**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: ____ ☐Male ☐ Female 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 _____

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
- ☐ use prescription 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
- ☐ impulsiveness

**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

# 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
- ☐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
- ☐Other: _____

**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
- ☐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
- ☐Other: _____

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

Consumer's name: _____

VI. **Community Support System:** ☐**No Needs** ☐**Decline to answer**

☐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: _____

☐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:** ☐**No Needs** ☐**Decline to answer**

☐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

☐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:**

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

# Individual Rights

**You have the right to:**

1) Information about their behavioral health status;
2) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
3) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
4) 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;
5) Be reasonable accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
6) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
7) 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;
8) Be free of any sexual exploitation or harassment;
9) Be free of exploitation, including physical and financial exploitation;
10) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
11) Request and receive copy of your medical records and to review your clinical record in the presence of an administrator or designee and be given an opportunity to make amendments or corrections;
12) Develop a plan of care and services in amount and duration which meets your age and cultural needs including the right to mental health specialist's consultations;
13) Refuse any proposed treatment, consistent with the requirements in chapter 71.05 and 71.34 RCW and to understand treatment options and alternatives;
14) Receive an explanation of all medications prescribed, including expected effect and possible side effects;
15) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC and other applicable stated and federal rules and laws;
16) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
17) Enrollees have a right to receive direct access to mental health specialists for beneficiaries with long-term or chronic care needs (e.g. severely and persistently mentally ill adults or severely emotionally disturbed children);
18) If you are Medicaid eligible, receive quality services, which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary. Contact a Clinical Program Manager at this Agency if you desire a second opinion;
19) Receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with POCCS or the Ombuds or Regional Support Network, if applicable, if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The Ombuds may, at your request, assist you in filing a grievance. The Ombuds' phone number is: 1(800) 346-4529;
20) File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies;
21) Disenroll from his/her mental health prepaid health plan when the consumer has "good cause" for disenrollment. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;
22) Choose a participating MHCP in accordance with WAC or any successor. If you do not make a choice, this Agency will assign a MHCP no later than 14 working days following your request for services;
23) Allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan;
24) Change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;
25) Appeal and denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;
26) File an administrative hearing with DSHS without first accessing the contractor's grievance process. Use the DSHS pre-hearing and administrative hearing process as described in chapter 388-02 WAC;

27) You also have the right to receive information about your counselor/case manager concerning their license, professional credentials, education, professional experience, and clinical orientation;
28) To be free from any sort of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
29) To receive services in a barrier-free location (accessible);
30) To request information about names, location, phones, and languages for local agencies;
31) To receive services within 2 hours for emergent care and 24 hours for urgent care; and
32) If the consumer does not make a choice, the mental health agency will assign a primary mental health care provider no later than fifteen working days after the enrollee requests services.

**Additional rights for consumers on Less Restrictive Alternative**

33) If the consumer is on a less restrictive alternative court order, to have access to attorneys, courts, and other legal redress;
34) Have the right to be told statements the consumer makes may be used in the involuntary proceedings;
35) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 as applicable;
36) Be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder; and
37) Any person who leaves a public or private agency following evaluation or treatment for mental disorder shall be given a written statement setting forth the substance of WAC 388-865-0585.

## Enrollee Responsibilities

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

1. The enrollee has the responsibility to participate in the development of the plan of care, or "treatment plan", with the treating provider or practitioner.
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. The enrollee has the responsibility once informed to decide on an Advance Directive.
4. The enrollee has the responsibility to get established with a primary care practitioner. In addition, the enrollee has the responsibility to request that medical provider to collaborate with the mental health practitioner, if consent is given to do so.
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. The enrollee has the responsibility to 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 <u>with</u> intake interviewer.**

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

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

**Staff/Witness:** _____

**Pend Oreille County Counseling Services**
**PO Box 5055 Newport, WA. 99156**

# 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 ☐ 03 Gay ☐ 04 Bisexual ☐ 05 Questioning/Other ☐ 08 Not asked/Under 13

