| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

Regular Business Hours: Mon – Fri 8:00 AM – 5:00 PM

# Child and Adolescent MH Intake Packet

☐ STEP 1: Gather the documents listed on page 2 of this packet.

☐ STEP 2: IF you have no income, fill out page 3.

☐ STEP 3: Fill out the rest of the packet completely.
**If you need any help with the packet, please call 903-957-4701.**
**Please ask for an interpreter if you need language assistance.**

☐ STEP 4: Return completed packet and required paperwork to your local clinic on that clinic's designated open access enrollment day. Enrollments will occur each designated day until all available spots are filled. Legal guardian must accompany child to appointment in order for child to be seen, sign consents, and documentation.

**Cooke County – Monday**
301 N. Grand Ave., Gainesville, 940-612-1389
**Grayson County - Tuesday and Wednesday**
315 W. McLain Dr., Sherman, 903-957-4701
**Fannin County - Thursday**
1221 E. 6th St., Bonham, 903-583-8583

**Enrollment appointments are usually available during normal business hours, except for observed holidays.**

☐ STEP 5: When enrolled into services, you will be assigned a Case Manager who will:

- be your main contact at TCC
- work with you to make a plan for your recovery, and
- will keep all your paperwork updated while you are in services
- coordinate scheduling an appointment with a prescriber if requested

☐ STEP 6: Once all the enrollment steps are completed, you are ready to begin services

**TCC Crisis Line – 24-hours a day – 1-877-277-2226**
**Hearing Impaired Crisis Line - 1-800-735-2989 (TDD/TT)**

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

# Documentation Needed

**Child & Adolescents:**

- **Medical Insurance Information for the child or parent's medical insurance information IF the child is covered on that insurance** *(Medicaid, Medicare, or private insurance)*
- **Medicaid Denial letter OR Proof of Medicaid Application** *(yourtexasbenefits.com)*
- **Social Security Card**
- **Birth Certificate of Child**
- **If the parents are divorced, a copy of the divorce decree designating custodial rights is required**
- **Parent's Driver's License or State ID Card**
- **Proof of residence** *(utility bill, rental agreement, etc.)*
- **Proof of Parent or Guardian's Income** *(bring the ones you have)*
  - **Four (4) most recent pay stubs**
  - **SSI or SSDI award letters**
  - **Retirement Documentation showing amounts**
  - **Proof of public assistance (food stamps, etc.)**
  - **W-2 or latest tax return**
  - **Page 3 of this packet, if you have no income at this time**
- **Behavioral Health medical records are desired (if you have any previous history of treatment)** *(hospital discharge records, or how to reach your previous provider)*

# Financial Statement

Client Name: _____

I _____, agree that all of my statements below are true.
(name)

1) I currently have an ID; Driver License, State ID, Birth Certificate, or Passport: ☐ Yes ☐ No

2) I am currently: ☐ Unemployed ☐ Employed part-time ☐ Employed full-time
☐ Receiving Social Security Income/Disability ☐ Pending Disability

3) I make or receive: $_____ ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly

4) I currently have any public health insurance, such as Medicaid, or private health insurance programs: ☐ Yes ☐ No If Yes, please specify; _____

5) I currently have a place to live: ☐ Yes ☐ No

6) I currently reside at: Address: _____

City: _____ State: _____ Zip Code: _____

7) I reside with: Name: _____ Phone: _____

8) Does anyone provide you with the following: Rent, utilities, car payment, insurance, food, clothes, medical bills, gas, medications, cigarettes, cable, phone, probation fees, etc.?
☐ Yes ☐ No If Yes, have that person fill out questions 9-11 and sign as the Support:

9) Name: _____ Relationship to Client: _____

10) How much do you spend in a month to support this person? ☐ $1 to $50 ☐ $51 to $100
☐ $101 to $200 ☐ $201 to $300 ☐ $301 to $400 ☐ $401 plus

11) Will this change, and if so, when and why?

☐ Applicant refuses or is unable to provide documentation.

