Reliant Services

Individual Demographic

Personal Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Home Address: _____

_____

Phone Number: _____ **Home or Cell:** _____

Maiden Name: _____ **Date of Birth:** _____ **Social Security:** _____

Ethnic Race
__ Alaskan Native
__ Asian-Pacific Islander
__ Asian Southeast
__ Black
__ Hispanic
__ Native American
__ White
__ Other (please specify) _____

Marital Status
__ Single/Never Married
__ Married
__ Separated
__ Divorced
__ Widowed
__ Living as Married

Employment Status
__ Full Time (35 hours or more)
__ Part time (17-34 hours)
__ Irregular (less than 17 hours)
__ Not Employed (seeking)
__ Not Employed (not seeking)
__ Retired
__ Disability

Religious Preference: _____

Highest Grade Completed: _____ **Primary Language**: _____ **Veteran**: __ Y __ N

Source of Support/Income
__ Wages, Salary
__ Social Security
__ Public Assistance
__ Pension/Unemployment/VA
__ Alimony/Child Support
__ Other (please specify)
__ None

Occupation
__ Employable or Working
__ Student
__ Homemaker
__ Retired
__ Unable to Work
__ Incarcerated
__ Temporary Layoff
__ Seasonal Worker

Living Arrangements
__ Alone/Independent
__ Friends/Others
__ Homeless/Shelter
__ Institute/Group Home
__ Non-relative Foster Care
__ Parents/Relatives/Adult Children
__ Spouse/Significant Other
__ Relative's Foster Care

Would you like the opportunity to register to vote? __ Y __ N
Are you interested in continuing your education? __ Y __ N

Ages, Names and Relationships of Individuals in the Household

Age	Name	Relationship

Employer: _____

Employer Address: _____

_____

_____

How Long With This Employer: ____ years ____ months **Individual Monthly Income:** _____

How Did You Hear About Reliant Services? _____

Emergency Contact Person

Name/Relationship: _____ **Phone#:** _____

Home Address: _____

_____

_____

Supervision Information

Are You Currently on Supervision (Probation/Parole/Other)? ___ Y ___ N **Which?** _____

Supervising County: _____ **Supervising Officer:** _____

PO Phone Number: _____ **Case Number:** _____

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

GAD-7

Over the <u>past 2 weeks</u>, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T* _____ = _____ + _____ + _____)

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

HELPS Brain Injury Screening Tool

H Have you ever **H**it your **H**ead or been **H**it on the **H**ead? ☐ Yes ☐ No

Note: Prompt individual to think about all incidents that may have occurred at any age, even those that did not seem serious: vehicle accidents, falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse, and also for service related injuries. A TBI can also occur from violent shaking of the head, such as being shaken as a baby or child.

E Were you ever seen in the **E**mergency room, hospital, or by a doctor because of an injury to your head? ☐ Yes ☐ No

Note: Many people are seen for treatment. However, there are those who cannot afford treatment, or who do not think they require medical attention.

L Did you ever **L**ose consciousness or experience a period of being dazed and confused because of an injury to your head? ☐ Yes ☐ No

Note: People with TBI may not lose consciousness but experience an "alteration of consciousness." This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P Do you experience any of these **P**roblems in your daily life since you hit your head? ☐ Yes ☐ No

Note: Ask your individual if s/he experiences any of the following problems and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.

- ☐ headaches
- ☐ dizziness
- ☐ anxiety
- ☐ depression
- ☐ difficulty concentrating
- ☐ difficulty remembering
- ☐ difficulty reading, writing, calculating
- ☐ poor problem solving
- ☐ difficulty performing your job/school work
- ☐ change in relationships with others
- ☐ poor judgement (being fired from job, arrests, fights)

S Any significant **S**icknesses? ☐ Yes ☐ No

Note: Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by Medical conditions, such as: brain tumor, meningitis, West Nile Virus, stroke, seizures. Also screen for instances of Oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

For the clinician:

Scoring the HELPS Screening Tool

A HELPS screening is considered positive for a *possible* TBI when the following 3 items are identified:

1) An event that could have caused a brain injury (yes to H, E **or** S), **and**

2) A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), **and**

3) The presence of two or more chronic problems listed under P that were not present before the injury.

