

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

To be completed during the first face-to-face meeting when it is determined that consumer will be receiving ongoing services with this agency. The purpose of this form is to confirm **assignment of Case Responsibility/1st Responder** and for the release of information regarding eligibility for services. This form **must be submitted to Western Highlands Network (WHN) in order for provider to access the CCIS data system.** Once this form has been submitted, provider **must** key the required Screening/Triage/Referral (STR) form and the LME Consumer Admission/Discharge form (LCAD) within 5 business days. For agencies that do not use the CCIS system, this form must be submitted to WHN via fax or mail and be accompanied by the forms referenced above. 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 TYPE OR LEGIBLY PRINT INFORMATION

Consumer's Legal Last Name	Legal First Name	Middle Initial	Maiden Name <i>(Required for female consumers)</i>
/ /	-	-	
Date of Birth	Gender	Social Security Number	WHN Consumer ID #
			County of Residence

I, _____ request that my services/supports be provided
Consumer or Guardian (if consumer is less than 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. This form does not constitute Consent for the Release of Information from the records of other providers.

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)	Signature Date <i>(must match agency Admit date listed on the LCAD)</i>
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Clinician and title (print & sign)	Date
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Provider/ Agency Name (please print)	Provider Phone #
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Fax to: A.) Access/UM Unit at **828-225-2782** (with initial authorization request, PCP, LCAD, DCCI and IPRS worksheet). **OR** Mail to: Western Highlands Network – Access/UM
356 Biltmore Avenue
Asheville, NC 28801

B.) **828-225-2797** (if admission paperwork directly keyed by provider thru CCIS).