

PEND OREILLE COUNTY COUNSELING SERVICES

**Intake Information
CONSUMER INFORMATION**

Date: _____

Legal Name: _____
Last First Middle

Previous or other last name: _____

Name preferred to be called (if different from above): _____

DOB: __/__/__ Age: ____ Gender: Male Female Transgender Intersex

SS# ____ - ____ - ____ Phone: _____

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

In case of an emergency POCCS has my permission to contact: _____

Emergency Contact Phone Number: (____) ____ - ____

Emergency Contact Address: _____
City State Zip

Parent's or legal Guardian's Name(s) (for minors): _____

Name and ages of all persons living in the home: _____

Name:	Ages:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Method of payment:

Medicaid Coupon Insurance other _____

PEND OREILLE COUNTY COUNSELING SERVICES

MEDICAL COUPON AGREEMENT

AS A CLIENT OF PEND OREILLE COUNTY COUNSELING SERVICES AND COMMUNITY ALOHOLISM CENTER. I UNDERSTAND THAT I MUST PROVIDE A COPY OF MY WASHINGTON STATE MEDICAL COUPON.

I UNDERSTAND THAT I WILL BE DENIED SERVICES UNLESS I PROVIDE A COPY OF MY MEDICAL COUPON PRIOR TO EACH APPOINTMENT.

PRINTED NAME OF CLIENT/GUARDIAN

SIGNATURE OF CLIENT/GUARDIAN

DATE

SIGNATURE OF WITNESS

I AM NOT ENTITLED TO WASHINGTON STATE MEDICAL COUPONS.

CLIENT/GUARDIAN SIGNATURE

DATE



MENTAL HEALTH DIVISION

GAIN-SS FORM

Section Completed by Clinician
Location of screen: Intake/Admission [] Tx Plan Session [] Crisis Episode []
Consumer: Declined [] Unable to complete []

Mental Health Division

Demographic Information and GAIN-SS (Self-Report) Complete by Consumer					
DATE	LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female

By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.

Completing the checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

Please answer the questions Yes or No.

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

During the past 12 months, have you had significant problems. . .

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. when something reminded you of the past, you became very distressed and upset?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. with thinking about ending your life or committing suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IDS Sub-scale Score (0 to 5)

During the past 12 months, did you do the following things two or more times?

a. Lie or con to get things you wanted or to avoid having to do something?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have a hard time paying attention at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have a hard time listening to instructions at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been a bully or threatened other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Start fights with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EDS Sub-scale Score (0 to 5)

During the past 12 months did. . .

a. you use alcohol or drugs weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SDS Sub-scale Score (0 to 5)

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Client/Guardian Signature : _____ Date _____

PEND OREILLE COUNTY COUNSELING SERVICES

CLIENT FINANCIAL PROFILE

CLIENT'S NAME: _____
SSN#: _____ DOB: _____ AGE: _____
MAILING ADDRESS: _____
PHYSICAL ADDRESS: _____
PHONE(S): Home: _____ Work: _____ Message: _____
RELATIONSHIP TO INSURED: _____

Pend Oreille County Counseling Services is required to provide medically necessary services for people who are Medicaid eligible. I understand that if I am not eligible for Medicaid Coupons I will need to pay full fee for services.

Payment for services is required at the time of the service.

I understand that I am responsible to pay any fees charged to this Agency if I do not have sufficient funds in my account for payment using my checking account. Additionally, I understand I will have to pay all future payments by cash or money order.

I understand that medical insurance companies will be billed at the standard rate and if there is a balance I agree to pay that balance immediately.

I hereby authorize payment directly to this Agency for any third party benefits to which I am entitled. I further authorize the release of information required to process third party claims.

I understand that this Agency reserves the right to use established collection procedures, including private collections agents or small claims court, if I do not meet my payment responsibility for services received from the Agency.

I have read and understand the above statement. I verify that the information I have provided on this form is accurate.

PRIVACY ACT STATEMENT: Solicitation of your social security number on this form is authorized by Policy. The primary purpose for soliciting this information is to establish identity, entitlement to benefits, provide for financial payments and to properly administer Mental Health requirements. This information is made available as a routine use on a need-to-know basis to personnel of this Agency. The State of Washington and other government agencies having statutory or other lawful authority to maintain such information in the performance of their official duties. Failure to provide the information requested on this form may result in denial of services.

CLIENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____

INCOME INFORMATION:
AVERAGE GROSS MONTHLY INCOME: \$ _____ NUMBER OF PEOPLE IN FAMILY: _____

SOURCE OF INCOME:
Earned Income \$ _____ Self-Employed \$ _____
Supported by parents/spouse \$ _____ Child Support \$ _____
Unemployment/Work's Comp \$ _____ SSI/Retirement \$ _____
Veteran's Benefits \$ _____ Disability/SSI \$ _____
Public Assistance \$ _____ Other \$ _____

TYPE OF PAYMENT:
() MEDICAL COUPONS () PRIVATE INSURANCE () CASH

PLEASE PROVIDE A COPY OF YOUR MEDICAL COUPON OR INSURANCE IDENTIFICATION INFORMATION Rev.5.09

PEND OREILLE COUNTY COUNSELING SERVICES
CONSUMER CHECKLIST

Name: _____

PLEASE COMPLETE THE FOLLOWING CHECKLIST TO HELP US EVALUATE WHAT SERVICES WE MAY BE ABLE TO OFFER YOU. FEEL FREE TO ADD ANY INFORMATION THAT YOU FEEL WOULD BE HELPFUL.