**Your signature below means that you agree that your financial statement is correct.**

Client Signature: _____ Date: _____

LAR Signature: _____ Date: _____
*(If client is under the age of 18, LAR must sign and date.)*

Support Signature: _____ Date: _____

Staff Signature: _____ Date: _____

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

## REGISTRATION DOCUMENT

Child's First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name:_____ Date of Birth:_____ Social Security #_____ Marital Status:_____

Gender: ☐ Male ☐ Female ☐ Transgender MtoF ☐ Transgender FtoM Preferred Pronouns: _____

Do you consider yourself ☐ Heterosexual or Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Other: _____

Primary Spoken Language: _____ Secondary Spoken Language: _____

Can they read & write? ☐ Yes ☐ No Do you or your child need an interpreter? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Hispanic Origin: ☐ No If Yes: ☐ Central American ☐ Cuban ☐ Dominican ☐ Mexican ☐ Puerto Rican ☐ South American

Are you currently homeless ☐ Yes ☐ No

Current Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Your phone number(s) _____

***By providing a telephone number and submitting this form you are consenting to be contacted by SMS. Message frequency varies. Message and data rates may apply. Reply STOP to opt out of further messaging. Reply HELP for more information. Refer to our Privacy Policy.***

### PEOPLE YOU MAY WANT US TO CONTACT ABOUT YOUR CHILD'S TREATMENT
**(You will need to sign a release before we can share your information)**

***(Minors MUST have a legal guardian AND financially responsible contact)***
***(Select all that apply)***

| Name: | Relationship to Child: | Phone: | Legal Guardian: | Emergency Contact: | Financially Responsible: |
|---|---|---|---|---|---|
| _____ | _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | _____ | ☐ | ☐ | ☐ |
| _____ | _____ | _____ | ☐ | ☐ | ☐ |

### ADDITIONAL INFORMATION

Highest grade level child has completed? _____ Did they graduate? ☐ Yes ☐ No ☐ N/A GED? ☐ Yes ☐ No ☐ N/A

Is child currently in school? ☐ Yes ☐ No Is child currently employed? ☐ Yes ☐ No

Were you in the military? ☐ Yes ☐ No Which branch? _____

Current Military Status _____ Which Campaign? _____

Are you eligible for VA Benefits? ☐ Yes ☐ No

Do you use: ☐ Wheelchair ☐ Walker ☐ Glasses ☐ Contacts ☐ Hearing Aid ☐ Dentures/Partial

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

**CONSENTS FOR EMERGENCY AND NON-EMERGENCY SERVICES**

In the event of a medical or psychiatric emergency, I hereby consent and give permission to TEXOMA COMMUNITY CENTER or any of its representatives at their sole discretion to call 911, my emergency contact, and/or my primary care physician.

I hereby consent and give permission to TEXOMA COMMUNITY CENTER or any of its representatives when medically necessary to use CPR, rescue breathing, abdominal thrusts, and first aid procedures. I also give my permission to EMS personnel to provide all medically necessary treatment when they are called on my behalf.

I understand that TEXOMA COMMUNITY CENTER will not be financially responsible or liable for any emergency treatment I receive.

I give my permission for TEXOMA COMMUNITY CENTER staff to transport me, my child, or my ward to and from TCC programs and/or any other necessary events, programs, facilities or community activities.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Individual seeking Services or Legally Authorized Representative, Guardian, or Parent of a Minor | Printed Name | Today's Date |

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

# Medical Questionnaire

**Height: _____ Weight: _____**

Please list any drug allergies your child has:

Please list any food or other allergies your child has (food, latex, etc):

