DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ACKNOWLEDGMENT AND CONSENT FOR TREATMENT

I am voluntarily applying for services at the Deschutes County Health Services (DCHS). I understand and agree that Deschutes County Health Services (DCHS) may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers, including other providers within DCHS, for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all ofmy health care;
- Perform various office, administrative, and business functions that support DCHS efforts to provide me with, and be reimbursed for, quality cost-effective health care; and
- Participate in the following as described in the Notice of Privacy Practices for Deschutes County Health Services;
    - Communicate with me through MyChart, an online secure patient portal.
    - As a member of the Reliance Community Health Information Exchange
    - Deschutes County Health Services is a member of an electronic health information exchange (HIE) called the OCHIN Collaborative. A purpose of this HIE is to allow health care providers to electronically share records regarding an individual. I understand and agree that DCHS may disclose any of my health information, including drug and alcohol treatment information protected by 42 CFR Part 2, to this HIE for the purpose of sharing the information with any individual or entity that has a treating provider relationship with me at the time he/she/it accesses the information. I understand that upon my written request, the HIE must provide me with a list of all entities to which my information has been disclosed within the past two years. The HIE would be responsible for responding to the request within 30 days.

I understand that my health information may include information both created and received by DCHS, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand that the health information used or disclosed may include vocational rehabilitation, alcohol and drug records, HIV/AIDS records, genetics information, and mental health or developmental disability records held by publicly funded providers. I understand that I may be offered telehealth/phone options for services, and if so, my provider will talk to me about whether this is appropriate for my services.

I understand that the Notice of Privacy Practices for Deschutes County Health Services may be revised from time to time and that I am entitled to receive a copy of any revised version. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices for Deschutes County Health Services in effect will be posted in the waiting / reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices for Deschutes County Health Services, and I understand that DCHS is not required by law to agree to such requests.

By signing below, I agree that I am requesting services from DCHS, have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices for Deschutes County Health Services.

Print Client's Name: _____ Client's Date of Birth: _____

Signature: _____ Date: _____

Client, guardian or authorized personal representative

Print Name if signed by someone other than client: _____

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION MRN _____

PATIENT INFORMATION

PLEASE PRINT: (Information about the individual seeking services) **DATE:**

Last Name	First Name	Middle Initial	DOB

Full Name at Birth	SSN

What is Individual's identified gender?

☐ Female ☐ Non-binary
☐ Male ☐ Genderqueer
☐ Transgender Female/Trans Woman ☐ Two Spirit
☐ Transgender Male/Trans Man ☐ Questioning
☐ Additional gender category/ (or Other), please specify: _____

What sex was assigned at birth on Individual's original birth certificate? ☐ Male ☐ Female ☐Intersex ☐ Choose not to disclose	Pronouns (She, He, They, Other): Preferred Name:

Contact information:

Privacy laws allow us to communicate with you using your preferred method, when reasonable. By completing this section, you are notifying DCHS of how you would like us to communicate with you, which can include information about your services. By selecting the methods listed below, you are agreeing to and accepting any liability involved.

Cell Phone: ☐ Individual's Phone ☐ Parent/Guardian's Phone	OK to text: ☐ Yes ☐ No OK to leave detailed voicemail: ☐ Yes ☐ No
Home Phone:	OK to leave detailed voicemail: ☐ Yes ☐ No
Other Phone:	OK to leave detailed voicemail: ☐ Yes ☐ No
Email Address: ☐ Individual's Email ☐ Parent/Guardian's Email	OK to send non-secure emails: ☐ Yes ☐ No

Street/Physical Address	City	State	Zip
Mailing/Secondary Address (if different)	City	State	Zip

County of Residence	Individual resides with: ☐ Living Alone Last: First: Relationship:

Reason For Seeking Services:

INDIVIDUAL NEEDS

Interpreter/Special Needs (Please mark all that apply):

☐ Hearing Impaired/Aid ☐ Reading/Literacy Aid ☐ None ☐Other_____
☐ Preferred language if other than English, please indicate: _____

Deschutes County encourages persons with disabilities to participate in all programs and activities. This location is accessible to people with disabilities. If you need accommodations to make participation possible, please call 541-322-7500.

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EMERGENCY CONTACT				
First and Last Name of Emergency Contact:				
Relationship	Address	City	State	Zip
*Emergency Information Can we leave a message (Please choose): ☐ Yes ☐ No **Phone #**_____				

Custody Attestation

For a child under the age of 14, please attest to one of the following below:
The adult person seeking to register the child for DCBH services is:_____.
This person is legally authorized to obtain medical and mental health services for the child because (select which option applies):

☐ The person is a legal parent of the child, and the person's parental rights regarding the child, including custodial rights, have not been restricted in any way.
☐ The person is a legal parent of the child and has been awarded legal custody of the child by court order.
☐ The person is not a legal parent of the child but has been awarded legal custody or guardianship of the child by court order or appointment.
☐ Other. If none of the above apply, but you believe you are authorized to obtain medical and/or mental health services for the child, please explain the basis for your belief:
_____

Should the accuracy of the above attestation be brought into question at any time in the future, or for any other reason, DCHS may demand legal documentation supporting such attestation.

MARITAL STATUS		
☐ Married	☐ Divorced	Name of spouse/partner (if applicable):
☐ Significant Other	☐ Domestic Partnership	
☐ Single	☐ Widowed	
☐ Legally Separated	☐ Other	

LIVING ARRANGEMENT

Please choose which best describes Individual's living situation:

☐ Homeless	☐ Foster Home	☐ Residential Facility/Group Home
☐ Jail	☐ Prison	☐ Room and Board
☐ Supportive Housing	☐ Supportive Housing (scattered site)	☐ Supportive Housing (Congregate Setting)
☐ Alcohol/Drug Free Housing	☐ Oxford Home	☐ Other Private Residence
☐ Private Residence (Home)	☐ Private Residence (relative)	☐ Private Residence (non-relative)
☐ Residential Facility (SUD)	☐ Residential Facility (BRS)	☐ Residential Facility (CSEC)
☐ Residential Facility (PRTS)	☐ Residential Facility (SCIP/SAIP)	☐ Residential Facility (SRTF for YAT)
☐ Unknown	☐ Secure Residential (SRTF Adult)	☐ Residential Sub-Acute Care Facility
☐ Residential Facility (RTH for YAT)		

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RACE AND ETHNICITY

Race/Ethnicity (Please mark all that apply):

☐ Alaska Native ☐ Black/African American ☐ American Indian ☐ Asian Indian
☐ Japanese ☐ Chinese ☐ Mexican ☐ Other Asian
☐ Filipino ☐ Samoan ☐ Korean ☐ Guamanian or Chamorro
☐ Native Hawaiian ☐ White/Caucasian ☐ Vietnamese ☐ Other Pacific Islander
☐ Mexican American ☐ Cuban ☐ Other ☐ Non-Hispanic or Latino/a
☐ Chicano/a ☐ Two or more races ☐ Puerto Rican ☐ Unknown
☐ Patient Refused ☐ Multiple Hispanic, Latino/a, or ☐ Single Race
☐ Another Hispanic Latino/a or Spanish Origin
Spanish Origins

Tribal Affiliations (Please mark all that apply):

☐ Burns Paiute Tribe ☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw
☐ Confederated Tribes of Grand Ronde ☐ Confederated Tribes of Siletz
☐ Confederated Tribes of the Umatilla ☐ Confederated Tribes of Warm Springs
☐ Coquille Indian Tribe ☐ Cow Creek Band of Umpqua Indians
☐ Klamath Tribes ☐ Not Applicable
☐ Other (Please describe):

LEGAL STATUS

Please choose which best describes Individual's situation:

☐ DUII Diversion Client ☐ DUII Convicted Client ☐ 30 Day Civil Commitment
☐ 90 Day Civil Commitment ☐ 180 Day Civil Commitment ☐ Incarcerated
☐ Parole ☐ Probation ☐ Psychiatric Services Review Board (PSRB)
☐ Juvenile PSRB ☐ Guardianship (Child Welfare) ☐ Guardianship (Court)
☐ Aid and Assist ☐ Involuntary Custody ☐ Pre-Arrest Jail Diversion
☐ Post-Arrest Jail Diversion ☐ Unknown ☐ None

EDUCATION

Check highest grade Individual completed:

☐K ☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐ 12/GED ☐AA/AS ☐BA/BS ☐MA/MS
☐PHD/PSYD/MD ☐College Courses Taken

OTHER INFORMATION

Referred by:

Is there Child Protective Services involvement? ☐ Yes ☐ No
Caseworker Name: Phone #:

Do you have a Declaration for Mental Health Treatment and/or an Advanced Directive? ☐ Yes ☐ No
If yes, please provide a copy to our staff.

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

FINANCIAL INFORMATION

The information on this form is used to determine eligibility for our sliding fee discount program.

HEALTH INSURANCE	
Name of Individual Seeking Services	Name of Responsible Party
Primary Health Insurance Plan ID #*(OHP, Medicare, etc.)	Policy Holder Name and DOB* (Required if not self)
Secondary Health Insurance Plan ID #	Policy Holder Name and DOB*(Required if not self)

EMPLOYMENT STATUS

Please choose the one that best describes Individual's employment status:

☐ Full Time ☐ Disabled ☐ Retired
☐ Part Time ☐ Homemaker ☐ Not in Labor Force
☐ Unemployed ☐ Student ☐ Other (Volunteer etc.)
☐ Hospital Patient, Incarcerated or Other Residential Institution ☐ Unknown
☐ Sheltered Employment (Opportunity Foundation, Good Will, etc.)

INCOME

The information on this form is used to determine eligibility for our sliding fee discount program

Monthly household income sources	Individual	Spouse	Parent(s)	Other	Total
Wages (salaries, tips, etc.)					
Public Assistance					
Retirement/Pension/SSI					
Disability/SSDI					
Other					
None: If no income to report, explain how you are supported:					

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FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS *The information on this form is used to determine eligibility for our sliding fee discount program*			
List number of household members living with Individual in each category			
Individual **1**	Spouse/Partner	Parent/Guardian	Dependents

- ❖ I confirm that the information shown is correct and I know proof is required for approval. Despite my insurance status or ability to provide proof, I am responsible for the balance on my account for any professional services delivered by DCBH. I approve the release of any medical and financial facts necessary to process insurance claims.
- ❖ I will notify DCBH promptly of any change to the above information.

Responsible Party Signature	Date

Please do not write in shaded boxes (**Staff use only**)

STAFF VERIFICATION CHECKLIST (attach copies)	
Proof of ID: Photo ID, Driver's License, Birth Certificate, Social Security Card	Sliding Fee amount: Effective Date:
Staff Signature Line-please sign after explaining financial and sliding fee scale to responsible party Signature:	Date of staff signature Expiration date