Intake Packet
For Adults Ages 18+
Receiving Services from
Catholic Social Services of Washtenaw County

Behavioral Health Services

Policy No.: IPS 101		Subject: Notice of Privacy Practices
Effective Date: 04/13/2003	**Revised Date:** 06/06/2012	**Reviewed Date:** 12/02/15

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING HEALTH AND SERVICE INFORMATION:
We understand that health and service information about you is personal. We are committed to protecting health and service information about you. We create paper and/or electronic records of the care and services you receive at Catholic Social Services of Washtenaw County (CSSW). We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records of your service generated by CSSW.

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
Confidential or individually identifiable information about your past, present, or future health or condition, the provision of health care to you or payment for the health care is considered Confidential (Protected Health Information) [PHI]. We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice, though **we reserve the right to change our privacy practices and the terms of this Notice at any time**. If we do so, we will post a new Notice at the reception desk. A copy of the Notice will be posted on our website (www.csswashtenaw.org) or you may request a copy of the new notice from the Chief Privacy Officer:

Chief Privacy Officer
Catholic Social Services of Washtenaw County
4925 Packard Road
Ann Arbor MI 48108-1521

Client Copy

HOW WE MAY USE AND DISCLOSE YOUR PHI.
We use and disclose PHI for a variety of reasons. For most, we need your written authorization. However, the law provides that we are permitted to make some uses/disclosures without your authorization. The following offers more description and examples of our potential uses/disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations (TPO)** once you become our client:

  For services: We may use your PHI to provide you services. For example, your PHI will be used by members of your service management team.

  To obtain payment: We may use your PHI in order to bill and collect payment for your services. For example, we may release portions of your PHI to Medicaid, a private insurance plan, or a state office to get paid for services that we delivered to you.

  For service operations: We may use your PHI in the course of operating our agency. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes. Since we are an integrated system, designated staff in our central office may use your PHI for similar purposes. Release of your PHI to the county, state, and/or the Medicaid agency might also be necessary to determine your eligibility for publicly funded services.

Appointment reminders: Unless you provide us with reasonable alternative instructions, we may send appointment reminders and similar materials to your home. This included leaving a message on your answering machine or voice mail.

Exceptions: State and Federal law allows us to use/disclose your PHI without your consent in certain situations. For example, we may disclose your PHI if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent if able. Also, if we provide you treatment, we will disclose your PHI for TPO.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes we are generally required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Not Requiring Authorization:** The law provides that we may use/disclose your PHI without authorization in the following circumstances:

When required by law: We will disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We will disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For health oversight activities: We will disclose PHI to an accrediting organization or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

Relating to decedents: We will disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For quality assurance purposes: In certain circumstances, and under supervision of a privacy board, we may disclose PHI to other agencies in order to assist medical or psychiatric research.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we will disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: We will disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

- **Uses and Disclosures Requiring that You Have an Opportunity to Object:** In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able.

To families, friends or others involved in your care: We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

Client Copy

YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights relating to your PHI:

- **To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

- **To choose how we contact you:** You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying will be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (i) correct; (ii) not created by us and/or not part of our records. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, PHI has been released by CSSW other than instances of disclosure for which you gave permission. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before April 13, 2003. We will respond to your written request for such a list within sixty (60) days of receiving it. (Your request can relate to disclosures going as far back as six (6) years but not prior to April 14, 2003). There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- **To receive this notice:** You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request. If you request an electronic copy via email, you must sign an authorization form to allow us to communicate with you in that manner.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may file a written complaint with the U.S. Department of Health and Human Services by contacting:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington DC 20201
1-877-696-6775

Or with Catholic Social Services, by contacting:

Chief Privacy Officer
Catholic Social Services of Washtenaw County
4925 Packard Road
Ann Arbor MI 48108-1521
(734) 971-9781

Client Copy

We will take no retaliatory action against you if you make such complaints.

