



DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT 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: _____
Patient or Patient's Authorized Personal Representative

Date: _____

By: _____
DCHS Employee Witness Signature

Date: _____



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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 <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female-to-male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Gender non binary, neither exclusively male nor female <input type="checkbox"/> Additional gender category/ (or Other), please specify: _____				
What sex were you assigned at birth on your original birth certificate? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to answer		Preferred Pronoun (She, He, They, Other) Preferred Name: _____		
Home #	For confidential consideration, where may we leave a message (mark all that apply) <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> 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: _____ <input type="checkbox"/> Living Alone			

Reason For Seeking Services

INDIVIDUAL NEEDS
Interpreter/Special Needs (Please mark all that apply): <input type="checkbox"/> Hearing Impaired/Aid <input type="checkbox"/> Reading/Literacy Aid <input type="checkbox"/> None <input type="checkbox"/> Other _____ <input type="checkbox"/> 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 accommodations to make participation possible, please call 541-322-7500.



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Client Initials: _____

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EMERGENCY CONTACT				
First and Last Name of Emergency Contact:				
Relationship	Address	City	State	Zip
*Emergency Information Can we leave a message (Please choose) <input type="checkbox"/> Yes <input type="checkbox"/> No Phone #				

MILITARY STATUS	
Have you ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently serving (reserve/active)? <input type="checkbox"/> Yes <input type="checkbox"/> No

MARITAL STATUS	
<input type="checkbox"/> Married <input type="checkbox"/> Significant Other <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Other
Name of spouse/partner (if applicable):	

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



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

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

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

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



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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
<input type="checkbox"/> Full Time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Not in Labor Force <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Other (volunteer etc.) <input type="checkbox"/> Hospital Patient, Incarcerated or Other Residential Institution <input type="checkbox"/> Unknown <input type="checkbox"/> Sheltered Employment (Opportunity Foundation, Good Will, etc.)
Do you want help with employment? <input type="checkbox"/> Yes or <input type="checkbox"/> No

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:					

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FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS			
List number of household members living with you in each category			
Self	Spouse/Partner	Parent/Guardian	Dependents
<p>❖ 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.</p> <p>❖ <u>I will notify DCBH promptly of any change to the above information.</u></p>			
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	Date of staff signature	
Signature:	Responsible Party Initials	Expiration date
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.		



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Infectious Disease Risk Assessment (IDRA) (ADULTS ONLY)

The following information is needed to help estimate your risk for HIV/AIDS and/or other infectious diseases. **It is not required that you answer these questions to participate in an assessment or counseling.** However, we would appreciate you taking the time to fill out as much of this as possible. **Your answers to these questions will be kept confidential.** Your signature at the end of this page indicates that you have read and/or answered this information.

Tuberculosis (TB)

Have you ever been diagnosed or treated for TB?

Yes No Don't Know

Have you known or lived with someone who was diagnosed with TB?

Yes No Don't Know

Have you ever been homeless or lived in a shelter?

Yes No

Have you ever been in jail/prison?

Yes No

If you answered "Yes" to any of the above TB questions, please proceed to TB Symptoms questions. If you answered "No" to all TB questions proceed to STDs section.

TB Symptoms

Do you have a fever?

Yes No

Do you sweat excessively at night (unrelated to room temperature)?

Yes No

Do you have a cough that has lasted for many weeks?

Yes No

Do you cough up blood?

Yes No

Do you get shortness of breath?

Yes No

Have you lost weight without meaning to?

Yes No

If you answered "Yes" to two or more symptoms, please call the disease reporting line at 322-7418 for immediate follow-up.

If you answered "No" to all symptoms, you may contact 322-7400 for a voluntary screening appointment.

STDs

Have you or anyone you have had sex with had any sexually transmitted diseases?

Myself Partner No
 Don't Know

Hepatitis, HIV/AIDS

Many people are worried about Hepatitis C and HIV/AIDS. Some should be worried and need to make changes to avoid being infected or spreading the infection to others. However, many people are not at risk of Hepatitis C or HIV (the virus known to cause AIDS). To find out if you are at an increased risk, please consider the following questions.

Have you used needles to inject drugs?

Yes No

In the past 12 months have you had a tattoo, ear/body piercing, or acupuncture from an unauthorized facility or come into contact with someone else's blood?

Yes No

Have you had unprotected sex with:

- a person who has injected illicit drugs
- more than one person in the past 6 months?
- a person in exchange for money, drugs, or in order to survive?
- a man who has had sex with another man?
- someone who has the blood disease hemophilia?

Yes No Don't Know
 Yes No Don't Know
 Yes No Don't Know
 Yes No Don't Know
 Yes No Don't Know

Have you ever had sex with (or shared needles with) a person who tested positive for HIV or has AIDS?

Yes No Don't Know

If you answered "Yes" or "Don't Know" to any of the previous questions, you may be at increased risk for Hepatitis B, Hepatitis C, HIV, TB, or other infectious diseases. You may want to contact the Public Health Division or your primary care physician for an appointment to have a current HIV, TB, or STD test.

Individual or Caregiver Signature



AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

MRN: _____

Legal Last Name of Client:	First:	MI:	Date of Birth:
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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: _____ or _____ HIV/AIDS Authorize or Refuse: _____ 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:**

ACKNOWLEDGEMENT	<p>**This authorization is valid for one year from the date of signing unless otherwise specified.</p> <p>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.</p> <p>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.</p> <p>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."</p>

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



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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