



**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 in the following as described in the Notice of Privacy Practices for Deschutes County Health Services;
  - Communicate with me through MyChart, an online secure patient portal.
  - As a member of the Reliance Community Health Information Exchange
  - Deschutes County Health Services is a member of an electronic health information exchange (HIE) called the OCHIN Collaborative. A purpose of this HIE is to allow health care providers to electronically share records regarding an individual. I understand and agree that DCHS may disclose any of my health information, including drug and alcohol treatment information protected by 42 CFR Part 2, to this HIE for the purpose of sharing the information with any individual or entity that has a treating provider relationship with me at the time he/she/it accesses the information. I understand that upon my written request, the HIE must provide me with a list of all entities to which my information has been disclosed within the past two years. The HIE would be responsible for responding to the request within 30 days.

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 been offered a copy of the Notice of Privacy Practices for Deschutes County Health Services.**

**Print Client's Name:** \_\_\_\_\_ **Client's Date of Birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Client, guardian or authorized personal representative*

**Print Name if signed by someone other than client:** \_\_\_\_\_



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

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 chose not to accept 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 chose not to accept the Client Information Packet, additional information, or assistance

\_\_\_\_\_  
Individual or Caregiver Signature

\_\_\_\_\_  
Date





# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN \_\_\_\_\_

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 <b>Phone #</b> _____				

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"/> Divorced <input type="checkbox"/> Significant Other <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <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"/> Residential Facility (RTH for YAT)	<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"/> Secure Residential (SRTF Adult)	<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) <input type="checkbox"/> Residential Sub-Acute Care Facility



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN \_\_\_\_\_

### RACE AND ETHNICITY

Race/Ethnicity (Please mark all that apply):

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Alaska Native                               | <input type="checkbox"/> Black/African American                          | <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian Indian             |
| <input type="checkbox"/> Japanese                                    | <input type="checkbox"/> Chinese   | <input type="checkbox"/> Mexican         | <input type="checkbox"/> Other Asian              |
| <input type="checkbox"/> Filipino                                    | <input type="checkbox"/> Samoan  | <input type="checkbox"/> Korean          | <input type="checkbox"/> Guamanian or Chamorro    |
| <input type="checkbox"/> Native Hawaiian                             | <input type="checkbox"/> White/Caucasian                                 | <input type="checkbox"/> Vietnamese      | <input type="checkbox"/> Other Pacific Islander   |
| <input type="checkbox"/> Mexican American                            | <input type="checkbox"/> Cuban   | <input type="checkbox"/> Other           | <input type="checkbox"/> Non-Hispanic or Latino/a |
| <input type="checkbox"/> Chicano/a                                   | <input type="checkbox"/> Two or more races                               | <input type="checkbox"/> Puerto Rican    | <input type="checkbox"/> Unknown                  |
| <input type="checkbox"/> Patient Refused                             | <input type="checkbox"/> Multiple Hispanic, Latino/a, or Spanish Origins | <input type="checkbox"/> Single Race     |   |
| <input type="checkbox"/> Another Hispanic Latino/a or Spanish Origin |  |  |   |

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"/> 30 Day Civil Commitment                  |
| <input type="checkbox"/> 90 Day Civil Commitment    | <input type="checkbox"/> 180 Day Civil Commitment     | <input type="checkbox"/> Incarcerated                             |
| <input type="checkbox"/> Parole                     | <input type="checkbox"/> Probation                    | <input type="checkbox"/> Psychiatric Services Review Board (PSRB) |
| <input type="checkbox"/> Juvenile PSRB              | <input type="checkbox"/> Guardianship (Child Welfare) | <input type="checkbox"/> Guardianship (Court)                     |
| <input type="checkbox"/> Aid and Assist             | <input type="checkbox"/> Involuntary Custody          | <input type="checkbox"/> Pre-Arrest Jail Diversion                |
| <input type="checkbox"/> Post-Arrest Jail Diversion | <input type="checkbox"/> Unknown                      | <input type="checkbox"/> None                                     |

### EDUCATION

Check highest grade individual completed:

- K  1  2  3  4  5  6  7  8  9  10  11  12/GED  AA/AS  BA/BS  MA/MS  
 PHD/PSYD/MD  College Courses Taken

### OTHER INFORMATION

Have you had previous mental health counseling?  Yes  No

If Yes, Where?

Referred by:

Is there Child Protective Services involvement?  Yes  No

Caseworker Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have a Declaration for Mental Health Treatment and/or an Advanced Directive?  Yes  No

Would you like help completing a Declaration for Mental Health Treatment?  Yes  No



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN \_\_\_\_\_

## 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					
<i>The information on this form is used to determine eligibility for our sliding fee discount program</i>					
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:					

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.



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN \_\_\_\_\_

## FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS			
<i>The information on this form is used to determine eligibility for our sliding fee discount program</i>			
List number of household members living with you in each category			
Self <b>1</b>	Spouse/Partner	Parent/Guardian	Dependents
<ul style="list-style-type: none"> <li>❖ 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.</li> <li>❖ <u>I will notify DCBH promptly of any change to the above information.</u></li> </ul>			
Responsible Party Signature		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.		Responsible Party Initials	

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  Signature:	Date of staff signature
	Expiration date







# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

MRN \_\_\_\_\_

## 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  Yes  No  Don't Know
- more than one person in the past 6 months?  Yes  No  Don't Know
- a person in exchange for money, drugs, or in order to survive?  Yes  No  Don't Know
- a man who has had sex with another man?  Yes  No  Don't Know
- someone who has the blood disease hemophilia?  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