CONTACT PERSON FOR INFORMATION, OR TO SUBMIT A COMPLAINT:
If you have questions about this Notice or any complaints about our privacy practices, please contact:

Chief Privacy Officer
Catholic Social Services of Washtenaw County
4925 Packard Road
Ann Arbor MI 48108-1521

Here are some places in Washtenaw County that can help you live a healthy lifestyle. For a list of food pantries ask the front desk for the Food Gatherers packet.

Ask the front desk for an application for the Bridge Program (food stamps/EBT), or go online to http://www.michigan.gov/mibridges to apply.

Fresh Food

Project FRESH gives women with children, seniors and disabled adults who live in subsidized housing coupons to shop at farmers markets. Ask your WIC or Senior agency for more information. Most of the markets below also accept EBT.

Ann Arbor Farmers Market
315 Detroit St
Ann Arbor, MI 48104
a2gov.org/market
Jan - April & May- Dec
Saturday 8 AM - 3 PM.
EBT/Bridge Cards and Project FRESH coupons accepted

Westside Farmers Market
2501 Jackson Avenue
Ann Arbor, MI 48103
westsidefarmersmarket.com
Jun - Sep
Thursday 3 PM - 7 PM.
EBT/Bridge Cards and Project FRESH coupons accepted

Ypsilanti Depot Town Farmers' Market
100 Market Place
Ypsilanti, MI 48198
May – Oct
Saturday 8 AM - 1 PM
EBT/Bridge Cards and Project FRESH coupons

Saline Farmers' Market
S Ann Arbor St.
Saline, MI 48176
cityofsaline.org/farmersmarket
May - Oct
Saturday 8 AM - 12 PM
Project FRESH coupons accepted

Downtown Ypsilanti Farmers' Market
S Hamilton St. and Ferris St.
Ypsilanti, MI 48197
734-786-8401
growinghope.net/programs/market
May - Oct
Tuesday 2 PM - 6 PM.
EBT/Bridge Cards and Project FRESH coupons accepted

Nutrition

Looking for classes on healthy cooking? The classes below are free. Call or email to find out about dates and times.

Fit 2B Me and What's On My Plate? Free classes on nutrition with hands-on opportunities to make & taste healthy recipes. Find out how to be more active and have better food choices that fit your needs. RSVP via phone (734)222-3956 or email morrism4@anr.msu.edu

Washtenaw County Public Health (WCPH) puts on classes for low-income residents at food pantries, public housing facilities, farmers' markets and other venues. Nutrition education is *focused on those who receive Food Stamps* (also known as SNAP) or are eligible to receive Food Stamps. For more information contact Amanda Naugle at naugle@ewashtenaw.org or (734) 544-2973.

Low-Cost Gyms- fees and hours subject to change without notice from CSSW

YMCA Ann Arbor
http://www.annarborymca.org/
400 W. Washington St. Ann Arbor MI 48103
734.996.9622
M-F 5:30am to 10pm; Sat-Sun 7am to 7pm
Financial assistance available

Planet Fitness
http://www.planetfitness.com/
2748 Washtenaw Ave Ypsilanti MI 48197
734.390.0143
$19.99 per month. $39 annual fee

One on One Athletic Club
www.1on1club.com
2875 Boardwalk St. Ann Arbor MI 48104
734.761.4440
Open 24 hours on week days and from 7 AM to 8 PM Sat. & Sun.
Membership starts at $10. Classes & sports available for a nominal fee.
Free personal training w/ membership

Anytime Fitness
http://anytimefitness.com/
2 Ann Arbor Locations
3393 Plymouth Rd Suite B Ann Arbor MI 48105
734.418.3338
301 North Maple Rd Ann Arbor MI 48103
734.222.0955
Free 7 day trial

Washtenaw County Parks

Parks offer a great, free, way to exercise. To find a list of the sports areas in county parks go to *http://www.ewashtenaw.org/government/departments/parks_recreation/directions/parks_map.html.*

Client Copy

I. PERSONAL INFORMATION

Date _____/_____/_______

Who referred you to CSS?	❑ Phone Book ❑ Doctor ❑ Hospital ❑ Friend ❑ Relative ❑ Church Personnel ❑ I've been here before ❑ I've always known about the Agency ❑ Insurance Company ❑ Lawyer ❑ Other: ______________________________

