Crawford County Mental Health Center

CLIENT REGISTRATION FORM

**When client arrives for intake complete form.

Are you an employee of CCMHC? ☐ **Yes** ☐ **No** **Are you a family member of a CCMHC employee?** ☐ **Yes** ☐ **No**

Full Legal Name: _____
Last First MI (Sr., Jr., II, etc.)

DOB: _____ **SSN:** _____

Referred By (agency, individual, hospital, self, etc.):
How did you hear about us?

☐ CHC ☐ Community Partner ☐ Internet Search
☐ PCP ☐ Self ☐ Sign/Billboard
☐ Hospital ☐ Family/Friend ☐ TV
☐ School/Interlocal/College ☐ Jail
☐ Law Enforcement ☐ Other _____

(Place a checkmark beside which phone is preferred:)

☐ **Home Phone:** _____ ☐ **Cell Phone:** _____

Email Address: _____

Physical Address: _____

City: _____

Mailing Address same as Physical Address: ☐ Yes If no, list below.

Mailing Address: _____

City: _____ **St:** _____ **Zip:** _____

Preferred Spoken/Written Language:
☐ English ☐ Spanish ☐ American Sign Language ☐ Other specify: _____

Is Language Interpretation Services Needed?
☐ No ☐ Spanish ☐ American Sign Language ☐ Other specify: _____

Adults: Does client have Court Appointed Guardian? ☐ Yes ☐ 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)

☐ **No Insurance (Check if client has No Insurance)**

Cardholder Name: _____ **Employer:** _____

Relationship to Client: _____ **SSN**: _____ **DOB:** _____

☐ Other: (ex. EAP): _____

Household Income _____ **Number of Dependents** _____

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
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Asian
☐ Other/Unk
☐ American Indian/Alaskan Native

Ethnicity:

☐ Hispanic/Latino
☐ Not Hispanic or Latino

Living Situation:

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

Military Status:

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

Highest Level of Education: (mark the highest level of education you have achieved)

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

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**	
☐	None	☐	Not Applicable
☐	State mental health hospital	☐	Eligible and Receiving Payments
☐	Private Psychiatric hospital (detached from general hospital)	☐	Eligible but not Receiving Payments
☐	Out of home crisis stabilization	☐	Potentially Eligible
☐	General Hospital Psychiatric Ward (within a general hospital)	☐	Determined to be Ineligible
☐	Inpatient Substance Abuse Treatment (excluding detox, etc.)	☐	Determination Decision on Appeal
☐	Residential mental health treatment within a state correctional facility		

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

HEALTH QUESTIONAIRE

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 resulted in HIV, another STD, or Hepatitis C?

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

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

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 QUESTIONAIRE

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

☐ AA, NA, etc
☐ Involved in a community group
☐ Connection with friends or peer group
☐ Family
☐ Other social supports _____
☐ 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
☐ VA Benefits
☐ Unemployment Benefits
☐ Social Security
☐ Retirement
☐ Family/Spouse
☐ Food Stamps
☐ Other _____

ACCESSIBILITY QUESTIONAIRE

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

Are you deaf or have serious difficulty hearing?

☐ Yes ☐ No ☐ 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

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

☐ Yes ☐ No ☐ Decline to Answer

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

☐ NA ☐ 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)

ADULT AIMS ADMISSION DATA

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

Current Educational Status:

- ☐ No Educational Participation
- ☐ Avocational Educational Involvement
- ☐ Pre-Educational Explorations
- ☐ Working On GED
- ☐ Working On English as A Second Language
- ☐ Basic Educational Skills
- ☐ Attending Vocational School or Apprenticeship, Vocational Program, (CNA Training)
- ☐ Attending High School
- ☐ Attending College (1 – 6 Hours)
- ☐ Attending College (7 Or More Hours)
- ☐ Other (Specify) _____

Current Vocational Status:

- ☐ No Vocational Activity
- ☐ Prevocational Activity
- ☐ Screening and Evaluation of Vocational Interests and Abilities
- ☐ Active Job Search
- ☐ Participating in A Sheltered Work Program/Sheltered Employment
- ☐ Employed in Transitional Employment
- ☐ Participating in Ongoing Volunteer Activity
- ☐ Any Person Who Remains Home to Take Care of Children or Others
- ☐ Any Job or Set of Jobs Requiring Less Than 30 Hours Per Week
- ☐ Any Job or Set of Jobs Requiring More Than 30 Hours Per Week
- ☐ Other
- ☐ Retired

Current Residential Status:

- ☐ Nursing Home
- ☐ NFMH
- ☐ Group Home
- ☐ Boarding Home
- ☐ Lives with Relatives (Heavily Dependent for Personal Care and Control)
- ☐ Lives with Relatives (But Is Largely Independent)
- ☐ Supervised Housing Program
- ☐ Independent Living
- ☐ Other
- ☐ Precariously Housed
- ☐ Homeless

Evidenced Based Services at Admission:

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

Days in the Hospital in the Last 30 Days:

_____ Number of Days in Psychiatric Hospital (detached from general hospital)

_____ Number of Days in General Hospital Psychiatric Hospital (within a general hospital)

_____Total Number of Psychiatric Hospitalizations at Admission

Law Enforcement Information:

_____ Total number of arrests within last 30 days

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

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

_____ Number of convicted felonies against Persons within last 30 days

_____ Number of convicted misdemeanors within last 30 days

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**