![MC900018541[1]]()

**Opening Avenues to Reentry Success**

**(OARS)**

**Informed Consent for**

**Mental Health Evaluation, Treatment and**

 **Community Reintegration Services**

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| --- | --- |
| Participant Name | DOC Number |
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**Consent to Evaluate/Treat:** I voluntarily consent to participate in the OARS Program. I understand that this program will assist me with my transition back into the community by providing pre-release evaluation, treatment, and post-release wrap-around services. I understand that I am only eligible to participate in this program while I am actively under DOC supervision.

**Benefits to Evaluation/Treatment:** The benefits of participating in the program include assistance transitioning back into the community such as: housing, transportation, case management support, financial assistance, structured meaningful activities, educational, vocational, and/or volunteer opportunities, mental health services, medication monitoring, and a variety of treatment services. The benefits of treatment may include improved health status, better quality of life, improved self-awareness, and insight into my strengths and vision for my future.

**Program Expectations:** I understand that participation in this program will require that I will:

* Follow all of my rules of supervision
* Cooperate with treatment recommendations, including taking all medications as prescribed before and after my release
* Work with my OARS Team to identify treatment and educational opportunities available both before and after my release from the institution
* Participate in the development of my Individualized Service Plan (ISP)
* Sign releases of information and consent forms for housing and treatment services
* Be responsible and respectful with regards to any housing that is provided for me through this program
* Talk with a member of my OARS Team if I have any concerns about the program expectations that are asked of me
* Be honest with my OARS Team

If I do not follow through with the program expectations, the OARS Team will talk with me about my reasons, and how that may affect my participation in the program. I understand I have the right to participate in planning with the team, and the expectations listed above are an important part of my involvement in the OARS program. If I am unable to cooperate with these expectations I may be discharged from the program. Additionally, if my legal status or program eligibility changes, I may be discharged from the program.

**Costs and Finances:** I will be honest with my OARS Team about my income and expenses. I will work with the OARS Case Manager to budget my finances. For my housing I will need to sign a lease and arrange for utilities and phone services in my own name, though my case manager will assist me as needed. Security deposits for rent paid by the program remain the funds of the program and are not the participants. While I am in the OARS Program, I will also be required to contribute a portion of my earned income and benefits to my housing costs or other costs as I am able. If a representative payee is required by the Social Security Administration, then I will also need to cooperate with my representative payee. If I should receive a back payment amount from SSI/SSDI, I understand that I will need to contribute a portion towards my cost of care and living expenses. Items purchased with program funds (such as furniture) remains the property of the program *If I abscond or abandon property from an OARS supported residence*. I also understand that I will not have a bill to pay for the OARS services I receive after I’m discharged from the program.

**Confidentiality:** I understand that in order to be involved in the OARS Program, I will need to consent to release confidential information about me to members of the OARS Team, and possibly others, such as friends or family members who are supportive people in my life. I understand that members of my OARS team may search the internet, if they have a professional purpose, to obtain information about me. Information from my confidential healthcare and treatment record will only be disclosed to my OARS Team and other service providers who have a need to know that information. Any information disclosed from my healthcare and treatment record will comply with the requirements of confidentiality laws and rules.

**Right to Withdraw Consent:** I have the right to withdraw my consent for the OARS Program at any time by providing a written request. If I do so I will no longer receive the services and benefits provided by the OARS program, but I understand that I will still be required to follow my rules of supervision as set forth by my community corrections agent.

**Program Completion:** I understand that the OARS Program is a transition-focused program to enhance my ability and opportunities to succeed in the community. The program may last between six months and two years after my release. The OARS Team will talk with me about my progress meeting my goals, and what I can do to successfully complete the program. Before the OARS Program comes to a conclusion for me, the OARS Team will help to transition any services I receive to other community resources.

**Expiration of Consent:** This consent to treatment will expire at the completion/termination of OARS programming, unless otherwise specified.

**I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to participate in the OARS Program. I understand that I have the right to ask questions about the above information at any time.**

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**Participant Signature Date**