



2015 / I REMEMBER MAMA: WOMENADE SELF-SUFFICIENCY AWARD – APPLICATION INSTRUCTIONS

Womenade of Salt Lake City, a 501 (c) 3, promotes self-sufficiency and possibility in women and is pleased to offer this 8th annual Womenade Self-Sufficiency award to a woman who has made a life changing decision to break the cycle of substance abuse and addiction and is on the road to self-sufficiency and recognizing her possibility.

Applications will be reviewed by members of the Womenade Board and the winner will be announced at Volunteers of America, Utah's annual "*I Remember Mama*" event, **Friday, May 8, 2015**.

Eligible applicants are women who are within two weeks of completion of treatment or have completed substance abuse treatment.

Funds can be used to support school, vocational training, child-care, initiate/sustain a business or other endeavors which will promote self-sufficiency and possibility. Checks will be written to Volunteers of America, Utah, not to the winner alone. Winners will work with Volunteers of America, Utah to have a check(s) written to the place(s) they will use the money.

A one page summary of your request should include:

- Applicant's name
- Treatment completion date
- Requested amount (\$500-\$1,000)
- Description of how the award would assist the applicant in achieving her self-sufficiency goals

A signed release of confidentiality (attached) is also required with the application. **Please submit applications by Monday, April 20, 2015** via e-mail, US mail or fax to:

Brian Hutchinson
Volunteers of America, Utah
435 West Bearcat Drive
Salt Lake City, Utah 84115
Phone: (801) 808-9719
Fax: (801) 355-3546
brian.hutchinson@voaut.org

**AUTHORIZATION FOR THE RELEASE OF
CONFIDENTIAL & PROTECTED HEALTH INFORMATION**

I, _____, authorize
(Name of patient)

Volunteers of America, Utah
(Name or general designation of program making disclosure)

to disclose to Womenade Board of Directors and I Remember Mama Attendees the following
(Name of person or organization to which disclosure is to be made)

information: Womenade Self-Sufficiency Award application information and, if selected as award recipient, identification of myself as a woman in recovery.
(Specific nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is: for application review and the Womenade Self-Sufficiency award announcement.
(Specific purpose of disclosure)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

05/08/15 (Specification of the date, event, or condition upon which this consent expires)

I understand that the covered entity seeking this authorization is permitted under the HIPAA regulations, in accordance with 45 C.F.R. Section 164.508(b)(4), to condition my signing of this authorization on the provision of treatment, payment, enrollment or eligibility for benefits, and that by refusing to sign this authorization, I may be faced with the following consequences: Treatment may be refused if you have been court ordered to seek services, but will not sign a release authorizing our disclosure of information with the legal authority ordering you into this service.

Client Signature

Date