Hill Country MHDD ★★ since ★★ 1997
Caring People Dedicated to Quality Service

Request for Services

Name: _____
Chart #: _____
Clinic: _____

Date:_____ Name of Individual: _____ Date of Birth: _____

What is bringing you in today? _____

Primary Language: _____ Communication Method: _____

Translator/Interpreter required? ☐ YES ☐ NO Do you need assistance with reading or writing? ☐ YES ☐ NO

How can we best assist you with reading or writing in your recovery process? _____

Do you need any assistive technology in the course or your treatment? ☐ YES ☐ NO

Identify assistive technology need(s): _____

Our Intake process takes approximately 1 hour. We will begin within 30 minutes of return of these forms.

Please select your meeting preference: ☐Home/ MS Teams, I have internet access ☐In Clinic ☐Request Other

Are you or the person wanting services currently having thoughts of suicide, thoughts to hurt self, or thoughts to hurt someone else? YES NO

Social Security Number: _____ Gender: ____ Race/Ethnicity: _____ Email:_____

Physical Address: _____ County:_____

City, State, Zip: _____ Phone:_____Alt. Phone: _____

Insurance: _____ Policy Holder: _____ Policy #:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ School/Child ☐ Retired
Living Arrangement: ☐ Own Home ☐ Family Home ☐ Friend's House ☐ Nursing Home ☐ Homeless
☐ Other:_____
Highest Level of Education Completed: _____ Currently Enrolled? YES NO

Who Referred You To Us? ☐ CPS ☐ Court ☐ Probation ☐ Parole ☐ School ☐ Other: _____

Veteran? Yes No If yes, what branch? Army Marines Navy Airforce Coast Guard

Emergency Contact Name: _____ Phone:_____
Emergency Contact Relationship: ☐ Parent/Guardian ☐ Other:_____
Emergency Contact Address:_____

Legal Status: ☐ Minor ☐ Minor w/Conservator (Please provide guardianship/court orders for custody)
☐ Adult with Guardian ☐ Adult no Guardian

Name of Responsible Person (or Guardian) if applicable: _____
Physical Address of Responsible Person/Guardian:_____
Mailing Address of Responsible Person/Guardian: _____
Phone Number of Responsible Person/Guardian: _____

Primary Care Physician: _____ Phone: _____

»List any allergies or special precautions: _____

Client Name: _____ **Date of Completion:** _____

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

10. How often does anyone, including family, scream or curse at you?[1]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

ASSISTANCE

11. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

HOP17091665

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION *Supported in part by a grant from the AAFP Foundation*

The EveryONE Project™
Advancing health equity in every community

Adult Client Name (Under 18y see back): _____ Date of Completion: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate 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 yourself or 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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

IF UNDER AGE 18 YEARS, PLEASE COMPLETE THIS SIDE

PHQ-9 modified for Adolescents (PHQ-A)

Name:_____ **Clinician:**_____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleepingtoo much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like schoolwork, reading, or watching TV?				
8. Moving or speaking so slowly that other peoplecould have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Client Name: _____ Client Age: _____ Date of Completion: _____

CAGE-AID Questionnaire

The CAGE Adapted to Include Drugs (CAGE-AID) Questionnaire is an adaptation of the CAGE for the purpose of conjointly screening for alcohol and drug problems. The CAGE-AIDS focuses on lifetime use.

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Have you ever felt like you ought to cut down on your drinking or drug use? *

- ☐ Drinking - Yes
- ☐ Drugs - Yes
- ☐ Drinking - No
- ☐ Drugs - No

Have people annoyed you by criticizing your drinking or drug use? *

- ☐ Drinking - Yes
- ☐ Drugs - Yes
- ☐ Drinking - No
- ☐ Drugs - No

Have you felt bad or guilty about your drinking or drug use? *

- ☐ Drinking - Yes
- ☐ Drugs - Yes
- ☐ Drinking - No
- ☐ Drugs - No

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)? *

- ☐ Drinking - Yes
- ☐ Drugs - Yes
- ☐ Drinking - No
- ☐ Drugs - No

How many times in the past year have you had 5 (for men)/4 (for women) or more drinks in a single day? *

