CLIENT CONTACT INFORMATION SHEET

MHA SPEAKOUT SPEAKUP

Jolie' Knight- MHFA

418 E Pacific Ste #102

Spokane,WA 99202

mhaspeakoutspeakup@gmail.com

Birth Date: ____/____/____ Age:_____

Gender:
- ☐ Male
- ☐ Female

Name:_____

Address (Street and Number):_____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____-_____

May We Leave a Message
- ☐ Yes
- ☐ No

Cell/Other Phone: (____) ____-_____

May We Leave a Message
- ☐ Yes
- ☐ No

E-mail:

May We Email You?
- ☐ Yes
- ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:

Place of Employment:_____

Work Number: (____) ____-_____

If needed, is it OK to call here?
- ☐ Yes
- ☐ No

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (____) ____-_____

M.H.A SPEAKOUT SPEAKUP

418 E PACIFIC STE #102 SPOKANE, WA 99202

mhaspeakoutspeakup@gmail.com

(509) 385-5286

CLIENT RESPONSIBILITES FOR PROGRAM SERVICES

- Must cancel within 2 hours of appointment or it will be marked as a no call /no show
- If assigned a to do or task list, tasks must be completed as stated on service plan or before next appointment.

I understand in order to receive services I will follow the guidelines above if there are 3 marked no call no shows I will be terminated from services at M.H.A SPEAKOUT SPEAKUP.

X_____

Client signature

X_____

Case Manager

Signature: *Jolie' Knight* -CPC. FCS Case Manager, Director

Printed Name: Jolie' Knight CPC. FCS Case Manager, Director

Professional Title: Certified Peer Counselor

Name of Agency, etc.: M.H.A SPEAKOUT SPEAKUP

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Consent of release of information

I, _____ of _____

(print name) (county)

Authorize **MHA SPEAKOUT SPEAKUP** to disclose and/or receive information from

Agency/Person's Name:

_____

Address:

_____

City, State, Zip code: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

I understand that the purpose of this release is to allow **MHA SPEAKOUT SPEAKUP** to exchange information about me in any form including verbal, writing and electronic with the above-named entity to facilitate appropriate treatment, medical care and monitoring; and promote public safety. I also understand that if I decline to sign this or any additional requested releases that I am not eligible to participate in services with MHA SPEAKOUT SPEAKUP.

Types of information that may be shared include, but are not limited to:

- Substance use history, legal issues and license status.
- Diagnostic impression, symptomology, and treatment recommendations or services.
- Rental history
- Medical and/or psychiatric conditions
- Prescribed medications

- Results of urine, blood, hair, ect testing
- Monitoring program compliance and status
- Housing, utilities, employment
- Court records and criminal history
- Other:

_____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 43 CFR Part 2, and cannot be disclosed without my written consent. I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows; specification of the date, event, or condition upon which this consent expires: (initial one)

_____ Ninety (90) days from the date listed below _____Ninety (90) days after program completion

_____ Other (specify length of time)

Signature & Date:

_____

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HOUSING INTAKE GUIDELINES

Here at M.H.A Speakout Speakup we are a housing supportive agency; with this we **cannot guarantee** housing placement by a certain time.

We will do everything we can to assist in finding suitable housing in a timely manner but due to the current housing crisis in Spokane and surrounding areas, long wait lists, and requirements for certain properties such as income, credit score, etc.

As a nonprofit agency we strive to help our clients in the most efficient way we can, however we cannot predict unforeseen circumstances such as property availability and are unable to guarantee approval into all properties.

X_____

Client signature & Date

X_____

Case Manager

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Amerigroup

Foundational Community Supports Transition Assistance Program Participant Agreement

The Foundational Community Supports Transition Assistance Program (FCS TAP) gives funding assistance to FCS supportive housing enrollees. This time-limited support covers costs tied to your person-centered supportive housing plan. Costs linked to your transition will be paid by your FCS supportive housing provider. Then, your FCS supportive housing provider will be reimbursed by Amerigroup Washington, Inc., the program's third-party administrator. All FCS TAP approvals depend on available program funding.

FCS TAP offers move-in assistance by paying first and last month's rent, security deposit, and other costs related to getting or keeping affordable housing. FCS TAP does not pay ongoing rents. Speak with your provider to explore longer-term rental subsidies that may be available to you.

All FCS TAP disbursements are sent to your FCS supportive housing provider and delivered by the provider to recipients (i.e., a landlord, property manager, local retailer, and others). All items purchased with FCS TAP funding can only be used for their intended purpose.

It is optional to take part in FCS TAP. If you decide not to take part in the program, you will not be penalized in any way. Nor will you lose the FCS services you are eligible to receive as an FCS enrollee.

Eligibility and other considerations:

1) To be eligible for FCS TAP, you must:
   - ❑ Be actively receiving FCS-eligible Medicaid,
   - ❑ Be enrolled in FCS supportive housing services, and
   - ❑ Identify as having a behavioral health need.

   FCS TAP funds will be paid directly to your landlord or another entity giving you housing-related goods or services. Neither you nor your provider will receive compensation from the FCS TAP fund for taking part in the program. Your provider will deliver all FCS TAP payments directly to the recipient.
   Note: If you need to sign documents upon payment, consider joining your FCS provider as they deliver FCS TAP funding.
2) FCS TAP payments won't alter, change, or affect any financial responsibility or obligation for Medicaid benefits.
3) This agreement does not give you the right to request an administrative hearing. If funding is not approved or is stopped, you have the right to follow your provider's grievance process. Ask your FCS provider for more information about this process.

4) Receiving FCS TAP assistance will not affect your right to request an administrative hearing related to Medicaid programs, including FCS services.

Review, then sign:

I understand if I am no longer receiving FCS-eligible Medicaid benefits, then I am no longer approved to receive FCS supportive housing services. Or, if I choose not to take part in FCS TAP, then I will not have access to FCS TAP funding. I understand FCS TAP funding help is linked to the eligible FCS supportive housing enrollee, and any co-applicant for an apartment does not have rights to FCS TAP funding unless they are also eligible to take part in the program.

I also understand my FCS provider will deliver all FCS TAP payments to the rightful recipient. As the FCS supportive housing enrollee, I am responsible for the entire cost of my housing unless I am approved to receive longer-term rental help from another entity.

Enrollee name (Print)	Enrollee signature	Date
Legal guardian/Durable Power of Attorney or client representative		Date
FCS provider program staff signature		Date

Note: This document does not need to be sent to Amerigroup but should be kept in the FCS supportive housing enrollee's treatment record.