☐ 09 Choosing not to disclose

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 effects 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
105 South Garden Avenue or PO Box 5055 Newport, WA 99156
1-800-404-5151 or 509-447-5651 TTY: 509-447-0487
FAX: 509-447-2671 www.pendoreilleco.org

# PRIVACY POLICY

**THIS NOTICE DESCRIBES HOW MEDICAL, BEHAVIORAL HEALTH, MENTAL HEALTH AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C.§1320d *et seq.*, 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Under these laws, Pend Oreille County Counseling Services (POCCS) may not say to a person outside POCCS that you attend the program, nor may POCCS disclose any information identifying you as an alcohol or drug treatment patient, or disclose any other protected information except as permitted by federal law.

POCCS must obtain your written consent before it can disclose information about you for payment purposes. For example, POCCS must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. POCCS is also required to obtain your written consent before it can sell information about you or disclose information about you for marketing purposes, and POCCS must obtain your written consent before disclosing any of your psychotherapy records. Generally, you must also sign a written consent before POCCS can share information for treatment purposes or for health care operations. However, federal law permits POCCS to disclose information *without* your written permission. Under relevant statute: Chapter 10.77 and RCW 71.05, RCW 26.44.030, and Chapter 388-865 WAC

1. Pursuant to an agreement with a qualified service organization/business associate;
2. For research, audit or evaluations;
3. To report a crime committed on POCCS's premises or against POCCS personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by court order.

For example, POCCS can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before POCCS can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you orally or in writing.

Your Rights

Under HIPAA, you have the right to request restrictions on certain uses and disclosures of your health information. POCCS is only required to agree to your request if you request a restriction on disclosures to your health plan for payment or health care operations purposes, and you pay for the services you receive from POCCS yourself (out-of-pocket), unless the disclosure is otherwise required by law. In any other situation, POCCS is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. POCCS will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by POCCS. Currently POCCS does not use electronic health records. You have the right to a copy of your records, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in POCCS's records, and to request and receive an accounting of disclosures of your health-related information made by POCCS during the six years prior to your request. You also have the right to receive a paper copy of this notice.

POCCS's Duties

POCCS is required by law to maintain the privacy of your health information, provide you with notice of its legal duties and privacy practices with respect to your health information, and to notify you if you are affected by any breach of your unsecured health information. POCCS is required by law to abide by the terms of this notice. POCCS reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. POCCS will provide all active patients with a new copy of any revised notifications and will also post the updated notice on its website http://pendoreilleco.org/your-government/counseling-services/.

Complaints and Reporting Violations

You may complain to POCCS and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. To file a complaint with POCCS, please contact the Compliance Coordinator at (509) 447-5651 or (800) 404-5151.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact

For further information, contact the Compliance Coordinator at (509) 447-5651 or (800) 404-5151 or by mail at P.O. Box 5055, Newport, WA 99156

Acknowledgement

I hereby acknowledge that I received a copy of the POCCS Privacy Policy.

_____

Individuals Printed Name

_____ _____

Individuals Signature Date

# PEND OREILLE COUNTY
# COUNSELING SERVICES

**This is to acknowledge receipt of the**
**Individual Rights**
**and the**
**Privacy Policy**

| _____ | _____ | _____ |
|---|---|---|
| **Printed Name of Client/Guardian** | **Client/Guardian Signature** | **Date** |

## WASHINGTON STATE BEHAVIORAL HEALTH

**This is to acknowledge that I have received the**
**Washington State Behavioral Health Benefits Book**

| _____ | _____ | _____ |
|---|---|---|
| **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 pet care
- ✓ 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 Behavioral Health Organization (SCRBHO)
  312 West 8th, Spokane, WA 99204 Office: 509-477-4683 Fax: 509-477-6204
- Contact Spokane Regional BHO 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.

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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 are not 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. You 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 missed appointments, will needs 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 I. 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 509-447-5651 during office hours. After office hours you will need to call toll free 1-866-847-8540.

_____ _____

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.

### How Do I Apply for These Services?

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.

### What Services Are Provided in The Medicaid Personal Care Program?

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

**Services for individuals who need help with activities of daily living may also receive help with:**

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

### How Are Individuals Assessed for The Program?

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.

