Request for Services

Please complete this Request for Services and return to front desk. You will be asked to provide a digital signature for Annual Consents which are covered in this form. The Enrollment process takes approximately 1.5 hours and will be completed through Microsoft Teams on the same day the request is submitted. You may be asked to return if there are no appointments remaining.

Date: ____________ Name of Individual: ____________________________________ Date of Birth: __________________

Preferred Name: _______________________ What is bringing you in today? ______________________________________

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

Primary Language: ______________________________ Translator/Interpreter needed? ☐ YES ☐ NO

Are there any barriers to communication: ☐ YES ☐ NO Explain: ____

Do you need assistance with reading or writing? ☐ YES ☐ NO How can we assist? _____________________________

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

Are you or the person wanting services currently having thoughts of suicide, thoughts to hurt self or thoughts to hurt someone else? ☐ YES* ☐ NO *If YES, please let staff know before continuing

Are you or the person wanting services currently: ☐ Pregnant ☐ Injecting Drugs ☐ Homeless ☐ At risk of overdosing ☐ Involved with CPS ☐ None

Social Security Number: ________________________________ Race: _____________ Ethnicity: ____________________

Sex: _________ Gender Identity *(optional)*: ___________________ Sexual Orientation *(optional)*: ___________________

Physical Address: ____ County: ____________________

City, State, Zip: ____

Mailing Address: ____ *County*: ____________________

City, State, Zip: ____

Email: ____ Phone: ______________________ Alt. Phone: __________________

Insurance: _________________________ Policy Holder: _______________________ Policy #: ________________________

Emergency Contact Name: ____ Phone: _____________________

Emergency Contact Relationship: ______________________ Address: ____

MUST COMPLETE FOR INDIVIDUALS AGES 17 AND UNDER

Name of Parent, Responsible Person or Guardian: ____

Phone Number of Parent, Responsible Person or Guardian: ____

Is minor included in custody agreement, divorce decree or court order affecting parent-child relationship? ☐ Yes ☐ No

If yes, custody documentation will be needed to determine who can consent to and participate in treatment

Does minor have a guardian other than parent? ☐ Yes ☐ No

If yes, what is the relationship of guardian: ☐ Grandparent ☐ Adult Sibling ☐ Aunt/Uncle ☐ Other: ______________

Is there any court order, power of attorney or letter of guardianship? ☐ Yes ☐ No

If yes, please provide any relevant paperwork related to guardianship

Request for Services continued

Please check the most appropriate response:

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ School/Child ☐ Retired
Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Living Arrangement: ☐ Own Home ☐ Family Home ☐ Friend's House ☐ Nursing Home ☐ Homeless ☐ Other
Highest Level of Education Completed: ____________________ Currently Enrolled? ☐ Yes ☐ No
Veteran or Active Duty? ☐ Yes ☐ No If yes, what branch? ☐ Army ☐ Marines ☐Navy ☐ Air Force ☐ Coast Guard
Smoking and Tobacco Use: ☐ Current Daily Use ☐ Occasional Use ☐ Former Use ☐ Never Used

Clinical Information

Are you currently receiving outpatient mental health services (PCP, psychiatrist, counseling)? ☐ Yes ☐ No
If Yes, name of office/ clinic? ______________________________________ Phone Number:_______________________
Have you been on mental health medications in the past 90 days? ☐ Yes ☐ No ☐ Unknown

Have you been discharged from an inpatient psychiatric facility within the last 14 days? ☐ Yes ☐ No
If yes, name of facility ____ Discharge Date _____________
Reason for admission: ____

Have you been released from jail/juvenile detention/prison within the last 30 days? ☐ Yes ☐ No
If YES, please write the name of facility: __________________________________ Release Date ________________

Primary Care Physician: ____Phone: _________________________
List any allergies or special precautions: ____

(It is recommended that you sign a Release of Information for each inpatient/outpatient clinic you have been receiving services from. Please see administrative staff for form)

Diagnosis Information

Please list ALL mental health diagnosis you have been given: *(Name, and dates to the best of your knowledge)*

1. ____
2. ____
3. ____
4. ____

Medication Information

Please list ALL medications you are CURRENTLY taking: *(Name, dosages, when and how often do you take it)*