Note:

- A positive screening is **not sufficient to diagnose TBI** as the reason for current symptoms and difficulties – other possible causes may need to be ruled out
- **Some individuals could present exceptions** to the screening results, such as people who do have TBI-related problems but answered "no" to some questions
- Consider positive responses within the context of the person's self-report and documentation of altered behavioral and/or cognitive functioning

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Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

PTSD Checklist – Civilian Version (PCL-C)

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, pick the answer that indicates how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

Patient Health Questionnaire (PHQ-9)

Over the past 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	Every day
1. Little interest or pleasure in doing things	0	1	2	3	4
2. Feeling down, depressed, or hopeless	0	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	4
4. Feeling tired or having little energy	0	1	2	3	4
5. Poor appetite or overeating	0	1	2	3	4
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	4
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	4
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4
	add columns				

TOTAL: _____

10. 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 ____

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes **No** If yes, enter 1 _____

2. Did a parent or other adult in the household **often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes **No** If yes, enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes **No** If yes, enter 1 _____

4. Did you **often** feel that…
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes **No** If yes, enter 1 _____

5. Did you **often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes **No** If yes, enter 1 _____

6. Were your parents **ever** separated or divorced?

Yes **No** If yes, enter 1 _____

7. Was your mother or stepmother…

Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes **No** If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

Yes **No** If yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes **No** If yes, enter 1 _____

10. Did a household member go to prison?

Yes **No** If yes, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

The Mood Disorder Questionnaire

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and…

…you felt so good/hyper that other people thought you were not your normal self or so much that you got in trouble?	☐ Yes	☐ No
…you were so irritable that you shouted at people or started fights or arguments?	☐ Yes	☐ No
…you felt much more self-confident than usual?	☐ Yes	☐ No
…you got much less sleep than usual and found you didn't really miss it?	☐ Yes	☐ No
…you were much more talkative or spoke much faster than usual?	☐ Yes	☐ No
…your thoughts raced through your head or you couldn't slow your mind down?	☐ Yes	☐ No
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐ Yes	☐ No
…you had much more energy than usual?	☐ Yes	☐ No
…you were much more active or did many more things than usual?	☐ Yes	☐ No
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐ Yes	☐ No
…you were much more interested in sex than usual?	☐ Yes	☐ No
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐ Yes	☐ No
…spending money got you or your family into trouble?	☐ Yes	☐ No

Continued on next page

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ Yes ☐ No

3. How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

Please circle one response only.

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, Aunts, uncles) had manic-depressive illness or bipolar disorder? ☐ Yes ☐ No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ Yes ☐ No

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

Infectious Disease Behavioral Screen

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

☐ I have read and understand the above. Signature: _____

Please mark the one most accurate response to each question.

1. Have you had 2 or more sexual partners in the past 10 years?

   ☐ Yes ☐ No

2. Have you had anal sex (penis in anus) with any of your sexual partners during the past 10 years?

   ☐ Yes ☐ No

3. How often have you used a condom when having anal sex in the past 10 years?

   ☐ Never ☐ Sometimes ☐ Always ☐ Have not had anal sex

4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?

   ☐ Yes ☐ No

5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?

   ☐ Yes ☐ No

6. Have you ever had sex with someone so that they would give you money or drugs?

☐ Yes ☐ No

7. Have you ever injected street drugs, steroids, or vitamins with a needle?

☐ Yes ☐ No

If yes, have you ever shared needles?

☐ Yes ☐ No

8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?

☐ Yes ☐ No ☐ Don't know

9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?

☐ Yes ☐ No ☐ Don't know

10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?

☐ Yes ☐ No ☐ Don't know

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

Transfer responses from the Infectious Disease Behavioral Screen onto this form and total the corresponding numeric values.

