Crossroads Recovery Center
Pre-Admission Screening Form

Screened By: _____ Walk-in ____ Phone ___-___-____ Date: _____
Client's Name: _____ SS#: ___-__-____ DOB: _____ Gender: ___ Age: __
Address: _____
Homeless: _____ Income Source: _____ Highest Grade Completed: _____
County: _____ Veteran Status: _____ Marital Status: _____
Does client have __ Medicaid __ Medicare __ Private Insurance?
ID# _____ SSI-SSDI eligibility: _____ Qualify: _____
Referred By: _____ Contact Person: _____ Phone: ___-___-____
Reason for referral: _____
Referred for-what level of care? _____
Current legal problems: _____ Explain: _____
Probation: _____ With whom and for what? _____
P.O. Contact Info: _____
DHS involvement? _____ Explain: _____
DHS worker: _____ County: _____ Contact info: _____
New or existing client? _____ Referred due to overdose: _____
Number of lifetime overdoses: _____ Primary DOC: _____ Secondary DOC: _____
Primary form of consumption: ☐oral ☐snort ☐IV ☐smoke

DOC	Age of first use	Amount	Frequency	Days at a time	Method	Date of last use

Longest time of not using: _____ How did client stay clean? _____ Reason for relapse: _____

Substance Treatment	Address	Dates	Type of Discharge

Number of non-medicated detox: _____
Number of medicated detox: _____ Substance: _____ Length of admission: _____

Mental Health Treatment	Outpatient/Inpatient	Dates	Diagnosis	Medications	Doctor

Current Medication: _____

Client Name _____ Case Number _____

Attendance Policy

Gulf Coast Mental Health Center/Crossroads Recovery Center

NO-SHOWS:

When you confirm your appointment and have not cancelled it, it is considered a "NO-SHOW." After two consecutive no-shows, if no further contact is made by you, your case will be closed.

CANCELLATIONS:

You should cancel your appointments when you know you're unable to attend. You may call the facility and leave a voicemail if the front desk attendant is unavailable. Cancelling several times may result in your case being closed.

MEDICATION:

If you are referred to the Medication Clinic to see a nurse practitioner or a doctor, it is very urgent that you attend all appointments. If you run out of your medication before your next appointment, please call the office to request a refill. If you do not attend your appointments with your therapist, your medication clinic appointments may be cancelled.

UNATTENDED CHILDREN:

We are not responsible for children left in the lobby while you are in session with your therapist, doctor or nurse practitioner. If you must bring a child(ren) with you, an adult must accompany them, unless other arrangements are made with your therapist.

Client Signature _____ Date_____

Client Representative _____ Date_____

OFFICE PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you and family, we would like to present our office payment policy in order to minimize misunderstanding about fees. GULF COAST MENTAL HEALTH IS NOT A STATE AGENCY or CHARITY, but rather a NON-PROFIT PUBLIC SERVICE AGENCY. We must CHARGE FEES for our services IN ORDER TO MAINTAIN OUR OPERATION. We ask for payment at the time of service. This includes payments for Therapist's appointments and Med Checks.

FEES ARE BASED ON INCOME & HOUSEHOLD

As a courtesy, we will file charges with your insurance carrier(s). By signing Insurance Releases, you authorize and requests insurance payments be made directly to Gulf Coast Mental Health Center. HOWEVER YOU ARE RESPONSIBLE FOR YOUR FEE IF THERE IS A DEDUCTIBLE OR YOUR INSURANCE DOES NOT COVER OUR SERVICES. We advise that you familiarize yourself with the benefits of your plan. Prior to any service, we will assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to services. We accept Cash, Checks, Master Card, Visa, Discover and Debit Cards.

If you do not have insurance our Intake Fee, is $30.00, Full Fee $150.00. You will have to provide proof of income compare to our Sliding Scale Fee. Our minimum fee is $25.00 which will have to be paid for each visit.

THIS POLICY IS OFFERED IN AN ATTEMPT TO DEVELOP AND SUSTAIN A CONTINUED PROFESSIONAL AND PLEASANT RELATIONSHIP. YOUR COOPERATION IS GREATLY APPRECIATED.

I have read and understand the above policies

Signature_____ Date_____

GULF COAST MENTAL HEALTH CENTER

Rights of Individuals Receiving Services

Name _____

ID Number _____

☐ Initial ☐ Annual Review

I, _____ (Name) began receiving services provided by GULF COAST MENTAL HEALTH CENTER (Name of Provider)

on _____ (Intake/Admission Date) and have been informed of the following:

1. My options within the program and of other services available
2. The program's rules and regulations
3. The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs
4. My right to refuse treatment and withdraw from this program at any time
5. My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
6. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution
7. My right to be informed of and provided a copy of the local procedure for filing a grievance/complaint at the local level or with the DMH Office of Consumer Support
8. My right to privacy in respect to facility visitors in day programs and residential programs as much as physically possible
9. My right regarding the program's nondiscrimination policies related to HIV infection and AIDS
10. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth
11. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times
12. My right to review my records, except when restricted by law
13. My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Care. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment; 2) having access to information in my clinical records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel
14. My right to retain all Constitutional rights, except when restricted by due process and resulting court order
15. My right to have a family member or representative of my choice notified should I be admitted to a hospital
16. My right to receive care in a safe setting
17. My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable

Additionally, rights for individuals in supervised and residential living arrangements:

18. My right to be provided a means of communicating with persons outside the program
19. My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically
20. My right to be provided with safe storage, accessibility, and accountability of my funds contraindicated and documented in my case record
21. My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record
22. My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record

Release of Information Without Consent: This service provider/program/facility may, without consent, divulge information and/or contact a third party(ies) regarding the individual receiving services if there is indication, by word or action, that he/she: (1) is, or recently has been, abusing a child, or has been abused; (2) intends to physically harm another person; (3) intends to physically harm his or her self; (4) is unable to provide for his/her own physical safety, including but not limited to, a medical emergency; or (5) if necessary for the continued treatment of the individual receiving services; or (6) in the case of marital/couples counseling, information in the chart cannot be disclosed without the written consent of both parties.

