FAITH & HOPE BEHAVIORAL HEALTH

WELCOME!!!

Welcome to the Faith & Hope Behavioral Health. We hope that you'll see this program as a way of understanding your behavioral health, improve, and restore everyday functioning that leads to healthier life.

Sincerely,

Neal Angrum

CEO

WHAT CAN YOU EXPECT FROM THE FAITH & HOPE BEHAVIORAL HEALTH?

With the Faith & Hope Behavioral Health, you will have a counselor visit you in your home and help you solve and deal with problems related to the way you think, feel, and act. As well within school, home and community problems, the way you feel about yourself, decision making, fighting, drug use, loneliness and self-harm.

The Faith & Hope Behavioral Health will provide treatment through counseling as well, providing an option for medication management.

CODE OF ETHICS/CONDUCT

1. To avoid real or perceived conflicts of interest.
2. To be honest and realistic when documenting services provided.
3. To reject bribery in all its forms.
4. To improve the understanding of behavioral health services.
5. To treat all staff and clients fairly and not engage in any acts of discrimination.
6. To provide a safe environment for clients and staff.
7. Abide by all applicable federal and state laws, including HIPPA.
8. To abide by this Code of Ethics

FAITH & HOPE BEHAVIORAL HEALTH

GRIEVANCE POLICY

As a client at Faith & Hope Behavioral Health, you are encouraged to state complaints or grievances if you believe your rights have been violated.

Grievances can be filed with the Social Services Coordinator and the organization will issue a formal written response. If you are unsatisfied with the finding of the written response, you can appeal the decision to the Director of Services. The Director of Services will issue a written response. If you are not satisfied with the Director of Services response, you will be referred to a 3rd party for resolution.

What to do in a Crisis?

- In the case of an Emergency, call 911/Poison Control 1-800-222-1222.

You may contact Faith & Hope Behavioral Health 24 hours a day, 7days a week. To contact our office, call (318) 406-3044, Monday thru Friday, 8 a.m. to 4 p.m. or, you may contact your assigned MHS.

Address

Faith & Hope Behavioral Health

3000 Kilpatrick Blvd Suite 200

Monroe, LA 71202

(318) 381-8584 phone

(877) 819-9001 fax

FAITH & HOPE BEHAVIORAL HEALTH

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You may contact Faith & Hope Behavioral Health 24 hours a day, 7 days a week. To contact our office, call (318) 381-8584, Monday thru Friday, 9AM – 5PM or you may contact your assigned MHS.

ADDRESS

Faith & Hope Behavioral Health

30000 Kilpatrick Blvd Suit 200

Monroe, LA 71201

P: (318) 381-8584

F: (877) 817-9001

______________________________ _______________

Client Date

______________________________ _______________

Parent or Guardian Date

______________________________ _______________

MHS/Staff Date

FAITH & HOPE BEHAVIORAL HEALTH

RIGHTS AND RESPONSIBILITIES

What are your rights?

- Be treated with respect.
- Receive services in a safe and clean environment.
- Receive services no matter what your race religion, sex, age or disability.
- Expect the people working with you to never physically or sexually abuse you, or say hurtful things to you.
- Have an Assessment and Treatment Plan.
- Have a Treatment Plan developed by you, the LPC and MHS.
- Have information kept confidential (Only between you and the MHS, unless you try to harm yourself or someone else).
- Fair Treatment.
- You have the right to confidentiality, unless you report to be in danger to yourself or others (Counselors must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other mental health professionals, suspected abuse of children and vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency, and insurance agencies. In these situations, there are limits to confidentiality

What are your responsibilities?

- Be courteous to other recipients and staff of Faith & Hope Behavioral Health.
- Ask questions about anything you do not understand.
- Actively participate in your treatment and in meeting your goals.
- Attend services alcohol and drug free.

