

**Western Highlands Network  
Assignment of Case Responsibility/1<sup>st</sup> Responder**

The purpose of this form is to confirm assignment of Case Responsibility/1<sup>st</sup> Responder and release information regarding eligibility for services. This form **must accompany** the Introductory, Complete, or Basic Benefit PCP, LME Consumer Admission and Discharge form, an IPRS worksheet from the new provider, the STR and the Description of Consumer Clinical Issues (DCCI) **unless the referenced information is keyed by the provider directly through CCIS**. This form does **not** constitute consent for treatment, which **must** be obtained by the **new** provider before services are delivered.

**NEW PROVIDER! PLEASE REMEMBER:** Check and ensure consumer is not moving to a lower level of care and losing connection with medical doctors/medications. This means the **new** provider **must be** responsible for medications.

Please **PRINT** information below.

Consumer's Legal Last Name	Legal First Name	Middle Initial	<b>Maiden Name (REQUIRED for female, put last name if not applicable or unknown)</b>
____ / ____ / ____	____ - ____ - ____	_____	_____
Date of Birth	Social Security Number	WHN Consumer ID #	Agency Admission Date
_____	_____		
State	County		

I, \_\_\_\_\_ request that my services/supports be provided  
Consumer or Guardian (if consumer is under 18 y/o)

by \_\_\_\_\_  
New Provider/Agency Name

**Provider E-mail address:** \_\_\_\_\_

**Authorization of Release**

**CONSUMER:** By signing this form, I understand that my previous case responsible provider is no longer responsible for my care. I hereby authorize Western Highlands Network to disclose/release/share information with the agency listed above for the purpose of Care Coordination, Service and Benefit eligibility, including information related to alcohol and/or drug abuse information according to Federal regulations (42 CFR Part 2) and/or information regarding communicable diseases in addition to the names of previous treatment agencies. I hereby authorize Western Highlands Network to provide my previous case responsible agency with information from and/or a copy of this form.

I understand that this does **not** prohibit me from transferring providers through Western Highlands Network in the future.

Consumer Signature (Guardian if consumer is under 18 years old)	Date
New Provider Clinician and title (print & sign)	Date
New Provider/ Agency Name (please print)	Provider Phone #

This form is to be completed by consumer and/or guardian and the **new** provider at your first meeting with that **new** provider. The **new** provider will mail or fax the form to Western Highlands with the required paperwork to make the case ACTIVE in the WHN system to the **new** provider. A written **Consent for the Release of Information** must be delivered to the 1st provider in order to obtain past treatment/supports information.

Mail to:  
Western Highlands Network – Access/UM Unit  
356 Biltmore Avenue  
Asheville, NC 28801

**OR**

Fax to:  
A.) Access/UM Unit at **828-225-2782** (with initial authorization request, PCP, LCAD, DCCI, and IPRS worksheet).  
B.) 828-225-2797 (if admission paperwork directly keyed by provider thru CCIS).