- ◯ 0 to 2 times
- ◯ 3 or more times

Gender (born, identified, expressed)

- ◯ Male
- ◯ Female
- ◯ Does not identify as either
- ◯ Other

C: Have you ever felt that you ought to **C**ut down on your drinking or drug use?
A: Have people **A**nnoyed you by criticizing your drinking or drug use?
G: Have you ever felt bad or **G**uilty about your drinking or drug use?
E: 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 (**E**ye opener)?

This tool was developed by Richard Brown, MD and Laura Saunders at the University of Wisconsin.

Authorization and Assignment of Benefits

Assessment date: _____

I refuse to give information: Yes or No

I have insurance coverage: Yes or No

I have the following insurance coverage: _____

I authorize the payment of insurance benefits from my third-party insurance provider or other organization for all covered services provided by HCMHDDC: Yes or No

I authorize HCMHDDC to disclose or receive information necessary for the purpose of processing claims and securing payment. Yes or No

I understand there may be services provided to me my third-party insurance provider will not cover as a benefit and will not pay. I understand I am responsible for payment: Yes or No

I have been informed my third-party insurance may consider Hill Country MHDDC as "Out-of-network" and may be subject to the terms of my insurance contract. Yes or No

General Information and Consents

I authorize HCMHDDC to contact SSA for verification of eligibility and benefits related to SSI, SSDI, Medicaid, and Medicare programs.: Yes or No

I acknowledge that I have been provided a copy of this Financial Assessment Form and Monthly Ability to pay scale with maximum amount to pay indicated.: Yes or No

I have received a copy of the Rights booklet: Yes or No

Boxed information is to be filled out by HCMHDDC appropriate staff.

My family's MMF or Maximum Ability' to Pay has been assessed to be: $ ____

Staff Person to discuss information: _____

Staff Phone Number:

Receipt of Notice of Privacy Practice

Assessment Date: _____

I acknowledge that I have received a copy of Hill Country MHDD Centers Notice of Privacy Practices.

Yes or No

Opportunity to register to vote

Assessment Date: _____

Are you registered to vote: Yes No I cannot vote

Do you want to register to vote: Yes No

Give Individual Voter Registration Card or sign up on website.
https://vrapp.sos.state.tx.us/index.asp

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by HILL COUNTY MHD CENTERS.

We can help you complete the voter registration application form. The decision whether to seek or accept help is yours. You may fill out the application form in private and mail yourself.

If you believe that someone has interfered with your right to register or to decline to register to vote, and your right to privacy in deciding whether to register or in applying to register to vote. You may file a complaint with the Elections Division of the Secretary of State, P.O. Box 12060, Austin TX 78711 1-800252-8683.

If you decline to register to vote, this decision will remain confidential and be used only for voter registration purposes. If you decide to register to vote, information regarding the office to which the application was submitted will remain confidential, and only used for voter Identification purposes.

Consent for Telehealth Services

To serve the needs of the people in the community, hospital and health care services are now available by interactive video communication and/or electronic transmission.

I have been asked to take part in a telehealth consultation. This will be done with one of Hill Country MHDD Centers providers. The purpose is to assess my medical condition. This is done through a two-way audio/video link with a health care provider at a remote location. I must give my informed consent to participate.

I understand the provider will be at a different location from me. An additional health care provider may be present with me in the room during treatment.
I will be informed if any additional personnel are to be present with me in the room or in the room at the location of the provider.

I understand I have the right to refuse to sign this authorization. Hill Country MHDD Centers will not withhold treatment, Medicaid benefits, or payment processing if I refuse to sign. I will receive a copy of this signed authorization.

I understand that I have the right to access my medical history, examination, tests, photographs or other images related to my treatment.

I understand consultation will become part of my medical record kept by Hill Country MHDD Centers. The provider may store or retain my medical information to comply with any applicable state or federal records retention requirements.