Court Order Policy: Written information/materials regarding the individual receiving services are subject to Court Order. Should a court order all, or any portion of, the case records of the individual receiving services, this service provider will submit them to the court.

I have been informed of, understand, and have received a written copy of the above information.

Individual Receiving Services	Date	Legal Representative	Date
Staff/Credentials	Date	Relation to Individual	

Gulf Coast Mental Health Center

GRIEVANCE & PRIVACY POLICY/ CONSENT TO RECEIVE SERVICES

Name _____

ID Number _____

GRIEVANCE: _____ (Initial)

If you as a service recipient, or a family member, have a complaint of any kind regarding the services you received here please note the following action you may take:

1. You may approach any staff member to discuss your grievance. The staff member will take immediate steps to try and resolve your grievance. If it is not possible to resolve your grievance immediately, then a more formal process is available.
2. You may ask the receptionist or any staff member for a **Consumer Grievance Form.**
3. Complete the **Consumer Grievance Form,** describing in detail the circumstances of your grievance, listing specific dates, any staff member(s) involved, etc. Give the completed form to the receptionist or any staff member. The **Consumer Advocate** (a staff member who is an advocate for individuals receiving services) will be given the grievance form within twenty-four (24) hours.
4. The Consumer Advocate will try and resolve your grievance after meeting with you and discussing your concerns.
5. If you are not satisfied with the resolution, the Consumer Advocate will meet with any staff member(s) involved with your grievance. They will come up with a proposed resolution to your grievance, which will be presented to you for a response within ten (10) days of the initial written statement.
6. If you are still not satisfied, the Consumer Advocate will notify the Executive Director, who will study your grievance statement and the proposed resolution. The Executive Director will render a decision, with the Consumer Advocate acting on your behalf in the decision process within five (5) days.
7. If you are unsatisfied with the Executive Director's decision, you are entitled to a hearing before the Region XIII Commission if you so choose. You must request this hearing in writing to the Executive Director. A review panel will be established of Commissioners, you, and another consumer of your choice to review the situation. The Executive Director will notify you in writing of the date and time of the review hearing (within 10 days of written request). After review, the commission will notify you of its decision in wnting within five (5) days of the hearing. Actions or recommendation by the Commission will be final.

Dissatisfaction with the local grievance procedure or complaints about retribution or adverse consequences should be reported to the DMH Help Line (1-877-210-8513) and may be investigated by OCS and/or program staff.

NOTICE OF PRIVACY PRACTICES: _____ (Initial)

I acknowledge that I have received the Notice of Privacy Practices for Gulf Coast Mental Health Center, effective April 14, 2003.

I have been informed of the policies and procedures for reporting a complaint or grievance concerning any treatment or service that I receive.

CONSENT TO RECEIVE SERVICES: _____ (Initial)

The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I consent to receive services as may be recommended by the professional staff. I understand the professional staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.

I understand that I have the freedom of choice to receive services in a setting that is integrated in and supports full access to the greater community; and is a setting that facilitiates individual choice reguarding services and supports, and who provides them.

I understand that State and Federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations.

I understand that I am responsible for payment of services at the time that the services are rendered. I understand that a return appointment will be made only if I have no outstanding balance, unless prior arrangements have been made on the account. I understand that I must be the parent or legal guardian in order to consent to treatment for a minor child. I also understand that information regarding a minor child may be released to either parent, whether custodial or not, upon request.

I have read and understand the above.

_____ _____

Individual Receiving Services or Authorized Rep. *(specify relationship)* Date

_____ _____

Staff Signature / Credentials Date

Adult Information/Screener Sheet

Date:_____ Name:_____

Address:_____

Phone Number:_____

Within the last Month	Over a Month Ago	Please check any of the issues below that apply to you
		Problems w/ Alcohol or Drug Use or Withdrawal
		Anger Outbursts/Mood Swings/Irritability
		Depression (sad, crying frequently, isolating)
		Anxiety (sweaty palms, increased heart rate)
		Difficulties with Eating or Sleeping
		Divorce or Relational Issues (Domestic Abuse)
		Grief
		Hallucinations (hearing voices/seeing things others do not)
		Involvement with Any Court System
		Low Self-Esteem
		Work Issues (being on time, problems with peers)
		Self-Harming (hits, cuts, scratches, or bites self)
		Suicidal/Homicidal Ideation (talks about killing self or others)

Concerns_____

_____

_____

_____

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
☐	☐	☐	☐

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screener/Recent – Self-Report

Answer Questions 1 and 2	In The Past Month: YES	In The Past Month: NO
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts about killing yourself?*		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) *Have you thought about how you might do this?*		
4) *Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?*		
5) *Have you started to work out or worked out the details of how to kill yourself?* *Do you intend to carry out this plan?*		

	In the Past 3 Months
6) *Have you done any of the following?* *Attempted to kill yourself even if ending your life was only part of your motivation* *Started to do something to end your life but someone or something stopped you before you actually did anything* *Started to do something to end your life but you stopped yourself before you actually did anything* *Taken any steps towards making a suicide attempt or preparing to kill yourself* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. *In your entire lifetime, how many times have you done any of these things?*	