Stephen Center HERO Application

Personal Information

Full Legal Name: ____
Phone: __________
Date of Birth: ________
E-mail: ____
Social Security Number: __________

Chemical Dependency Evaluation

Do you have a current (completed within 1 year) chemical dependency evaluation?
[ ] Yes
[ ] No
Who completed your evaluation?
Name: ____
Phone: __________
Address: ____

Legal History

Do you have any past, pending, or present legal issues/criminal history?
[ ] Yes
[ ] No

If yes, please provide details:

____
____
____
____

Payer Source

Check all applicable insurance (if not listed, we do not currently accept):
[ ] NE Medicaid NTC
[ ] NE Medicaid UHC
[ ] NE Medicaid Molina

Provide ID number: ____

Current Medications

What current medications are you taking? (Name and dosage)

____
____
____
____
____
____
____

Are you taking your medication as prescribed?

[ ] Yes
[ ] No

Additional Information

Is there any other information you would like to share?

____
____
____
____
____
____
____

Support Person for Transition

Would you like someone to assist you with entering treatment?

[ ] Yes
[ ] No

If yes, please provide the following and complete a release of information for the individual:
Name: ____
Relationship: ____

**If the completed packet was not submitted online, then it can be emailed or faxed.*
Email: hero.admissions@stephencenter.org
Fax: 402-715-5452

Release of Information #1

Please complete the following sections for each individual and/or organization that you authorize to release information.

Consent to Release Protected Health Information
Date: ________
I, ____ hereby authorize Stephen Center to release and/or obtain information with respect to any medical, psychiatric, drug, and/or alcohol-related conditions obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers listed below.

I understand that my signature below will not affect the ability to determine, limit, or restrict my treatment. I understand that that any information may be redisclosed by the receiving provider under this consent, but only if it pertains to treatment, payment, and healthcare operations. I understand I have the right to limit or restrict the re-disclosure of my information by other service providers in relation to treatment, payment, and healthcare operations.

[ ] Check only if you DO NOT want receiving service providers to limit or restrict the re-disclosure of my SUD/PHI at this time.

The information I would like to limit is:

____

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Release of Information

Please select below who will receive or provide the information.

Recipient of Information (Release To)
[ ] Individual
[ ] Organization

Source of Information (Release From)
[ ] Individual
[ ] Organization

Name: ________________________________
Organization: ___________________________
Address: ______________________________
City: _________________________________
State: ________________
Zip Code: ____________

Relationship: __________________________
Phone: __________
Fax: __________
Cell: __________
Work/Direct Phone: __________ Ext: _____
E-mail: _______________________________

Date of Implementation: March 2025

Purpose of Disclosure

Please check all that apply:

[ ] To facilitate referral for additional services
[ ] To aid in diagnosis, continuing care, and treatment
[ ] To assist in discharge planning
[ ] To facilitate understanding and support in treatment
[ ] Verification of insurance benefits and utilization review
[ ] Case management
[ ] Care coordination

Information to be Disclosed

Please check all that apply:

[ ] Admission/Discharge Information including Diagnosis
[ ] Assessment and Treatment Recommendations
[ ] Financial Information
[ ] Urine Drug Screen/Breathalyzer Results
[ ] Treatment Compliance and Attendance
[ ] Progress and Treatment Reports
[ ] Treatment Plan including Treatment Goal Progress
[ ] History & Physical/Psych Evaluation/Consultations
[ ] Family Therapy
[ ] Couples Therapy
[ ] Lab Orders/Results
[ ] Other: ____

Terms of Release

This release may be revoked or revised by me in writing at any time. This release is valid until: ______________________________________ or until revoked by me in writing, 1 year from the date of signature.

I understand I have the right to receive a copy of this authorization.

Confidentiality Prohibition on Re-disclosure:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part II and 45 CFR HIPAA) prohibit recipients of this information from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signature: ____

Date: ________

**If you are completing this document via Microsoft Edge, you can sign using the native draw function.*

Release of Information #2

Please complete the following sections for each individual and/or organization that you authorize to release information.

Consent to Release Protected Health Information
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Recipient of Information (Release To)
[ ] Individual
[ ] Organization

Source of Information (Release From)
[ ] Individual
[ ] Organization

Name: _______________________________
Organization: ___________________________
Address: _____________________________
City: ________________________________
State: ________________
Zip Code: ____________

Relationship: __________________________
Phone: __________
Fax: __________
Cell: __________
Work/Direct Phone: __________ Ext: _____
E-mail: _______________________________

Date of Implementation: March 2025

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Please check all that apply:

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[ ] To facilitate understanding and support in treatment
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Information to be Disclosed

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[ ] Assessment and Treatment Recommendations
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Recipient of Information (Release To)	Source of Information (Release From)
[ ] Individual	[ ] Individual
[ ] Organization	[ ] Organization

Name: ________________________________	Relationship: ___________________________
Organization: ___________________________	Phone: ___________
Address: ________________________________	Fax: ___________
City: ___________________________________	Cell: ___________
State: _________________	Work/Direct Phone: ___________ Ext: _____
Zip Code: _____________	E-mail: _________________________________

Date of Implementation: March 2025

Purpose of Disclosure

Please check all that apply:

[ ] To facilitate referral for additional services
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[ ] To assist in discharge planning
[ ] To facilitate understanding and support in treatment
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Information to be Disclosed

Please check all that apply:

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