**Division of Unemployment Insurance**
Unemployment Insurance Benefits Services
P.O. Box 400, Denver, CO 80201-0400

COLORADO
Department of
Labor and Employment

# REPORT ON TREATMENT PROGRAM

I am not currently participating in a treatment program, nor have I completed one. Agree ☐ Disagree ☐

**Section 1. Consent to Release Information**

Complete this section to authorize your treatment program to provide information to the Division of Unemployment Insurance (UI). You are responsible for returning this form. See instructions in **Section 3**.

| 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 Employment Security Act 8-73-108 (4)(b). | |
|---|---|
| Claimant Signature | Date |
| Claimant Name (print) | |

**Section 2. Treatment Program Information**

To be completed by an authorized representative of your treatment program only.

| The person named above has applied for UI benefits. Obtaining the information requested below will help UI make a determination of eligibility and entitlement. Any alteration must be initialed. Your cooperation in providing this information is appreciated. | | | |
|---|---|---|---|
| Name and Address of Treatment Program or Facility | Type of Program<br>☐ Private facility ☐ Public facility<br>☐ Alcoholics Anonymous or other 12-step program | | |
| Nature of Treatment<br>☐ Residential ☐ Inpatient ☐ Outpatient<br>☐ Confined ☐ Combination (Please explain)<br>________________ | Treatment Schedule | | |
| | Start Date | End Date | Days and Hours |
| Additional Comments | | | |
| Name of Authorized Representative | Telephone Number | | |
| Authorized-Representative Signature | Date | | |

**Section 3. Acknowledgement**

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 to include your name and address below. You can upload the completed form into your MyUI+ account, or print and mail to the address above.

| I have read and understand the above statement provided by my physician. | | |
|---|---|---|
| Claimant Signature | | |
| Claimant ID | Last Four of SSN<br>XXX-XX- | Date |
| Comments | | |