**Beth Samson** - Transition Coordinator

Butler Area School District
110 Campus Lane
Butler, PA 16001
724-214-3128

Dear Parent/Guardian,

Your child may be eligible for additional supports through local community agencies due to their educational diagnosis. We would like to assist you with linking your child to supports by connecting you with the **Alliance for Nonprofit Resources' (ANR)** Developmental Programs Coordinator. Through this referral process, ANR will review your child's educational records to determine eligibility. Once eligibility has been determined, ANR will provide recommendations for agencies who can support your child in the community. Butler Area School District recommends that your child is linked with ANR at least 5 years prior to graduation.

At this time, the **Center for Community Resources,** Inc. (CCR) is the local agency that is contracted through Butler County MH/ID/D&A to provide supports for individuals who are eligible, and may be one of the providers discussed through the eligibility process with ANR. CCR is an umbrella agency that can provide information and referral services for individuals with Mental Health and Drug/Alcohol treatment needs. Additionally, CCR provides support coordination for individuals who are eligible based on their educational diagnosis and needs. A Supports Coordinator can:

- ✓ Assist your child in finding and accessing community opportunities regardless of barriers.
- ✓ Link your child to community activities and supports they want, are interested in, and that they have chosen for themselves.
- ✓ Be an advocate for your child to ensure opportunity in their everyday life.
- ✓ Complete an application for the Medicaid Home and Community Based Waiver Program.
- ✓ Assist your child in completing applications for funding for supported employment, residential programs, day or vocational activities, respite, environmental adaptations to homes or adaptive equipment, as funding is available.
- ✓ Offer the opportunity to complete a Prioritization of Urgency of Need for Services form and identify community supports and services that may help your child while they wait, if funding is not available.

**To learn more regarding ANR's referral process or to schedule an intake**, please visit www.anrinfo.org or call 724-431-1543. For more information on CCR's services and supports, please call 724-431-0095. If you have additional questions about how these services can help support your child, please contact me at 724-214-3128.

If you are interested at this time in linking with these local agencies for support, please complete the attached "ANR AUTHORIZATION FOR RELEASE OF INFORMATION", and return it to your child's special education teacher. Once it is received, your child's ER/RR, IEP, and other school records will be provided to ANR for review and a representative from ANR will contact you regarding your next steps.

Thank you,

B Samson

Beth Samson
Transition Coordinator
Butler Area School District

***10/2017***

Alliance for Nonprofit Resources
127 South Main Street
Butler, PA 16001

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Client Name: ______________________________ Date of Birth: ____/____/____

I hereby request and authorize Butler Area School District (Name of Facility/Person) 110 Campus Lane, Butler PA 16001 (Facility Address)

to release the following information only as stated below to Alliance for Nonprofit Resources (ANR) (Name of Facility/Person).

**These records are requested for the purpose of:**

☐ Collaboration and coordination of services ☐ Assessment and/or Service Planning ☑ All of the above
☐ Recommendations ☐ Other: ____________________

**Please include approximate dates of service for information being requested:** ____________________

**The records to be released (identify all that apply) are:**

| | | |
|---|---|---|
| ☑ Individual Education Plan/CER | ☐ Psychiatric Evaluation | ☐ Psychological Evaluation |
| ☐ CYS Records, & Summary Reports | ☐ Medication Evaluation & History | ☐ Social History |
| ☐ Treatment History & Recommendations | ☐ Medical History | ☐ Lab Reports |
| ☐ Intake/Assessment | ☐ Follow-up Reports/SC Updates | ☐ Presence in Tx. (Admit/Discharge Dates) |
| ☑ Brief Description of Progress | ☐ Synopsis of Prognosis/Diagnosis | ☐ Presence in BSU (Enrollment/Disenrollment) |
| ☐ Statement re: Relapse | ☑ Verbal Communications | ☐ Previous Housing Assistance |

☑ Other (Specify): School records (grades, schedule, attendance, school photo ID)

*** HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be disclosed through this authorization unless otherwise indicated. Do not Release: ☐ HIV ☐ Drug & Alcohol**

The Authorization shall be in effect for a period of **1 year** from the date of signature, unless another timeframe/event is documented ____________________.
(extended date/event, if applicable)

**I understand the following:**

- I have the right to revoke this Authorization at any time in writing, except to the extent that action has already been taken.
  **Alliance for Nonprofit Resources, Inc. has forms for you to use if you wish to revoke this Authorization at any time before it expires.**
- The information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me by law.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: (1) Whether the client is or is not in treatment (2) The prognosis of the client (3) The nature of the program (4) A brief description of the progress of the client (5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- Alliance for Nonprofit Resources, Inc. may not require that I sign this Authorization in order to obtain treatment.
- I am entitled to a copy of this completed Authorization form: ☐ **ACCEPTED** ☐ **DECLINED** **Client Initials:** ________

I have read this Authorization, or had it explained to me, and I understand its contents.

Signature: ______________________________ Date: ____/____/____
Client/Legal Representative Signature

If you are the legal representative of the person listed above, please check off the basis for your authority:

☐ Parent of Minor ☐ Power of Attorney (copy must be in chart)
☐ Guardianship Order (copy must be in chart) ☐ Other: ____________

Staff/Witness Signature: ______________________________ Date: ____/____/____

Witness Signature: ______________________________ Date: ____/____/____

**(Two witnesses are required for oral authorizations or when the client is physically unable to sign)**

**This information has been disclosed to you from records whose confidentiality is protected by state statute. State regulations limit your right to make further disclosures of this information without prior written consent of the person to whom it pertains.