**Does your child have any of the following medical conditions?**

- ☐ **YES** ☐ **NO** **Arthritis**
- ☐ **YES** ☐ **NO** **Asthma/COPD**
- ☐ **YES** ☐ **NO** **Bleeding Disorders/Blood Clots**
- ☐ **YES** ☐ **NO** **Cerebral Palsy**
- ☐ **YES** ☐ **NO** **Congestive Heart Failure**
- ☐ **YES** ☐ **NO** **Diabetes**
- ☐ **YES** ☐ **NO** **GERD/Acid Reflux/Stomach Ulcer**
- ☐ **YES** ☐ **NO** **Gout**
- ☐ **YES** ☐ **NO** **Heart Disease**
- ☐ **YES** ☐ **NO** **High Cholesterol**
- ☐ **YES** ☐ **NO** **Hypertension/Elevated Blood Pressure**
- ☐ **YES** ☐ **NO** **Liver Disease**
- ☐ **YES** ☐ **NO** **Pregnant**
- ☐ **YES** ☐ **NO** **Seizure Disorder**
- ☐ **YES** ☐ **NO** **Speech Impairment**
- ☐ **YES** ☐ **NO** **Thyroid Dysfunction**

**Please describe any yes answers from above:**

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

## Current Medications

*Please complete this page OR attach a list of your current medications*

| Prescription Medications (name, strength, dosage): | Prescribed by (doctor, clinic, or hospital): |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Over-the-Counter Medications or Vitamins that your child takes regularly:

_____

_____

_____

_____

_____

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

OTHER TREATMENT

Does your child have a Primary Care Physician? ☐ Yes ☐ No (If yes, please list on next line)

Current Primary Care Doctor _____ Location _____

Would you like to give consent for TCC to coordinate care and communicate with their Primary Care Physician about their treatment and medications? ☐ Yes ☐ No

If they do not have a Primary Care Physician, would you like a referral for a Primary Care Physician? ☐ Yes ☐ No

Where does your child go when they are sick? _____ Location _____

Other Current Doctor _____ Location _____

Other Current Doctor _____ Location _____

Other Current Doctor _____ Location _____

Recent Medical Hospitalizations (date, place, reason) please provide discharge packet, if available

Recent Psychiatric Hospitalizations (date, place, reason) please provide discharge packet, if available

Has your child ever been treated for any mental health disorder? ☐ Yes ☐ No

What type of treatment including where & when:

Please list any mental health diagnoses that they have received and how old they were:

Is there a family history of mental illness? Please describe:

Recent Inpatient Alcohol or Substance Use Treatment (date, place, reason) please provide discharge packet, if available

Does child currently drink alcohol? ☐ Yes ☐ No If yes, how much & how often? _____

| **Office Use:** | | | |
|---|---|---|---|
| Client Name: | Client # | Medicaid # | Date: |

Does child currently use illicit drugs? ☐ Yes ☐ No If yes, describe use _____

Has child ever been treated for the use of alcohol, illicit or illegal drugs? ☐ Yes ☐ No

What type of treatment? including where and when:

Please describe any past use of alcohol or illicit drugs that caused problems for you or your family:

| _____ | _____ | _____ |
|---|---|---|
| Signature of Individual seeking Services or Legally Authorized Representative, Guardian, or Parent of a Minor | Printed Name | Today's Date |

Individual's Name:_____ Case #:_____ MDCD#:_____

TEXOMA COMMUNITY CENTER

# Parent History Questionnaire

Please answer the following questions carefully and completely. Your answers will help us in understanding your child. The questionnaire will be reviewed with you during your first intake appointment.

Child's Name:_____ Date:_____

Nickname:_____ Age:____ Date of Birth:_____

Name of legal guardians:_____

Problems and Concerns:

1. Please list, in order of urgency, the problem(s) for which you are seeking help for your child:

A. _____

B. _____

C. _____

D. _____

E. _____

2. How old was your child when you first began noticing these problems?

3. What changes do you expect to occur for the better in your child's behaviors with treatment?

4. Are you able to participate in your child's treatment? _____

_____

Family Situation:

1. Please list all people this child is currently living with:

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Individual's Name:_____ Case #:_____ MDCD#:_____

2. Other brothers or sisters not at home (biological, step, and other siblings)?

| Name | Age | Relation to Child |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

3. Information about all parents (including step-parents and other parent figures):

| Name | Age | Education | Occupation | Frequency of contact |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Pregnancy and Delivery Information:

1. Was baby full term? _____ If not, how many weeks premature?_____ Birth weight? _____
2. Length of hospital stay for mother?_____ Length of hospital stay for child?_____
3. Did the mother experience any of the following difficulties during pregnancy?

