CenterPointe
and bodies!
healthy minds, strong communities

Date:

Legal Name: Last: First: M.I.: Date of Birth: / / _ Age: Gender:

Preferred Name: SSN#: Preferred Language: Needs Interpreter? ☐ Yes ☐ No

Primary Phone # :( ) Secondary Phone #: ( ) May we send you text reminders? ☐ Yes ☐ No

Email: May we contact you via email? ☐ Yes ☐ No

US Citizen: ☐ Yes ☐ No Veteran ☐ Yes ☐ No | Probation: ☐ Yes ☐ No Attorney: ☐ Yes ☐ No

Registered to vote? Yes No if no, would you like to register to vote here today? Yes No
:

Ethnicity: Hispanic ☐ Not of Hispanic Origin ☐ | Race: American Indian/Alaska Naïve ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐

| Street Address | Apt/Unit# | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

## Emergency Contact Information:

Emergency Contact: Phone # :( ) Relationship:

## Insurance Information:

Do you have health insurance? ☐ Yes ☐ No
Insurance Carrier: _
Member ID#: _

Do you have Medicaid? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No
Will filling insurance pose a risk to you? (Domestic Violence, child abuse, or other danger? ☐ Yes ☐ No

## Current Living Situation:

Living Arrangement? (Please check at least one checkbox)

☐ in your own place such as a house, apartment, or mobile home; or in someone else's household; or
☐ in a group care or board and care facility; or
☐ in an institution such as a hospital or a nursing home
☐ City Mission
☐ Homeless

Where did you sleep last night? _

Are you currently pregnant? ☐ Yes ☐ No | Have you Used IV drugs in the last 90 days? ☐ Yes ☐ No

Have you used drugs other than those required for medical reasons? ☐ Yes ☐ No

## Previous Behavioral Health:

Have you ever had a mental health diagnosis? ☐ No ☐ Yes (describe below)

Have you ever received behavioral health services? ☐ No ☐ Yes (describe below)

| With whom? | When? | Type of treatment? |
|---|---|---|
| | | |
| | | |

Have you ever been hospitalized for mental health or substance use? ☐ No ☐ Yes (explain below) When?

Where? | Primary Care Provider ☐ Yes ☐ No Name:

## Social, Educational and Work History

Marital Status: | Highest Level of Education:

Work Status (circle one): Employed Unemployed / Retired / Disabled | Annual Income:_____ Employment ☐ SSI/SSDI ☐ VA Benefits ☐ Other ☐ | How many Hours per week? _

Do you drink alcohol? ☐ Yes ☐ No | Do you currently smoke or use other tobacco products? ☐ Yes ☐ No

Are you currently experiencing any of the following?

☐ Mental health symptoms that feels uncontrollable
☐ Thoughts of suicide or self-injurious behaviors (cutting)
☐ Thoughts of hurting someone else
☐ Intense feelings, emotions, or negative thoughts
☐ Thoughts of using a substance
☐ Fearing for your safety

I am seeking:
☐ Housing
☐ Employment
☐ Utility/Rental Assistance
☐ Medicaid/Medicaid Status
☐ A food box
☐ Clothing or household items
☐ Stopping Smoking
☐ Disability
☐ General Assistance
☐ Food Stamps
☐ Assessment
☐ Ongoing mental Health and/or substance use therapy
☐ Psychiatric Services
☐ Treatment (IOP, residential, day rehab, etc.)
☐ Primary Care

| | |
|---|---|
| Number of Dependents (including yourself): | Number of arrests in the last 30 days: |
| Attempted suicide in las 30 days: ☐ YES ☐ NO | |
| Number of Poor Physical Health Days in last 30 days: | Number of Poor Mental Health Days in last 30 days: |
| Education Activity:<br>☐ Attending College 1-6 hours<br>☐ Attending College 7 or more hours<br>☐ Attending Vocational or High School<br>☐ Avocational involvement<br>☐ Basic Educational Kills<br>☐ No Participation<br>☐ Other<br>☐ Pre-educational Exploration<br>☐ Working on English (ESL)<br>☐ Working on GED | Educational Level<br>☐ Kindergarten<br>☐ Less than one grade completed or no schooling<br>☐ Grade 1 ☐ Grade 6 ☐ 11 Grade<br>☐ Grade 2 ☐ Grade 7 ☐ 12 Grade =<br>☐ Grade 3 ☐ Grade 8 ☐ 1st year of College or University<br>☐ Grade 4 ☐ Grade 9 ☐ 2nd year of College or Associate Degree<br>☐ Grade 5 ☐ Grade 10 ☐ 3rd Year of College or University 4th Year<br>☐ Bachelor's Degree<br>☐ Doctorate Degree |
| School Absences:<br>☐ 1 day every 2 weeks<br>☐ 1 day per week<br>☐ 1 or less days per month<br>☐ 2 or more days per week<br>☐ Home Schooled<br>☐ Not Enrolled | How often do you use social supports?<br>☐ 1-3 times in past month<br>☐ 16-30 times in past month<br>☐ 4-7 times in past month<br>☐ 8-15 times in past month<br>☐ No Attendance in past month<br>☐ Some attendance in past month |
| SSI Eligibility<br>☐ Determined to be Ineligible –N/A<br>☐ Eligible/Not Received Benefit<br>☐ Eligible/Receive Payments<br>☐ Potential Eligible | Primary Funding Source<br>☐ Other Source<br>☐ State Behavioral Health Funds<br>☐ State Children and Family Services<br>☐ State Medicaid |
| What is your substance used 1:<br><br>Route: Age of First Use:<br>☐ IV Substance Volume of use:<br>☐ Nasal Frequency of use:<br>☐ Oral ☐ 1-2 time in the last week<br>☐ Other ☐ 1–3-time month<br>☐ Smoke ☐ 3-6 past week<br>☐ Daily | Do you have a second substance used? Yes/ No<br><br>2nd Substance used:<br>Route: Age of First Use:<br>☐ IV Substance Volume of use:<br>☐ Nasal Frequency of use:<br>☐ Oral ☐ 1-2 time in the last week<br>☐ Other ☐ 1–3-time month<br>☐ Smoke ☐ 3-6 past week<br>☐ Daily |

If participating in a housing program, I acknowledge that there are no cost barriers to receiving services outside of costs related to my tenancy (e.g., rent, repairs, etc.) ☐ Yes ☐ No ☐ N/A

I have received and reviewed a copy of Privacy Practices ☐ Yes ☐ No

I have received and reviewed Consent to Treatment and Received Services. ☐ Yes ☐ No

I have received and reviewed a copy of the Rights and Consumer Responsibilities. ☐ Yes ☐ No

I have received and reviewed a copy of the Grievance Procedures. ☐ Yes ☐ No

I have received and reviewed a copy of Advance Directives Information ☐ Yes ☐ No

Do you have an official form of identification? ☐ Yes ☐ No

Voter Registration – Would you like to register to vote here today? ☐ Yes ☐ No

Consent to be photographed for ID purposes only. If you decline to be photographed, it will not impact eligibility to receive services.

☐ I consent to be photographed

☐ I do NOT consent to be photographed

**United States Citizenship Attestation Form**

☐ I am a citizen of the United States of America

☐ I am a qualified alien under the federal Immigration and Nationality Act. My Immigration Status and alien number is:

| | |
|---|---|
| Do you have an official form of identification? ☐ Yes ☐ No<br>Voter Registration – Would you like to register to vote here?<br><br>☐ Yes ☐ No ☐ Would like the form to fill out later | Consent to be photographed for ID Purposes only. If you decline to be photographed, it will not impact eligibility to receive services.<br>☐ I consent to be photographed<br>☐ I DO NOT consent to be photographed |

CenterPointe is a Tobacco Free Environment. Were you explained the Tobacco Free Policy? ☐ Yes ☐ No

| | |
|---|---|
| | |

| | |
|---|---|
| Housing Cost (monthly rent, mortgage, lease amount, not to exceed $586 per month)* | |
| Utility cost - if the utilities are not included in rent/lease amount, must not exceed $491 a month* | |
| Utilities - if only a portion of utilities are included in rent/lease amount, not to exceed $257 a month* | |
| Transportation Costs (average gasoline cost or bus pass cost, not to exceed $300 a month* | |
| Daycare costs - $175 for each child age two or older* | |
| Daycare costs - $200 for each child age one or younger* | |
| Total Number of family members dependent on taxable income (individual + spouse (if applicable) + children (if applicable) **participant counts as 1*** | |
| **The fees per session for the services are as follows:** | |
| Individual/Family Therapy* | |
| Group Therapy* | |
| Medication Management* | |
| RS/SL/CS/Housing* | |
| Other service* | |
| | |

CenterPointe accepts numerous commercial insurance policies as well as all Nebraska Medicaid plans. We will file claims to your insurance on your (or dependents) behalf. However, you are responsible for costs deemed to be patient responsibility by your insurance carrier. This includes copays, deductibles, and services not covered by your carrier's plan. Please check with your insurance carrier for specific coverage details.

**I have received and reviewed and agree to CenterPointe Financial Agreement. *** ☐ **Yes** ☐ **No**

**Orientation Checklist**

| | |
|---|---|
| Welcome Packet/Info (HIV info, copies of privacy notice, program rules, staff roles and code of ethics, primary staff person, illegal, legal, and prescription drug policies, mission statement, hours of operation, after hours ER number) | ☐ |
| Orientation to the building including location of fire exits, fire extinguishers and first aid kits; fire and tornado drills and emergency procedures; explanation of sign in procedures | ☐ |
| Participant fees, arrangements for payments, financial questionnaire and agreement, assignment of benefits | ☐ |
| Consent to Treat Packet including participant right and responsibilities grievance procedures, attendance policy and explanation of need for and use of assessments and evaluations. | ☐ |
| Opportunities for participant input, including treatment plan development, quality of care, achievement of outcomes, and participant satisfaction | ☐ |
| Criteria/reasons for discharge; post discharge contact, and records requests | ☐ |

Client Signature:

Date:

## Consent for Telehealth Services

**And I understand that:**

**a. I retain the right to refuse telehealth consultations at any time without affecting my/my childs right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.**
**b. All existing confidentiality protections shall apply to my telehealth consultation.**

**c. I shall have access to all medical information resulting from the telehealth consultation, as provided by law.**

**d. Information from the telehealth service (images that can be identified as my child/mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.**
**e. If I decline telehealth services, other alternative options are available to me, including in-person services. These options are:**
**in-person therapy once virus precautions are lifted or**

**in-office sessions, if I am symptom free.**

**f. I will be informed whether the telehealth consultation will be or will not be recorded.**

**g. I will be informed of all people who will be present at all sites during my telehealth service.**

**h. I retain the right to exclude anyone from either the originating or distant site.**

**i. I understand that this consent is valid for six months for follow-up telehealth services with this health care provider.**

**j. If/when I participate in groups, I agree to protect the confidentiality of all participants information. This includes the environment in which I conduct the telehealth session (ie. use of headphones, sessions in a private location without unauthorized participants).**
**k. I further understand that there are potential risks to telemedicine, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand that either the healthcare provider or I can discontinue my/my childs telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation.**
**I have read this document carefully and my questions have been answered to my satisfaction. I consent to participate in telehealth as outlined above.**

Client Signature: Date:

ASQ

**In the past few weeks, have you wished you were dead?***

☐ Yes ☐ No

**In the past few weeks, have you felt that you or your family would be better off if you were dead?***

☐ Yes ☐ No

**In the past week, have you been having thoughts about killing yourself?***

☐ Yes ☐ No

**Have you ever tried to kill yourself?***

☐ Yes ☐ No

**Are you having thoughts of killing yourself right now?**

☐ Yes ☐ No

**Would you like to talk to the Crisis team?**

☐ Yes ☐ No

Office use only: ROI ☐ EC ☐ Insurance ☐ Attorney/Probation ☐ PCP