Problems with mood:

- sad/tearful
- poor appetite
- overeating
- low energy/fatigue
- poor concentration
- feelings of hopeless/helpless
- loss of interest/pleasure
- difficulty thinking/making decisions
- poor short/long-term memory
- early morning waking
- mood swings
- racing thoughts

- decreased need for sleep
- increased need for sleep
- irritability

Problems with anxiety:

- anxiety attacks
- panic attacks
- shortness of breath
- fast heart rate
- shaking/trembling
- nausea/abdominal distress
- nightmares
- chest pain/discomfort
- PMS
- Excessive anger

Sexual problems:

- Sexually impulsive
- loss of interest in sex
- sexual dysfunction
- unusual sexual practices
- sexual contact with children
- forced others into sexual acts

Learning:

- learning disability
- unable to read/write
- history of special education
- did not finish high school
- attention deficit/hyperactivity

Substance use:

- smoke cigarettes
- caffeine use
- drink alcohol
- use illegal drugs

Problems with self:

- low self-esteem
- dislike of self
- excessive guilt
- anger toward self
- feelings of worthlessness
- feelings of emotional pain
- self-mutilation
- suicidal thoughts
- previous suicide attempt
- feelings of detachment

History

- Dysfunctional family of origin
- drug/alcohol problems
- drug/alcohol problems in family
- history of sexual abuse
- history of physical abuse
- history of emotional abuse
- previous traumatic experience
- recurrent distressing memories
- recurrent distressing dreams
- flashbacks
- previous hospitalization for mental illness
- previous serious illness
- previous counseling
- personal history of mental illness
- family history of mental illness

Perception:

- have strange or unusual thoughts
- see things that others do not
- hear things that others do not
- feel/smell/taste things others do not

Social problems

- problems maintaining relationships
- parenting problems
- fire setting
- history of serious legal problems
- history of school behavior problems
- history of hurting animals
- incarcerated in jail/prison
- involved with CPS
- violence towards others
- problems with money
- problems with gambling
- difficulty holding a job
- lying

Recent History:

- loss of a relationship
- death of a loved one
- death of a loved pet
- problems with children
- marital problems
- other family issues
- loss of a job
- money problems
- housing problems
- problems with friends
- any other losses

Physical

- physical disability
- blind/deaf
- developmentally delayed
- chronic illness
- acute illness

use prescription drugs

impulsiveness

ADDITIONAL INFORMATION FOR CHILDREN

Anxiety/Separation

- Somatic complaints (headache/stomach ache etc.)
- refusal to go to school
- persistent refusal to sleep alone
- repeated nightmares
- unrealistic and persistent worry about possible harm to loved ones
- excessive distress in anticipation of separation from home or loved ones

Attention deficit/Hyperactivity

- squirms and restless while sitting
- easily distracted
- problems waiting for turn
- problems following instructions
- does not seem to listen
- loses things needed to complete tasks
- blurts out answers
- often goes from one activity to another
- talks excessively
- often interrupts or intrudes on others

Conduct/Disruptive Behavior

- ran away from home over night more than once
- lies frequently
- has been physically cruel to people
- has been physically cruel to animals
- stealing/hoarding things
- often initiates physical fights
- often argues with adults
- often angry and resentful
- deliberately annoys other people
- defies or refuses adult requests and rules
- breaking and entering
- often disobedient, throwing things, tantrums
- destroying others property
- often truant
- has used weapons in a fight
- coerces others into sexual activity
- sexual inappropriate activity
- blames others for mistakes
- often spiteful or vindictive
- often swears
- loss of toilet training

Consumer/Guardian Name: _____

PEND OREILLE COUNTY COUNSELING SERVICES
PO BOX 5055, Newport, WA 99156, 509-447-5651

Consumer Name: _____ Date: _____

To be completed by the consumer, or together with the parent/guardian for consumers who are twelve years old and younger. If you need help with reading or writing, please call to schedule an appointment for a staff person to help you prior to your Intake appointment.

STRENGTHS: This may include: *hobbies, talents, interests, skills, achievements or awards, who is important to you in your life, who you can count on, things that are going well for you in your life, your positive personality traits/characteristics or what friends say they like about you.* Please write as much as you like. We are interested in what you have to say and share.

NEEDS: The following information is helpful in determining your needs and factors impacting your life. Examples have been provided to help in each area to help. Check all boxes that you believe apply to you. If one is not there that applies to you, please fill it in under "Other." If you have "No Needs" in a particular area, check the box by "No Needs." If you prefer to not answer, check the box by "Decline."

I. Daily Living Skills:

No Needs

Decline to answer

- I have no income
- I cannot manage my own money
- I don't know how to drive
- I have not been eating nutritionally
- I can't do my own shopping
- I have poor grooming

- I have difficulty caring for myself
- My license if suspended or revoked
- I have no transportation
- I cannot cook my own meals
- I do not bathe regularly
- Other: _____

II. Housing/Living Situation:

No Needs

Decline to answer

- I am homeless
- My home has no electricity
- I have no telephone service
- I need housing assistance
- I need firewood
- I am being evicted or home foreclosed
- Other: _____

- I live in a shelter
- My home has no running water
- I cannot afford my rent/mortgage
- I need energy assistance
- My home has no heat
- There is conflict between the people living in my home

III. Social Recreational Activities:

No Needs

Decline to answer

- I don't do any social/recreational activities
- I have no friends
- I cannot seem to keep friends
- I don't have any hobbies
- I am nervous around people
- I am anxious in public places/group settings
- Other: _____

- I have been withdrawing or isolating from others
- I have difficulty getting along with people
- I have difficulty talking to people
- I need to develop new friendship
- I seem to get in trouble with the people I hang out with
- I worry that people say negative things about me