### How Frequently and By Whom Are Personal Care Services Provided?

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 Q: 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)

**RCW 71.34.500**
**Minor thirteen or older may be admitted for inpatient mental treatment or approved substance use disorder treatment program without parental consent—Professional person in charge must concur - Written renewal of consent required. (*Effective April 1, 2018.*)**

(1) A minor thirteen years or older may admit himself or herself to an evaluation and treatment facility for inpatient mental health treatment or an approved substance use disorder treatment program for inpatient substance use disorder treatment without parental consent. The admission shall occur only if the professional person in charge of the facility concurs with the need for inpatient treatment. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for inpatient treatment of a minor under the age of thirteen.

(2) When, in the judgment of the professional person in charge of an evaluation and treatment facility or approved substance use disorder treatment program, there is reason to believe that a minor is in need of inpatient treatment because of a mental disorder or substance use disorder, and the facility provides the type of evaluation and treatment needed by the minor, and it is not feasible to treat the minor in any less restrictive setting or the minor's home, the minor may be admitted to the facility.

(3) Written renewal of voluntary consent must be obtained from the applicant no less than once every twelve months. The minor's need for continued inpatient treatments shall be reviewed and documented no less than every one hundred eighty days.

**RCW 71.34.510**
**Notice to parents when minor admitted to inpatient treatment without parental consent.**

The administrator of the treatment facility shall provide notice to the parents of a minor when the minor is voluntarily admitted to inpatient treatment under RCW 71.34.500. The notice shall be in the form most likely to reach the parent within twenty-four hours of the minor's voluntary admission and shall advise the parent: (1) That the minor has been admitted to inpatient treatment; (2) of the location and telephone number of the facility providing such treatment; (3) of the name of a professional person on the staff of the facility providing treatment who is designated to discuss the minor's need for inpatient treatment with the parent; and (4) of the medical necessity for admission.

**RCW 71.34.520**
**Minor voluntarily admitted may give notice to leave at any time. (*Effective until April 1, 2018.*)**

(1) Any minor thirteen years or older voluntarily admitted to an evaluation and treatment facility under RCW 71.34.500 may give notice of intent to leave at any time. The notice need not follow any specific form so long as it is written and the intent of the minor can be discerned.

(2) The staff member receiving the notice shall date it immediately, record its existence in the minor's clinical record, and send copies of it to the minor's attorney, if any, the county designated mental health professional, and the parent.

(3) The professional person shall discharge the minor, thirteen years or older, from the facility by the second judicial day following receipt of the minor's notice of intent to leave.

**RCW 71.34.530**

**Age of consent—Outpatient treatment of minors.**

Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

## Parent-Initiated Treatment (RCW 71.34.600-660)

**RCW 71.34.610**

**Review of admission and inpatient treatment of minors—Determination of medical necessity—Department review—Minor declines necessary treatment—At-risk youth petition—Costs—Public funds.**

(1) The department shall assure that, for any minor admitted to inpatient treatment under RCW 71.34.600, a review is conducted by a physician or other mental health professional who is employed by the department, or an agency under contract with the department, and who neither has a financial interest in continued inpatient treatment of the minor nor is affiliated with the facility providing the treatment. The physician or other mental health professional shall conduct the review not less than seven nor more than fourteen days following the date the minor was brought to the facility under RCW 71.34.600 to determine whether it is a medical necessity to continue the minor's treatment on an inpatient basis.

(2) In making a determination under subsection (1) of this section, the department shall consider the opinion of the treatment provider, the safety of the minor, and the likelihood the minor's mental health will deteriorate if released from inpatient treatment. The department shall consult with the parent in advance of making its determination.

(3) If, after any review conducted by the department under this section, the department determines it is no longer a medical necessity for a minor to receive inpatient treatment, the department shall immediately notify the parents and the facility. The facility shall release the minor to the parents within twenty-four hours of receiving notice. If the professional person in charge and the parent believe that it is a medical necessity for the minor to remain in inpatient treatment, the minor shall be released to the parent on the second judicial day following the department's determination in order to allow the parent time to file an at-risk youth petition under chapter 13.32A RCW. If the department determines it is a medical necessity for the minor to receive outpatient treatment and the minor declines to obtain such treatment, such refusal shall be grounds for the parent to file an at-risk youth petition.