___ Measles
___ Flu, infections, high fever
___ Diabetes
___ Spotting or bleeding
___ frequent nausea/vomiting
___ swelling or toxemia
___ high blood pressure
___ venereal disease
___ alcohol/substance use or abuse. Please specify _____
___ other difficulties. Please specify _____

4. Were any of the following present during or soon after delivery? (Check all that apply)

____ Mother was put to sleep
____ C-section performed
____ Instruments used to deliver
____ Rh factor present
____ Breech birth or presentation
____ born with cord around neck
____ baby was jaundiced
____ baby aspirated me conium (breathed waste)
____ baby needed oxygen
____ baby had trouble sucking
____ baby had trouble keeping food down
____ baby was blue
____ Baby was placed in an incubator. For how long? _____
____ other medical problems at birth (describe):

Individual's Name:_____ Case #:_____ MDCD#:_____

Developmental/Medical History

1. Did any of the following occur during infancy? (Check all that apply)

___ Problems with sleeping
___ frequently fussy or colicky
___ trouble breathing
___ problems eating or gaining weight
___ convulsions or seizures
___ excessive diarrhea or dehydration
___ mother was depressed or anxious

2. Estimate the age at which the following occurred:

_____ sat without support
_____ took first steps
_____ walked alone
_____ spoke first word
_____ spoke in 2 to 3 word phrases or sentences
_____ printed name
_____ toilet trained – bladder (day)
_____ toilet trained – bladder (night)
_____ toilet trained – bowel (day)
_____ toilet trained – bowel (night)
_____ recognized the alphabet
_____ rode a bicycle

3. Has your child had any serious illnesses, injuries, hospitalizations, or accidents?

| Type | Age |
|---|---|
| | |
| | |
| | |
| | |

4. Please write the ages (in years) that your child had any of the following illnesses (from the beginning of the illness to the end):

___ Allergies
___ Asthma
___ Blood transfusion
___ convulsions/seizures
___ diabetes
___ heart trouble
___ high fever
___ meningitis/encephalitis
___ pneumonia
___ prolonged colic
___ tonsillitis
___ frequent ear infections
___ anemia or other disorder of the blood (AIDS/STD's)
___ tumor or cancer
___ Head injuries. If yes, was your child hospitalized? ___ If yes, how long did your child remain in the hospital?_____ Was there a loss of consciousness (if yes, how long)?_____
___ Other (please explain)_____

5. My child's physicians are: _____

6. Are immunizations current? _____ Date of last tetanus?_____

7. Please list all medications taken by your child:

| Name of Medication | Dose | When Taken | For what reason | Prescribed by: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have these medications been helpful with treating your child's symptoms?

8. Please describe any problems your child may have had in the following areas:

Age of last exam

Vision_____

Hearing_____

Speech_____

9. Please describe your child's eating habits. (Note any problems in this area).

10. Please describe your child's sleep habits. (Note any problems in going to sleep, sleeping alone, night awakenings, length of sleep, nightmares, sleeping walking, etc.)

11. Please describe the sleeping arrangements for your child.

School Information

1. Current grade_____ School_____ District_____

Current teachers_____

2. Has your child ever repeated a grade?_____ If yes, what grade and what was the reason?

_____

3. Does your child receive special education services?_____ If yes, what grade did your child begin receiving these services?_____ What type of special education services does your child receive?

4. Please list all the schools your child has attended.

| School | Age/Grade |
| --- | --- |
| | |
| | |
| | |
| | |

_____ _____

Signature of Legal Guardian Date

Consumer's Name:_____ Case #:_____ MDCD#:_____ Date:_____

## TEXOMA COMMUNITY CENTER (TCC) INFORMATION AND TREATMENT AGREEMENT FOR MENTAL HEALTH SERVICES

Your relationship with the Center and its representatives is professional and therapeutic. In order to preserve this relationship, it is imperative that the Center or its representatives not have any other type of relationship with you and/or your family. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The Center and its representatives care about helping you and are not in a position to befriend you and/or the members of your family, or to have a social, business, or personal relationship with you and/or your family members. Gifts, bartering, and trading services between you or your family and the Center is not appropriate.

