

Client Contact Information

Name: _____ Date of Birth: ____/____/____

ProviderOne #: _____ WA Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Ok to leave a message?: Yes No

Message # (if any): (____) _____ Ok to leave a message?: Yes No

Email: _____ Ok to send emails?: Yes No

Occupation: _____

Employer: _____

Employer Phone #: (____) _____ Ok to call, if necessary?: Yes No

Emergency Contact(s):

Name: _____ Relationship: _____

Phone #: (____) _____ Ok to leave a message?: Yes No

Name: _____ Relationship: _____

Phone #: (____) _____ Ok to leave a message?: Yes No

Name: _____ Relationship: _____

Phone #: (____) _____ Ok to leave a message?: Yes No

Client Responsibilities

I, _____, acknowledge that to remain active in the Foundation Community Support (FCS) program, there are guidelines that must be adhered to:

- Appointment cancellations require a minimum of 2 hours notice. Failure to do so will result in a No Call / No Show. Three (3) No Call / No Shows will result in removal from the program.
- I am required to complete any task(s) given to me by my Case Manager, as stated on my Service Plan, by my next appointment.
- I am required to attend an appointment once per month, either by phone or in person.
- I am required to keep my State Medicaid coverage active. If my insurance changes or my benefits are terminated, I will notify MHA Speak Out Speak Up as soon as possible.

By signing below, I understand and agree to follow these guidelines. Failure to do so may result in termination from the FCS program through MHA Speak Out Speak Up.

Client Name (print): _____

Client Signature: _____

MHA Staff: _____

Housing Intake Guidelines

Here at MHA Speak Out Speak Up, we are a housing supportive agency. With this, we can not guarantee housing placement within a certain timeframe. All housing is case by case as circumstances may vary and approval is not guaranteed. Our funds are not based on emergent needs.

As a non-profit agency, we will do everything we can to assist in finding suitable housing in a timely manner but due to many variables: the current housing crisis in Spokane and surrounding areas, long wait lists, requirements from Property Owners such as income, credit score, criminal history, etc., however, we can not predict unforeseen circumstances (such as property availability).

Client Name (print): _____

Client Signature: _____

MHA Staff: _____

Client FCS Housing TAP Funding

I, _____, acknowledge that the Foundation Community Support (FCS) program can change how and what funds, within the program, are allocated each year. MHA Speak Out Speak Up has no control over what the FCS program determines, as far as how the funds can be used or when the funds will become available.

I also understand that MHA Speak Out Speak Up has no control over when the funds will run out.

Client Name (print): _____

Client Signature: _____

MHA Staff: _____

MHA Speak Out Speak Up
3012 N Nevada St - Suite # 1
Spokane, WA 99207

Ph: (509) 385-5286
Fax: (509) 206-9500
www.MHASpeakOutSpeakUp.org

Authorization for Release of Information

_____/_____/_____
Last Name First Name M.I. Date of Birth

_____-_____-_____
Address City, State, Zip Code Soc Sec #

(_____)_____-_____
Phone # Email

*** If Release is for information about dependent child/ren, list name(s) of dependent child/ren:**

Provider authorized to release information/records:

_____(_____)_____-_____
Provider/Clinic Name Phone #

_____-_____-_____
Address City State Zip Code

Reason or purpose for disclosure:

Specific information to be disclosed:

Individual's Full Name, Date of Birth and Diagnosis (including Diagnostic Code(s))

The following types of records must be specifically authorized.

This authorization includes information about the following (check all that apply):

- ☐ Chemical dependency treatment
- ☐ HIV/AIDS test results, diagnosis or treatment
- ☐ Mental health
- ☐ Sexually transmitted disease(s)

NOTICE TO THOSE RECEIVING INFORMATION:

If these records contain information about HIV/AIDS, sexually transmitted disease(s), or drug or alcohol abuse, you MAY NOT further disclose that information under Federal and State law without specific permission from the Person and meeting specific legal requirements.

This authorization will expire in 180 days from the date signed below or on _____, 20____.
Month Date Year

Organization authorized to receive information/records:

MHA Speak Out Speak Up (509) 385 -5286
Agency Name Phone #

3012 N Nevada St - Ste # 1 Spokane WA 99207
Address City State Zip Code

MHA Speak Out Speak Up
3012 N Nevada St - Suite # 1
Spokane, WA 99207

Ph: (509) 385-5286
Fax: (509) 206-9500
www.MHASpeakOutSpeakUp.org

I have read and understand the following statements about my rights:

- * I may cancel this authorization at any time before the expiration date or event noted above by notifying *MHA Speak Out Speak Up* in writing. The cancellation will not affect any information received prior to the date that the cancellation was received.
- * I may see and copy the information described on this form, if requested.
- * I am not required to sign this form and am doing so voluntarily.

Signature of Person authorizing records release

Relationship to Patient

Print Name

Date



Informed Choice for Client Services

MHA Speak Out Speak Up is committed to allowing all Clients to have a choice when it comes to services. Informed choice is the process by which the individual receiving services makes decisions relative to their Provider, services, and outcomes.

How MHA supports Informed Choice: MHA Speak Out Speak Up provides counseling and guidance, information and support to help you make choices that meet your strengths, resources, priorities, concerns, abilities, capabilities, and interests. We will help you understand your choices throughout the process, as well as help you understand and evaluate the options available to you. MHA Speak Out Speak Up will provide you with a list of local resources in your area, upon request.

If, at any time, you would like information regarding additional services or other service providers, we will provide you with a list of contact information.

By signing below, I confirm that I have been informed of my rights to informed choices.

Client Name (print): _____

Client Signature: _____

MHA Staff: _____

Safety Plan

1. List 3 warning signs that a crisis may be developing:

- _____
- _____
- _____

2. List 3 internal coping strategies that can take your mind off your problems:

- _____
- _____
- _____

3. Who or What are 3 people or places that provide distraction:

Write name/place and phone #

- _____ Phone #: _____
- _____ Phone #: _____
- _____ Phone #: _____

4. Who can you ask for help: Write name(s) and phone #(s)

- _____ Phone #: _____
- _____ Phone #: _____
- _____ Phone #: _____

5. Professionals or agencies you can contact during a crisis:

Clinician: _____ Phone #: _____

Local Urgent Care or Emergency Department:

Address _____ Phone #: _____

Call or text 988 or chat: 988lifeline.org

6. Write out 2 things to make your surroundings safer:

- _____
- _____

Patient Health Questionnaire-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following issues?

Circle the number that best describes your answers:

No days 1-2 days 3-5 days 6-7 days

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 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
Column Totals: 0= _____ 1= _____ 2= _____ 3= _____				
GRAND TOTAL: _____				
.....				
If you checked off <u>any</u> problems, how <u>difficult</u> 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				

MHA Staff: _____

Ask Suicide-Screening Questions (ASQ)

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 questions, 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 questions # 5). No intervention is necessary (* NOTE: Clinical judgement can always override a negative screen).
- ❖ If patient answers **YES** to any 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.

RESOURCES AVAILABLE:

24/7 National Suicide Prevention Lifeline

1-800-273-TALK (8255)

En Espanol: 1-888-628-9454

24/7 Crisis Text Line

Text **'HOME'** to 741-741

Housing Disclosure

Some people ask their Housing Specialist to talk to property managers on their behalf. For instance, if a person was interested in housing, the Housing Specialist might meet the property manager of a complex to learn more about the grounds or amenities. The Housing Specialist may advocate for the client and talk about the positives of the client. Housing Specialists may mention to property managers if the client has caregiving services coming in or they may talk about the client's other resources, such as PACT services. The reason someone may want a Housing Specialist to talk about these things could include, but are not limited to:

- Extra help with housing assistance when housed. Housing Specialists can describe the client's strengths for living at the complex, learn about available units and request showings.
- Extra feedback about how the client is doing, once housed. Housing Specialists can keep in touch with property managers once clients are housed and ask how the client is doing and for feedback.

Other people do not give Housing Specialists permission to talk to property managers on their behalf. Instead, the Housing Specialist helps provide housing leads, filling out applications, and other housing activities. The reason why some people would not want to disclose support might include:

- Concern that property managers may not accept a person for housing with a disability or mental health condition. It is true that there is a stigma about mental health problems and some property managers may try to discriminate. It is also true that property managers do work with government or federal housing programs and subsidies.
- Some people do not mind if their property manager knows that they are working with a Housing Specialist or program.
- Some people do not feel that this type of help is necessary.

Either option is fine. You should pick the strategy or mix of strategies that work for you. It is okay to change your mind during the housing search or after you are housed.

You probably have your own personal feelings about disclosure. Try working on the table below with your Housing Specialist:

<i>Possible Advantages of Disclosure</i>	<i>Possible Disadvantages of Disclosure</i>
	

When Housing Specialists talk to property manager, it is usually possible for them to keep some things private. For example, some people do not want their Housing Specialist to share information such as diagnosis or medications. Talk this over with your Housing Specialist and write down the things that you would not want the Housing Specialist to share with a property manager:

If you want your Housing Specialist to share information, please list the information that may be shared with property managers:

For today, please mark the box that best describes your intent for disclosure:

- ☐ I do not want my Housing Specialist to talk to property managers.
- ☐ I am not sure right now and I would like more time to think about this and receive more information.
- ☐ It is okay with me if my Housing Specialist speaks to property managers on my behalf and shares necessary information.
- ☐ It is okay with me if my Housing Specialist speaks to property managers on my behalf and shares only the information listed above when speaking with them.

Client Name (print): _____

Client Signature: _____

MHA Staff: _____