CLIENT INFORMATION	
LAST NAME	
FIRST NAME	
MIDDLE NAME	
BIRTHDATE	
SOCIAL SECURITY #	
DRIVERS LICENSE #	
ADDRESS	
CITY	❑ Ann Arbor ❑ Ypsilanti ❑ Chelsea ❑ Dexter ❑ Manchester ❑ Milan ❑ Saline ❑ Whitmore Lake ❑ Other: ____
ZIP	
PHONE – HOME	
PHONE – OTHER	Cell: Work: Relative:
OCCUPATION	
EMPLOYER	
CITY/STATE	
INCOME (amount)	$ ___________________/year **or** $________________/month
# supported by income:	_____ Adults _____ Children under 18

In Case Of Emergency Please Contact	
NAME OF EMERGENCY CONTACT:	
EMERGENCY CONTACT PERSON PHONE:	
EMERGENCY CONTACT PERSON ADDRESS:	

RACE			
	❑ American Indian	❑ Asian/White	❑ Black/American Indian
	❑ American Indian/White	❑ Black/African American	❑ Native Hawaiian/SPI|Native Hawaiian
	❑ Alaska Native	❑ Black/Caucasian	❑ White
	❑ Asian		❑ Other: ___________________________
			❑ Unknown

ARE YOU HISPANIC?	❑ Yes ❑ No
GENDER	❑ Male ❑ Female ❑ Transgender ❑ Other: _________________

DISABILITY	❑ None, or ______________________________	
EDUCATION	❑ Did not complete High School ❑ Completed High School/GED ❑ Some College ❑ College degree	❑ Post Graduate Degree ❑ Other: ____________________
MILITARY SERVICE	❑ Yes ❑ No	
RELIGION	❑ None ❑ Catholic ❑ Protestant/Christian/Protestant Christian ❑ Jewish	❑ Islam ❑ Unknown ❑ Other:____________
MARITAL STATUS	❑ Single Adult, Never Married ❑ Single Adult, Previously Married ❑ Single Child, under 18 ❑ Married	❑ LTP ❑ Widowed ❑ Unknown
MARRIAGE or COMMITMENT DATE	❑ N/A	
DATE: DIVORCE	❑ N/A	
CONCERNS REGARDING RACE, CULTURE, GENDER	**Please write below any concerns you may have as they relate to race, culture, gender, etc.** ❑ N/A	

CHILDREN *Last NAME*	*CHILDREN* **FIRST NAME**	BIRTH-DATE	RACE	GENDER	GRADE	LIVING WITH YOU?
						❑ Yes ❑ No
						❑ Yes ❑ No
						❑ Yes ❑ No
						❑ Yes ❑ No
						❑ Yes ❑ No

OTHERS LIVING IN HOME/IMPORTANT TO SITUATION grandparents, foster child, lawyer, etc.	**RELATIONSHIP**

II. MEDICAL HISTORY RECORD

PHYSICAL ILLNESSES, DISEASES, SERIOUS ACCIDENTS OR HOSPITALIZATIONS:

____ AGE__________

____ AGE__________

____ AGE__________

WHEN DID YOU LAST HAVE A PHYSICAL EXAM? ____

DO YOU EXERCISE REGULARLY? ❑ Yes ❑ No

If yes, how?____

DO YOU HAVE ANY PHYSICAL PAIN ISSUES? ❑ Yes ❑ No

If yes, please explain____

HOW WOULD YOU RATE YOUR PRESENT PHYSICAL CONDITION?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

CHECK ANY OF THE FOLLOWING PHYSICAL CONDITIONS THAT APPLY TO YOU:

❑ Asthma
❑ Cancer
❑ Chest Pains
❑ Menstrual Irregularities
❑ High Blood Pressure
❑ Thyroid Problems
❑ Migraine Headaches
❑ Multiple Sclerosis
❑ Stomach Ulcers
❑ Diabetes Mellitus
❑ Ulcerative Colitis
❑ Other:_________________

LIST ANY ALLERGIES, DRUG SENSITIVITIES OR PHYSICAL HANDICAPS:______________________

____

LIST ANY FAMILY HISTORY OF MEDICAL ILLNESS:____

____

LIST ALL MEDICATIONS (PRESENTLY TAKING)	DOSAGE	FREQUENCY	REASON
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
LIST ALL PSYCHIATRIC MEDICATIONS (TAKEN IN THE PAST)	**DOSAGE**	**FREQUENCY**	**REASON**
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	
		_______ times/day	

DO YOU TAKE OVER THE COUNTER MEDICATIONS IF NEEDED? ☐ Yes ☐ No
If yes, what do you take? ____

____

____

PRIMARY CARE PHYSICIAN(S)

NAME____

ADDRESS____
CITY: ____ STATE___________ ZIP___________
PHONE: ____

PREVIOUS COUNSELING/MENTAL HEALTH SERVICES:

DATE(S) ORGANIZATION/AGENCY
_____/_____/_______ ____

_____/_____/_______ ____

_____/_____/_______ ____

PSYCHIATRIC HOSPITALIZATIONS ☐ NOT APPLICABLE

DATE(S) ORGANIZATION/AGENCY
_____/_____/_______ ____

_____/_____/_______ ____

_____/_____/_______ ____

August 22, 2016

III. PERSONAL HISTORY

1. **What brings you to therapy**? (What are the issues that are troubling you?) ______

2. **How long have these problems been going on?** ______

3. **What incident led to you call to our agency?** ______

4. **What would you like to accomplish by coming to therapy (What are your goals?)?** ______

5. **What things stand out about your growing up years?** ______

6. **Has anyone in your family ever been diagnosed or treated for the following:**

ADD/ ADHD:	❑ Yes	❑ No	Depression:	❑ Yes	❑ No
Alcohol Abuse:	❑ Yes	❑ No	PTSD:	❑ Yes	❑ No
Anxiety:	❑ Yes	❑ No	Schizophrenia:	❑ Yes	❑ No
Anger Issues:	❑ Yes	❑ No	Substance Abuse (not alcohol:)	❑ Yes	❑ No
Bipolar Disorder:	❑ Yes	❑ No	Other: ______		

If yes, please explain ______

7. **These questions are to assess for safety, your therapist will follow-up with you about this when you meet:**

Do you have any thoughts of harming or killing yourself? ❑ Yes ❑ No

Have you ever attempted to harm or kill yourself in the past? ❑ Yes ❑ No

Do you have any thoughts of harming or killing someone else? ❑ Yes ❑ No

Is anybody harming you or has somebody harmed you in the past? ❑ Yes ❑ No

8. **What do you consider some of your personal strengths and who are your supports?** ______

9. **Any other information you would like your therapist to know**: ______

PATIENT HEALTH QUESTIONAIRE - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems? (Circle your answer)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle your answer)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

GENERALIZED ANXIETY DISORDER – 7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems? (Circle your answer)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

IV. DRUG/ALCOHOL USE

PLEASE CHECK

CAGE QUESTIONAIRE

1. Have you ever felt you should cut down on your drinking or drug use? ………………………… …❑ Yes ❑ No

2. Have people annoyed you by criticizing your drinking or drug use? .... ❑ Yes ❑ No

3. Have you ever felt bad or guilty about your drinking or drug use?...❑ Yes ❑ No

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?..❑ Yes ❑ No

PLEASE CHECK

1. Do you smoke cigarettes? ………………………………………………………………………...❑ Yes ❑ No

If yes, how much do you smoke per day? ____

- If yes, have you thought of quitting or tried to quit? (Please explain)______________________________________

  ____

2. Do you drink or use other drugs?...❑ Yes ❑ No

3. Please check yes or no if you have used the following (if yes, for how long, how much, and when did you last use?)

Alcohol:❑ Yes ❑ No____
Cocaine:❑ Yes ❑ No____
Crack:❑ Yes ❑ No____
Ecstasy:❑ Yes ❑ No____
Heroine:❑ Yes ❑ No____
LSD or Hallucinogens:❑ Yes ❑ No____
Marijuana:❑ Yes ❑ No____
Methadone:❑ Yes ❑ No____
Methamphetamine:❑ Yes ❑ No____
Pain killers (not as prescribed):❑ Yes ❑ No____
Stimulants:❑ Yes ❑ No____
Suboxone:❑ Yes ❑ No____
Tranquilizers:❑ Yes ❑ No____
Other:❑ Yes ❑ No____

4. How many caffeinated beverages do you drink a day? **Coffee:**_______________ **Soda:**_____________ **Tea:**______________

5. Have you ever received in-patient or out-patient treatment for alcohol or drug abuse or dependency?……………………………………………………………… … ❑ Yes ❑ No

DATE(S) ORGANIZATION/AGENCY

_____/_____/_______ ____

_____/_____/_______ ____

_____/_____/_______ ____

6. Have you ever attended Alcoholics or Narcotics Anonymous meetings?...................................... ❑ Yes ❑ No

CATHOLIC SOCIAL SERVICES OF WASHTENAW COUNTY
BEHAVIORAL HEALTH SERVICES
INTAKE PACKET

Catholic Social Services of Washtenaw County maintains strict standards of confidentiality that are in keeping with federal law and regulations as regards client records. Generally, without your written consent, our program may not say to a person outside the program that a client attends the program or disclose any information identifying a client, including information that the client may be an alcohol/drug abuser, unless: 1) The client consents in writing. 2) The disclosure is allowed by a court order, or 3) The disclosure is made to medical personnel for research, audit or program evaluation.

The information asked of you in this questionnaire will be used for the sole purpose of assisting your therapist in determining the best course of treatment.

CLIENT RIGHTS

You cannot be discriminated against because of your race, color, sex, age, religion, national origin, or sexual orientation.

As a client of Catholic Social Services of Washtenaw County, you have a right to know and participate in your service plan and to be kept informed of any changes in the plan. As a voluntary client, you also have the right to refuse any service.

You have the right to see the information in your case record. This record contains all the written information that this agency has about you. If you disagree with/contest any information in your case record, your written statement(s) regarding this will be kept in your case record.

Information disclosed by another adult family member while in joint meetings and recorded in case record will not be shown without that person's authorization.

All specific information you disclose, whether written or oral, is kept in strict confidence within the agency. Your written permission is needed prior to any information being given out. Exceptions include:

1. Court orders requiring certain information
2. When a danger to yourself or others is presented
3. Licensing, certification or accreditation audits on
4. Reimbursement sources who pay all or a portion of the cost of services

You have the right to provide us with feedback about your experience with Catholic Social Services. Any complaints you might have should be taken up first with the program staff. If this is not possible or satisfactory, complaints should be taken to the Program Director or Agency Administration who can explain the agency's grievance procedures.

Client* Signature____ Date _____/_____/_______

Client Signature____ Date _____/_____/_______

CSS/Notary Witness Signature____ Date _____/_____/_______

*PARENT MUST SIGN IF CLIENT IS UNDER AGE 18

August 22, 2016

CATHOLIC SOCIAL SERVICES OF WASHTENAW COUNTY

BEHAVIORAL HEALTH SERVICES

CONSENT TO TREATMENT / STATEMENT OF UNDERSTANDING

I, the undersigned:

- Understand that I have rights as recipient of Behavioral Health Services at Catholic Social Services of Washtenaw County.
- I have received the "Clients Rights" Information which explains confidentiality practices and regulations which govern the release of any information regarding my participation in services if the program.
- I have received the "Know Your Rights" Information, which explains confidentiality practices, and regulations, which govern the release of any information regarding my participation in the program, related to substance abuse treatment. (42 CFR)
- I have received the "Healthy Lifestyles" handout which lists fresh food, health, and nutrition resources within Washtenaw County
- Understand that I am expected to participate in the development of my service plan.
- Understand that for crisis help, I can telephone University of Michigan Emergency Psychiatric Services at 734.996.4747 or St Joseph Mercy Hospital 734.712.3000 or The Washtenaw County resource information (211) information can be obtained by contacting 734.477.6211
- Am voluntarily consenting to treatment as fully explained to me by staff of Catholic Social Services of Washtenaw County.
- Understand that I am free to withdraw my consent and discontinue treatment at any time.
- I understand that the Behavioral Health Services department will be making "reminder calls" for my appointments and will be using the phone number(s) I have given to make this call. The agency uses an automated system that allows opting in for text messages.
- Agree to pay for services rendered to me throughout my course of treatment.

____ _____/_____/_______
Client Signature Date

____ _____/_____/_______
Client Signature Date

____ _____/_____/_______
Signature of Parent or Guardian if client is under the age of 18 *Date*

____ _____/_____/_______
CSS Witness Signature/Notary Signature Date

August 22, 2016

CATHOLIC SOCIAL SERVICES OF WASHTENAW COUNTY

IPS 101A: CLIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received Catholic Social Services of Washtenaw County's Notice of Privacy Practices. I understand that Catholic Social Services of Washtenaw County can use my Protected Health Information for Treatment, Payment and Operations.

Client Signature: ______________________________________ Date: _____/_____/_______ Time:______

Printed Name: ____

If required, signature of Parent,
Guardian or Legal Representative: _________________________ Date: _____/_____/_______ Time:______

Printed Name:____ Relationship:____________

CSS/Notary Witness Signature:__________________________________ Date: __/_____/_______ Time:_____

End of IPS 101A: Client Acknowledgment of Receipt

You have now completed this form, Thank You!

Catholic Social Services of Washtenaw County
Behavioral Health Services & Primary Care Provider Communication Form

Client Consent to Exchange Information

Client Name: ____ **Date of Birth**: _____/_____/_______

I, ____________________________,______
❒ **Authorize Communication between My PCP and** *Catholic Social Services of Washtenaw County* (initial ______)
❒ **DO NOT Authorize Communication between My PCP and** *Catholic Social Services of Washtenaw County* (initial ______)

Primary Care Physician Name	**Address**	**Phone Number**

I understand this exchange information is with regard to my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage.

Only the following information (initial** all that apply**):

☐ _______ *My entire record; (**initial OR**)*

☒ _______ **Assessment** ☒ _______ **Treatment Recommendations** ☒ _______ **Expected length of treatment** ☒ _______ **Attendance Records** ☒ _______ **Progress Report of my treatment**	☐ _______ Treatment Plan ☐ _______ Name of new treatment provider ____________________ ☐ _______ Other Evaluation (Specify) _______________________ ☐ _______ Diagnosis ☐ _______ Other (Specify):________________________

Form in which the information should be released (initial** options**):

☒ _______ **Verbal**
☒ _______ **Written**
☒ _______ **Other**: **Electronic** I authorize CSSW staff to communicate by means of E-mail, fax and cordless or cellular telephones, where the use of these means is expedient or timely.

The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

I may revoke this consent at any time by contacting CSSW at 734.971.9781 except to the extent that action has been taken in reliance upon it.
NOTE: Once information has been disclosed, CSSW can no longer protect it from further disclosure.
I understand I have the right to receive a copy of this authorization form.

____ _____/_____/_______
Client Signature **Date**

____ _____/_____/_______
Witness **Date**

Provider Information (to be completed by CSSW)—Please Print
Catholic Social Services of Washtenaw County 4925 Packard Rd. Ann Arbor, MI 48108-1521 Phone: 734.971.9781 Fax: 734.971.2730

DSM V DIAGNOSIS **CODE AND NAME:**		**Treatment Plan: Type (i.e. ind., family, group, meds)**	
Medication(s) Prescribed:		**Frequency (i.e. weekly, etc.)**	
		Estimated length of time	
Comments:			
For urgent or emergency situation, please call the primary care physician in addition to sending form			

❒ Conclusion of mental health/substance treatment
❒ Date of last session: _____/_____/_______ ; Treatment completed? ❒ Yes ❒ No
❒ Notification of prescription or change in medications (see Comments section above)
❒ Other: ____

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE CLIENT'S CHART. IF THE FORM IS SENT BY FAX, STAMP CONFIRMATION THAT FAX WAS SENT.

Date Sent: ____/____/______ **Clinician Initials:** ______ **(Please check method)** ❒ **FAX** ❒ **MAIL**

Catholic Social Services of Washtenaw County
Behavioral Health Services & Primary Care Provider
Communication Form

Client Name: ____ **Date of Birth**: _____/_____/_______

Please complete the following information regarding the person listed on the previous page and forward it to the CSSW behavioral health provider.