I understand I have the right to be informed of and to object to the videotaping or other recording of this treatment.

I understand I have the right to revoke this authorization. To revoke, my representative or I must deliver a written statement, signed by my representative or me, to the organization or facility where I gave my authorization, providing the date and purpose of my intent to revoke. My revocation will be effective the date it is received by the organization/facility except to the extent the organization has already relied on my authorization.

I acknowledge that Hill Country MHDD Centers has explained the telehealth treatment service in a satisfactory manner and that all questions that I have asked about this service have been answered to my satisfaction. This authorization if good for one year unless revoked.

Rights Review and Consent for Evaluation and Services

I. Hill Country Mental Health and Developmental Disabilities Centers (HCMHDDC) offers mental health evaluations and determination of disability (DID) and treatment to qualified individuals requesting services.
II. You have the following rights whether you consent to evaluation or treatment.
a. You have the right to informed consent, or the right to be informed of intended benefit or possible risks.
b. You have the right to refuse treatment or services.
c. You have the right to review, ask questions about and offer suggestions related to your mental
health services.
d. You have the right to make complaints about your mental health services.
e. You have the right to review your mental health records unless there is clinical justification to prohibit a requested review. All record reviews must be in writing.
f. You have the right to receive a copy in writing of your rights as an individual in services.
III. You have the right to be informed about the nature or reason for evaluation and treatment, as well as what options might be available other than the recommended treatment or services.

NOTE: Informed consent does not mean you are consenting to release of information, however there may be situations when information about your mental health or services may be disclosed to other stakeholders without your consent. Release of information will follow state and federal laws.

Consent for Evaluation and Services

I have been informed about my rights to consent or not to consent to evaluation or treatment or services.
I have been informed about my rights to consent or not to consent to evaluation or treatment or services.
I agree to receive and participate in mental health or IDD treatment and services.
I understand I have a responsibility to keep all scheduled appointments with clinic staff. Barring any unforeseen emergency, I will give at least 24 hours' notice prior to cancelling any clinic appointment. I understand if I miss 2 consecutive appointments without giving 24 hours' notice, my case may be reviewed by clinical staff for possible discharge from clinic services. If my case is closed, I will receive a letter notifying me all services, including medications have been discontinued.

I understand and have been informed I have the right to appeal decisions to deny, terminate or reduce services, I understand if I have questions about my rights as an individual in services, I may ask staff or the Rights Protection Officer for clarification, and that my rights will be reviewed with me annually.

Rights Protection Officer
819 Water Street, Suite 300
Kerrville, Texas 78028
830.792.3300 x2066

Disability Rights Texas
7800 Shoal Creek Blvd
Austin, Texas 78757
512.374.0755

Financial Assessment

- Date of Assessment: _____
- Number of Family Members: _____
- Number of Family Members Receiving Services: _____

Income

- Client Employment Income 1 Frequency: _____

  Please circle one of the following: Weekly, Bi-Weekly, Monthly, or annual salary.

- Client Employment Income 2 Frequency: _____

  Please circle one of the following: Weekly, Bi-Weekly, Monthly, or annual salary.

- SSI Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- SSI Amount $: _____
- SSDI Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- SSDI Amount $: _____
- Soc Sec Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Soc Sec Amount $: _____
- Spouse Emp Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Spouse Emp Amount $: _____
- Spouse other income Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Spouse Amount $: _____
- Parent 1 Employment Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Parent 1 Employment Amount $: _____
- Parent 2 Employment Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Parent 2 Employment Amount $: _____
- Other Income Frequency: Weekly, Bi-Weekly, Monthly, or annual salary.
- Other Income Amount $: _____

Exceptional Expenses

- **Major Medical Expense Weekly, Bi-Weekly, Monthly: $**
- **Major Casualty Expense Weekly, Bi-Weekly, Monthly: $**
- **Child Care Expense Weekly, Bi-Weekly, Monthly: $ _**
- **Other Expense Weekly, Bi-Weekly, Monthly: $ _____**