## APPOINTMENTS/CANCELLATIONS

You will be seen as close to your appointment time as possible, but an appointment insures a place on the schedule. Time seen is based on schedule, emergencies, consultations, etc. Being late to an appointment may cause your place on the schedule to be cancelled. Cancellations must be received at least 24 hours before the scheduled appointment. You are responsible for calling to cancel or reschedule the appointment. Also, please be advised that if you are going to be more than 15 minutes late for an appointment, you may have to reschedule, or wait for a no-show later that day, as a courtesy to those who have been scheduled after you.

## CONSENTS AND INFORMATION RELATED TO SAFETY

- Children cannot be left unattended by the legally authorized representative at any Texoma Community Center facility. If a child is left unattended, the Center is obligated to report such conduct to the Texas Department of Family and Protective Services.
- The Center staff may refuse to see any one that presents for a session under the influence of illicit drugs and/or alcohol.
- Smoking is only allowed in designated areas, and during activities only at designated times. Smoking is never allowed inside the facility or any of the vehicles.
- Respect the property and rights of others. Property includes the Mental Health Services building, all contents in the building/grounds, and the Center vehicles. Rights of others include peers, staff, and community.
- Incoming calls for consumers are not accepted to protect confidentiality. Personal phone calls will be limited to 3 minutes. Do not intentionally listen to others' calls. Respect their privacy.
- Any inappropriate conduct including but not limited to violence, threats, cursing, screaming, physical aggression, or use of illicit drug and/or alcohol intoxication by either consumers or persons accompanying them may be reported to law enforcement, and will result in the termination of the appointment.
- In the event that the Center staff reasonably believe that you and/or your family member(s)or friend are a danger, physically or emotionally, to themselves or any other person, TCC may contact medical and law enforcement personnel, including, but not limited to: a general hospital, the local emergency room, a psychiatric hospital, the courts, a judge, protective agencies (Child Protective Services or Adult Protective Services), primary care physician, the police, emergency medical service (ambulance), and/or 911.

## INFORMATION FOR INDIVIDUALS TRANSPORTED BY CENTER STAFF

- Do not ask staff to drive you somewhere that has not been pre-approved. Transportation will only be authorized to transport consumers to medical appointments. The Transportation Supervisor or Program Manager must approve any exceptions.
- No eating or drinking on the vans, vehicles, or carpeted areas of Mental Health. No trash is to be left on the vans, vehicles, or TCC property TCC is not responsible for lost personal items.
- If weather conditions cause unsafe road conditions, skills training activities and transportation will be cancelled.
- While being transported, you must stay in your seat and keep your seat belt buckled until the van or vehicle comes to a complete stop. Do not distract the driver while they are transporting. Any violations of safety rules on the van or Center cars will result in a written incident report. If continued violations occur or consumer
- Refuses to comply with safety rules, the consumer may be suspended from being transported by MH staff.