IV. Health:

No Needs

Decline to answer

- I have poor health
- I have lots of medical issues
- I need an eye exam
- It is hard for me to walk without assistance

- I am in chronic pain
- I need to eat healthier
- I need to see a dentist
- Other: _____
- I am not ambulatory
- I need to see a doctor
- I don't have medical insurance

Date of your last medical evaluation? _____

Do you believe or suspect you may have a problem with drugs or alcohol? No Yes- If yes, please describe: _____

V. Education/Vocation:

No Needs

Decline to answer

- I am failing school
- I get into trouble at school often
- I have an IFSP
- I am unemployed
- I need help making a resume
- Other: _____

- My grades have dropped
- I have an IEP
- I didn't graduate high school
- I need to find a job
- I want to go to college
- I haven't been doing my homework
- I have a 504 plan
- I need/want to get my GED
- I have no job skills

Consumer's name: _____

VI. Community Support System:

- I have no support from my family
- My friends don't support me
- I argue with my friends or family
- I lost a loved one recently
- I need help with parenting skills
- Other: _____

- No Needs
- Decline to answer
- I have no friends in the area
- I would like to join a support group
- There is conflict within the family
- I need to build a support system
- My partner and I are experiencing difficulty getting along

VII. Legal:

- I am on probation
- I am on deferred prosecution
- There are guardianship/custody issues
- I am being sued
- I am applying for Social Security Disability
- I am getting divorced or considering divorce
- I have an open CPS (Child Protective Services) case

- No Needs
- Decline to answer
- I am on parole
- I have legal charges pending
- I am on an At-Risk Youth petition
- I am filing for bankruptcy or considering it
- I need an attorney or legal advice
- I am being violated on the Becca Bill
- I have an open APS (Adult Protective Services) case

Is this court ordered treatment? YES NO

Is your treatment ordered by the Department of Corrections (DOC)? YES NO

Are you under DOC supervision? NO YES- CCO Name & phone: _____

VIII. Cultural Values:

What is your **ethnicity** (e.g. Caucasian, Asian, French-Canadian, Native American and Mexican mix, Irish descent, etc.)?
_____ or Decline to answer

Describe/define your **culture** (to include the groups or types of people you most identify with e.g. Goth, Prep, Jocks, Yuppie, Hippie, Law Enforcement, Christians, etc.): _____ or Decline to answer

What **socioeconomics** do you most identify with (e.g., poor, middle class, etc.)?
_____ or Decline to answer

What **political affiliations** do you most identify with (e.g. Republican, Environmentalist)?
_____ or Decline to answer

What past and/or current **geographic area** do you most identify with (e.g. Canadian, Brooklyn N.Y., rural, big city, etc.)?
_____ or Decline to answer

What **family traditions** did/do you practice (e.g. reunions, celebrated holidays, foods eaten, etc.)?
_____ or Decline to answer

What **spiritual/religious beliefs** do you value/practice (e.g. Buddhism, Wiccan, Medicine Wheel, etc.)?
_____ or Decline to answer

Are there any **important rituals** you value and/or practice (e.g. baptism, bar mitzvah, etc.)?
_____ or Decline to answer

Do you have any **symbols** that have meaning or importance to you (e.g. Flag, Yin-Yang, Cross, Angela wings, etc.)?
_____ or Decline to answer

What is your predominant language? English Spanish French German Russian
 Korean Chinese Japanese Filipino Other: _____

Do you speak more than one language fluently? YES NO If yes, in which language do you primarily think?

What generation/time period do you think most influences your values in life (e.g. Generation X, 50's kid, etc.)?
_____ or Decline to answer

What are your beliefs/values regarding sexual orientation (e.g. gay/lesbian, bisexual, questioning, transgender, heterosexual, etc.)?
_____ or Decline to answer

Consumer's name: _____

IX. Mental Health Treatment:

- I believe I am having emotional or psychological issues
- I need help figuring out how to manage my mental health symptoms so I can function day to day
- I have experienced trauma and/or abuse and need help for it
- I am having suicidal thoughts
- I am having homicidal thoughts
- I am cutting, stabbing, or burning on my body
- I need to see the psychiatrist for psychotropic medications
- I need help managing crisis to prevent psychiatric hospitalizations
- I am on an LRA from a psychiatric hospital
- I am unable to care for my basic needs as a result of my mental illness
- I have anger management problems
- I am having relationship problems
- I need help coping with my grief
- I am completely stressed out
- I can't leave my house due to panic or anxiety
- I have had counseling in the past
- I have been diagnosed with a mental health condition in the past
- My family or friends suggested I may need counseling
- I believe I need counseling for: _____
- Other reasons I am seeking Mental Health evaluation or treatment: _____

My desired Outcomes/Goals from counseling:

- | | |
|---|--|
| <input type="checkbox"/> Learn information about my mental health | <input type="checkbox"/> Learn to manage my mental health effectively |
| <input type="checkbox"/> Learn coping skills | <input type="checkbox"/> Learn relaxation skills |
| <input type="checkbox"/> Learn anger management skills | <input type="checkbox"/> Learn conflict resolution skills |
| <input type="checkbox"/> Learn to prevent crisis | <input type="checkbox"/> Learn to prevent psychiatric hospitalizations |
| <input type="checkbox"/> Stop hurting myself | <input type="checkbox"/> Stop hurting others |
| <input type="checkbox"/> Heal from my trauma/abuse | <input type="checkbox"/> Learn effective communication skills |
| <input type="checkbox"/> Build my self-esteem | <input type="checkbox"/> Learn problem-solving skills |
| <input type="checkbox"/> Learn to get along better with others | <input type="checkbox"/> Heal my grief |
| <input type="checkbox"/> Change my behavior(s) | |
| <input type="checkbox"/> Other(s): _____ | |

Support persons: Please add your comments, desired outcomes/goals and/or concerns: _____

Consumer/Guardian Signature: _____ **Date:** _____

Support Person(s): _____ **Date:** _____

PEND OREILLE COUNTY COUNSELING SERVICES
Intake Information
TREATMENT PREFERENCES

Name: _____ Date: ___/___/___

We will make every effort to accommodate a request for a specific therapist. Decisions are based on current caseload needs and appropriate clinical fit. If you have a preference as to a therapist/case manager, please write their name in the space provided below.