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

BH Non-Medical Drivers of Health (NMDOH) Assessment

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you rent, own or stay in as part of a household?
   ☐ Yes ☐ No
2. Think about the place you live. Do you have problems with any of the following?
   ☐ Bug infestation
   ☐ Lead paint or pipes
   ☐ Over or stove not working
   ☐ Water leaks
   ☐ Mold
   ☐ Inadequate heat
   ☐ No or not working smoking detectors
   ☐ 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.
   ☐ Often true ☐ Sometimes true ☐ Never true
4. Within the past 12 months, the food you bought didn't last and you didn't have money to get more.
   ☐ 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?
   ☐ 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 electric, gas, oil or water company threatened to shut off services in your home?
   ☐ Yes ☐ No ☐ Already shut off

CHILD CARE

7. Do problems getting childcare make it difficult for you to work or study? ☐ Yes ☐ No

EMPLOYMENT

8. Do you have a job? ☐ Yes ☐ No

EDUCATION

9. Do you have a GED or high school diploma?
   ☐ Yes ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Often ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Fairly Often ☐ Frequently
12. How often does anyone, including family, insult or talk down to you?
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Fairly Often ☐ Frequently
13. How often does anyone, including family, threaten you with harm?
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Fairly Often ☐ Frequently
14. How often does anyone, including family, scream or curse at you?
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Fairly Often ☐ Frequently

ASSISTANCE

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

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, 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 <u>any</u> problems, how <u>difficult</u> 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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
- [ ] Drinking - No
- [ ] Drugs - Yes
- [ ] Drugs - No

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

- [ ] Drinking - Yes
- [ ] Drinking - No
- [ ] Drugs - Yes
- [ ] Drugs - No

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

- [ ] Drinking - Yes
- [ ] Drinking - No
- [ ] Drugs - Yes
- [ ] 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
- [ ] Drinking - No
- [ ] Drugs - Yes
- [ ] 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.

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.

- You have the right to informed consent, or the right to be informed of intended benefit or possible risks.
- You have the right to refuse treatment or services.
- You have the right to review, ask questions about and offer suggestions related to your mental health services.
- You have the right to make complaints about your mental health services.
- 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.
- 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.
☐ Yes ☐ No

I agree to receive and participate in a mental health evaluation or determination of intellectual developmental disability. ☐ Yes ☐ No

I agree to receive and participate in mental health or IDD treatment and services. ☐ Yes ☐ No

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

Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of Hill Country MHDD Centers Notice of Privacy Practices.
□ Yes □ No

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.

1. 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.

2. 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.

3. 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.

4. 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.

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

6. 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.

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

8. 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.

I consent to Telehealth services: □ Yes □ No

Emergency Contact

I authorize HCMHDDC to contact the individual and/or physician indicated in the event I become incapacitated due to an emergency. □ **Yes** □ **No**

Opportunity to register to vote

Are you registered to vote?: □ **Yes** □ **No** □ **I cannot vote**

Do you want to register to vote today?: □ **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.

Authorization for Publication (Chart Photograph)

I authorize Hill Country MHDD Centers to utilize my photograph for documentation in my medical records chart. I understand that I have the right to refuse to authorize this use and Hill Country MHDD Centers will not withhold treatment, benefits or payment processing if I refuse. I understand that I have a right to receive a copy of this authorization if requested.

I understand that 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 Hill Country MHDD Centers providing the date and purpose of this authorization and my intent to revoke the authorization.

I understand that revocation will be effective the date it is received by HCMHDD, except to the extent that the organization has already relied upon my authorization to disclose my health information. Unless this Authorization is revoked earlier, it will automatically terminate one year from the date of original authorization.

I consent to the use of my image as described: □ **Yes** □ **No**

My Signature Certifies that I have read, understand and agree to the indicated consents.