FAITH & HOPE BEHAVIORAL HEALTH

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_______________________________ _______________

Client Date

_______________________________ _______________

Parent or Guardian Date

_______________________________ _______________

MHS/Staff Date

FAITH & HOPE BEHAVIORAL HEALTH

ORIENTATION CHECKLIST

The following information has been provided as part of the consumer orientation. A check of the item and the signatures below indicate that each are has been fully explained and is understood by the consumer

— Rights and grievance and appeal procedures

— Services provided, days and hours of operation, expected level of participation

— Access to emergency services, after hours

— Code of ethics/conduct

— Confidentiality policy, limits of confidentiality

— Methods, opportunities, and policy on input

— Fire, safety, and emergency precautions

— Policy on restraint

— Policy on tobacco products

— Policy on illicit or licit drugs brought into the program

— Policy on weapons brought into the program

— Identification of the person responsible for service coordination

— Program rules, including restrictions and the loss and regaining of rights

— Individual plan development

— Discharge/transition criteria and procedures

______________________________ ______________

Client's Name Date

______________________________ ______________

Client's Signature Date

______________________________ ______________

MHS/Staff Date

FAITH & HOPE BEHAVIORAL HEALTH

ADMISSION FORM

Recipient Information

Name: ________________________ Date of Birth: ________________

Medicaid#: ________________________ SSN: ________________

Address: ________________________ City:____________ Zip:________

Home Phone: ______________ Cell:____________ Other Phone__________

Race: ___Black/African American ____White ____Asian/Pacific ___Indian ___Alaskan ____Other

Ethnicity: ____Hispanic _____Non-Hispanic **Sex:** ____ Female ______ Male

Marital Status: ____Never Married ____Married ____Widowed ____Separated _____Divorced

Education: Last Grade Completed ____________ Current School: ________________

Household Comp:______Adult Only _____Adult w/relative _____Adult w/non-relative _____Child w/both parents

_______Child w/one parent _____ Child w/relative _____Child w/foster family

Parent/Guardian/Representative:

Name: ________________________ Relationship: ______________

Address: ________________________ City:____________ Zip:________

Home Phone: ____________ Cell:____________ Other Phone____________

Emergency Contact

Name: ________________________ Relationship: ______________

Address: ________________________ City:____________ Zip:________

Home Phone: ____________ Cell:____________ Other Phone____________

Primary Care Physician:

Address & Phone: ________________________________

*Medical conditions or Allergies: YES NO Diagnosis: ________________________

Use of medications or tools/equipment used to assist with daily living? YES NO

Are there any special needs that we need to be made aware of? YES NO

***If you answered YES to any of the above questions, describe on the back.**

Who referred you to our agency? ________________________

Client's Signature: ________________________ Date: ____________

Parent/Guardian's Signature: ________________________ Date: ____________

MHS/Staff's Signature: ________________________ Date: ____________

FAITH & HOPE BEHAVIORAL HEALTH

REFERRAL FORM

3000 Kilpatrick Blvd. Suit 200

Monroe, LA 71201

P: (318) 381-8584

F: (877) 817-9001

Youth's Information

Name: ________________________ DOB: ________________

SSN: ______________ Medicaid#: ______________ Phone: ________________

Race: ______________ Sex: ______________ Language: ________________

Parent/Caregiver's

Name: ____

Address: ____

Behaviors of Concern:

SCHOOL: ____

- Out of school/refuses to attend
- Harm or serious threat to staff
- Disruptive/Hyperactive
- Failing all or most classes
- Noncompliant/Refuses to follow rules requested from authority
- Violent (fighting, bullying, etc.) to staff/peers
- Victim of bullying (cyber/internet, face-to-face, etc.)
- Must have special accommodation(s) to maintain behavior in class
- No friends/peer relationships
- Crying Spells
- Disrespect to adults/parents/teachers

HOME:

- Taken out of/or at risk of removal
- Needs close Supervision to stay in home
- Isolates/Withdrawn
- Serious threat or harm or intimidation
- Disregards rules/curfew/out of control
- Major changes in home
- Severe damage to property
- Behavior interferes with parent/guardian's work
- Changes in mood
- Enuresis
- Encopresis
- Nightmares
- Crying Spells
- Other: ________________

COMMUNITY:

- Incarcerated due to serious law violation
- Has committed serious property damage
- Been arrested
- Serious/repeated delinquent behavior
- On probation for offense within the last 3 months
- Plays with fire
- Does significant harm to small animals
- Violent offense

Reason for Referral:

FAITH & HOPE BEHAVIORAL HEALTH

Client Chart Checklist

Client's Name:			
Referral Source:			
Referring Person:			
Case Assignment:	CPST:	PSR:	LMHP:

	Data Forms	**Date(s)**	**Notes**
	Referral		
	Medicaid Verification Form		
	Medical Emergency Form		
	Client Entrance Survey		
	Office Forms		
	Signed Medical Release		
	Signed Education Release		
	Hold Harmless		
	Assessment		
	Psychosocial Assessment		Signed by LMHP, Recipient, Parent or Guardian
	Case Summary		
	Treatment Plan		Signed by LMHP, Recipient, Parent or Guardian
	Orientation		
	Client's orientation checklist		Client's Signature
	Rights and responsibilities		
	Doctor's Notes		
	Doctor's notes for clients		
	Miscellaneous		
	Freedom of Choice		
	Initial Authorization Request		
	Referral Source updates		

Date Assigned:

FAITH & HOPE BEHAVIORAL HEALTH

Authorization to Release Medical Records

Name: ______________________________ DOB: ________ SSN: ____________

Address: ____

This is a request to have my protected health information released to or obtained from a third party. Specifically, I am requesting that the agency listed below forward the indicated information.

Name/Address of Agency: ____

- Discharge Summary
- Laboratory/X-ray
- Clinical Evaluation
- History and Physical Exam
- Medication History
- Psychological
- Integrated Summary
- Date of Service Letter
- Social History
- Drug and Alcohol Information
- Quarterly Reports
- Service Agreements
- Psychiatric Evaluation
- H.I.V. Information
- Other Information

Purpose of Disclosure: ____

Please mail or fax the requested medical record to:

Name: Faith & Hope Behavioral Health

Address: 3000 Kilpatrick Blvd. Suit 200 Monroe, LA 71201

Phone: (318) 381-8584 Fax: (877) 819-9001

I understand the information released is for professional purposes only and may not be provided in whole or part to any other agency or person other that the one listed above. This consent may be revoked in writing at any time, expect hen action has already been taken. Under those circumstances, the consent will expire upon completion of the transaction. This authorization expires 180 days from the date of signature unless otherwise stated.

Federal Law prohibits the receiving party of this confidential information to further disclose without the consent of the client or guardian to whom it pertains.

Please understand that failure to sign and authorized for release of information for purposes other than treatment, payment, or operations will not impact health care provided. I acknowledge and give consent for this information to be released via facsimile transmission or mail.

Signature of Patient or Guardian: ____________________________ Date: _______

Witness Signature: ____________________________________ Date: _______

FAITH & HOPE BEHAVIORAL HEALTH

FREEDOM OF CHOICE

Member Name: ______________________________________ Member DOB: ____________

I am aware that providers and facilities available to me can be found under "*forms*" at

( ) AmeriHealth Caritas http://www.amerihealthcaritasla.com/provider/index.aspx

( ) Aetna Better Health of Louisiana http://www.aetnabetterhealth.com/louisiana

( ) Healthy Blue (AmeriGroup) http://www.providers.amerigroup.com

The Provider I choose is:

Faith & Hope Behavioral Health
3000 Kilpatrick Blvd. Suit 200
Monroe, La. 71201
Office: 318-381-8584
Fax: 877-819-9001

By signing below: I acknowledge that I freely choose to receive services from the above provider and I acknowledge my responsibility to notify my previous provider to coordinate care.

______________________________________ ______________________________

Member/Legal Guardian Signature Date

____

Legal Guardian Name (if applicable)

Providers: A freedom of choice form is required prior to service authorizations. The form requires a member/legal guardian signature, date, and identified provider with telephone number. The provider is responsible for coordinating care with the member's prior provider.

Member Name (First, Last Name): Member DOB:
Member ID #:

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from **one provider** unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. Amerihealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. Louisiana Healthcare Connections: https://providersearch.louisianahealthconnect.com/ or call 1-866-595-8133 (Hearing Loss: 711)
5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The provider that I have freely selected to deliver MHR services to me or my child is:

Provider Name:	
Provider Phone Number:	
Provider Contact Name:	
Provider Address:	

By signing the form below, I understand that I have chosen to receive services from this MHR provider and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

____ Date
Member/Legal Guardian Signature

____
Printed Legal Guardian Name (if applicable)

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

____ Date
Provider Signature

FAITH & HOPE BEHAVIORAL HEALTH

INDEMNIFICATION HOLD HARMLESS

AND RELEASE AGREEMENT

The undersigned, parents or guardian of ____, a recipient of mental health services through Faith & Hope Behavioral Health, hereby indemnifies and holds harmless Faith & Hope Behavioral Health, its personnel and any and all related corporate entities which may be affiliated with the provider of said MHS services. This indemnity and hold harmless agreement releases Faith & Hope Behavioral health, and any of its affiliates from any claims of any kind whatsoever or of any nature for injury to the person or his/her parents or siblings or any individual claiming damages in association with MHS services. This indemnity and hold harmless agreement shall be considered a complete and total waiver of any and all liability on the part of Faith & hope Behavioral Health, and any corporate entity or person associated with same.

____ ________________________

Parent or Guardian Signature Date

____ ________________________

Witness Date

____ ________________________

Provider Signature Date

FAITH & HOPE BEHAVIORAL HEALTH

CRISIS/WELLNESS PLAN

CLIENT NAME: ______________________________ DOB: _______________

Date: _____________ Circle: *Initial* *6-Month ITT* *Update*

Purpose of Update | (Not needed for Initials/6-Month ITT)

	House Changing		Increase in Symptoms
	New Employment		Medical Hospitalization
	Loss of Job		Psychiatric Hospitalization (debriefing form required)
	Loss of a loved one/natural support (debriefing form required)		Behavior resulting in jail placement (debriefing form required)
	Self-Harm Behavior (debriefing form required)		Significant Life Event (Other):
	Significant Life Event (Other):		Significant Life Event (Other):

PREVENTION

These are things that I do every day to stay well:

1.	2.
3.	4.

Location of Individual Crisis/Wellness Plan: ______________________________

List of My Supporters:

Name	Relationship	Task	Phone Number

Supporters Can Help Me By:

1.	2.
3.	4.

Contact: Faith & Hope Behavioral Health (318) 381-8584

MHS Name & Contact Number: ______________________________

FAITH & HOPE BEHAVIORAL HEALTH

CLIENT NAME: ______________________ DOB: ___________

Location of My Medication List: ______________________________

These are medications I have tried in the past and wish to avoid:

1.	2.
3.	4:

Consumer Self-Report of Triggers and Behaviors

These things trigger my symptoms:

	People Leaving		Holidays
	Anniversaries ex: yearly date of loss of loved one		Lack of family contact
	Contact with family		Being around people of the same sex
	Being around people of the opposite sex		Being in enclosed spaces
	Being touched		Yelling
	Physical Illness		Being questioned/teased/judged
	Seeing others upset or out of control		Feeling ignored
	Financial problems ex: big bills		Feeling overwhelmed
	Change in environment		Nighttime/trying to go to sleep
	Other (List):		Other (List):
	Other (List):		Other (List):

This is what happens when I encounter a trigger

	Forgetfulness (ex. Missed appointments)		Fleeting/Running from current location
	Clenching fists		Clenching teeth
	Increase or decrease in eating		Isolating/avoiding others
	Making threats of self-harm		Making threats to harm others
	Increase in negative thoughts		Lack of motivation
	Pacing		Property destruction
	Racing heart		Rapid breathing
	Remove/add clothing		Irrational thought patterns
	Fidgeting/Rocking/Restless		Increased anxiety and nervousness

FAITH & HOPE BEHAVIORAL HEALTH

CLIENT NAME: ______________________________ DOB: _______________

'his is what happens when I encounter a trigger (cont.)

	Sweating		Obsessive thoughts
	Wringing hands		Yelling/Screaming
	Increase in substance use		Increase in alcohol use
	Increase in smoking cigarettes		Other (List):
	Other (List):		Other (List):
	Other (List):		Other (List):

This is what I can try to do when my triggers affect me

	Breathing exercises		Cleaning
	Coloring/Drawing		Crying
	Exercise (ex. walking & biking)		Guided Imagery
	Journal Writing		Looking at pictures of friends/family
	Listening to music		Playing Music
	Singing		Progressive Muscle Relaxation
	Quiet/Alone time		Ripping Paper
	Watching/Playing sports		Using a stress ball
	Talking with someone		Talking with therapist/caseworker
	Writing		Working
	Spending time with friends		Going to school
	Watching TV		Attending support group (List):
	Other (List):		Other (List):
	Other (List):		Other (List):

FAITH & HOPE BEHAVIORAL HEALTH

CLIENT NAME: ____________________________ DOB: ______________

If I have to go to the hospital, I prefer to attend the following (list all that apply):

____

I wish to avoid the following hospitals (list all that apply):

____

ACTION STEPS

This is how my support team will know I am in crisis (staff can support individual's perception and add to the definition based on history):

____

____

____

When I am in crisis I will:

____

____

	Come to see me face to face for as long as needed		Call one of my supports to come see me
	Review my Individual Crisis/Wellness Plan with me		Talk to me over the phone for as long as I need
	Validate my feelings		Help me put a plan in place for the next day(s)
	Making sure my therapist is made aware of my symptoms and have him/her come out for a session as soon as possible		Help cancel work/appointments to help focus on wellness
	Help me get to the hospital for my own safety if needed		Other:
	Other:		Other:

By signing below, I am confirming that I was part of the development of the plan and that agree to follow the plan. I also understand that I can request an updated or new plan to be developed at any time

Client Signature: ______________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________

Staff Signature/Title/Credentials: ______________________________ Date: __________

FAITH & HOPE BEHAVIORAL HEALTH

SUICIDAL ASSESSMENT CHECK LIST

CLIENT NAME: ______________________________ DATE: ____________

(Suggested points to cover with client/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

- Does the individual have frequent suicidal thoughts? Y or N
- Has there been suicide attempts by the client or significant others in his/her life? Y or N
- Does the client have a detailed, feasible plan? Y or N
- Has he/she made special arrangements as giving away prized possessions? Y or N
- Does the client fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y or N

(2) REACTIONS TO PRECIPITATING EVENTS

- Is the client experiencing severe psychological distress? Y or N
- Have there been major changes in recent behavior along with negative feelings and thoughts? Y or N
  (Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

- Is there a lack of significant other to help the client survive? Y or N
- Does the client feel alienated? Y or N

(4) HISTORY OF BEHAVIOR

- Does the client take life-threatening risks or display poor impulse control? Y or N
- Does the client show any self-injurious behavior? Y or N?

***Use this checklist as an exploratory guide with clients about whom you are concerned. Each "yes" raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time and location where it is unlikely the act would be disrupted. Further high risk indicators include the client having made final arrangements and about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a client's regular records.**

Client Signature: ______________________________ Date: ____________

Parent/Guardian Signature: ______________________________ Date: ____________

MHS Signature: ______________________________ Date: ____________

FAITH & HOPE BEHAVIORAL HEALTH

Welcome to Faith & Hope Behavioral Health! This document contains our office policies. If you have any question, our counselor will gladly discuss them with you.

Confidentiality

The Law protects the privacy of communication between the client and the counselor. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA. Your signature on this Agreement provides consent to the following activities.

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professional is also legally bound to keep the information confidential.
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and agreed not to release any information outside of the practice without the permission of a professional staff member.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or other who can help provide protection.

______________________________ ______________________

Client's Signature Date

______________________________ ______________________

Guardian Signature (if client is a minor) Date

FAITH & HOPE BEHAVIORAL HEALTH

Consent for Treatment-Child/Adolescent

1. (Legal guardian) consent for treatment as deemed necessary for the wellbeing of the child. I understand my child may refuse treatment at any time unless court ordered. I (legal guardian) understand that if treatment is refused that it will be determined to the client and continued refusal may result in termination from the program.

2. I (legal guardian) authorize Faith & Hope Behavioral Health staff to seek emergency medical treatment in the event that the child becomes ill or has an accident while participating in services. This Shall include emergency first aid by authorized personnel of the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physicians, emergency room, rescue unit charge and other supplies (i.e. glasses).

3. I (legal guardian) understand that detain information from my record may be contained in a computerized record keeping system for reimbursement and statistical and program planning purposes.

4. A child's record rating to substance abuse are protected by Federal confidentially rules (42CRF Part2). The Federal Rules prohibit this agency or its staff from making and disclosure regarding substance abuse and /or treatment without the written consent of the person to whom it pertains of as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

5. I (child) have received a copy of the client right and responsibilities, grievance procedure, and orientation handbook including the alleged benefits, potential risk and possible alternate methods of treatment for the service(s) being provided to me.

6. I (legal guardian) hereby give consent for this client to be transported by Faith & Hope Behavioral Health. I agree that upon my child's riding in any vehicle provided by FAITH & HOPE, I hereby release, and discharge FAITH & HOPE all claims, demands, damages, action and from any and all liability of any nature whatsoever for any injury, harm or complication that my that may result directly or indirectly by reason of any transportation or daily services provided by an individual under the direction of FAITH & HOPE.

FAITH & HOPE BEHAVIORAL HEALTH

7. I (legal guardian) have read and understand the understand the confidentiality Regulations as developed by FAITH & HOPE. I understand That the FAITH & HOPE will have explain the consequence of treatment.

8. I (legal guardian) understand that the Mental Health Rehabilitation Services Program does not utilize physical restraints. Employees are trained in verbal de-escalation technique and will attempt to resolve crisis in the least restrictive manner possible, However, in the case of crisis/emergency situations staff will call 911 and assist in ensuring environmental safety.

Signed: ______________________________ Date: __________________
Recipient

Signed: ______________________________ Date: __________________
Legal Guardian

Signed: ______________________________ Date: __________________
Staff

FAITH & HOPE BEHAVIORAL HEALTH

Consent for Treatment-Adult

1. I consent for treatment as deemed necessary for the wellbeing of the child. I understand my child may refuse treatment at any time unless court ordered. I (legal guardian) understand that if treatment is refused that it will be determined to the client and continued refusal may result in termination from the program.

2. I authorize Faith & Hope Behavioral Health staff to seek emergency medical treatment in the event that the child becomes ill or has an accident while participating in services. This Shall include emergency first aid by authorized personnel of the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physicians, emergency room, rescue unit charge and other supplies (i.e. glasses).

3. I understand that detain information from my record may be contained in a computerized record keeping system for reimbursement and statistical and program planning purposes.

4. Record rating to substance abuse are protected by Federal confidentially rules (42CRF Part2). The Federal Rules prohibit this agency or its staff from making and disclosure regarding substance abuse and /or treatment without the written consent of the person to whom it pertains of as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

5. I have received a copy of the client right and responsibilities, grievance procedure, and orientation handbook including the alleged benefits, potential risk and possible alternate methods of treatment for the service(s) being provided to me.

FAITH & HOPE BEHAVIORAL HEALTH

6. I hereby give consent for this client to be transported by Faith & Hope Behavioral Health. I agree that upon my child's riding in any vehicle provided by FAITH & HOPE, I hereby releases and discharge FAITH & HOPE all claims, demands, damages, action and from any and all liability of any nature whatsoever for any injury, harm or complication that my that may result directly or indirectly by reason of any transportation or daily services provided by an individual under the direction of FAITH & HOPE.

7. I have read and understand the understand the confidentiality Regulations as developed by FAITH & HOPE. I understand that the FAITH & HOPE will have explain the consequence of treatment.

Signed: ______________________________ Date: ____________________
Recipient

Signed: ______________________________ Date: ____________________
Legal Guardian

Signed: ______________________________ Date: ____________________
Staff

FAITH & HOPE BEHAVIORAL HEALTH

DISCLAIMER, RELEASE OF LIABILITY AND CONFIDENTIALITY

I understand that Faith and Hope is a behavioral health organization operating on a cost reimbursement basis only.

With the intent to bind my heirs, relatives, legal representative and assigns, I expressly release and hold harmless Faith and Hope, employees, and all other persons working with them on their behalf, from all liability, loss, damage, claims, actions or judgments of any kind which may arise in connection with the treatment which I have received or will receive.

All services received and all information obtained is kept confidential and cannot be released without your permission. You need to know however, that there are special situations under which confidential information could be revealed as such:

1. You (or your legal guardian) sign written release of confidential information, thus giving your permission.

2. In the case of an emergency where a "Duty to Warn" and "Duty to Protect"

ethic requires your counselor to break confidentiality when a danger exists to you or to someone else. (This includes suspected or confirmed reports of child/elderly or incapacitated adult abuse, neglect or exploitation.)

3. Under very special circumstances, the court may subpoena your records, and may order a counselor to give testimony during a court hearing.

I have read this disclaimer and release of liability and understand and have executed it as my free and voluntary act.

Parent/Guardian/Participant Signature: ______________________________

Date:__________

Participant Name: ______________________________

Address: ______________________________

____

____

FAITH & HOPE BEHAVIORAL HEALTH

CLIENT ENTRANCE SURVEY

Please complete the following information prior to completing the survey.

Gender:

Female ___
Male ___
Transgender ____

Time in Program

< 3 months ___
3-5 months ___
6-8 months ___
9-11months ___
1-2 years ___
> 3 years ___

Race:

Black ___
White ___
Hispanic ____
Asian ____
Native American
Indian ____
Arabic _____
Other(specify) _____________

Survey was completed with help from:

Help from NO ONE ____
Help from staff member ____
Help from friend _____
Help from family member ____

Age:

11 and under _____
12 – 17 ____
18 – 21 ____
22 – 29 ____
30 – 39 ____
40 – 49 ____
50 – 59 ____
60 + _____

FAITH & HOPE BEHAVIORAL HEALTH
SURVEY QUESTIONS

1. I am satisfied with the referral process (locating treatment).

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

2. It was easy to find the facility.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

3. The staff did a good a job in reference to customer service

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

4. I received feedback from staff regarding services quickly.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

5. All of my question were answered during intake.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

6. I feel safe in the environment.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

7. I am likely to recommend your organization to someone needing services.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

8. I have been treated with dignity and respect.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

9. I am satisfied with the program orientation.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

10. My expectations in reference to admission were fully met.

1	2	3	4	5
Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Does Not Apply

FAITH & HOPE BEHAVIORAL HEALTH

SURVEY QUESTIONS

Please provide us with comments, expectation, or feedback about this program.

FAITH & HOPE BEHAVIORAL HEALTH

My signature below acknowledges that I have received a handbook, completed orientation prior to services, and I understand my rights and responsibilities in this program.

_______________________________ Client's Name

_______________________________ Date

_______________________________ Client/Guardian's Signature