Consumer's Name:_____ Case #:_____ MDCD#:_____ Date:_____

## INFORMATION PERTAINING TO INDIVIDUALS PARTICIPATING IN GROUP SKILLS TRAINING

- Those attending Group Skills Training are expected to stay until posted hours are over, unless there is an emergency. If you leave the Group Skills Training, you will need to advise Skills Training staff. If you leave against the advice of the staff there will be an incident report filed, and you may be in jeopardy of suspension.
- You are expected to stay awake during Skills Training activities.
- While attending activities at TCC, you must clean up after yourself in all areas
  TCC discourages borrowing, lending or giving of money or other items (such as cigarettes) at any time. When everyone contributes money for a group meal or goes out to eat, you may choose to bring your own food. Do not ask for food or money from others.
- If you are sick or have cold/flu like symptoms, do not come to Group Skills Training. If you have been ill for an extended time, or in the hospital, you will need a release from your doctor to return to Group Skills Training. If the hospital was Behavioral Health Center or North Texas State Hospital, you will need to attend your after care appointment with your case manager before returning.
- You are expected to wear modest attire with all undergarments to Skills Training activities. Examples of inappropriate clothing are short skirts, short dresses or short shorts; clothing that is tight or sheer; and clothing that is generally offensive to others. This applies to men and women.
- Proper hygiene will be maintained while participating in Skills Training activities or programs. Bathe daily before coming to the program. Offensive body odors may be cause for removal from skills training for the day. Mental Health staff may refuse to transport consumers with offensive body odor.

## AFTER-HOURS EMERGENCIES

Emergencies are urgent issues requiring immediate action. After hours, callers will reach an answering service; the on-call worker will return the call as soon as possible to provide crisis intervention services. A Qualified Mental Health Professional (QMHP) is on call when the Center's offices are closed, and can be reached twenty-four-hours, seven-days-per-week at the following number:

1-877-277-2226

For consumers who have a hearing impairment and need access to after-hours crisis services, they should first contact Relay Texas in order to facilitate communication between the consumer and the answering service at: 1-800-735-2989 (TDD/TT). The on-call staff will then call the individual back using Relay Texas to facilitate communication.

## CRITERIA FOR DISCHARGE

***Discharges from Mental Health Services may occur for any of the following reasons:***

- You and program staff mutually agree to the termination of services.
- You move outside of Grayson, Fannin, or Cooke counties.
- You achieve the outcomes on the Care Plan.
- You no longer meet the criteria for services, or the services are no longer medically necessary.
- You do not respond to treatment, and are not willing to participate in your treatment; whereas, a continuation of services could be interpreted as fraudulent, infringement of your rights, or unsafe conditions for staff.
- You are non-compliant with appointments. Non-compliance is defined as two consecutive cancellations, or four cancellations within 90 days, or two no shows within 90 days. Cancellations may be medically excused. No excuses accepted for no-shows.
- If the assigned Mental Health staff has not been able to contact you, or heard from you within 30 days.
- You are expected to follow the Mental Health Services Guidelines. Disruptive behavior will not be tolerated for the safety of other consumers. After reasonable effort is made to correct inappropriate conduct, you may be removed from the program for that day, and possibly suspended until the treatment team reviews the situation, or have services discontinued.

***You have the right to appeal a denial, termination or suspension of services. To appeal this decision, please contact the Human Rights Officer at: (903) 957-4874***