______________________________ ______________________________

Name of Individual (Printed) **Signature** **Date**

Financial Assessment

- Number of Family Members:___________
- Number of Dependents: _____________
- Number of Family Members Receiving Services: __________

Income

- Client Employment Income Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually

  Employment Income Amount $: _________

- Client Employment Income 2 Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually

  Employment Income Amount $: _________

- SSI Frequency: □ Monthly □ Annually □ N/A
- SSI Amount $: _________
- SSDI Frequency: □ Monthly □ Annually □ N/A
- SSDI Amount $: ________
- Soc Sec Frequency: □ Monthly □ Annually □ N/A
- Soc Sec Amount $: _________
- Spouse Income Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually
- Spouse Income Amount $: _________
- Spouse Other Income Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually
- Spouse Other Income Amount $: _________
- Parent 1 Employment Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually
- Parent 1 Employment Amount $: ________
- Parent 2 Employment Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually
- Parent 2 Employment Amount $: _________
- Other Income Frequency: □ Weekly □ Bi-Weekly □ Monthly □ Annually
- Other Income Amount $: _________

Does client receive TANF, SNAP or Child Support? ▫ Yes ▫ No

TANF Amount: _____________

SNAP Amount: _____________

Child Support Amount: ____________

Exceptional Expenses

- **Major Medical Expense Amount $: ___________ Frequency: ▫ Monthly ▫ Annually ▫ NA**
- **Major Casualty Expense Amount $: ___________ Frequency: ▫ Monthly ▫ Annually ▫ NA**
- **Child Care Expense Amount $: ___________ Frequency: ▫ Weekly ▫ Monthly ▫ Annually ▫ NA**
- **Other Expense Amount $: ___________ Frequency: ▫ Weekly ▫ Monthly ▫ Annually ▫ NA**

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: ______________________________

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 ☐ No

_____________________________________ _____________________________________

Name of Individual (Printed) Signature Date

Authorization and Assignment of Benefits

I have insurance coverage. ☐ **Yes** ☐ **No**

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

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

I have the following insurance coverage. ☐ **Medicaid** ☐ **Medicare** ☐ **Private Insurance**

I refuse to give information. ☐ **Yes** ☐ **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** ☐ **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** ☐ **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** ☐ **No**

I authorize HCMHDDC to contact the individual and/or physician indicated in the event I become incapacitated due to an emergency. ☐ **Yes** ☐ **No**

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

I received a copy of the Rights booklet. ☐ **Yes** ☐ **No**

If you live in Val Verde, Edwards, Uvalde or Kinney County, do you live in a Colonia? ☐ **Yes** ☐ **No**

I understand by signing this form, the information stated on this Financial Assessment form is true and correct to the best of my knowledge.

______________________________ ______________________________

Name of Individual (Printed) **Signature** **Date**

HILL COUNTRY COMMUNITY MHMR CENTER
AUTHORIZATION AND CONSENT FOR THE
DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME

CASE

Patient: ____________________________ SSN: ____________________DOB:____________________

I authorize and request the ____ to provide/receive the following
(name of organization)
information with regard to my clinical/hospital records on (specify dates of treatment):____________________

If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult, I

further understand the record released may contain references to family and myself.

Provide to/Receive from: ____

I understand that such disclosure will be made for the following purpose:

______ To assist in additional funding

_____ To coordinate discharge placement/planning

______ To assist in evaluation and treatment

_____ To assist in educational placement

______ To provide information to person(s) ____

______ To request that the following information/authorizations (in addition to school records) be provided to assigned Service Coordinator:

- Notification of all ARD meetings
- Copy of IEP (Individual Educations Plan) resulting from any ARD Meetings
- Visits and observations in the classroom and/or work locations
- Information regarding outcome of IEP implementation from teachers and other staff

I also authorize the disclosure/use/receipt of my health information regarding:

☐ HIV/AIDS (pursuant to Texas Health and Safety Code, Chapter 81, Subchapter F)

☐ Alcohol and drug abuse treatment (pursuant to 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records)

Other ____

And will be limited to the following specific types of information:

____

____

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

I understand that if I am authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

I understand that I (or my personal representative, if any) have the right to revoke this authorization. To revoke this authorization, I must deliver a written statement, signed by my representative or me, to the organization or facility where I gave my authorization (identified above), which provides the date and purpose of this authorization and my intent to revoke it. My revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices.

If not earlier revoked, this authorization shall terminate on: ____.

______________________________________ ______________________
Consumer Date

______________________________________ ______________________
Representative Date

____
Relationship to Consumer

____ ____________________
Witness Date

____
Address

NOTE: A photocopy or facsimile is as valid as the original