STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division of Economic and Housing Stability
Bureau of Child Development and Head Start Collaboration

Form 2691
May 2020

VERIFICATION FOR PARTICIPATION IN A MENTAL HEALTH OR SUBSTANCE MISUSE TREATMENT PROGRAM

SECTION I: CLIENT INFORMATION

Full Name: _____ DHHS Case #: _____

Address: _____

Email: _____

☐ I certify that I am participating in an approved Mental Health Treatment Program

☐ I certify that I am participating in an approved Substance Misuse Treatment Program

By signing this form, I authorize the release of this information to the Department of Health and Human Services (DHHS). I understand information will be held in strictest confidence and will be reviewed by, or shared with, authorized DHHS staff involved in the authorization of the NH Child Care Scholarship Program.

Client's Signature: _____ *Date:* _____

SECTION II: LICENSED PROFESSIONAL

"Licensed Professional" means one of the following: attending physician, physician's assistant, advance practice registered nurse, licensed mental health professional, licensed behavioral health professional, licensed alcohol and drug counselor, certified recovery support worker or board certified psychologist

Name: _____ License/Certification #: _____

Business Name: _____

Address: _____

Email: _____ Telephone #: _____

The individual's treatment need(s) is*: (check as many as apply)*

☐ Mental Health Treatment Program ☐ Substance Misuse Treatment Program

How many **hours per week** is treatment provided? _____

Length of expected duration of the treatment program *(not to exceed 12 months from the date below)*: _____

☐ I attest that:

I am the individual's attending physician; physician's assistant; advance practice registered nurse; licensed mental health professional; licensed behavioral health professional; licensed alcohol and drug counselor; certified recovery support worker; or board certified psychologist and I am providing ongoing treatment.

_____ _____ _____

Signature *Title* *Date*

Instructions to the "Verification for Participation In A Mental Health or Substance Misuse Treatment Program"

PURPOSE:

The "Verification for Participation in a Mental Health or Substance Misuse Treatment Program" is used to verify that the client is participating in an approved mental health or substance misuse treatment program. Pursuant to RSA 167:83, II, to be eligible for the NH Child Care Scholarship Program for a mental health treatment program or substance misuse treatment program the client must be a recipient of the New Hampshire Employment Program (NHEP) or the Family Assistance Program (FAP).

INSTRUCTIONS:

The client and the licensed professional must print or type the information to complete Form 2961. The client must sign and date the form, authorizing the release of information to DHHS and provide it to the Attending Physician, Physician's Assistant, Advance Practice Registered Nurse, Licensed Mental Health Professional, Licensed Behavioral Health professional, Licensed Alcohol and Drug Counselor, Certified Recovery Support Worker or Board Certified Psychologist and return it as below. All sections **MUST** be complete. An incomplete form will **NOT** be accepted and no eligibility can be authorized.

FORM COMPLETION:

- **SECTION I: Client's Information**
  - Enter the client's full name;
  - Enter the client's DHHS case number;
  - Enter the client's address;
  - Check off the certification for which the client is participating;
  - Sign and date the form to authorize the release of information;
  - Provide the form to the licensed professional for verification.
- **SECTION II: Licensed Professional**
  - Enter the licensed professional's full name, license/certification number, telephone number, business name, if applicable address and email;
  - Indicate the individual's treatment need(s);
  - Enter how many hours per week treatment is provided;
  - Indicate the length of the expected duration of the treatment program (not to exceed 12 months from the date of licensed professional's signature);
  - Indicate attestation of the licensed professional's role; and
  - Sign, enter the professional's title and date the form.

The Licensed Professional should confirm with the client that they are a recipient of NHEP or FAP.

Either the client or the licensed professional may return the completed form to:

DHHS Centralized Scanning Unit,
P.O. Box 181, Concord, NH 03302.

RETENTION:

Form 2691 will be retained in the eligibility record.