client Name \_\_\_\_\_ 2. Date \_\_\_\_\_

AAIR is committed to offering each client a genuine, free, and independent choice among secular and spiritual providers. AAIR guarantees each client a choice among individual providers, service agencies, and service options whenever feasible, that best meet his or her unique spectrum of needs. Providers must MINIMALLY offer clients two or more options of treatment or recovery support providers, and must inform clients that they may also contact the AAIR call center if they would like to learn more about other service options and to obtain a list of alternative providers in their local area.

**Section B Provider Options**

I certify that I have administered an assessment and offered the following provider options to this client for his/her care. At least two (2) providers were identified as matching the needs and personal preferences of the client, and among them is at least one (1) provider to which this client has no religious objection:

\_\_\_\_\_  
AAIR Provider Name AAIR Provider Identification Number

\_\_\_\_\_  
AAIR Provider Name AAIR Provider Identification Number

\_\_\_\_\_  
AAIR Provider Name AAIR Provider Identification Number

**Section C Provider Selection**

After the client was presented with the options in Section A and was given information about the providers, the client selected the following provider:

\_\_\_\_\_  
1. AAIR Provider Name AAIR Provider Identification Number

**Section D Provider Certification**

I certify that the information provided in this form is true and correct.

\_\_\_\_\_  
1. SIGNATURE, AAIR Provider Name 2. AAIR Provider Identification Number

\_\_\_\_\_  
3. PRINT, AAIR Provider Name 4. Date

**Statement Guaranteeing Client Choice of Treatment - *Continued***

**Section E Client Certification**

I certify that I was presented with at least two options of treatment and recovery support providers at this location, and I was informed of my right to contact the AAIR call center to learn about other service options.

1. SIGNATURE, Client Name

2. Client Identification Number

3. PRINT, Client Name

4. Date

**AAIR Call Center**

3130 Kilgore Road, Suite 100, Rancho Cordova, CA 95670

Toll-free telephone: (866) 350-8772, Fax: (916) 679-4600

## Tribal Enrollment, Indian Descendant, or Indian Household Verification Form

### Tribal Enrollment, Indian Descendant, and Indian Household Verification Form

*This form is for a client who does not have a tribal enrollment or Bureau of Indian Affairs card*

The Access to American Indian Recovery (AAIR) program is requesting tribal enrollment, Indian descent, or Indian household verification from the tribe for the person named below. Please send a copy of the tribal enrollment verification to AAIR or complete this form as verification.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Tribe, Rancheria, Village, Band

\_\_\_\_\_  
Tribal Enrollment Number

The above named person is:

- Enrolled (Please provide the tribal enrollment number above)
- Eligible for tribal enrollment
- A descendent of an enrolled tribal member
- A non-Indian minor under the legal custody of an enrolled tribal member or under the legal custody of a descendent of an enrolled tribal member
- Not enrolled, eligible for enrollment, or a descendent of an enrolled tribal member

I declare under the penalty of perjury that the statements on this application are correct to the best of my knowledge. I am authorized to sign this verification.

\_\_\_\_\_  
Signature, Authorized Tribal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name, Authorized Tribal Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address (Street, City, and ZIP Code)

\_\_\_\_\_  
Telephone Number (Including Area Code)