DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

ACKNOWLEDGMENT AND CONSENT FOR TREATMENT

I am voluntarily applying for services at the Deschutes County Health Services (DCHS). I understand and agree that Deschutes County Health Services (DCHS) may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers, including other providers within DCHS, for my care and treatment
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative, and business functions that support DCHS efforts to provide me with, and be reimbursed for, quality cost-effective health care; and
- Participate as a member of the OCHIN Collaborative, as described in the Notice of Privacy Practices for Deschutes County Health Services.
- Participate as a member of the Reliance Community Health Information Exchange, as described in the Notice of Privacy Practices for Deschutes County Health Services.

I understand that my health information may include information both created and received by DCHS, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand that the health information used or disclosed may include vocational rehabilitation, alcohol and drug records, HIV/AIDS records, genetics information, and mental health or developmental disability records held by publicly funded providers.

I understand that the Notice of Privacy Practices for Deschutes County Health Services may be revised from time to time and that I am entitled to receive a copy of any revised version. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices for Deschutes County Health Services in effect will be posted in the waiting / reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices for Deschutes County Health Services, and I understand that DCHS is not required by law to agree to such requests.

By signing below, I agree that I am requesting services from DCHS, have reviewed the information above and that I have received a copy of the Notice of Privacy Practices for Deschutes County Health Services.

Printed Client's Name:_____

By: _____ **Date: _____**

Patient or Patient's Authorized Personal Representative

By: _____ **Date: _____**

DCHS Employee Witness Signature

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

PATIENT INFORMATION

PLEASE PRINT: (Information about the individual seeking services) **DATE:**

Last Name	First Name	Middle Initial	DOB

Full Name at Birth	SSN

What is your identified gender

☐ Female ☐ Female-to-male (FTM)/Transgender Male/Trans Man

☐ Male ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Gender non binary, neither exclusively male nor female

☐ Additional gender category/ (or Other), please specify: _____

What sex were you assigned at birth on your original birth certificate? ☐ Male ☐ Female ☐ Decline to answer	Preferred Pronoun (She, He, They, Other)
Home #	For confidential consideration, where may we leave a message (mark all that apply) ☐ Home ☐ Cell ☐ Work ☐ Message #
Cell #	
Work/Message #	

Street/Physical Address	City	State	Zip
Mailing/Secondary Address (if different)	City	State	Zip

County of Residence	Individual resides with Last: First: Relationship: ☐ Living Alone

Reason For Seeking Services

INDIVIDUAL NEEDS

Interpreter/Special Needs (Please mark all that apply):

☐ Hearing Impaired/Aid ☐ Reading/Literacy Aid ☐ None ☐Other_____

☐ Preferred Language Interpreted: If so, what Language: _____

Deschutes County encourages persons with disabilities to participate in all programs and activities. This location is accessible to people with disabilities. If you need accomodations to make participation possible, please call 541-322-7500.

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

Client Initials:_____ MRN _____

EMERGENCY CONTACT				
First and Last Name of Emergency Contact:				
Relationship	Address	City	State	Zip
*Emergency Information Can we leave a message (Please choose) ☐ Yes ☐ No **Phone #**				

MILITARY STATUS	
Have you ever served in the military? ☐ Yes ☐ No	Are you currently serving (reserve/active)? ☐ Yes ☐ No

MARITAL STATUS		
☐ Married ☐ Significant Other ☐ Single ☐ Legally Separated	☐ Divorced ☐ Domestic Partnership ☐ Widowed ☐ Other	Name of spouse/partner (if applicable):

LIVING ARRANGEMENT		
Please choose which best describes your living situation		
☐ Homeless	☐ Foster Home	☐ Residential Facility/Group Home
☐ Jail	☐ Prison	☐Room and Board
☐ Supportive Housing	☐Supportive Housing (scattered site)	☐ Supportive Housing (Congregate Setting)
☐ Alcohol/Drug Free Housing	☐ Oxford Home	☐ Other Private Residence
☐ Private Residence (Home)	☐ Private Residence (relative)	☐ Private Residence (non-relative)
☐ Residential Facility (SUD)	☐ Residential Facility (BRS)	☐ Residential Facility (CSEC)
☐ Residential Facility (PRTS)	☐Residential Facility (SCIP/SAIP)	☐ Residential Facility (SRTF for YAT)
☐ Unknown		

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

Client Initials:_____ MRN _____

RACE AND ETHNICITY
Race (Please mark all that apply) ☐ Alaska Native ☐ Black/African American ☐ Hispanic ☐ Asian ☐ Hawaiian/Pacific Island ☐ American Indian ☐ White/Caucasian ☐ Other ☐ Single race ☐ Two or more races
Tribal Affiliations (Please mark all that apply) ☐ Burns Paiute Tribe ☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw ☐ Confederated Tribes of Grand Ronde ☐ Confederated Tribes of Siletz ☐ Confederated Tribes of the Umatilla ☐ Confederated Tribes of Warm Springs ☐ Coquille Indian Tribe ☐ Cow Creek Band of Umpqua Indians ☐ Klamath Tribes ☐ Not Applicable ☐ Other (Please describe):

LEGAL STATUS
Please choose which best describes your situation ☐DUII Diversion Client ☐ DUII Convicted Client ☐ 30 Day Civil Commitment ☐ 90 Day Civil Commitment ☐ 180 day Civil Commitment ☐ Incarcerated ☐ Parole ☐ Probation ☐ Psychiatric Services Review Board(PSRB) ☐ Juvenile PSRB ☐ Guardianship (Child Welfare) ☐ Guardianship (Court) ☐ Aid and Assist ☐ None ☐ Involuntary Custody ☐Unknown

EDUCATION
Check highest grade <u>individual</u> completed K☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ 11☐ 12/GED☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ PHD/PSYD/MD ☐ College Courses Taken ☐

OTHER INFORMATION		
Have you had previous mental health counseling? ☐ Yes ☐ No If Yes, Where?		
Referred by		
Is there Child Protective Services involvement? ☐ Yes ☐ No Caseworker Name Phone #		
Do you have a Declaration for Mental Health Treatment and/or an Advanced Directive?	☐ Yes	☐ No
Would you like help completing a Declaration for Mental Health Treatment?	☐ Yes	☐No

MRN _____

FINANCIAL INFORMATION

HEALTH INSURANCE	
Name of Individual Seeking Services	Name of Responsible Party
Primary Health Insurance Plan ID #*(OHP, Medicare, etc.)	Policy Holder Name and DOB* (Required if not self)
Secondary Health Insurance Plan ID #	Policy Holder Name and DOB*(Required if not self)

EMPLOYMENT STATUS

Please choose the one that best describes your employment status

☐ Full Time	☐ Disabled	☐ Retired
☐ Part Time	☐ Homemaker	☐ Not in Labor Force
☐ Unemployed	☐ Student	☐ Other (volunteer etc.)
☐ Hospital Patient, Incarcerated or Other Residential Institution		☐ Unknown
☐ Sheltered Employment (Opportunity Foundation, Good Will, etc.)		

INCOME					
Monthly household income sources	Self	Spouse	Parent(s)	Other	Total
Wages (salaries, tips, etc.)					
Public Assistance					
Retirement/Pension/SSI					
Disability/SSDI					
Other					
None: If no income to report. Explain how you are supported:					

Deschutes County encourages persons with disabilities to participate in all programs and activities. This location is accessible to people with disabilities. If you need accomodations to make participation possible, please call 541-322-7500.

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS			
List number of household members living with you in each category			
Self	Spouse/Partner	Parent/Guardian	Dependents

- I confirm that the information shown is correct and I know proof is required for approval. Despite my insurance status or ability to provide proof, I am responsible for the balance on my account for any professional services delivered by DCBH. I approve the release of any medical and financial facts necessary to process insurance claims.

- I will notify DCBH promptly of any change to the above information.

Responsible Party Signature	Date

Please do not write in shaded boxes (**Staff use only**)

STAFF VERIFICATION CHECKLIST (attach copies)		
Proof of ID: Photo ID, Drivers License, Birth Certificate, Social Security Card		Sliding Fee amount:
		Effective Date
Staff Signature Line-please sign after explaining financial and sliding fee scale to responsible party Signature:		Date of staff signature
By initialing, I (responsible party) am stating that the financial & sliding fee scale process was explained to me if I were to lose OHP/Medicaid/Medicare/Private Insurance.	Responsible Party Initials	Expiration date

DESCHUTES COUNTY HEALTH SERVICES

MEDICAL HISTORY FORM

MRN:_____

Confidential Medical Information

- **Individuals 14+ please complete. Parents or caregivers need to complete the form for children age 13 and under. The following information is needed to help understand your mental and physical health conditions. It is not required that you answer all of these questions to participate in an assessment or treatment. However, we would appreciate it if you would take the time to fill out as much of this form as possible.**

INDIVIDUAL NAME:_____**DATE:**_____

MEDICAL HISTORY		
Please check the box if you have had or currently have any of the following:		
☐ Major accidents	☐ Diabetes	☐ Eating disorder
☐ Drug overdose	☐ Asthma or breathing problem	☐ GI bleeding
☐ Kidney problems	☐ Neurological problems	☐ Ulcer
☐ Skin infections	☐ Sexually transmitted infection	☐ Heart murmur
☐ High blood pressure	☐ Liver problems	☐ Lung or Pulmonary disease
☐ Mental Health Hospitalization	☐ Suicidal thoughts	☐ Pancreatitis
☐ Rash	☐ Cardiac disease	☐ Tuberculosis
☐ Hallucinations	☐ Hepatitis (A,B or C)	☐ Thyroid problems
☐ Severe drug/ alcohol withdrawal	☐ Head injury	☐ Seizures or convulsions
☐ Physical/Emotional/Intellectual/Developmental Disability		
Allergies to medications (Please list)		
Other issues not listed above (Please list)		
Explain any of the checked above that you have experienced **within the last 6 months**		
Approximate dates for major accidents/injuries, illnesses and mental health hospitalizations		
Do you currently have a doctor ☐ Yes ☐ No If yes, name of Doctor		Last date you saw your doctor
Are you currently taking any medication		☐ Yes ☐ No
If yes, please list medications and dosages		
Nicotine/Tobacco use ☐ Yes ☐ No Amount per day		Are you interested in cutting back/quitting ☐ Yes ☐ No Would you like a Tobacco Quit Line referral ☐ Yes ☐ No
Any substance/drug use during the last 90 days	☐ Yes	☐ No ☐ Unknown
Are you pregnant ☐ Yes ☐ No ☐N/A		If yes, due date

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

MRN:_____

Legal Last Name of Client:	First:	MI:	Date of Birth:
Other names used by Client:			

By signing this form, I authorize the following record holder to disclose the following specific confidential information.

RECORD HOLDER

Record Holder's Identity:	**Specific information to be disclosed:** **(include date range if applicable)**:	***Mutual Exchange: Please Initial and Circle**
		YES or NO

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information: Please Initial under either **authorize** or **refuse**. ***Mutual exchange allows information to be released back and forth between the record holder(s) and the recipient(s).**

Authorize or Refuse:	**Authorize or Refuse**:
_____or_____ HIV/AIDS	_____ or _____ Alcohol/Drug diagnosis, treatment, referral
_____or_____ Genetic Testing Information	_____or_____ Mental Health (except psychotherapy notes)

RECIPIENT

Release to: (address required if information is to be mailed to recipient). If releasing to a team, list members.	Purpose of release:	Expiration date or event:**

ACKNOWLEDGEMNT

****This authorization is valid for one year from the date of signing unless otherwise specified.**

I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form. **I know that, except when services are provided for research purposes or solely for the purpose of creating protected health information for disclosure to a third person, Deschutes County cannot deny Client services if I do not sign this authorization.**

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT re-disclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.

I understand that Client's personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client's personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form. I acknowledge that I have reviewed Deschutes County's written "Notice of Privacy Practices For Deschutes County."

SIGNATURE

Full legal signature of individual or authorized personal representative X	Relationship to Client:	Date:
Print Name of Person Signing This Authorization X		

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

MRN:_____

Legal Last Name of Client:	First:	MI:	Date of Birth:
Other names used by Client:			

By signing this form, I authorize the following record holder to disclose the following specific confidential information.

RECORD HOLDER

Record Holder's Identity:	**Specific information to be disclosed:** **(include date range if applicable)**:	***Mutual Exchange: Please Initial and Circle**
		YES or NO

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information: Please Initial under either **authorize** or **refuse**. ***Mutual exchange allows information to be released back and forth between the record holder(s) and the recipient(s).**

Authorize or Refuse:	**Authorize or Refuse**:
_____or_____ HIV/AIDS	_____ or _____ Alcohol/Drug diagnosis, treatment, referral
_____or_____ Genetic Testing Information	_____or_____ Mental Health (except psychotherapy notes)

RECIPIENT

Release to: (address required if information is to be mailed to recipient). If releasing to a team, list members.	Purpose of release:	Expiration date or event:**

ACKNOWLEDGEMNT

****This authorization is valid for one year from the date of signing unless otherwise specified.**

I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form. **I know that, except when services are provided for research purposes or solely for the purpose of creating protected health information for disclosure to a third person, Deschutes County cannot deny Client services if I do not sign this authorization.**

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT re-disclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.

I understand that Client's personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client's personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form. I acknowledge that I have reviewed Deschutes County's written "Notice of Privacy Practices For Deschutes County."

SIGNATURE

Full legal signature of individual or authorized personal representative X	Relationship to Client:	Date:
Print Name of Person Signing This Authorization X		

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

MRN:_____

Legal Last Name of Client:	First:	MI:	Date of Birth:
Other names used by Client:			

By signing this form, I authorize the following record holder to disclose the following specific confidential information.

RECORD HOLDER

Record Holder's Identity:	**Specific information to be disclosed:** **(include date range if applicable)**:	***Mutual Exchange: Please Initial and Circle**
		YES or NO

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information: Please Initial under either **authorize** or **refuse**. ***Mutual exchange allows information to be released back and forth between the record holder(s) and the recipient(s).**

Authorize or Refuse:	**Authorize or Refuse**:
_____or_____ HIV/AIDS	_____ or _____ Alcohol/Drug diagnosis, treatment, referral
_____or_____ Genetic Testing Information	_____or_____ Mental Health (except psychotherapy notes)

RECIPIENT

Release to: (address required if information is to be mailed to recipient). If releasing to a team, list members.	Purpose of release:	Expiration date or event:**

ACKNOWLEDGEMNT

****This authorization is valid for one year from the date of signing unless otherwise specified.**

I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form. **I know that, except when services are provided for research purposes or solely for the purpose of creating protected health information for disclosure to a third person, Deschutes County cannot deny Client services if I do not sign this authorization.**

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT re-disclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.

I understand that Client's personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client's personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form. I acknowledge that I have reviewed Deschutes County's written "Notice of Privacy Practices For Deschutes County."

SIGNATURE

Full legal signature of individual or authorized personal representative X	Relationship to Client:	Date:
Print Name of Person Signing This Authorization X		

Client Initials:_____ MRN # _____

Information Packet Receipt Acknowledgement

By initialing and signing this form, you acknowledge receipt or declination of the following information from Deschutes County Health Services, Behavioral Health. We encourage you to review all forms in the Client Information Packet carefully. You may obtain copies by visiting our website or on request from our staff.

The Client Information Packet contains the following information:

- Individual Rights and Responsibilities
- Notice of Privacy Practices
- Information concerning grievances and appeals (including a grievance form)
- Copy of the Acknowledgment and Consent for Treatment
- Voter Registration information, *as requested*
- Declaration of Mental Health Treatment information, *as requested*

Please initial next to whether you received or declined the Client Information Packet:

_____ I accepted the Client Information Packet

☐ I requested and received voter registration information

☐ I requested and received Declaration of Mental Health Treatment information

_____ I declined the Client Information Packet, additional information, or assistance

_____ _____

Individual or Caregiver Signature Date