My choice of therapist/Case Manager is: _____

Client/Guardian Signature: _____

RESOURCE MANAGEMENT TO COMPLETE

Preference given: Yes No

If no, reason provided: _____

PEND OREILLE COUNTY COUNSELING SERVICES
PO Box 5055, Newport, WA 99156
509 447-5651/TTY: 509 447-0487/Fax 509 447-6438

INDIVIDUAL RIGHTS

You have the right to:

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
- Be free of any sexual harassment;
- Be free of exploitation, including physical and financial exploitation;
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
- Receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency, or regional support network (RSN), if applicable, if you believe your rights have been violated; and
- File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.
- All research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.

Medicaid Recipient Additional Rights:

- Receive medically necessary mental health services, consistent with the Access to Care Standards adopted by the department in its managed care waiver with the federal government.
- Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.
- Receive information about the structure and operation of the BHO.
- Receive emergency or urgent care or crisis services.
- Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.
- Receive age and culturally appropriate services.
- Be provided a certified interpreter and translated material at no cost to you.
- Receive information you request and help in the language or format of your choice.
- Have available treatment options and alternatives explained to you.
- Refuse any proposed treatment.
- Receive care that does not discriminate against you.
- Be free of any sexual exploitation or harassment.
- Receive an explanation of all medications prescribed and possible side effects.
- Make a mental health advance directive that states your choices and preferences for mental health care.
- Receive information about medical advance directives.
- Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.
- Change behavioral health care providers at any time for any reason.
- Request and receive a copy of your medical or behavioral health services records, and be told the cost for copying.
- Be free from retaliation.
- Request and receive policies and procedures of the BHO and behavioral health agency as they relate to your rights.
- Receive the amount and duration of services you need.
- Receive services in a barrier-free (accessible) location.
- Medically necessary services in accordance with the Early Periodic Screen, Diagnosis and Treatment (EPSDT) under WAC 182-534-0100, if you are twenty years of age or younger.
- Receive enrollment notices, informational materials, materials related to grievances, appeals, and administrative hearings, and instructional materials relating to services provided by the BHO, in an easily understood format and non-English language that you prefer.
- Be treated with dignity, privacy and respect, and to receive treatment options and alternatives in a manner that is appropriate to your condition.
- Participate in treatment decisions, including the right to refuse treatment.
- Be free from seclusion or restraint used as a means of coercion, discipline, convenience, or retaliation.
- A second opinion from a qualified professional within your BHO area at no cost, or to have one arranged outside the network at no cost to you, as provided in 42 C.F.R. § 438.206(3).
- Receive medically necessary behavioral health services outside of the BHO, if those services cannot be provided adequately and timely within the BHO.

- File a grievance with the BHO if you are not satisfied with a service.
- Receive a notice of action so that you may appeal any decision by the BHO that denies or limits authorization of a requested service, that reduces, suspends, or terminates a previously authorized service; or that denies payment for a service, in whole or in part.
- File an appeal if the BHO fails to provide services in a timely manner as defined by the state, or act within the timeframes provided in 42 CFR § 438.408(b).
- Request an administrative (fair) hearing if your grievance or appeal is not resolved in your favor.
- Services by the behavioral health Ombuds office: 1(800) 346-4529 to help you in filing a grievance or appeal, or to request an administrative hearing.

This agency shall obtain your consent for each release of information to another person or entity. This consent for release of information shall include:

- Name of the consenting patient;
- Name or designation of the provider authorized to make the disclosure;
- Name of the person or organization to whom the information is to be released;
- Nature of the information to be released, as limited as possible;
- Purpose of the disclosure, as specific as possible;
- Specification of the date or event on which the consent expires;
- Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;
- Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and
- A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.

This agency shall notify you that outside persons or organizations which provide services to the agency are required by written agreement to protect your confidentiality.

You have the right to be given a copy of these rights both at admission and in case of discharge.

Enrollee Responsibilities

As a consumer of mental health services at Pend Oreille County Counseling Services, you are responsible to:

1. Participate in the development of your service plan or "treatment plan" in collaboration with your counselor.
2. The enrollee has the responsibility to participate fully in that treatment plan including keeping appointments and work towards the goals of that treatment plans best as he or she is able to do.
3. Once informed to decide on whether you want to develop a Mental Health Advance Directive.
4. Get established with a primary care practitioner and if you give consent, to request that the medical provider and counselor collaborate on your care.
5. Not come to the counseling center under the influence of alcohol or other drugs.
6. Not engage in any threats or acts of violence on the premises of the counseling center.
7. Raise concerns or questions at any time to any person regarding their treatment or service from the provider or practitioner.

In Box, write questions or comments regarding rights & responsibility for Agency staff to address.

This Section to be completed with intake interviewer.

My rights & responsibilities have been discussed with me to include my questions/concerns.