1. Yes (5) No (0)

2. Yes (10) No (0)

3. Never (20) Sometimes (15) Always (10) No anal sex (0)

4. Yes (15) No (0)

5. Yes (10) No (0)

6. Yes (20) No (0)

7. Yes (30) No (0)

8. Yes (30) No (0) Don't know (15)

9. Yes (30) No (0) Don't know (15)

10. Yes (30) No (0) Don't know (15)

My score: _____

Scoring Guide:

☐ 0 to 29 indicates low risk for acquiring/transmitting HIV. You do not need to be evaluated further, unless it is believed to be necessary based on other information you have provided.

☐ 30 to 119 indicates medium risk for acquiring/transmitting HIV and hepatitis. You should receive further evaluation and appropriate referrals should be provided.

☐ 120 or higher indicates high risk for acquiring/transmitting HIV and hepatitis. You should contact the Colorado Department of Public Health and Environment, 303-692-2759, or your local county health department for further evaluation and follow-up.

Note: Answering "yes" to question 7 indicates past or present injection drug use and testing for HIV and hepatitis B and C is strongly encouraged as behaviors associated with injection drug use place you at an increased risk for acquiring and/or transmitting these infections.

Score is over 120	**High Risk** A score over 120 indicates you are at high risk from acquiring/ transmitting HIV and/or Hepatitis. See your counselor right away for referral to your local county health department or the Colorado Department of Public Health and Environment for further evaluation and follow-up.
Score is 30-119	**Medium Risk** A score of 30-119 indicates that you are at medium risk for acquiring/transmitting HIV and or Hepatitis. See your counselor for more information about ways that you can reduce your risk and other programs that can help you.
Score is 0-29	**Low Risk** A score of 0-29 indicates that you are at low risk for acquiring HIV and/or Hepatitis. Low risk doesn't necessarily mean no risk. See your counselor if you have questions or concerns about behaviors that may place a person at risk.

Your clinician is referring you to the following program/agency for follow-up:

Program/Agency: _____
Address: _____
Contact: _____ **Phone:** _____

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Reliant Services

Infectious Disease Medical Screen

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

☐ I have read and understand the above. Signature: _____

Please mark the one most accurate response to each question.

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)?

   ☐ Yes ☐ No

2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)?

   ☐ Yes ☐ No

3. Are you a recipient of clotting factor made prior to 1987?

   ☐ Yes ☐ No

4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C infected blood?

   ☐ Yes ☐ No

5. Were you born to a mother who had hepatitis?

   ☐ Yes ☐ No

6. Have you ever had symptoms of liver disease or abnormal liver function/enzyme tests?

☐ Yes ☐ No

7. Have any of your sexual partners been infected with hepatitis B or C?

☐ Yes ☐ No

8. Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. unsterile needles)?

☐ Yes ☐ No

9. Mark all of the following that currently apply to you or that applied to you in the past.

☐ Close contact with active TB

☐ Medical condition that increases risk of TB disease (e.g., HIV, other immune disorders, diabetes, silicosis, [black lung] or coal miners disease), bleeding/clotting disorders, specific malignancies, kidney failure, etc.)

☐ Abnormal chest x-ray showing fibrotic lesions

☐ Resident or employee of a high-risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.)

☐ Health care worker or volunteer who serves high-risk individuals

☐ Foreign-born person who has arrived within the last five years from countries that have a high TB incidence or prevalence (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)

☐ Person from a medically underserved, low-income population

☐ Member of a high-risk racial, ethnic, or other minority population with an increased prevalence of TB (e.g. Asian and Pacific Islanders, Hispanics, African-Americans, Native Americans, migrant farm workers, homeless persons)

☐ History of inadequately treated TB

10. Have you had a cough for more than three weeks?

☐ Yes ☐ No

11. Have you coughed up blood/colored mucus?

☐ Yes ☐ No

12. Do you have swollen, non-tender lymph nodes?

☐ Yes ☐ No

13. Have you had a prolonged loss of appetite or unexplained weight loss of ten pounds or more?

☐ Yes ☐ No

14. Have you had recurrent fevers or heavy night sweats for more than three weeks?

☐ Yes ☐ No

Response Guide:

If you answered "yes" to any question #1-7, please see your counselor for a referral to be screened for hepatitis B and C.

If you answered "yes" to question #8, please see your counselor for a referral for infectious disease screening and testing.

If you answered "yes" to any of the categories in question #9, please see your counselor for a referral to be screened for tuberculosis.

If you answered "yes" to any question #10-14, please see your counselor immediately for a referral for tuberculosis screening and treatment.

Individual Signature: _____ **Counselor Signature:** _____

Individual Name: _____ **Counselor Name:** _____

Date: _____ **Date:** _____

Your counselor is referring you to the following program/agency for follow-up:

Program/Agency: _____
Address: _____
Contact: _____ **Phone:** _____

For clinician use only:

☐ **At risk for TB**

(based on positive response to any questions 9-14).

Reliant Services

Individual Handbook/Documents

INDIVIDUAL COPY

Please read the following documents. You will review these with your clinician at intake.

INDIVIDUAL RIGHTS

1. In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:
    - Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence.
    - Be treated with dignity and respect.
    - Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service support needs.
    - Have all service explained, including expected outcomes and possible risks.
    - Confidentiality, and the right to consent disclosure in accordance with 42 CFR Part 2 and 42 CFR Part 205.50
    - Give informed consent in writing prior to the start of services, except in medical emergency or as otherwise permitted by law.
    - Inspect their Service Record unless there is potentially a detrimental and/or harmful impact on individual's wellbeing.
    - Refuse participation in experimentation.
    - Receive support regarding any medication specific to the individual's diagnosed clinical needs.
    - Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety.
    - Be free of abuse/neglect and to report any incident of abuse or neglect without being subject to retaliation.
    - Have religious freedom.
    - Be free of seclusion and restraint.
    - Be informed at the start of services, and periodically after, of the rights guaranteed by this rule.
    - Be informed of the policies and procedures, service agreements and fees applicable to services provided.
    - Have family and guardian involvement in service planning and delivery.
    - Make a declaration for mental health treatment, when legally an adult.
    - File grievance, including appealing decisions resulting from a grievance.

2. Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows.
    - Information given to the individual must be in written form, or upon request, in an alternative format or language appropriate to the individuals' need.
    - The rights, and how to exercise them, must be explained to the individual and if appropriate, to the guardian.
    - Individual rights must be posted in writing in a common area.

ADMISSION TO TREATMENT

Reliant Services believes addiction is a disease. Further, we believe for any disease to be treated, the patient/individual must be able to name his/her disease and understand its developmental course. Also, we believe that a person affected by a disease must understand the symptoms of the disease and its long-term consequences (prognosis) if left untreated. Finally, we believe an individual must accept the presence of the disease in his/her life if he/she is to commit to learning new behaviors and skills required to live with the disease.

Most individuals who enter alcohol and/or drug treatment programs have evidenced some symptoms of either substance abuse or dependence. Regardless of whether a individual is mandated to treatment (the result of a diversion agreement or court order) or voluntarily enters a program as a result of the effects of substance abuse, almost every individual brings with him/her some experience of alcohol or other drug use/abuse which has resulted in an unpleasant consequence. Discussion of this experience usually initiates individual engagement. Whether by phone or in person, a individual sharing his/her experience is usually the beginning of the first of the three steps in the Admission process.

Step 1 - A individual who contacts Reliant Services to discuss his/her treatment is encouraged to visit the office at the earliest time possible. This initial face-to-face contact allows for a prospective individual to gain firsthand knowledge of the program and for Reliant Services to gain firsthand knowledge of the individual, including a determination as to the level of stress (or crisis) a individual may be experiencing. A individual in severe crisis will meet with a counselor as soon as possible and stabilization will be achieved or a referral to the appropriate individual or agency will be made. Absent crisis, a individual will be given an intake packet to complete and return to his/her counselor at the time of intake. This packet includes:

1. A individual demographic sheet including general information, employer information, insurance information and an emergency contact
2. A Colorado Impaired Driver Education Program Pre-Test (if applicable)
3. Screening tools:
    - **GAD-7**
    - **HELPS Brain Injury Screening Tool**
    - **PTSD Checklist-Civilian Version, PCL-C**
    - **Patient Health Questionnaire, PHQ-9**
    - **Adverse Childhood Experience (ACE) Questionnaire**
    - **Mood Disorder Questionnaire, MDQ**
    - **Infectious Disease Behavioral Screen**
    - **Infectious Disease Medical Screen**
4. Individual Handbook

Initial discussion regarding the costs of treatment is held at this time and the various options for fees are discussed. A individual may elect to pay the full cost of the treatment episode or, based on income, elect a subsidized payment plan. Individuals who appear to meet income requirements are sent to the appropriate agency for income verification. Finally, an appointment is scheduled with a primary counselor at the earliest time, rarely more than ten days later, and a copy of the program's philosophical approach to treatment is provided.

Step 2 - On the day of the intake appointment, individual will present completed Intake Packet for individual and clinician's review. Pending screening results and/or any other pertinent information, external referrals will be discussed (if applicable). The clinician will discuss expectations regarding a individual's behavior in treatment and infractions which may result in discharge. Consequences of alcohol and/or other drug use during treatment, unexcused absences from appointments, nonpayment of fees and failure to participate in planned treatment activities are discussed and reviewed. A form verifying an individual's understanding is then signed by the individual. Copies will be provided upon request by individual.

Step 3 - This step normally constitutes a two hour session with a counselor, during which a comprehensive diagnostic assessment is completed, a diagnostic impression and treatment recommendations are made. Initial placement criteria developed by the American Society of Addiction Medicine is used to determine the least restrictive level of care appropriate to a individual's needs. If an individual is determined appropriate for outpatient or enhanced outpatient treatment based on ASAM criteria, a Service Plan will be initiated during this session. If an individual requires a more intensive level of care than outpatient, he/she may be referred to a residential program. An individual who is deemed inappropriate for treatment at this agency at this time (for example, due to destabilized mental or emotional state), will be referred to an appropriate individual or agency which will help the individual develop readiness for treatment.

CONFIDENTIALITY

1. Reliant Services will keep information about my case confidential, as per Notice of Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit any disclosure of my personal information, unless I have provided specific written permission. The federal rules restrict any use of my protected information to criminally investigate any person criminally. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Part 160 and 164, prohibits disclosure of protected information without written consent, unless otherwise noted in the regulations. Confidentiality will include the fact that I come to Reliant Services for treatment, with the following exceptions:

    a. If a medical emergency occurs, information that is necessary to help may be shared with my physician or other appropriate person.
    b. If the therapist is given information or has cause to believe that child abuse has or is occurring, it is the legal responsibility of the therapist to report to Services to Families Division (SCF) or law enforcement.
    c. In a life-threatening situation, if an individual verbalizes thoughts of harming self and/or an individual verbalizes history or intent to harm a vulnerable person (infant, elderly or at risk adult) information will be released to the appropriate authority.
    d. In verifying insurance coverage, medical card eligibility, employee assistance program eligibility or coverage and victims compensation eligibility, Reliant Services may release information only relating to the fact that I am receiving care and only that information regarding my coverage may be solicited.
    e. Your records may be reviewed by a quality assurance team.
    f. Reliant Services may disclose information regarding my case when given written permission by me.
    g. Or by court order.

GROUP EXPECTATIONS AND GUIDELINES

1. Arrive on time and prepared for group, i.e. phone off/silent, any previous written work completed and in hand.
2. Payment expected prior to services provided. Any special arrangements need to be discussed with primary clinician and/or Program Director.
3. Any information and/or attendees in group is confidential and is expected to remain just that. Information of any group member neglecting this will be thoroughly investigated by treatment team and appropriate action will be taken promptly.
4. Offer feedback to peer group members. Discuss what you see, hear and ultimately feel.
5. “Take Time”, focus on the issues that apply to you. Be open minded.
6. Participate as fully as possible. We realize some are more extroverted than other, so please don’t think you need to share as much as the “talker” in the group. We just ask to take a chance by participating more than your comfort level is used to.
7. Use “I” statements. Stating “you” in a group setting could likely be perceived as deflection or accusatory. “Own your own stuff”.
8. Only water will be allowed in group sessions. There will be times where celebrations will occur, i.e. pizza party, graduation cake, but these will be planned and approved by clinical staff.
9. We realize life doesn’t plan for emergencies. If you need to take a call, please do it outside of the group location. Should you be away for longer than five (5) minutes, refusal for re-entry and denial of credit for that group will be considered.
10. No “Power Plays”, i.e. acts or threats of violence, bullying, refusal to respect others’ time sharing or offering feedback. Violation of this expectation is subject for immediate discharge.
11. Use group sessions as an opportunity for personal growth.
12. Pay attention to your own body language and resistance to topics discussed.
13. You “earned” your seat in group. Do not apologize for the way you feel.

ATTENDANCE POLICY

The intent of this policy is to increase individual participation, improve outcomes, and achieve accountability.

Absences: Ordinary work responsibilities do not justify an excused absence. You are required to attend your scheduled treatment. Treatment absences will result in sanction as deemed appropriate by supervising entities. In case of illness or emergency, documentation may be required to ensure honesty.
Tardiness: Reliant Services will allow up to ten minutes late unless previously approved from group facilitator. If you are going to be more than ten minutes late to group, you will not receive credit for attending.
Weather Policy: Reliant Services staff will monitor the weather to determine the appropriateness of delaying the opening of the office.
Holidays: Reliant Services recognized the following holidays and does not conduct business on those days or the day designated as the formal holiday: New Year's Day, Martin Luther King, Jr Day, President's Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran's Day, Thanksgiving, and Christmas. Your clinician will reschedule the group if it falls on any of those days and you are responsible for attending the make-up group.

GRIEVANCE PROCEDURE

Individuals dissatisfied with any portion of the program, supervision plan, or program sanctions have the option of filing a grievance.

1. The individual shall verbally, write or type, legibly and in detail, the problem he/she is having. The grievance will include the individual's suggested resolution of the problem and shall be submitted within 72 hours of the initial complaint.
2. The grievance will be forwarded to the Clinical Director, who will discuss and if possible, resolve the grievance within five (5) days.
3. A written response for each grievance will be provided to the individual along with the original grievance. A copy of the grievance and resolution will be maintained in a confidential file by the Clinical Director.
4. If the issue is not resolved, the individual has the option of notifying the appropriate state regulatory agencies.

Colorado Department of Human Services / Office of Behavioral Health
3824 W. Princeton Circle
Denver, CO 80236
Phone 303.866.7400 | Fax 303.866.7481

Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202
Phone 303.894.7800 | Fax 303.894.7693
www.colorado.gov/pacific/dora/DPO_File_Complaint

Colorado Department of Public Health and Environment
CDPHE, HFEMSD-C1
Attention: SUD Provider Complaint Intake
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone 1.800.886.7689 ext. 2904

FEE SCHEDULE

Reliant Services operates on a fee system that is individualized to each individual of the program. The following schedule is set but can be subject to change.

Level II DUI Services

Intake $60.00
Education $25.00
Track Therapy $25.00
Education Manual $20.00
Therapy Journals (6) $20.00

Traditional Outpatient Services

Intake $75.00
Group (Relapse Prevention, Seeking Safety, Cognitive Awareness) $30.00
Individual Counseling $60.00

Assessments/Referrals/Specialized Services

Complete Substance Use Disorder Assessment and Report $300.00-$400.00
Substance Use Disorder Interview and Report $175.00
Court Appearance/Testimony $150.00/hr
Document Preparation $125.00/hr
Travel $75.00 hr (>15 minutes one way), $0.51/mile

I understand that I am responsible for prompt payment. I understand if unpaid balance exceeds the cost of three (3) sessions that I am enrolled in, refusal of entry and/or suspension of services can occur. I understand I will not be allowed back in to services until payment arrangements are made and my balance is below limit stated above. I understand any change in fees during my treatment will be recorded in electronic file (Communications Log) and initialed by me to acknowledge that I am aware of the changes.

With the exception of DUII services, I understand that I will not be refused service for my inability to pay. However, inability to pay must be substantiated and refusal to pay will be grounds for suspension or termination. Costs of outpatient services (not the DUII program) are supported by individual fees. I understand that I am responsible for prompt payment. I am aware that I must cancel or reschedule any appointment that I am not able to keep as early as possible prior to the appointment time. If the appointment is not cancelled, it is my responsibility to pay for it. I have read, understand and been provided a copy of fee agreement, fee schedule and collection procedures at time of intake interview.

I understand and agree **my** rights of confidentiality **regarding my contact information**, **will be given to a collection agency** for the purpose of the collection of the unpaid fees.

Reliant Services

EMERGENCY PROCEDURES FOR OUTPATIENT

INDIVIDUAL COPY

FIRE

1. Upon observing a fire, or the smell of smoke, immediately notify a staff member.
2. Staff will be responsible for contacting 911.
3. Exit the building immediately.

TORNADO

1. In the event of a tornado warning, all staff and any individuals present who choose not to leave the building will move to the center of the office building. Everyone shall be seated on the floor, remain quiet, and be prepared to cover their heads in the event of an actual tornado.
2. Staff will secure the building and will release all parties once the danger has passed.

GAS LEAKS

1. Upon smelling the odor of gas, the party noting the smell shall advise a staff member.
2. Staff will investigate the odor and, if necessary, contact the appropriate utility company.
3. If the odor of gas is so overwhelming that it presents a potential hazard to employees and individuals, the building will be evacuated and 911 called.

POTENTIAL THREATS

1. In the event of a perceived threat, I will be instructed and directed further by staff to ensure safety.

SEVERE WEATHER

1. In the event of severe weather, other than tornado warnings, a manager will make a determination regarding the early closing of the office.
2. If closing, staff will make all reasonable attempts to notify individuals reporting that day, in order to reschedule.
3. A sign shall be posted on the front door notifying individuals that the office has been closed due to inclement weather.

Reliant Services

INFORMATIONAL RESOURCES FOR INFECTIOUS DISEASES

INDIVIDUAL COPY

For information on any infectious disease, please contact:

Center for Disease Control and Prevention National Hotline
English: 1 (800) 342-2437
Spanish: 1 (800) 344-7432

For information on HIV and/or AIDS, Hep C, and STD testing please contact:

Colorado AIDS Project Locations:

Denver
701 E. Colfax Avenue, #212
Denver, CO 80203
(303) 837-1501

Boulder
2118 14th Street
Boulder, CO 80302
(303) 444-6121

Greeley
2017 9th Street
Greeley, CO 80631
(970) 484-4469 **(Fort Collins)**
(970) 353-1177 **(Greeley)**
(800) 464-4611 **(Toll Free)**

Tri-County Health Department Aurora, Northglenn, and Denver (303) 363-3018 Ext 6	**Plains Medical Center** 820 1st Street Limon, CO 80828 (719) 775-2367
Jefferson County Health Department 6303 Wadsworth Bypass Arvada, CO 80033 (303) 275-7500	**Northeast** Sunrise Community Health Center 100 North 11th Avenue Greeley, CO 80631 (970) 395-1102
East Side Family Health Center 501 28th Street Denver, CO 80205 (303) 436-4600 HIV, STD testing by appointment	**Hep C Connect** 1325 S Colorado Blvd, Denver, CO 80222 (303) 860-0800
Denver Public Health 605 Bannock Street, Room 162 Denver, CO 80204 (303) 436-7251 HIV, STV testing by appointment Monday, Wednesday: 8am – 5:30pm Tuesday, Thursday, and Friday: 8am – 4pm	**Harm Reduction Action Center** 733 Santa Fe Drive Denver, CO 80204 (303) 572-7800 Syringe Access Hours: 9am – 12pm Monday-Friday
Pueblo Community Health Center 110 E. Routt Avenue Pueblo, CO 81004 (719) 543-8711	**For Information on tuberculosis testing, please contact:** **Denver Metro TB Clinic** http://denverhealth.org/ 777 Bannock Street Denver, CO 80204 (303) 436-7286