(4) If the evaluation conducted under RCW 71.34.600 is done by the department, the reviews required by subsection (1) of this section shall be done by contract with an independent agency.

(5) The department may, subject to available funds, contract with other governmental agencies to conduct the reviews under this section. The department may seek reimbursement from the parents, their insurance, or Medicaid for the expense of any review conducted by an agency under contract.

(6) In addition to the review required under this section, the department may periodically determine and re-determine the medical necessity of treatment for purposes of payment with public funds

**RCW 71.34.620**

**Minor may petition court for release from facility.**

Following the review conducted under RCW 71.34.610, a minor child may petition the

superior court for his or her release from the facility. The petition may be filed not sooner than five days following the review. The court shall release the minor unless it finds, upon a preponderance of the evidence, that it is a medical necessity for the minor to remain at the facility.

**RCW 71.34.630**

**Minor not released by petition under RCW 71.34.620—Release within thirty days—Professional may initiate proceedings to stop release. (*Effective until April 1, 2018.*)**

If the minor is not released as a result of the petition filed under RCW 71.34.620, he or she shall be released not later than thirty days following the later of: (1) The date of the department's determination under RCW 71.34.610(2); or (2) the filing of a petition for judicial review under RCW 71.34.620, unless a professional person or the *county designated mental health professional initiates proceedings under this chapter.

**RCW 71.34.640**

**Evaluation of treatment of minors.**

The department shall randomly select and review the information on children who are admitted to inpatient treatment on application of the child's parent regardless of the source of payment, if any. The review shall determine whether the children reviewed were appropriately admitted into treatment based on an objective evaluation of the child's condition and the outcome of the child's treatment.

**RCW 71.34.650**

**Parent may request determination whether minor has mental disorder requiring outpatient treatment—Consent of minor not required—Discharge of minor. (*Effective until April 1, 2018.*)**

(1) A parent may bring, or authorize the bringing of, his or her minor child to a provider of outpatient mental health treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a mental disorder and is in need of outpatient treatment.

(2) The consent of the minor is not required for evaluation if the parent brings the minor to the provider.

(3) The professional person may evaluate whether the minor has a mental disorder and is in need of outpatient treatment.

(4) Any minor admitted to inpatient treatment under RCW 71.34.500 or 71.34.600 shall be discharged immediately from inpatient treatment upon written request of the parent.

**RCW 71.34.660**

**Limitation on liability for admitting or accepting minor child. (*Effective until April 1, 2018.*)** A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment under RCW 71.34.600 or 71.34.650 based solely upon the fact that the minor did not consent to evaluation or treatment if the minor's parent has consented to the evaluation or treatment.

**_____ 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 of 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:

# GAIN-SS FORM

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

| **Demographic Information and GAIN-SS (Self-Report) Complete by Consumer** | | | | | |
|---|---|---|---|---|---|
| DATE | LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH | GENDER<br>☐ Male ☐ 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? | ☐ Yes | ☐ No |
| b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day? | ☐ Yes | ☐ No |
| c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen? | ☐ Yes | ☐ No |
| d. when something reminded you of the past, you became very distressed and upset? | ☐ Yes | ☐ No |
| e. with thinking about ending your life or committing suicide? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| b. Have a hard time paying attention at school, work or home? | ☐ Yes | ☐ No |
| c. Have a hard time listening to instructions at school, work or home? | ☐ Yes | ☐ No |
| d. Been a bully or threatened other people? | ☐ Yes | ☐ No |
| e. Start fights with other people? | ☐ Yes | ☐ No |
| EDS Sub-scale Score (0 to 5) _____ | | |
| During the past 12 months did. . . | | |
| a. you use alcohol or drugs weekly? | ☐ Yes | ☐ 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)? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| SDS Sub-scale Score (0 to 5) _____ | | |



Client/Guardian Signature: _____ Date _____