Client/Guardian Signature: _____ **Date:** _____

Staff/Witness: _____

Legal Representation

I am at least thirteen years old and have legal capacity to make decisions as to my mental health.

If there is a legal guardianship or power of attorney in place, a copy **must** be provided to POCCS. The guardian or power of attorney must sign all documents consenting to treatment, client rights and responsibilities and consent to release confidential information.

I do not have a guardianship or power of attorney assigned but would like additional information.

YES

NO

The remainder of this form must be completed and signed for consumers who are minors (children twelve years old and younger) and adults who have a guardian or recognized person with power of attorney.

I, _____ attest to having the legal authority to sign consent for
(parent/guardian)

treatment and other required documents for mental health services regarding

_____. Upon request I will be able to provide documentary evidence
(identified consumer)

verifying this declaration. I further understand that I will need to provide this documentation prior to the identified consumer starting regular counseling services and that if I cannot provide documentation within 30 days of the intake date, then services will be closed.

Client/Guardian Signature: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

Pend Oreille County Counseling Services
ETHNICITY/DISABILITY/SEXUAL INFORMATION

1. I understand that the information provided on this form is voluntary.
2. I further understand that:
 - a) it will not create an adverse action as a result of failure to finish this information.
 - b) this information will be maintained confidentially and separate from client or employee personnel files.
 - c) this information will be used for Civil Rights purposes.
 - d) this information will be provided only to a Civil Rights Complaint Investigator. Otherwise, the data will be released only as compiled data on the aggregate and not related to individuals or as provided in the Privacy Act Statement.

ETHNICITY:

- 010 White 021 Native American 040 African American 050 Other
 999 Information not provided

HISPANIC ORIGIN:

- 998 Not Hispanic 722 Mexican, Mexican American, Hispanic 799 Other Spanish
 999 Information not provided

SEXUAL ORIENTATION:

- 01 Heterosexual 02 Gay 09 Information not provided

DISABILITY STATUS:

This disability should have a major impact on and your ability to function in the community and to procure food, clothing, and safe place to live.

- a) Development or intelligence; i.e. mental retardation or developmental disorder, organic brain syndrome.
- c) Physical (unable to walk without assistance, unable to care for self, chronic illness)
- d) Alcohol or drug dependence; i.e. dependence on alcohol or drugs which negatively affects the individual's ability to maintain a stable living arrangement, unable to remain in competitive employment, unable to provide adequate care for dependents, legal problem relating to substance abuse.
- e) Vision impairments (does not include wearing eye glasses)
- x) Other - Medical or physical disabilities not listed above _____
- y) Unknown
- z) None

PRINTED NAME OF CLIENT/GUARDIAN

PRINTED NAME OF PARENT/GUARDIAN (if child)

SIGNATURE OF CLIENT/GUARDIAN

DATE

PEND OREILLE COUNTY COUNSELING SERVICES

CONSUMER TB/HEPATITIS SCREEN

The Occupational Safety and Health Administration (OSHA) and Washington Industrial Safety and Health Administration (WISHA) guidelines require health care facilities to take steps to prevent the transmission of the Tuberculosis (TB) in the work place.

This Agency strives to protect patients and staff from Tuberculosis (TB) & Hepatitis through screening, education, and when appropriate, referral for prevention or treatment.

PLEASE INDICATE WITH A "X" WHICH STATEMENTS APPLY TO TB.

I have Tuberculosis (TB). Someone in my immediate family has TB.
 I have recently been exposed to TB. To the best of my knowledge I do not have TB.

I HAVE THE FOLLOWING SYMPTOMS:

Drenching night sweats of more than a two week duration.
 Unexplained weight loss. Coughing lasting more than two weeks.
 Coughing or spitting up blood. Hoarseness.
 Chest pain None of the above.

PLEASE INDICATE WITH A "X" WHICH STATEMENTS APPLY TO HEPATITIS.

I have hepatitis To the best of my knowledge I do not have Hepatitis.

I HAVE THE FOLLOWING SYMPTOMS:

Fatigue Nausea & vomiting
 Lack of appetite Yellowing of the skin
 Low grade fever Tenderness in the area of the Liver

PRINTED NAME OF CLIENT/GUARDIAN

PRINTED NAME OF PARENT/GUARDIAN

SIGNATURE OF CLIENT/PARENT/GUARDIAN

DATE

PEND OREILLE COUNTY COUNSELING SERVICES
P. O. Box 5055, Newport, WA 99156
CONSENT FOR TREATMENT

As a client of this Agency, I understand that I have all the rights outlined in the client's Statement of Rights. The statement of rights is also posted in the lobby.

I understand that if I have the responsibility to provide accurate financial information, I have the right to know my fee and the fee policies of the Center. I further understand I have the responsibility to pay an agreed upon fee at the time of service.

I understand that if I have medical coupons, that I am responsible to provide the Center with a copy of my coupon at each visit. A copy may be made at the Newport Center. If I do not bring my coupon I may be denied service until the coupon is provided.

I understand that I have the responsibility to actively participate in the development of an Individual Plan of treatment and to keep scheduled appointments and follow the agreed upon Individual Plan.

I understand that I have the right to know the therapeutic and side affects of any medication recommendations that I accept. I further understand that I have the responsibility to follow medication directions and cautions.

I understand that if I am unable to keep an appointment, I need to give a 24 hour notice of cancellation and that it is my responsibility to reschedule. A new appointment will not be made unless I request one. If I do not contact the Agency within two weeks of a missed appointment, my file will be closed. I further understand that if I miss two (2) consecutive appointments my file will be closed. In either of these situations I will need to complete a new Initial Service Assessment for reinstatement. Exception to this may be made for special circumstances by approval of the Agency Director or Clinical Director.