Consumer's Name:_____ Case #:_____ MDCD#:_____ Date:_____

**TREATMENT AGREEMENT INFORMATION**

- I agree that I will participate in the planning, care, assessment, evaluation, treatment, or other services that are considered medically necessary and advisable.
- I understand that the results of services including assessment, evaluation, treatment, or other service cannot be guaranteed as to result or cure and the results of any such services are largely dependent on my participation.
- I understand and agree to follow the treatment recommendations of TCC and its representatives once these have been agreed upon with TCC, its representatives, and me.
- I understand that I may refuse to receive treatment, or any portion of treatment, at TCC I also understand that the use of illicit drugs and/or alcohol may be dangerous for persons receiving medications, and consequently, the physician may refuse to prescribe for me under such circumstances. I further understand that I may be asked to obtain a drug test and results consistent with illicit drug or alcohol abuse or misuse may be grounds for the denial of medications.
- If services for my family member or me include medications, I understand I must take the medication(s) just as the physician has prescribed. I understand that I should not increase, decrease, stop, or otherwise alter medication(s) without consent from the prescribing physician.
- I understand that I should notify TCC or its representatives at least one week in advance if my family member(s) in services or I need a refill of the medication(s) prescribed by TCC's physician(s). I understand that if I fail to notify TCC or its representatives of this, I may be without medications for a brief period of time.
- I understand that I should notify TCC or its representatives, if I become pregnant, if symptoms become worse, if other concerns such as side effects, if suicidal or homicidal ideation or intent or plan is experienced, if I decide to seek treatment elsewhere, or if I am dissatisfied with services received from TCC.
- I understand that if I miss two scheduled Dr's appointments in a row, that I may have to go without my medications until I can get back in to see the Dr.
- I understand that if I have Medicaid, I would usually have to see the Dr. before I may obtain a prescription for a 90-day supply of medications.
- I specifically consent for the Center and its representatives to contact me by telephone and/or mail, including leaving a message via answering machine or voice mail.
- I understand I may bring a family member to my Dr.'s appointment or treatment planning appointment if I feel it would be helpful, or if the Center staff recommend such action, and I (or your LAR) am willing to sign releases of information for those persons, as long as their presence is not disruptive to my treatment.
- I understand that inappropriate behavior from either me or my friend or family member attending my appointment, such as: threatening, cursing or other behaviors that can be construed as disrespectful and hostile toward staff that are not due to mental illness will result in immediate termination of the appointment, and if necessary contacting the police.
- I give my permission for TEXOMA COMMUNITY CENTER to photograph any significant skin conditions (wounds, rashes, lesions, ulcers, etc) for the purposes of: assessment, diagnosis, monitoring progress of treatment. I am aware that these photographs will be uploaded into my electronic medical record.
- I give my permission for TEXOMA COMMUNITY CENTER to upload my profile photograph into my electronic medical record profile for identification purposes.

*By signing below, I certify that I understand and agree to the above information presented to me. I have been given ample opportunity to ask questions about any information that is unclear to me.* ***I have been offered a copy of this document.***

_____ _____

Consumer's or LAR's Signature Date

_____ _____

Staff's Signature Date

**Comments**:

**Level of Care Acknowledgement Consent**

Following enrollment in Mental Health services at Texoma Community Center, an individual will be enrolled into a Level of Care (LOC) Service Package. Below are the core services included for each level of care.

**Adult Mental Health Services** (Add-on services are available)

- LOC-1S: pharmacological management, skills training, and routine case management (1.3-2.25 monthly hours)
- LOC-2: pharmacological management; routine case management; counseling (3.25-5.5 monthly hours) (MDD diagnosis only)
- LOC-3: pharmacological management; individual or group psychosocial rehabilitative; supportive housing (5.87-20.35 monthly hours)
- LOC-4: pharmacological management; individual or group psychosocial rehabilitative; supportive housing or supported employment as needed (10-26.65 monthly hours)
- LOC-EO: Early onset psychosis: individual or group psychosocial rehabilitative services: supported employment and education services; peer support; family partner as needed (7.5-20.35 monthly hours)

For additional information, definitions, and clarification on Levels of Care, reference the Friends and Family Guide to Adult Mental Health included with the informational packet.

**Child and Adolescent Services** (Add-on services are available)

- LOC-1: medication management
- LOC-2: routine case management; skills training OR counseling
- LOC-3: routine case management; skills training and counseling
- LOC-4: Intensive case management, family partner support, skills training, and counseling
- YES Waiver: Intensive case management, routine case management, skills training, counseling, medication training and support, and pharmacological management
- LOC-YC: young child: routine case management, skills training, counseling
- LOC-EO: Early onset psychosis: individual or group psychosocial rehabilitative services: supported employment and education services; peer support; family partner as needed

For additional information, definitions and clarification on Levels of Care reference the Family Guide: Children's Mental Health Services included with the informational packet.

By signing below, I certify that I have read and understand the above information presented to me. I have been given ample opportunity to ask questions about any information that is unclear to me. I understand that this will also be reviewed each time a needs assessment is performed (ANSA or CANS).

_____ _____

Consumer or LAR signature Date

_____ _____

Staff Signature Date

Name: _____ _____ MDCD #: _____

TEXOMA COMMUNITY CENTER

# RECEIPT OF DOCUMENTS ACKNOWLEDGEMENT FORM

Date: _____

Please place your initials beside each document that you have signed and/or received a copy and explanation of. If the document listed is not applicable to you, please write N/A in the blank.

