OhioPHP

VOLUNTEER PEER MONITOR FORM

OhioPHP VOLUNTEER PEER MONITOR DUTIES & RESPONSIBILITIES

The Ohio Professionals Health Program, Inc. (OhioPHP) is a nonprofit organization which offers confidential assistance to physicians and other healthcare professionals who may be affected by mental, emotional and behavioral illness, substance-related and addictive disorders, or other issues impacting their health and well-being. The role of the Volunteer Peer Monitor is to assess a participant's compliance and provide quarterly status reports. We appreciate the willingness of monitors to assist colleagues and serve in this very important role.

Effective monitoring is composed of these essential activities:

1. Assessing Compliance: The participant and the monitor should arrange a time to review the participant's OhioPHP Agreement. Monitors are encouraged to make the following inquiries as applicable:
   - Inquire about the participant's work-life balance and overall well-being.
   - Assess the participant's overall attitude.
   - Note the participant's appearance and grooming.
   - Ask about family life, spouse or significant other and other relationships.
   - Explore if participant is meeting continuing education requirements.
   - Inquire about relationships in the work place. Is there a reasonable work schedule?
   - Explore any major concerns.
2. Reporting: Status reports are required on a quarterly basis. These reports can be completed online via OhioPHP's third-party administrator, Affinity, or they can also be found on our website, www.ophp.org.

CONTACT INFORMATION

OhioPHP Participant Name: ______________________

Volunteer Peer Monitor Name: ______________________

Degree/Specialty: ______________________

E-mail Address (required for online reporting): ______________________

Street Address: ______________________

City: ______________ State: ______________ Zip: __________

Cell Phone Number: ______________ Work Phone Number: ______________

Preferred Method of Contact: ☐ Cell Phone ☐ Work Phone ☐ E-mail

______________________ ______________________

Volunteer Peer Monitor Signature Date

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FORM

PRACTITIONER OR PARTICIPANT INFORMATION

Name:

Address:

City: State: Zip:

E-Mail Address:

Primary Phone Number: Other Phone Number:

I, ____ (Practitioner Name) hereby authorize the Ohio Professionals Health Program ("OhioPHP") to disclose the below specified information to the following authorized individual/organization for the following purpose:

□ Monitoring services and/or One-Bite Program or Safe Haven Program monitoring services conducted by OhioPHP in relation to screening/evaluation of and/or treatment for the diagnosis of a mental health condition and/or substance use disorder.

□ Other: ____.

Information to be released shall include any or all of the following:

Diagnosis; copy of monitoring agreement; compliance and involvement with the treatment plan and/or monitoring agreement; any change or regression in status, progress or compliance; unilateral cessation of participation or advocacy relationship either on my part of that of OhioPHP; results of toxicology tests; quarterly reports and/or final summary; mental health records (other than psychotherapy notes); and other reports or materials in my file.

RELEASE INFORMATION TO THE FOLLOWING INDIVIDUAL/ORGANIZATION

Company: Contact Name:

Address:

Primary Phone Number: Fax Number:

E-Mail Address:

1. I understand that substance use disorder records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.
2. I understand that I have the right to withdraw this authorization at any time to the extent the lawful recipient has not already acted in reliance upon this document. Otherwise, this authorization shall expire without my written revocation one (1) year after either (A) the completion of my agreement with OhioPHP or (B) a determination by a treatment provider that I do not have an active diagnosis for a mental health condition and/or substance use disorder. I authorize a photocopy of this release to be used in lieu of an original signed document.
3. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance use disorder information unless the further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 C. F. R. Part 2.
4. OhioPHP will not condition treatment, payment, enrollment, or eligibility on my authorization and consent for the release of information. However, One-Bite Program and/or Safe Haven Program participants are advised that individuals are deemed to have waived any right to confidentiality that would prevent the monitoring organization conducting the One-Bite Program and/or Safe Haven Program from making reports required by Ohio law, which requires OhioPHP to screen or refer eligible individuals to evaluation and/or treatment, and to report to licensing authorities any individual who is determined to be ineligible to participate in either program.
5. I also hereby authorize OhioPHP to disclose those records as may be necessary for OhioPHP's contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of OhioPHP.

____ ____

Signature of Practitioner/Participant Date