I understand that my case and client file will be reviewed by my therapist's supervisor and that consultation may be made with other clinical staff within the Agency. Disclosure may also be made under RCW 70.02.030 and RCW 70.02.050.

I understand that I may not participate in treatment if I have infectious TB. If I have symptoms of TB I will be asked to obtain a TB test prior to treatment.

I acknowledge that I have received the following information to take home with me: Statement of Client Rights; Portions of RCW 71.05 and RCW 70.02 pertaining to client confidentiality; Non Discrimination Policy; Ambitious information; and other counseling information.

My signature indicates that I have read this consent form and agree to accept treatment for myself or my dependent child, under these conditions.

Client/Parent/Legal Guardian Signature

Date

**PEND OREILLE COUNTY
COUNSELING SERVICES**

**This is to acknowledge receipt of HIPAA
Notice of Privacy Act Practices and Clients Rights**

Printed Name of Client/Guardian

Client/Guardian Signature

Date

ADVANCE DIRECTIVE for Psychiatric Care

What is a mental health advance directive?

A mental health advance directive is a written document that describes your directions and preferences for treatment and care during times when you are incapacitated due to a mental illness (having difficulty communicating and making decisions). This document can inform others about what treatment you want or don't want, and it can identify a person called an 'agent' who you trust to make decisions and act on your behalf. Anything that might be involved in your treatment can be a part of a mental health advance directive.

Advance Directives are a contract requirement for NCRSN and your local community mental health center according to the following: "Establish, implement and maintain written policies and procedures regarding Advance Directives for Psychiatric Care in accordance with 42-CFR-434.28. 42-CFR-43.28 is a federal regulation that lets people know about their rights to have an Advance Directives." Your mental health provider "...shall comply, respect and utilize Advance Directives for service recipients who are experiencing situation for which they have planned in advance and created this directive so long as they are clinically appropriate."

Why should I have a mental health advance directive?

There are advantages to having a mental health advance directive:

- You have more control over what happens to you during periods of crisis (i.e., psychiatric hospitalizations).
- Communicate your preference for treatment in the event of a psychiatric emergency
- Your directive can help your case manager and others who are involved in your mental health treatment/life.
- The law requires providers to respect what you write in a mental health advance directive to the fullest extent possible.

Are there any disadvantages to having an advance directive:

Having an advance directive is one means to have your voice heard even if/when you are incapacitated from a mental illness but it will take some time on your part to complete and/or develop an advance directive. Receipt of mental health services are not conditional on you having an Advance Directive. If you do not anticipate needing an advance directive, then completing one may not be of interest to you.

An Advance Directive may include the following:

- ✓ provider contact list
- ✓ Stated preferences for childcare
- ✓ Instructions for petcare
- ✓ Instructions for notifying an employer
- ✓ Hospital preferences
- ✓ Family/friends to be notified
- ✓ Medications
- ✓ Medications that you never want
- ✓ What works
- ✓ What doesn't work
- ✓ Other treatment preferences
- ✓ Health information
- ✓ Discharge planning

➤ **Must be signed by the consumer to be valid**

- *If you name an agent, that person must be given a copy. After that, it is up to you who you give a copy to. Think about giving one to your current mental health provider, your lawyer (if you have one) and trusted family members. Bring a copy if you are being admitted to a mental health facility. Any treatment provider who gets a copy is required to make it a part of your medical record.*
- *Advance Directive can be changed or revoked at any time by the consumer*
- *By law, your agent cannot be your doctor, your case manager/therapist or your residential provider unless that person is also your spouse, adult child, or sibling.*

Consumer Name: _____

How do I complete a mental health advance directive?

A model "fill-in-the-blanks" form was included in the state law and it is probably the best and easiest way to create a mental health advance directive. (*You have the right to use or create other advance directive forms*). You may find the State form at: <http://www.dshs.wa.gov/dbhr/advdirectives.shtml> or request a copy of this form from the POCCS Intake specialist or a counselor/case manager.

Will everything in my mental health advance directive be followed?

Here are the instances in which your mental health advance directive may not be followed:

- Your instructions are against hospital policy or are unavailable
- Following your directive would violate state or federal law
- Your instructions would endanger you or others
- You are hospitalized under the Involuntary Treatment Act, or are in jail

How may I obtain further information on Advance Directives

- Contact your case manager/counselor
- Attend and Advance Directive workshop
- Obtain assistance from a lawyer or legal services office
- Request an Advance Directive workbook
- Read additional publications on Advance Directives
- Contact Spokane County Regional Support Network (SCRSN)
312 West 8th, Spokane, WA 99204 Office: 509-477-4683 Fax: 509-477-6204
- Contact SCRSN Ombuds Services at 1-800-346-4529
- Contact Washington Protection & Advocacy Systems at 1-800-562-2702
- See the State web site http://www.dshs.wa.gov/dbhr/mh_information.shtml
- Read information on RCW 71.32 regarding Advance Directives

Non compliance with the Advance Directive

- Enrollees that have complaints concerning noncompliance with their advance directive for psychiatric care may be filed with the Mental Health Division by contacting the Compliance Section at 1-888-713-6010.

CONSUMER TO COMPLETE

I have been informed of Advance Directives and decline at this time. I understand that declining does not terminate my rights to initiate an Advance Directive at a future date.

I am interested in developing an Advance Directive and have been provided a packet.