Provider Information
(to be completed by Primary Care Physician) ~ Please Print

Physician Name(s):	
Address:	
City, State:	
Telephone:	

Medical History: ____

____

____

____

Medication(s) Prescribed: ____

____

____

____

Comments: ____

____

____

____

____ _____/_____/_______
Signature/Credentials **Date**

SEND A COPY OF THIS FORM TO THE BEHAVIORAL HEALTH PROVIDER, RETAINING THE ORIGINAL IN THE PATIENT'S CHART. IF THE FORM IS SENT BY FAX, PROVIDE CONFIRMATION THAT THE FAX WAS SENT.

Date Sent: _____/_____/______ **PCP/Clinician Initials:** ______ **(Please check method)** ❒ **FAX** ❒ **MAIL**

Catholic Social Services of Washtenaw County
BHS Missed Therapy Appointment Policies/Procedures

Statement of Understanding regarding Missed CSSW BHS Therapy Services:

Achieving the optimum benefits from counseling is dependent upon regular, consistent attendance at all sessions scheduled with a therapist. When there is a need to cancel a therapy appointment, a minimum of 24 hours notice is required. Any appointment missed without a minimum of 24 hours notice, will be considered a no show (no notice provided) or late cancel.

Please note: late cancels include a cancellation provided during a reminder call, arrivals of 15 minutes or more later than the scheduled appointment time, and any other cancellation provided with less than 24 hours notice.

______ After a **first** no show/late cancel with my/my child's BHS therapist, I will discuss the reason for this missed appointment with the therapist. My/my child's therapist will determine if it is reasonable to schedule another therapy appointment.

______ Any no show/late cancel to my/my child's scheduled therapy appointment will result in the cancellation of any upcoming appointments with my/my child's psychiatrist. Psychiatry appointments will not be reinstated without prior approval from Catholic Social Services of Washtenaw County, Behavioral Health Services Administration.

______ After a **second** no show/late cancel to a therapy session, BHS staff does not have the authorization to schedule another therapy appointment, regardless of the circumstances, without first consulting with supervisory staff.

______ The outcome of this consultation may include, but is not necessarily limited to, (1) approval to schedule another therapy session or (2) a direct communication between you and Catholic Social Services of Washtenaw County, Behavioral Health Services Administration.

______ I am responsible to attend all scheduled appointments at CSSW even in the event that a reminder call is not received.
CSSW reserves the right to suspend and/or discontinue BHS services, therapy as well as psychiatry, if repeated missed appointments occur.

______ ***Managed Medicaid consumers:*** Following a second no show/late cancel appointment with a BHS therapist, I may be directed to contact Catholic Social Services of Washtenaw County, Behavioral Health Services Administration, at 734-971-9781 for consideration of continued service provision at CSSW.

______ ***Other Insurance/sliding fee scale consumers:*** A no show fee of $50 will be assessed following any no show/late cancel appointment with a BHS therapist. Payment in full is required before appointments with a therapist can be scheduled. If a second no show/late cancel (and resulting no show fee) for a therapy appointment occurs, I may be required to contact Catholic Social Services of Washtenaw County, Behavioral Health Services Administration, at 734-971-9781 for consideration of continued service provision at CSSW.

________________________________ _____/_____/_______
Client/guardian signatures Date

___________________________________ _____/_____/_______
CSSW witness signature Date

United States Citizenship Attestation Form

❒ I am a citizen of the United States.

— OR —

❒ I am not a citizen of the United States.

I hereby attest that my response and the information provided on this form is true, complete, and accurate and I understand that this information may be used to verify my United States citizenship as it pertains to any funders of services of Catholic Social Services of Washtenaw County.

Catholic Social Services of Washtenaw County follows Local, State and Federal laws and Regulations as they relate to discrimination and program service delivery.

Client* Signature: ____ Date: _____/_____/_______

Client Signature: ____ Date: _____/_____/_______
*Parent must sign if client is under age 18

10-11-2012