

Date
Social Security Number XXX-XX-
Due Date

REPORT ON TREATMENT PROGRAM

By signing your name in **Section 1**, you authorize your treatment program to provide information to Unemployment Insurance (UI) Division. **Section 2** is to be completed by an authorized representative of your treatment program. Complete and sign **Section 3** only **after** the treatment-program representative has completed **Section 2**. By signing your name in this section, you are confirming that you understand the information provided by the treatment-program representative. You are responsible for returning the form.

Section 1. Consent to Release Information

I consent to release the requested information for the purposes of processing my claim for UI benefits with the understanding that the information is for use in determining my eligibility and entitlement for UI benefits in accordance with the Colorado law.	
Claimant Signature	Date

Section 2. (To be completed by treatment-program representative only)

The person named above has applied for unemployment insurance benefits. Obtaining the information requested below will help the UI Division make a determination of eligibility and entitlement. Any alteration must be initialed. Your cooperation in providing this information is appreciated. The completed form must be returned to us by the patient.			
Name and Address of Treatment Program or Facility	Type of Program <input type="checkbox"/> Private facility <input type="checkbox"/> Public facility <input type="checkbox"/> Alcoholics Anonymous or other 12-step program		
Nature of Treatment <input type="checkbox"/> Residential <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Confined <input type="checkbox"/> Combination (Please explain) _____	Treatment Schedule		
	Start Date	End Date	Days and Hours
Additional Comments			
Name of Authorized Representative			Telephone Number
Authorized-Representative Signature			Date

Section 3.

I have read and understand the above statement provided by the treatment-program representative.	
Comments	
Claimant Signature	Date

NOTE: Please be aware that according to Colorado law, you must be able to work, available to start work, and actively seeking work during each week in which payment of benefits is requested. If you do not meet all of these requirements, we may not be able to pay you benefits.