Client/Guardian Signature: _____

Pend Oreille County Counseling Services

Statement of Understanding

I _____ as a client of Pend Oreille County Counseling Services understand and acknowledge the following conditions:

- A. Clients who are not appropriate or noncompliant with service requirements will be closed for services.
- B. Clients missing two consecutive appointments, regularly missing or rescheduling appointments, or missing 25% of scheduled appointments may be closed.
- C. Newly assigned clients will be closed if their counselor is unable to contact them after two unsuccessful attempts. Clients will also be closed if they do not contact their counselor within two weeks of a missed appointment.
- D. Consistent attendance and participation is essential to achieve therapeutic success. Clients regularly missing or rescheduling appointments may be closed.
- E. Individuals must come in for services at a minimum of once every 30 days.
- F. Clients are asked to present **15 minutes prior** to the scheduled appointment time. If clients do not arrive at POCCS by the exact appointment time, it will be considered a missed appointment and may be given to a walk-in/wait list client. Clients who are late for appointments will be considered as a "no show" and therefore missed their appointment. You may choose to wait at the office to see if your therapist has another "no show" that you can attend that day or reschedule.
- G. Client must participate in treatment goals. Those not fully participating in treatment may be closed. This includes not completing homework or taking a poor attitude toward treatment.
- H. Clients who are closed from services as a result of missed appointments, will need to complete a new Intake before being assigned to individual counseling services again.
- I. Clients, who are intoxicated or appear to be intoxicated by use of alcohol, abuse of prescription drugs, illegal drugs, or any other intoxicant will not be seen in session. Clients will be warned once and not allowed to participate in the session. A second incident will result in closure of services.
- J. Clients closed for the reasons in H. above must complete a Chemical dependency Assessment within 30-days of re-establishing Mental Health Services.
- K. Crisis services will continue to be available for clients who have been closed for services 24 hours a day, 7 days a week by calling 447-5651 during office hours. After office hours you will need to call toll free 1-800-767-6081.

Signature of Client/Guardian

Date

Medicaid Personal Care Program

What Is The Medicaid Personal Care (MPC) Program?

The Medicaid Personal Care Program provides assistance with activities of daily living to Medicaid recipients who have a chronic illness, medical condition or disability. Services may be provided in the eligible individual's home or community residence.

To apply for MPC in Pend Oreille County, contact *Home and Community Services in the Rural Resources office on 301 W Spruce, Suite D, Newport, WA 99156, 509-550-7049, Fax: 509-550-7055 or info@ruralresources.org*. The Qualified applicants must meet both the Medicaid Program's financial and medical requirements.

Services provided in the program include assistance with these activities of daily living:

- Bathing;
- Toileting;
- Mobility, including transferring from place to place;
- Eating;
- Nutritional planning and meal preparation; and
- Dressing

- Household services related to medical needs;
- Food shopping;
- Escort services to a medical appointment; and
- Personal hygiene and grooming.

An assessment of the recipient's personal care needs and the applicant's available support system is completed. If the applicant's personal care needs can be met by the program's services, then the applicant is encouraged to identify a personal care provider to assist them with their care. Providers may not be a member of the recipient's immediate family, but may be a friend or neighbor. If the recipient does not know a provider, the nurse case monitor can assist the recipient locate one.

The frequency of services provided to the recipient is determined by the assessment. Depending on the assessment, services may be provided from one to seven days a week. Once the assessment is completed, a plan of care with the recipient, and the appropriate training for the provider will be arranged. Skilled nursing services, such as those provided by a registered nurse, are not provided by this program.

- YES - Needs have been identified that may be appropriate for Medicaid Personal Care. I have been provided information and a referral to Home & Community Services for further assistance.
- NO - at this time MPC is not necessary but I have been provided information on how to access services in the future if/when a need is identified.

Consumer/Parent/Guardian Signature: _____
(Please sign to indicate you have been informed of MPC)

Appendix N: Mental Health Treatment Options for Minor Children

Parents or guardians seeking a mental health evaluation or treatment for a child must be notified of all legally available treatment options. These include minor-initiated treatment, parent-initiated treatment, and involuntary commitment.

Minor-Initiated Treatment (RCW 71.34.500-530)

A minor child, 13 to 18 years old, of age or older may request an evaluation for outpatient or inpatient mental health treatment without parental consent. If the facility agrees with the need for mental health treatment, the child may be offered mental health services. For a child under the age of 13, either parental consent or consent from an approved guardian is required for inpatient treatment.

Parent-Initiated Treatment (RCW 71.34.600-660)

If the child is under the age of 18, the parent, guardian or authorized individual may bring the child to any mental health facility or hospital and request that a mental health evaluation be provided. This evaluation cannot take longer than 72 hours. Consent of the child is not required for either an outpatient or inpatient evaluation, or recommended inpatient treatment.

If it is determined the child has a mental disorder, and there is medical need for inpatient treatment, the parent or guardian may request that the child be held for treatment. If the inpatient program believes the child needs treatment for more than 7 days, the state (DSHS) must then review the need for treatment. The child has the right to petition the Superior Court for release from the facility after the 7 days.

After the state review, if the state determines that the child no longer needs inpatient treatment, the parent or guardian must be immediately notified, and the child will be released within 24 hours. In this case, if the parent or guardian and facility both believe it is medically necessary for the child to remain in inpatient treatment, the facility will hold the child until the 2nd judicial day following the state review. This will allow the parent or guardian time to file an at-risk youth petition (RCW 13.32A.191) by calling the Department of Child and Family Services Intake Line or by going to their local Juvenile Court.

For information about possible out-of-home placement of the child, call the Department of Child and Family Services and request a family assessment per RCW 13.32A.150. Family Reconciliation Services (RCW 13.32A.040) may also be provided through this Department.