- [ ] Notice of Privacy Practices (Initially only, except if changes occur)
- [ ] Charges for Community Services Brochure
- [ ] Treatment Agreement and Center Information Form (Original to be filed in chart)
- [ ] Rights Booklet

*By signing this form, I (the undersigned consumer, child, adolescent, parent, and/or legally authorized representative) acknowledge and certify that I have been given a copy of each named document that I have placed my initials by, listed above. Further, I certify that I have read or have had each document read to me in my primary language and that I understand the terms and information contained therein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.*

| Signature of Consumer | Consumer Printed Name | Date |
|---|---|---|
| Signature of LAR (If applicable) | LAR Printed Name and relationship to Consumer | Date |

By signing below, I certify that I, and Texoma Community Center representative, have explained and provided a copy of the above listed documents to the consumer and/or LAR.

| Signature of Staff | Staff Printed Name & Credentials/Title | Date |
|---|---|---|

Name: _____ Case #:_____ MDCD#:_____

## Consent for Mode of Contact

We are pleased to provide individuals served with several options regarding how you may be contacted regarding services. Individuals in our services may be contacted via email, text, telephone, voicemail, and regular mail. Please let us know how we may contact you regarding appointment reminders, healthcare communications, and any other relevant Center information.

**I consent for Texoma Community Center (TCC) staff and/or contractors to contact me for appointment reminders, to obtain feedback regarding my experience with our services, and to provide general healthcare reminders and information.**

***Please initial*** **each of the following that apply:**

____ **I consent to receive text messages from TCC @ the number below.**

____ **I consent to receive voice messages from TCC @ the number(s) below.**

____ **I consent to receive e-mail from TCC at the email address below.**

____ **I consent to receive letters from TCC at my address of record.**

**Please provide us with the following information in order to contact you:**

**Home Phone:** _____ **Cell Phone:** _____

*By providing a telephone number and submitting this form you are consenting to be contacted by SMS. Message frequency varies. Message and data rates may apply. Reply STOP to opt out of further messaging. Reply HELP for more information. Refer to our Privacy Policy.*

**Email Address:** _____

## Consent for Telemedicine and Telehealth Services

To increase availability and access to Texoma Community Center Services, telehealth services are now available as appropriate.

____ **I consent to receive telehealth/telemedicine services for the purpose of assessing and treating my behavioral or physical health needs.**

- **I understand that this consent remains in effect unless I request a change or revoke this consent in writing.**
- **I understand that record of correspondence and services provided will become a part of my medical record kept by Texoma Community Center.**
- **I understand that electronic correspondence is not appropriate for emergencies or time-sensitive issues.**
- **I understand that I should not communicate personal or highly confidential information by email and that any email from Center that includes PHI will be encrypted.**
- **I understand that TCC can not guarantee the security and privacy of electronic communications.**
- **I authorize the release of any relevant medical information to the provider at TCC or their agents that is necessary to conduct these services.**

_____

**Signature of Individual/LAR** **Date**

_____

**Signature of Staff Witness** **Date**

***This Authorization is Hereby Revoked at my Request***

_____

**Signature of Individual/LAR** **Date**

_____

**Signature of Staff Witness** **Date**

Name: _____ _____ MDCD #: _____

TEXOMA COMMUNITY CENTER

# Review of Your Rights
# In Local Authority Programs

Date: _____

My signature below shows that the following statements are true:

- I have received a verbal explanation of my rights as a person receiving services from Texoma Community Center
- I have been given a copy of the rights booklet and its contents have been explained to me.
- I understand I have the right to participate in or refuse treatment.
- I understand my rights and know I can ask questions about my rights if I want to.

| | | |
|---|---|---|
| Client Signature | Client Printed Name | Date |
| Parent/Guardian/LAR Signature | Parent/Guardian/LAR Printed Name and Relationship to Client | Date |
| Staff's Signature Who Explained Rights | Staff Printed Name & Credentials/Title | Date |
| Third-Party Witness Signature(if applicable) | Third Party Witness Printed Name | Date |

**Comments**: