

Crawford County Mental Health Center

CLIENT REGISTRATION FORM

**When client arrives for intake complete form.

Are you an employee of CCMHC? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you an a family member of a CCMHC employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Legal Name: _____			
Last		First	MI (Sr., Jr., II, etc.)
DOB: _____		SSN: _____	
Referred By (agency, individual, hospital, self, etc.): _____			
(Place a checkmark beside which phone is preferred:)			
<input type="checkbox"/> Home Phone: _____		<input type="checkbox"/> Cell Phone: _____	
Email Address: _____			
Physical Address: _____		Mailing Address same as Physical Address: <input type="checkbox"/> Yes If no, list below.	
City: _____		Mailing Address: _____	
City: _____		St: _____	Zip: _____
Preferred Spoken/Written Language:			
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language		<input type="checkbox"/> Other specify: _____	
Is Language Interpretation Services Needed?			
<input type="checkbox"/> No <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language		<input type="checkbox"/> Other specify: _____	

Adults: Does client have Court Appointed Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, fill out Guardian information below.	
GUARDIAN/PARENT/FINANCIALLY RESPONSIBLE PERSON			
(If Client is own Guardian/Responsible Person leave this section blank)			
Guardian/Responsible Party for Payment: _____			
Relationship to Client: _____		SSN: _____	DOB: _____
Address: _____		City: _____	St: _____ Zip: _____
Phone #: _____			

PRIMARY INSURANCE INFORMATION (Obtain Copy of Insurance Card)			
<input type="checkbox"/> No Insurance (Check if client has No Insurance)			
Cardholder Name: _____		Employer: _____	
Relationship to Client: _____		SSN: _____	DOB: _____
<input type="checkbox"/> Other: (ex. EAP): _____			

Please Sign Guardian/Financially Responsible Person Signature on Backside of Form

IMPORTANT – READ CAREFULLY

The client or responsible party signing this form certifies that the information on this form is complete and correct, and authorizes Crawford County Mental Health Center to send information for billing as requested by payment sources. This information may include, if specifically requested, copies of the admission and evaluation, treatment plans, discharge summary, clinical progress notes, and any other records produced by this agency. This authorization will expire upon completion of processing of my insurance claim and any subsequent requests or audits by the payment source, unless expressly revoked by me at an earlier date. I further understand that revoking my consent may result in my being responsible for payment of the claim and the above payment source(s) not being used.

Based on your income above you may qualify for a discounted fee. Depending on your insurance coverage, your insurance may cover some or all of your fee. You will be responsible for the portion not covered by your insurance.

If the information furnished above is not accurate or complete, Crawford County Mental Health reserves the right to demand and receive its undiscounted fee, if you do not qualify for sliding scale discount. If insurance coverage is lost, client will be responsible for payment.

_____	_____	_____	_____
Signature Guardian/Financially Responsible Person	Date	Staff Member Signature	Date

Printed Name Guardian/Financially Responsible Person

Crawford County Mental Health Center

PERMISSION FOR ASSESSMENT AND TREATMENT

I understand that by signing this consent for evaluation and/or treatment at Crawford County Mental health that I am agreeing to participate in an evaluation and/or treatment at Crawford County Mental health for mental health and/or substance use conditions. This may include use of standard medical, psychiatric, psychological, and social work procedures deemed necessary for diagnosis and treatment of mental health and/or substance use.

I understand that my service provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing quality services to me. I understand that these discussions will be kept confidential unless I authorize that the information be released or unless allowed or required by law.

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the assessment is complete and a treatment plan has been formulated, I will be given the opportunity to review and discuss with my service provider the results of the evaluation, the nature of my condition, and any treatment, including alternatives to these recommendations.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

If medications should be prescribed or medical laboratory tests required as a part of my treatment, I hereby give my consent to release my name to the pharmacy (or indigent program) that I obtain medications from to assist in filling and managing prescriptions for me. I also give my consent to release my name and my diagnosis (if necessary) for the purpose of requesting laboratory tests and obtaining results that may be needed as a part of my treatment. This authorization for release of information will automatically expire upon close of my case at Crawford County Mental Health Center. I understand that I can cancel this release of information at any time by giving written notification. Permission is hereby given to Crawford County Mental Health Center, Inc. to provide assessment and treatment.

Our practitioners participate in the online Prescription Monitoring Program known as **K-TRACS** (Kansas Tracking and Reporting of Controlled Substances). The system collects prescription data on **ALL** Schedule I, II, and IV controlled substance and drugs of concern dispensed in or into the State of Kansas. This program is authorized pursuant to K.S.A 65-1681 through 65-1693.

I acknowledge having received a copy of the Patient Rights and Responsibilities brochure, a copy of Crawford County Mental Health Center’s agency brochure that outlines available services, and a copy of Crawford County Mental Health Center’s Notice of Information Practices (as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations).

Client Name (Please Print)

Client/Parent/Guardian Signature

Date

Staff Member Signature

Date

CRAWFORD COUNTY MENTAL HEALTH ADMISSION FORM FOR ALL CLIENTS

Client Name: _____ **DOB:** _____ **Date:** _____

Marital Status: Single Married Divorced Widowed Separated **Pre-Marital Name:** _____

Preferred Name: _____

Resident Co: Crawford Other: _____ **Responsible Co:** Crawford Other: _____

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting purposes. The options for some of these questions were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank you.

Gender: F M Transgender – F to M Transgender – M to F

Sexual Orientation:
 Heterosexual Bisexual Gay Lesbian Questioning Self-Identified Orientation
 Polyamorous Other: _____ Decline to Answer

Preferred Pronouns:
 He/His She/Hers They/Them Other: _____ Decline to Answer

Race (mark all that apply):
 White/Caucasian Asian
 Black/African American Other/Unk
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native

Ethnicity:
 Hispanic/Latino
 Not Hispanic or Latino

Living Situation:
 Own/Rent Jail Sober Living
 Living w/ Someone Else/Couch Surfing Dorm Other: _____
 Shelter (includes transitional) Residential Treatment Decline to Answer
 Street/Outdoors Nursing Home

Military Status:
 No Service Immediate Family Member in Active Duty
 Active Duty Immediate Family Member is a Veteran
 Veteran Reserves/Guard Never Activated
 Private Contractor that Deployed to Combat Zone Reserves/Guard Activated

Highest Level of Education: (mark the highest level of education you have achieved)
 Bachelor's Degree GED Special Ed. Ungraded No Formal Education
 Master's Degree HS Grad (Not GED) Vocational Training Unknown
 Doctorate Degree Preschool Grade Level (indicate 1-12) _____
 Grad Work No Degree Kindergarten Years of College: 1 2 3 4 (no degree)

Please Mark the MOST RECENT TYPE OF HOSPITALIZATION (Last type of inpatient psychiatric facility &/or substance abuse facility you received care)	Please Mark Your Eligibility for SSI or SSDI Benefits
<input type="checkbox"/> None	<input type="checkbox"/> Not Applicable
<input type="checkbox"/> State mental health hospital	<input type="checkbox"/> Eligible and Receiving Payments
<input type="checkbox"/> Private Psychiatric hospital (detached from general hospital)	<input type="checkbox"/> Eligible but not Receiving Payments
<input type="checkbox"/> Out of home crisis stabilization	<input type="checkbox"/> Potentially Eligible
<input type="checkbox"/> General Hospital Psychiatric Ward (within a general hospital)	<input type="checkbox"/> Determined to be Ineligible
<input type="checkbox"/> Inpatient Substance Abuse Treatment (excluding detox, etc.)	<input type="checkbox"/> Determination Decision on Appeal
<input type="checkbox"/> Residential mental health treatment within a state correctional facility	

*****Clients: Please fill out questions on the backside of this form.**

HEALTH QUESTIONNAIRE

Female Only: Pregnant? Yes No

Risk factors for infectious disease, including HIV, AIDS, HCV and STD's:

Have you participated in any high-risk behaviors that could result in HIV, another STD, or Hepatitis C?

- No Unprotected Sex
 IV Drug User Other _____
 Multiple Sex Partners

Have you tested positive for HIV/AIDS? Yes No Have you tested positive for Hepatitis B and/or C? Yes No

Have you tested positive for other Sexually Transmitted Diseases (STD's)? Yes No

Would you like a referral to be tested for any of the above? Yes No

TB Questions: Within the last month have you had any of the following? (Residential programs these questions are on the TB skin test form) Check each you have had.

- A cough lasting over 3 weeks? Fever, chills, or night sweats for no reason?
 Chest pain? Sputum production or blood with cough?
 Increased fatigue? Unexplained loss of appetite or sudden weight loss?
 Persistent shortness of breath

Outpatient TB referral: Did client answer yes to the above set of questions for TB? Yes No

(If Yes, Referral to Health Department for TB Test)

SOCIAL QUESTIONNAIRE

Do you have a Support System? Please check all that apply.

- AA, NA, etc Family
 Involved in a community group Other social supports _____
 Connection with friends or peer group No current community/social supports

Religion/Spiritual Orientation: Do you want your religious/spiritual considerations to be brought to the attention of your treatment providers? Yes No

If yes, list your religion/spiritual orientation: _____

Ethnic/Cultural Considerations/Issues: Do you want your ethnic/cultural considerations/issues to be brought to the attention of your treatment providers? (Food, clothing, tradition, beliefs, language, etc.) Yes No

If yes, list your ethnic/cultural considerations/issues: _____

Do you participate in any recreational activities/hobbies? Yes No

If yes, list your recreational activities/hobbies: _____

Do you have any of the following Financial Support/Resources and Community Resources? Please check all that apply.

- SSI/SSDI Retirement
 VA Benefits Family/Spouse
 Unemployment Benefits Food Stamps
 Social Security Other _____

ACCESSIBILITY QUESTIONNAIRE

Do you have a Physical Disability? Yes No Decline to Answer

If **Yes**, do you use an assistive device to get around? Mark all devices used.

- NA Cane Walker Wheelchair Decline to Answer

Do you have a developmental disability such as an intellectual disability or autism diagnosed by a medical professional?

- Yes No Decline to Answer

Because of a physical condition, do you have difficulty walking or climbing stairs?

- NA Yes No Decline to Answer

Are you deaf or have serious difficulty hearing?

- Yes No Decline to Answer

Are you blind or do you have serious difficulties seeing even when wearing glasses?

- Yes No Decline to Answer

Do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- NA Yes No Decline to Answer

*****Staff Only: Fill out Chronicity for all New Admissions. CHRONICITY QMHP USE Only: (Adult and Child)**

SUD Only	
Not SED/SPMI (receiving services other than Med Only)	SED (receiving services other than Med, TCM or CPST)
Not SED/SPMI (Med Only)	SPMI (receiving Med Only, Not CSS)
SED (receiving Med Only, Not TCM or CPST)	SPMI (receiving services other than Med or CSS)
SED (receiving TCM or CPST)	SPMI (receiving CSS services)

CHILD AIMS ADMISSION DATA

Client Name: _____ DOB: _____ Date: _____

Current Custody Status:

- | | |
|---|---|
| <input type="checkbox"/> No JJA or DCF involvement | <input type="checkbox"/> Child is in DCF custody and out of home placement |
| <input type="checkbox"/> Child in JJA custody and lives at home | <input type="checkbox"/> Child is in DCF custody and lives at home |
| <input type="checkbox"/> Child in JJA custody and out of home placement | <input type="checkbox"/> Child is under DCS supervision, but not in their custody |
| <input type="checkbox"/> Child is under supervision of JJA (but not in their custody) | |

Current Residential Setting:

- | | |
|---|--|
| <input type="checkbox"/> Jail/Detention | <input type="checkbox"/> Emergency Shelter |
| <input type="checkbox"/> State Hospital | <input type="checkbox"/> Therapeutic foster care |
| <input type="checkbox"/> Inpatient Psychiatric Unit | <input type="checkbox"/> Foster home |
| <input type="checkbox"/> Crisis Resolution/Stabilization Unit | <input type="checkbox"/> Temporarily living with a Relative or Family Friend |
| <input type="checkbox"/> Drug/Alcohol Treatment Center | <input type="checkbox"/> Permanent Home: Biological, adoptive or other |
| <input type="checkbox"/> Residential Treatment/Level VI | <input type="checkbox"/> Independent Living |
| <input type="checkbox"/> Group Home (Levels III, IV, V) | <input type="checkbox"/> Homeless |

Current Educational Placement:

- | | |
|---|---|
| <input type="checkbox"/> Not applicable (not listed below) | <input type="checkbox"/> Not in school (graduated) |
| <input type="checkbox"/> Institutional instruction: e.g. psych. Hospital, detention | <input type="checkbox"/> Not in school working on a GED |
| <input type="checkbox"/> Residential School | <input type="checkbox"/> Not in school (expelled) |
| <input type="checkbox"/> Home-based instruction from school district | <input type="checkbox"/> Not in school (drop-out) |
| <input type="checkbox"/> Special Education Classroom | <input type="checkbox"/> Preschool |
| <input type="checkbox"/> Regular Class w/ Special Ed. Services or Consultation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Regular classroom (100% of the day with no Special Ed.) | <input type="checkbox"/> Alternative Education with Intensive psychosocial |
| <input type="checkbox"/> Home Schooling not provided by the school district | <input type="checkbox"/> Not in school – summer break |
| <input type="checkbox"/> Not in school (suspended) | <input type="checkbox"/> Enrolled in post-secondary education (Technical School, College, Professional development such as cosmetology) |

Grade Level or Estimation by Age:

- | | |
|---|--|
| <input type="checkbox"/> PS-preschool | <input type="checkbox"/> Not in grades K-12: Graduated (transition aged youth) |
| <input type="checkbox"/> K=kindergarten | <input type="checkbox"/> Completing GED |
| <input type="checkbox"/> Grade Level 1-12 Specify: _____ | <input type="checkbox"/> Expelled |
| <input type="checkbox"/> NA (Child is too young to be in school) | <input type="checkbox"/> Drop out |
| <input type="checkbox"/> Enrolled in post-secondary education (Technical School, College, Professional development such as cosmetology) | |

School Attendance and Performance:

____ Number of Excused Absences
____ Number of Unexcused Absences

School Attending: _____

____ Number of Days In-School Suspension
____ Number of Days Out-of-School Suspension

Currently Charged/Found Truant? Yes No

Average Academic Performance:

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Above Average (A or B)/Highly Satisfactory | <input type="checkbox"/> Below Average (D)/Unsatisfactory | |
| <input type="checkbox"/> Average (C)/Satisfactory | <input type="checkbox"/> Failing (F)/Unsatisfactory | <input type="checkbox"/> Unknown |

Special Education:

- Is Child Identified on a 504? Yes No
Is Child Identified on an IEP? Yes No
If Yes, choose all that apply: MR/DD Physical Disabilities/Other Health Impaired
 Gifted Emotional/Behavioral Disturbance Learning Disability

Foster Care: _____ Number of New Foster Care Placements in the last 30 days.

KCSL (FC)

The Farm (TFI)

UMY

KCSL (adoption)

KVC

St. Francis

DCCCA

Cornerstones of Care

Admission Risk Factors:

Has there been a past known DCS report of physical abuse?

Yes No

Has there been a past known DCS report of sexual abuse?

Yes No

Has there been a past known DCS report of neglect/emotional abuse?

Yes No

Is there any known history of the child running away overnight?

Yes No

Is there any known history of the child attempting to harm self?

Yes No

Is there any known history of child abusing alcohol/drugs?

Yes No

(Abuse is defined as repetitive use that has created consequences for youth, or has put them in a dangerous situation)

Evidenced Based Services at Admission:

Supported Housing: **NO** Supportive Employment Services: **NO** Dual Diagnosis (for SPMI and Substance Abuse): **NO**

Law Enforcement Information:

_____ Total number of arrests within last 30 days

_____ Number of adjudicated felonies Not against property or person (eg drug crimes) within last 30 days

_____ Number of adjudicated felonies for PROPERTY crimes within last 30 days

_____ Number of adjudicated felonies against Persons within last 30 days

_____ Number of adjudicated misdemeanors within last 30 days

_____ Number of face-to-face contacts by law enforcement with the parent(s) or surrogate parent(s) for events involving the youth

Number of Days in a Residential Setting in the Last Month:

_____ Jail/Detention

_____ Emergency Shelter

_____ State Hospital

_____ Therapeutic Foster Care

_____ In-Patient Psychiatric Facility

_____ Foster Home

_____ Crisis Resolution/Stabilization Unit

_____ Temporarily Living with Relative/Family Friend

_____ Drug/Alcohol Treatment Center

_____ Permanent Home, Biological, Adoptive or Other

_____ Residential Treatment/Level 6

_____ Independent Living

_____ Group Home (Levels 3, 4, or 5)

_____ Homeless

_____ **Total Number of Days in Residential Setting Above**

Office Use Only - CBCL Score:

_____ Total Competence Scale is 10 to 80

_____ Total Problem Scale is 24 to 100

_____ Internalizing Scale is 33 to 100

_____ Externalizing Scale is 33 to 100



CRAWFORD COUNTY MENTAL HEALTH CENTER

911 E Centennial
Pittsburg, KS 66762
www.crawfordmentalhealth.org

620-231-5130
620-235-7101 Fax

INFORMED CONSENT CHECKLIST FOR TELEHEALTH SERVICES

Prior to starting video-conferencing and telephonic services, we discussed and agreed to the following:

- We agree to use the video-conferencing platform selected for our virtual sessions, and your provider will explain how to use it.
- We agree if video-conferencing is not available or the video-conferencing session gets disconnected we will utilize the telephone to conduct the session.
- If you are not an adult, we need permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- There are potential benefits and risks of video-conferencing and telephonic services (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without permission from the others person(s).
- You need to use a webcam or smartphone during the session for video-conferencing services.
- You must to be in the State of Kansas to receive telehealth services.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to not be driving during a session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify your provider 24 hours in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- As your provider, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in person.

Provider Name

Consumer Name

Provider Signature

Consumer/Guardian Signature

Date

Date

Crawford County Mental Health Center
ELECTRONIC COMMUNICATION ACKNOWLEDGMENT (Text and Email)

I agree to the following terms regarding communicating electronically with my providers at Crawford County Mental Health Center:

- I understand that communication using any electronic device, by nature, is not secure. By choosing to communicate in this way, I acknowledge I may be putting my own private health information at risk of exposure.
- In all crisis situations, I agree to use the Crawford County Mental Health Emergency Services 620-232-SAVE (7283) - to request assistance or to be seen in person.
- I understand the Emergency Services are available 24 hours a day, 7 days a week, and I am to directly contact them if I am having thoughts of hurting myself or others.
- I further understand that in the event of a crisis situation where my safety or others safety is in jeopardy, I will call 911 immediately.
- I agree to only use electronic communication with my provider(s) during their scheduled work days/hours.
- I understand that messages will be replied to within 24 hours or on my providers next scheduled day at work (in the event of weekends, holidays and vacation, sick leave, etc.).
- I understand that my provider will not read communication from me nor respond to me outside of regularly scheduled work hours.
- I agree to communicate electronically only in non-crisis situations limited to scheduling, rescheduling or cancelling appointments or when running late.
- I understand that my Crawford County Mental Health provider is also limited to using electronic communication for scheduling, rescheduling, cancelling and/or running late.
- I agree to not discuss treatment-oriented information or the sharing of personal information via electronic communication with my provider.
- I agree to not share my Crawford County Mental Health Center providers' electronic contact information with anyone without first obtaining permission from the provider to do so.
- I agree to allow my provider to assist me in programming the Crawford County Mental Health Center Emergency Services number into my phone.

I understand the risks of using Electronic Communication:

- Electronic communication can be circulated, forwarded and stored.
- Back-up copies of emails and text messages may exist even after the sender or recipient has deleted them.
- Messages can be intercepted, altered, forwarded or used without authorization or detection.
- When using electronic correspondence, I understand that it can be misaddressed or sent to the wrong recipient.
- Messages can be misinterpreted by recipients.
- Communications can be used as evidence in court proceedings and can be subpoenaed.
- Information I share electronically may become part of my patient record at Crawford County Mental Health Center.
- Electronic devices may be lost or out of possession by myself or my provider and may be accessed by others.

By signing below, I am aware and understand the risks of communicating through electronic devices and I hereby authorize my provider and Crawford County Mental Health Center to contact me electronically.

Client Name (Please Print)

Client/Parent/Guardian Signature

Date

Staff Member Signature

Date