Children admitted to inpatient facilities under minor initiated or parent initiated treatment procedures must be released from the facility immediately upon the written request of the parent.

Please note:

A provider is not obligated to provide treatment to a minor under the provisions of Parent-Initiated Treatment. However, no provider may refuse to treat a minor under these provisions solely on the basis the minor has not consented to the treatment.

If the child is admitted to an inpatient mental health facility, he/she will be seen by a mental health specialist and medical staff within 24 hours. If it is determined that your child would be better served by a chemical dependency treatment facility he/she will be referred to an approved treatment program defined under RCW 70.96A.020. **Involuntary Treatment (RCW 71.34.700-795)**

If the facility believes the child is in need of immediate inpatient mental health treatment and the child refuses to consent to a voluntary admission, the child may be held for up to 12 hours to enable a Designed Mental Health Professional (DMHP) to evaluate the child for possible involuntary commitment.

If no voluntary or less restrictive alternatives are available, and the DMHP determines that the child presents as a likelihood of serious harm or grave disability, as a result of a mental disorder, the child may be held at a facility. The child can be held for treatment up to 72 hours, excluding weekends and holidays. During this time, the facility may petition the court to have the child committed for an additional fourteen days if they believe further treatment is necessary. At the end of the 14 days, the facility may file a petition for up to one hundred eighty days of additional treatment. If the facility does not file a petition for an additional 14 or 180 days, the parent or guardian may seek review of the decision by filing notice with the court and providing a copy of the facility's report. To obtain a copy of the report, a Release of Information form must be completed and submitted to the records department of the inpatient facility.

If the DMHP does not hold the child, the parent or guardian may seek review of that decision by filing notice with the court and providing a copy of the DMHP's report or notes. To obtain a copy of the report or notes, a Release of Information form must be completed and submitted to the records department of the DMHP agency.

If the child is released from hospitalization on a conditional release or a court order for a less restrictive alternative and is not following the conditions of that order or has substantially deteriorated in his/her functioning the child may be taken into custody by a DMHP and transported to an inpatient evaluation and treatment facility. For further assistance or questions, call the local mental health crisis line and request to speak with a DMHP.

_____ Please initial here to indicate you have been provided with written and verbal notice of the available treatment options for the child.

Parent/Guardian Signature

Date

Facility Representative Signature

Date

Legal Consent For Children

Children under the age of 13 years old must be accompanied to the Intake by an adult, preferably the parent/guardian. If the child is accompanied by an adult who is not the parent/legal guardian, parental/legal guardian consent for the child to be seen by a mental health provider must be obtained prior to or along with the child at time of the intake interview.

As a treatment provider, we must comply with any legal court orders that may be filed regarding your child. Many times, these court documents identify parental or guardian rights to place a child in treatment. Legal documents that may apply include **Parenting Plans, Child Custody, Adoption, State Dependency, Foster Placement and Legal Guardianship.**

In the Intake packet, you will find a Consent For Treatment form (page 23) and a Legal Representation form (page 26). These forms are important for children under the age of 13 years old who need parental/legal guardian consent to receive counseling services.

If there is court ordered Dependency or Guardianship, we will need a copy of this paperwork and the designated individual(s) and/or agency must sign all paperwork.

If the legal document states there are *joint* custodial rights regarding routine medical or health treatment, then **both** parents/guardians must sign the forms on page 23 and page 26.

If the legal document states one parent/guardian has the sole right to decide, then the designated parent needs to sign page 23 and page 26.

Please be advised that a copy of the appropriate court document will be requested when you arrive for the Intake. The Intake will be cancelled if the appropriate signatures and/or documents are not provided. We regret any inconvenience this may cause.

Children 13 years of age and older have the right to access mental health services without parental consent. Therefore, children ages 13 through 17 years of age need to sign each *Client, Consumer or Client/Parent/Guardian Signature* line throughout the Intake paperwork. Parents/Guardians have the opportunity to provide input on page 18 of the Intake paperwork as support persons and are encouraged to sign as *Support Persons* on the appropriate signature line.

Please disregard this form if the above information does not apply to your child.

Please sign that you have read this form. Please speak with POCCS staff if you have any questions, concerns or need further explanation.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Medical History

Responses are confidential and are important for adequate clinical and medication management

Name: _____ DOB: _____ Age: _____ Today's Date _____

Primary Physician: _____ Phone: _____

Address: _____

Other physicians/specialist seen: (1) _____ Phone: _____

Address: _____

(2) _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

List all allergies _____

List all current medications: _____

List previous psychotropic medication. Please note if certain medications did not work or had unpleasant side effects?

Initial box indicating you have read/been informed of the following medication services information:
Pend Oreille County Counseling Services offers medication management services. This is decided on a case by case basis with your assigned therapist/case manager. Should psychiatric medications be a recommended part of your treatment, please be informed that it is our policy to immediately forward medication information to your identified primary care physician for management once your medications have been deemed stable, your request, and/or upon exit of services. Please keep your assigned therapist/case manager informed should you retain a primary care physician other than the one listed on this form.

Do you use: nicotine caffeine alcohol marijuana

other substances

Have you had a head injury brain surgery seizures coma

Please explain: _____

Problems with any of the following: heart lung liver kidneys bowel bladder PMS

muscular/skeletal system circulatory system reproductive system frequent headaches

Please explain: _____

List surgeries/hospitalizations with approximate dates: _____

Do you have religious preference regarding medical care? _____

Do you have a medical or psychiatric Advance Directive? YES NO

Intake specialist completes

Indications for medical/medication evaluation referral: YES NO

Referrals:

Consumer's comments regarding use of psychotropics as a treatment option: