**Changes Counseling & Consultation, LLC**

**8221 S. 700 E. Sandy, UT 84070**

**Phone 801-542-7060 Texts/UA tests: 801-987-0225**

**info@changescounseling.org www.changescounseling.org**

 ***We Care***

# MEDICAID ONLY CLIENT INTAKE PACKET

***E-FORM TELETHERAPY VERSION***

\*In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand. {See additional information page 18.}

**Please click/tab on each box to enter text. All Information given below is Privacy Protected.**

Client’s Name *(Last, First, Middle)*:

* List any Maiden Names, Aliases, *Dos Apellidos*, etc.:       [ ]  Male *[ ]*  Female

Full Address:

Cell Phone:       Home Phone:       E-mail:

SSN:       Birth Date:       Age:       Ethnicity:

Driver’s License #:

Marital Status: *[ ]* Single *[ ]* Married *[ ]* Separated *[ ]* Divorced *[ ]* Other

Religious Affiliation *(Voluntary):*  Background:       Current:

Please tell us, Who Referred You to Changes?

**Medicaid Type for MENTAL HEALTH & SUBSTANCE USE insurers (NOT the “MEDICAL” insurer):**

Medicaid Type covering Mental Health and Substance:       ID#:       County:

Main Policy Holder Name:       DOB:       Phone:

**In Case of Emergency Contact (required by the State):**

Name:       Phone:       Relation to You:       Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY, PLEASE GO TO SOUTH PARKING LOT, USING EITHER LOWER OR UPPER LEVEL DOORS. DO NOT LEAVE GROUNDS SO WE KNOW YOU ARE NOT IN THE BUILDING! BY SIGNING, I AGREE I HAVE BEEN INSTRUCTED ON EMERGENCY PROCEDURES.

I agree to pay Changes Counseling & *Consultation*, LLC the stated amount for services at the beginning of each session or group. I agree that I am responsible for payment of all services provided including all broken appointment within 24 hours of appointment. I hereby authorize the clinician to furnish information to insurance carriers or the appropriate agency concerning my treatment. I further agree to pay all reasonable costs of collection, usually 40% of the balance, including attorney’s fees in the event any amounts billed or owing is not fully paid within 30 days. If required for any reason to make an appearance in court on my case I will be billed at the rate of $90.00 per hour for all time expended, including travel time. Optum Salt Lake County Medicaid members do not have to pay for covered services received when they have Medicaid.

|  |  |  |
| --- | --- | --- |
| Client E-Signature | Guardian Name/E-Signature (if under 18) | Date |

Updated 11/2023

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 **CONSENT FOR THE TWO-WAY RELEASE**

**OF CONFIDENTIAL INFORMATION**

**Client Name:**

**Please Note:** If your treatment is subject to supervision by a court, probation officer, or other supervising agency, you are required to provide proof of ongoing compliance to that agency. **Unless you specify otherwise below**, signing this document authorizes communication regarding your compliance between Changes Counseling, LLC. and your reporting agency (if any). As needed, this may include the sharing of HIPAA-protected information with your Medicaid Administrative Network provider, such as: Molina, Optum, Healthy U of U, Health Choice Steward, Select Health , Medicaid Fee-for-Service, or TAM.

*[ ]  (Check this only if you’re sure): I* ***do not*** authorize communication with my court, probation officer, or reporting agency (if any).

*[ ]  (Check this only if you’re sure):* I want my evaluation sent **only** to my attorney, or other (please specify: ).

**(PLEASE LIST EVERYONE WHO NEEDS TO KNOW YOU CAME!** *(List fax/email if possible)*

|  |  |  |
| --- | --- | --- |
| **Court:**  | **Fax/Email:**  | **Phone:**  |
| * Case Number(s), if applicable:
 |
| **P.O./Agency:** | **Fax/Email:** | **Phone:** |
| **Attorney:** | **Fax/Email:** | **Phone:** |
| **Spouse/Family:** | **Fax/Email:** | **Phone:** |
| **Do you /your child have a Doctor? Yes / No** **May we contact him/her? Yes / No** **If so, Name please:** | **Fax/Email:** | **Phone:** |

**The information I authorize to be disclosed is (check applicable items):**

**☒** Evaluation results, treatment recommendation, treatment summaries, progress reports, notice of completion/non-compliance;

**☒ MEDICAID CLIENTS:** I acknowledge and consent to the sharing of relevant information between Changes Counseling and my Medicaid provider, including: evaluations, progress notes, Outcome Questionnaire (OQ-30/OQ45.2) results, etc.

 ***OR:*** *[ ]* OTHER/I ***do not*** consent for certain information to be shared with the Medicaid Administrative Network Provider:

*(Please Specify):*

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 C.F.R. Pts 160 & 164, and any alcohol and/or drug treatment records are protected under the federal regulations governing of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that my treatment records cannot be disclosed without my written consent unless otherwise provided for in the regulations; and that I may revoke this consent with **written** notice.

**IF YOU WANT TO LIMIT HOW LONG WE CAN RE-VERIFY (TO THOSE NAMED ABOVE) THAT YOU ATTENDED:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Six months following the discharge date from **Changes Counseling & Consultation, LLC.,**
 | *OR* | * Six months following a formal and effective release from confinement, probation, parole or other proceeding under which I was mandated to attend treatment.
 | ***OR*** | * The      th day of

 Year       |

**I have read the above, understand it and hereby give my consent to the above-mentioned disclosure.**

|  |  |  |
| --- | --- | --- |
| Client E-Signature | Guardian Name/E-Signature (if under 18) | Date |

Updated 11/2023

****

**Please Tell Us a little About Yourself!**

1. **Strengths and Talents:** What do people say you’re good at? What are some of your strengths, personal characteristics, abilities, or skills that help you in life? Don’t be shy…this is private, and you’re smarter and better than you might think! Whatever comes to mind please… try to think of at least three. Thanks! **🙂**

I am strong at…

I’mgood at…

I can do…

Friends say I…

1. **What’s Troubling You please? Would you tell us what happened that brings you to Changes today?**       **(If for a Court case, please tell us about it:**

What would you like to change in your life or yourself during therapy? Your wants are important and are used to help you create your treatment plan.

1. “I would like this to happen…

2. “I would also like…

3. What will show that your therapy is complete? (When you’re done, what will be different from now?)

1. **Family:** *(Check one):* [ ]  Spouse/ [ ]  Significant Other Age:       Occupation:

Children: 1) [ ]  M [ ]  F       Age:       2) [ ]  M [ ]  F       Age:

3) [ ]  M [ ]  F       Age:       4) [ ]  M [ ]  F       Age:       More?

1. **Support System:** Whom do you talk to about your problems?
2. **Childhood:** What is your birth order (first born, second born, third born, etc…)?

How many brothers and sisters do you have?      brothers      sisters

Did your parents divorce? (check one) [ ] NO [ ] YES If YES, how old were you?

Briefly describe your childhood and the environment in which you grew up:

1. **Recreation:** What do you like to do for fun, relaxation, or hobbies?
2. **Education/Employment:**

Level of Education: [ ]  Before H.S. [ ]  H.S. or GED [ ]  Some College [ ]  Associates [ ]  Grad [ ]  Post-Grad

Employed? (Y / N) Occupation:       Employed by?

Work Address:

Work Phone:       Number of Years with this Employer:

1. **Previous Treatment:** Please list any previous **substance abuse and mental health treatment**. If possible, please include previous treatment dates, clinician identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.

|  |  |  |
| --- | --- | --- |
| **When** | **Where** | **Purpose of Treatment** |
|       |       |       |
|       |       |       |
|       |       |       |

1. **Medical History:** Please list any **current or past medical problems**: If possible, Medicaid asks you to please include previous treatment dates, clinician identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports:
2. **Medications:**  Please list any medications you are currently taking (and their purpose):
3. **Please List Any Allergies: Medicines?**       **Foods?**       **Other?** (chemicals, animals, etc.)
4. **Family Mental Health History:** Has anyone in your family (father, mother, brothers, sisters, aunts, uncles, or grandparents) had substance abuse, depression, anxiety, bipolar, schizophrenia, or other disorder? (Please circle.) If yes, who was it and what did they have?       *If possible, please include previous treatment dates, clinician identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.*
5. **Family Medical History:** Has anyone in your family (father, mother, brothers, sisters, aunts, uncles, or grandparents) had MEDICAL problems? If yes, who, and what was the illness please?
6. **Legal:** Please list any legal problems, current or previous.

|  |  |
| --- | --- |
| **Date** | **Offense** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

1. ***For Adults****:* The Psychiatric Advance Directive (PAD) will be explained by the intake Therapist.
2. ***For Adolescents:*** Sexual activity **is** [ ]  – or – **is not** [ ]  part of my life. – or – [ ]  Skip this question.

Would you like to address any issues with your counselor? [ ]  YES [ ]  MAYBE [ ]  NO THANKS

Sexual behavioral history:

1. **Substance Use History: *(Please Be Honest!)***

If you were to drug test right now, what substances would show up? Substance/Last Use:

*Please indicate below the first time, last time, and how much you use each of the substances below. Cross out (put NA for) any substances which you have never used:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Age First Use** | **Last Use Date** | How Much Used? | **How Often Used?**  |
| Alcohol |       |       |       |       |
| Methamphetamine |       |       |       |       |
| Marijuana |       |       |       |       |
| Prescriptions Overused |       |       |       |       |
| Prescription Drugs (Not Yours) |       |       |       |       |
| Cocaine |       |       |       |       |
| Heroin |       |       |       |       |
| Hallucinogens |       |       |       |       |
| PCP |       |       |       |       |
| Ecstasy |       |       |       |       |
| Inhalants |       |       |       |       |
| Tobacco/Nicotine Vape |       |       |       |       |

**FREE Smoking Cessation!** IMPORTANT NOTICE! If you smoke and would like to quit, here’s Great News!

**IF YOU SMOKE or VAPE, would you like to quit free?** 🞏 YES 🞏 NO 🞏 NA

If you’re interested, here’s is the Utah “Way to Quit” program referral and information.

Website: **https://waytoquit.org/** - OR - **1-800-QUIT-NOW (800-784-8669)**

Also Utah Tobacco Prevention & Control Program <https://tobaccofree.utah.gov/> 801-538-6754

Note: Optum clients receive substance use therapy from Salt Lake County Substance Use-subsidized providers.

1. A Medicaid Booklet will be provided and discussed at your first session, regarding how to Receive Services, Access Emergency Services, Arrange Transportation, Quit Smoking Services, and How to Choose a Provider.

1. ***For Children/Adolescent Clients:*** Medicaid requests documented “information on any prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic).” What prenatal and perinatal (a number of weeks immediately before and after birth) events occurred in your child’s life?
2. ***For Child Clients*:** Child’s Developmental History:

**Physical:** [ ]  Normal? [ ]  Delayed? If Problems, Please describe:

**Psychological:** [ ]  Normal? [ ]  Delayed? If Problems, Please describe:

**Social:** [ ]  Normal? [ ]  Delayed? If Problems, Please describe:

**Intellectual:** [ ]  Normal? [ ]  Delayed? If Problems, Please describe:

**Academic:** [ ]  Normal? [ ]  Delayed? If Problems, Please describe:

# Thank You!

 *{* ***The section below is for staff use only – please skip to the following page.}***

**FOR THERAPIST**:

* ***Was the (C-SSRS) SI Screen Administered during first session?*** [ ]  YES [ ]  NO

 Results are: [ ]  NEGATIVE, NO SI REPORTED. *Give to administration for recording.*

 [ ]  POSITIVE – DO SAFETY PLAN TODAY. *Give to administration for recording.*

* + - *IF POSITIVE, FOLLOW UP EVERY SESSION.*
* ***Was the OQ/YOQ & ParentYOQ administered during first session?*** [ ]  YES [ ]  NO

OQ/YOQ & ParentYOQ last given date:

Next due date, under 30 days:

Results discussed with Client or Parent? [ ]  YES [ ]  NO

Feedback?      **BURNS ANXIETY INVENTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Instructions:** Put a check to indicate how much you have experienced each symptom **during the past week, including today**. Please answer all 25 items. | **0=Not At All** | **1=Somewhat** | **2=Moderately** | **3=A Lot** |
| **Category** **I:** **Anxious** **Feelings** |
| 1 |  Anxiety, nervousness, worry or fear | [ ]  | [ ]  | [ ]  | [ ]  |
| 2 |  Feeling that things around you are strange or unreal | [ ]  | [ ]  | [ ]  | [ ]  |
| 3 |  Feeling detached from all or part of your body | [ ]  | [ ]  | [ ]  | [ ]  |
| 4 |  Sudden unexpected panic spells | [ ]  | [ ]  | [ ]  | [ ]  |
| 5 |  Apprehension or a sense of impending doom | [ ]  | [ ]  | [ ]  | [ ]  |
| 6 |  Feeling tense, stressed, “uptight” or on edge | [ ]  | [ ]  | [ ]  | [ ]  |
| **Category** **II:** **Anxious** **Thoughts** |
| 7 |  Difficulty concentrating | [ ]  | [ ]  | [ ]  | [ ]  |
| 8 |  Racing thoughts | [ ]  | [ ]  | [ ]  | [ ]  |
| 9 |  Frightening thoughts | [ ]  | [ ]  | [ ]  | [ ]  |
| 10 |  Feeling that you’re on the verge of losing control | [ ]  | [ ]  | [ ]  | [ ]  |
| 11 |  Fears of cracking up or going crazy | [ ]  | [ ]  | [ ]  | [ ]  |
| 12 |  Fears of fainting or passing out | [ ]  | [ ]  | [ ]  | [ ]  |
| 13 |  Fears of physical illnesses or heart attacks or dying | [ ]  | [ ]  | [ ]  | [ ]  |
| 14 |  Concerns about looking foolish or inadequate | [ ]  | [ ]  | [ ]  | [ ]  |
| 15 |  Fears of being alone, isolated, or abandoned | [ ]  | [ ]  | [ ]  | [ ]  |
| 16 |  Fears of criticism or disapproval | [ ]  | [ ]  | [ ]  | [ ]  |
| 17 |  Fears that something terrible is about to happen | [ ]  | [ ]  | [ ]  | [ ]  |
| **Category** **III:** **Physical** **Symptoms** |
| 18 |  Skipping, racing or pounding of the heart (palpitations) | [ ]  | [ ]  | [ ]  | [ ]  |
| 19 |  Pain, pressure, or tightness in chest | [ ]  | [ ]  | [ ]  | [ ]  |
| 20 |  Tingling or numbness of toes and fingers | [ ]  | [ ]  | [ ]  | [ ]  |
| 21 |  Butterflies or discomfort in the stomach | [ ]  | [ ]  | [ ]  | [ ]  |
| 22 |  Constipation or diarrhea | [ ]  | [ ]  | [ ]  | [ ]  |
| 23 |  Restlessness or jumpiness | [ ]  | [ ]  | [ ]  | [ ]  |
| 24 |  Tight, tense muscles | [ ]  | [ ]  | [ ]  | [ ]  |
| 25 |  Sweating not brought on by heat | [ ]  | [ ]  | [ ]  | [ ]  |
| 26 |  A lump in the throat | [ ]  | [ ]  | [ ]  | [ ]  |
| 27 |  Trembling or shaking | [ ]  | [ ]  | [ ]  | [ ]  |
| 28 |  Rubbery or “jelly” legs | [ ]  | [ ]  | [ ]  | [ ]  |
| 29 |  Feeling dizzy, lightheaded or off balance | [ ]  | [ ]  | [ ]  | [ ]  |
| 30 |  Choking or smothering sensations or difficulty breathing | [ ]  | [ ]  | [ ]  | [ ]  |
| 31 |  Headaches or pains in the neck or back | [ ]  | [ ]  | [ ]  | [ ]  |
| 32 |  Hot flashes or cold chills | [ ]  | [ ]  | [ ]  | [ ]  |
| 33 | Feeling tired, weak, or easily exhausted | [ ]  | [ ]  | [ ]  | [ ]  |
|  **STAFF USE ONLY**  | **TOTAL SCORE:** |
| **TOTAL SCORE DEGREE OF ANXIETY** | **TOTAL SCORE DEGREE OF ANXIETY** |
| [ ]  0-4 Minimal or No Anxiety [ ]  5-10 Borderline Anxiety[ ]  11-20 Mild Anxiety 5-10 | [ ]  21-30 Moderate Anxiety [ ]  31-50 Severe Anxiety[ ]  51-99 Extreme Anxiety/Panic |

**Burn’s Depression Checklist**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Instructions:** Put a check to indicate how much you have experienced each symptom **during the past week, including today**. Please answer all 25 items. | **0 = Not At All** | **1 = Somewhat** | **2 = Moderately** | **3 = A Lot** | **4 = Extremely** |
| **Thoughts and Feelings** |
| 1 | Feeling sad or down in the dumps | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 2 | Feeling unhappy or blue | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 3 | Crying spells or tearfulness | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 4 | Feeling discouraged | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 5 | Feeling hopeless | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6 | Low self-esteem  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7 | Feeling worthless or inadequate | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8 | Guilt or shame | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9 | Criticizing yourself or blaming others | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10 | Difficulty making decisions | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Activities and Personal Relationships** |
| 11 | Loss of interest in family, friends or colleagues | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 12 | Loneliness | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13 | Spending less time with family or friends | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 14 | Loss of motivation | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 15 | Loss of interest in work or other activities | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 16 | Avoiding work or other activities | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 17 | Loss of pleasure or satisfaction in life | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Physical Symptoms** |
| 18 | Feeling tired | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 19 | Difficulty sleeping or sleeping too much | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 20 | Decreased or increased appetite | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 21 | Loss of interest in sex | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 22 | Worrying about your health | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Suicidal Urges** |
| 23 | Do you have any suicidal thoughts? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 24 | Would you like to end your life? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 25 | Do you have a plan for harming yourself? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **STAFF USE ONLY** | **TOTAL SCORE:**  |
| **TOTAL SCORE** | **LEVEL OF DEPRESSION** |
| No Depression | [ ]  0 – 5  |
| Normal but unhappy | [ ]  6 – 10  |
| Mild depression | [ ]  11 – 25  |
| Moderate depression | [ ]  26 – 50  |
| Severe depression | [ ]  51 –75  |
| Extreme depression | [ ]  76 – 100  |

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**MICHIGAN ALCOHOL SCREENING TEST (MAST-24)**

*Please select honestly the answer that most accurately applies to you* ***over the past few years****, even if you have recently quit drinking. Thank you!*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | YES | NO | Points |
| 1 | Do you feel you are a normal drinker? (“normal”= drink as much or less than most people)? | [ ]  | [ ]   | \*(2) |
| 2 | Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening? If yes, how long ago?       | [ ]  | [ ]  | (2) |
| 3 | Does your significant other, a parent, or other near relative ever complain about your drinking? | [ ]  | [ ]  | (1) |
| 4 | Can you stop drinking without a struggle after one or two drinks? | [ ]  | [ ]   | \*(2) |
| 5 | Do you ever feel guilty about your drinking? | [ ]  | [ ]  | (1) |
| 6 | Do friends or relatives think you are a normal drinker? | [ ]  | [ ]   | \*(2) |
| 7 | Are you able to stop drinking when you want to? | [ ]  | [ ]   | \*(2) |
| 8 | Have you ever attended a support groupbecause of *drinking?* | [ ]  | [ ]  | (5) |
| 9 | Have you gotten into physical fights when drinking? | [ ]  | [ ]  | (1) |
| 10 | Has your drinking ever created a problem between you and your significant other, a parent, or another relative? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 11 | Has your significant other ever gone to anyone for help about your drinking? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 12 | Have you ever lost friends because of your drinking? | [ ]  | [ ]  | (2) |
| 13 | Have you ever gotten into trouble at work or school because of drinking? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 14 | Have you ever lost a job because of drinking? | [ ]  | [ ]  | (2) |
| 15 | Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 16 | Do you drink before noon fairly often? | [ ]  | [ ]  | (1) |
| 17 | Have you ever been told you have liver trouble? Cirrhosis? | [ ]  | [ ]  | (2) |
| 18 | After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 19 | Have you ever gone to anyone for help about your drinking? If yes, when?        | [ ]  | [ ]  | (5) |
| 20 | Have you ever been in a hospital because of your drinking? If yes, when?       | [ ]  | [ ]  | (5) |
| 21 | Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 22 | Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem? If yes, how long ago?        | [ ]  | [ ]  | (2) |
| 23 | \*\*Have you ever been *charged* or arrested for any alcohol-related driving charge? If YES, how many times?       | [ ]  | [ ]  | \*\*(2) |
| 24 | \*\*Have you ever been *charged* or arrested for any other alcohol-related charge (Minor in Possession/Intoxication, etc.)? If YES, how many times?        | [ ]  | [ ]  | \*\*(2) |
| STAFF USE ONLY | TOTAL SCORE:        |
| *SCORING: (\*) Negative response meets criteria. Add up total number of points to determine client score.* *(\*\*) Each arrest is worth 2 points. Questionnaire adapted from MAST (M.L. Selzer, 1971).* |
| SCORE | Severity | Intervention Indicated |
|

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  0 – 3  | Minimal or No Drinking Problem |  [ ]  Minimal or None  |  |
| [ ]  3 – 4  | Mild Drinking Problem  |  [ ]  Brief Intervention  |  |
| [ ]  5 – 10  | Problem Drinker: Intermediate  |  [ ]  Outpatient (Intensive) |  |
| [ ]  11 – 15  | Problem Drinker: Substantial  |  [ ]  Intensive  |  |
| [ ]  16 – 20  | Severe  |  [ ]  Intensive  |  |

 |

*Questionnaire adapted from MAST (M.L. Selzer, 1971).*

**DRUG ABUSE SCREENING TEST (DAST - 20)**

*Please select honestly the answer which most applies to you* ***over the past few years,*** *even if you have recently quit using.*

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| 1 | Have you used drugs other than those required for medical reasons? If yes, when/what was your last use?        | [ ]  | [ ]  |
| 2 | Have you abused prescription drugs? If yes, when/what was your last use?        | [ ]  | [ ]  |
| 3 | Do you abuse more than one drug at a time? | [ ]  | [ ]  |
| 4 | Can you get through the week without using drugs (other than those prescribed for medical reasons)? | [ ]  | [ ]  |
| 5 | Are you always able to stop using drugs when you want to? | [ ]  | [ ]  |
| 6 | Have you had “blackouts” or “flashbacks” as a result of drug use? If yes, how long ago?        | [ ]  | [ ]  |
| 7 | Do you ever feel bad or guilty about your drug use? | [ ]  | [ ]  |
| 8 | Does your spouse (or parents) ever complain about your involvement with drugs? | [ ]  | [ ]  |
| 9 | Has drug abuse created problems between you and your spouse or your parents? If yes, how long ago?        | [ ]  | [ ]  |
| 10 | Have you lost friends because of your use of drugs? | [ ]  | [ ]  |
| 11 | Have you neglected your family because of your use of drugs? If yes, how long ago?        | [ ]  | [ ]  |
| 12 | Have you been in trouble at work (or school) because of drug abuse? If yes, how long ago?        | [ ]  | [ ]  |
| 13 | Have you lost your job because of drug abuse? If yes, how long ago?        | [ ]  | [ ]  |
| 14 | Have you gotten into fights when under the influence of drugs? If yes, how long ago?        | [ ]  | [ ]  |
| 15 | Have you engaged in illegal activities in order to obtain drugs? If yes, how long ago?        | [ ]  | [ ]  |
| 16 | Have you been arrested for possession of illegal drugs? If yes, how long ago?        | [ ]  | [ ]  |
| 17 | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? If yes, how long ago?        | [ ]  | [ ]  |
| 18 | Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsions, bleeding, etc.). If yes, how long ago?        | [ ]  | [ ]  |
| 19 | Have you gone to anyone for help for a drug problem? If yes, how long ago?        | [ ]  | [ ]  |
| 20 | Have you been involved in a treatment program specifically related to drug use? If yes, how long ago?        | [ ]  | [ ]  |
| STAFF USE  | TOTAL SCORE:        |
| *SCORING: \*Negative response meets criteria. Add up total number of points to determine client score.* |
| TOTAL SCORE | Severity | Intervention Indicated |
|

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  0  | N/A  | [ ]  N/A [ ]  Brief Intervention [ ]  Outpatient (Intensive)[ ]  Intensive [ ]  Intensive  |  |
| [ ]  1 – 5  | Low  |  |
| [ ]  6 – 10  | Intermediate  |  |
| [ ]  11-15  | Substantial  |  |
| [ ]  16-20  | Severe  |  |

 |

|  |
| --- |
| *Adopted or excerpted from materials provided by Dr. Harvey Skinner (January 5, 2009).* |

**POST-TRAMATIC STRESS QUESTIONAIRE (PCL-5)**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Instructions:** ***If your reason for coming to counseling is not related to or influenced by an emotional trauma please check here:*** [ ] **NA**; **then skip this page.** Qualifying traumas involve exposure to actual or threatened death, serious injury, or sexual violence, etc. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month (or so). | 0 = Not At All | 1 = Somewhat | *2 = Moderately* | *3 = A Lot* | *4 = Extremely* |
| **In the past month, how much were you bothered by:** |
| **Section 1: Intrusion Symptoms** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Repeated, disturbing, and unwanted memories of the stressful experience?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Repeated, disturbing dreams of the stressful experience?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there re-living it)?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling very upset when something reminded you of the stressful experience?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Section 2: Avoidance Symptoms** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Avoiding memories, thoughts, or feelings related to the stressful experience?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Section 3: Cognition & Mood Change** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble remembering important parts of the stressful experience?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Blaming yourself or someone else for the stressful experience or what happened after it?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Loss of interest in activities that you used to enjoy?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling distant or cut off from other people?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Section 4: Arousal & Reactivity** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Irritable behavior, angry outbursts, or acting aggressively?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Taking too many risks or doing things that could cause you harm?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Being “super-alert” or watchful or on guard?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling jumpy or easily startled?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Having difficulty concentrating? S
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble falling or staying asleep?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **STAFF USE ONLY** |
|  | **Sub-score** |  | **DSM-5 CATEGORIES** |
| **Section 1:** at least one response ≥ *Moderately* |        |  |  **Mild** |  **0-20** [ ]  |
| **Section 2:** at least one response ≥ *Moderately* |        |  |  **Moderate** |  **20-40** [ ]  |
| **Section 3:** at least two responses ≥ *Moderately* |        |  |  **Severe** |  **40-60** [ ]  |
| **Section 4:** at least two responses ≥ *Moderately* |        |  |  **Extreme** |  **60-80** [ ]  |
|  **Total Score:**        |  |  **DSM-V Designation:**        |

***Are you coming due to a Court case, probation/parole, investigation by police, DOPL, DCFS, DOT, etc.?***

[ ] **NO** [ ] **YES <IF** [ ] **NO , PLEASE SKIP TO THE NEXT PAGE>**

Name:  Date:

LSI-R SCORING

*(Staff Use)*

1)Adult Priors

 0 1 OMIT

2)Minor Arrests

 0 1 OMIT

3)Employment

 0 1 OMIT

4)Criminal Sociality

 0 1 OMIT

5)Substances

 0 1 OMIT

6)Psych. Assessment

 0 1 OMIT

7)Parental Figure(s)

 1 1 0 0 OMIT

8) Criminal Attitudes

 1 1 0 0 OMIT

**LSI-R:SV**

**TOTAL SCORE:**

Follow-up Needs

|  |  |
| --- | --- |
| 0-2 | Minimal |
| 3-5 | Recommended |
| 6-8 | Mandatory |

1) Have you had any prior adult convictions? [ ] **NO** [ ] **YES HOW MANY? \_\_\_\_**[ ] **NA**

2) Were you ever arrested (or ticketed) under the age of 16? [ ] **NO** [ ] **YES**

3) Are you currently unemployed, with no job waiting? [ ] **NO** [ ] **YES**

4) Are many of your friends involved in criminal activity/have criminal records? [ ] **NO** [ ] **YES**

5) Do you feel you have an alcohol problem? [ ] **NO** [ ] **YES**

 How much/how often do you currently drink?

 In the past year, has alcohol use caused problems at work/school? [ ] **NO** [ ] **YES**

 If so, how?

 Do you feel you have a drug problem? [ ] **NO** [ ] **YES**

 Drugs used in the past year? [ ] **NO** [ ] **YES**

 In the past year, has drug use caused problems at work/school? [ ] **NO** [ ] **YES**

 If so, how?

6) Psychological factors which may have impact on getting effective treatment, or which may

 require additional assessment *(therapist may also circle/list any such factors observed).*

 Mark any which apply:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Intellectual Disability  | ☐ School/Work Potential  | [ ]  Depression/Self Image  | [ ]  Hostility/Aggression |
| [ ]  Social Skills  | [ ]  Impulse Control  | [ ]  Withdrawal/Delusions | [ ]  Lack of Empathy/Guilt |
| [ ]  Thinking Errors | [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

7) How would you rate your relationship with your **current** parent(s)/parental figure? (Are they

helpful with problems you may have? Do you argue with them? Do you see them often?) . Circle:

 **0 1 2 3**

**Hostile/Uncaring/All deceased?........................……………………....Affectionate/Loving**

8) *(If applicable)* How do you feel about the crime(s) you’ve committed/been charged with? Do you feel it was justified? Do you think it was wrong? Do you feel sympathy for the victims of your crimes (if any)? Do you fully accept responsibility for your actions and their consequences?

**0 1 2 3**

**It Was Justified/Not My Fault……………………………………..I Feel Bad/Accept Responsibility**

What, if any, special circumstances justify your actions? Please explain:

*Additional Therapist Observations:*

SPECIAL INFORMATION REGARDING TELE-THERAPY, HIPAA COMPLIANCE, & E-SIGNATURES

During the Covid-19 pandemic, or in the case of tele-therapy, providing physical signatures for legal/medical documents was not be feasible, requiring the use of E-signatures instead. Be advised that if a document requires multiple witnesses to be legally binding (such as a Psychiatric Advance Directive or PAD), some Courts may not uphold its validity. By signing your name in the signature boxes contained in this document, you acknowledge the following:

1) that you are the person of record or are authorized to act on their behalf;

2) that you consent to and authorize the use of electronic records and electronic signatures, and waive the use of cryptographically-based, digital signatures;

3) that you have the right to obtain a paper copy of such records, and the right to withdraw consent, except as otherwise stipulated in the present document;

4) that your electronic documentation remains confidential under HIPAA standards, as outlined at: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>.

For more information on electronic signatures, and consumer consent disclosures, please reference the Uniform Electronic Transactions Act, as outlined in Utah Code at: <https://le.utah.gov/xcode/Title46/Chapter4/C46-4_1800010118000101.pdf>. You may also reference the Electronic Signatures in Global and National Commerce Act (E-Sign Act), at: <https://www.fdic.gov/regulations/compliance/manual/10/x-3.1.pdf>}.

**Changes Counseling**

**& Consultation, LLC**

**8221 S. 700 E. Sandy UT 84070**

**English/Spanish Telephone: 801-542-7060 \* Fax: 801-542-7061**

**Consent to Treatment**

I acknowledge that I have received, have read (or have had read to me), and understand the information about the therapy I am considering. I have had all my questions answered fully.

 I do hereby seek and consent to take part in the treatment provided by this agency. I

understand that developing a treatment plan and regularly reviewing the work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

 I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this agency and/or therapist at this agency.

 I am aware that I may stop my treatment at this agency at any time. The only thing I will still be responsible for is paying for the services I have already received or for missed appointments that I have not cancelled within 24 hours in advance. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will answer to the court.)

 If a Medicaid member, I will not be billed for covered services or costs. Non-covered services such as drug/alcohol tests, the Prime for Life program, workbooks, or other specialty services are mine to pay.

 I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I also know that sometimes seminars require a non-refundable deposit, in order to schedule it with enough clients to offer it. The deposit pays for part of the normal cost of the seminar, or helps pay for the Therapist, if the client cannot come, so that the seminar can be held for the other clients attending.

 I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost, date(s), and providers of any services or treatment I receive. I understand that I will be responsible for the cost of all services provided. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

 My signature below shows that I understand and agree with all of these statements***. In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand.***

Signature of Client Printed Name Date

 I, the therapist, have discussed the issues above with the client (and/or his or parent, guardian or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist Date

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**Program Expectations Agreement**

**In the event that I do agree to participate in treatment, I agree to the following:**

* I agree to fully participate in treatment and will not be disruptive or threatening in any way. I will not leave the class during session.
* I agree to pay at the beginning of each class or individual session. I agree to pay the fees for each scheduled group whether or not I am in attendance. I understand that once I am enrolled in a class,

**I am responsible to attend and pay for each class.** This arrangement does not apply to the Prime for Life program. Prime classes must be attended consecutively, without interruption, or I will need to repeat the entire series.

* **Involuntary Termination** from my program may result if I fail to attend group sessions or contact Changes during any 30 day period. Upon Involuntary Termination, my file may be closed and I may be required to be re-evaluated, at my own expense, and pay any outstanding balance before being readmitted to the program. I understand that, upon Involuntary Termination, I may be required to start my program over.
* I agree to **arrive 5-10 minutes early** in order to check in, pay for class and be in class on time. I agree that, if I am more than 5 minutes late for class, I may not receive credit for that particular class even if I attend the class. If, for any reason, I do not think I will be able to attend a session, I will contact my instructor/therapist in advance and make arrangements for making up the class in order to prevent a non-compliance letter from being sent to my judge, probation/parole officer or attorney.
* I agree to check in with the receptionist and **print my name** on and **sign** the sign-in sheet to receive credit for attendance. My name must be written legibly in order to receive credit for the class.
* I agree to **complete all homework assignments** and bring them to the next class. Homework will be due at the beginning of each class. If my homework is not completed and ready at the beginning of class, I will not receive credit for the class.
* I agree to keep the names and information revealed by other clients **confidential.**
* I understand that I am expected **to be free from the influences of any drugs and/or alcohol** at the time of my session. If I am under the influence of any substance, I am expected to report this to my instructor/therapist. I understand that I may not be allowed to participate in that particular session. If I am suspected of being under the influence of alcohol, I agree to submit to a Breathalyzer Alcohol Detector.
* I agree to **refrain from any and all violent or threatening behavior** while on the premises.Such behavior may result in my being asked to leave the premises and/or being arrested.
* I will not bring drinks (other than water) or food into the meeting rooms and understand that **smoking is not permitted** inside the building.
* In the event my instructor/therapist is absent due to vacation or emergency, I understand that a qualified replacement will conduct the sessions as necessary.

E-Signature Date

**Client Bill Of Rights**

As a client of Changes, Counseling & Consultation, LLC the following are among your rights:

* To have all personal information regarding your treatment to be kept private, except to those parties you designate.
* To know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
* To receive respectful treatment that will be helpful to you.
* To received treatment without discrimination or harassment and to be treated with dignity.
* To be provided a safe environment, free from sexual, physical or emotional abuse.
* To be advised of changes’ policy regarding your rights to privacy (See HIPPA Notification).
* To report unethical and/or illegal behavior by a therapist.
* To ask questions about your therapy.
* To request and receive information about the therapist’s professional capabilities, including licensure, education, training, experience, professional association memberships, specialization and limitations.
* To have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in case of emergency or vacations) and cancellation policies.
* To refuse electronic recording; and I may request it if I wish.
* To refuse to answer any questions or disclosed any information I choose not to reveal.
* To know if there are supervisors, consultants, students, etc. with whom my therapist will discuss my case.
* To request and, in most cases, receive a summary of my file, including the diagnosis, my progress and the type of treatments.
* To request a copy of my file to any therapist or agency I choose.
* To receive a second opinion at any time about my therapy or therapist methods.
* To request that my therapist inform me of my progress.
* To have any and all grievances or complaints addressed in a timely fashion by contacting Chris Smalley, Director, in writing at Changes 8221. S. 700 E Sandy UT 84070.

**Limits of Confidentiality**

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

* The Client threatens suicide.
* The Client threatens harm to another person(s), including murder, assault, or other physical harm.
* Any Client, Adult or Minor (under 18) who reports suspected child abuse, including but not limited to, physical beating and/or sexual abuse.
* If a Client is referred by the Court, Adult Probation and Parole, Salt Lake County Probation, or another corrections agency, a specific release of information will be required in order to coordinate services. Should such a release be refused treatment may not be provided.
* If a Client’s records and/or the testimony of the Therapist is subpoenaed by a court of law.
* If a Client’s obligation to pay is referred to an outside collection agency including small claims court, if no payment is made on an account for over 60 days, unless special arrangements have been made with the Therapist and/or the Office Manager.
* The Client request payment for third-party payer including Insurance Companies, DCFS, Crime Victim Reparations, etc.

E-Signature of Client or Guardian Date Revised: 10/2020

**Changes Counseling**

**& Consultation, LLC**

**8221 S. 700 E. Sandy UT 84070**

**Phone: 801-542-7060 Fax: 801-542-7061**

**HIPAA Notice Of Privacy Information**

 **I hereby authorize the use of disclosure of my protected health information as described below and understand and acknowledge the following:**

* I am not required to sign this authorization and may in fact refuse to sign this authorization.

Changes Counseling & Consultation, LLC will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.

* If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
* I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
* I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Changes Counseling & Consultation, LLC 8221 S. 700 E. Sandy Utah 84070. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
* If I have questions about this authorization, I may contact Chris Smalley at (801) 542-7060, who will provide me with more information about this authorization, or about changes Counseling & consultations, LLC privacy practices.
1. **Client Name:**
2. This authorization applies to **Treatment Recommendations and Notices of Compliance** to specific agencies.
3. This authorization will expire upon the **Completion of Treatment.**

**I certify that I have read, signed and received a copy of the Notice of Privacy practices. *In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand.***

E-Signature of Client Date

## Utah Dept of Health TB Screening Tool

**Bureau of Epidemiology**

(Adapted from the ACHA TB Screening Tool)

**Part I: Tuberculosis (TB) Screening Questionnaire**

Patient Name: Click or tap here to enter text. DOB: Click or tap here to enter text. Date: Click or tap here to enter text.

Have you ever had close contact with persons known or suspected to have active TB disease? [ ] Yes [ ]  No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) [ ] Yes [ ] No

Afghanistan

Algeria

Angola

Anguilla

Argentina

Armenia

Azerbaijan

Bangladesh

Belarus

Belize

Benin

Bhutan

Bolivia (Plurinational State of)

Bosnia and Herzegovina

Botswana

Brazil

Brunei Darussalam

Bulgaria

Burkina Faso

Burundi

Cabo Verde

Cambodia

Cameroon

Central African Republic

Chad

China

China, Hong Kong SAR

China, Macao SAR

Colombia

Comoros

Congo

Côte d'Ivoire

Democratic People's Republic of Korea

Democratic Republic of the Congo

Djibouti

Dominican Republic

Ecuador

El Salvador

Equatorial Guinea

Eritrea

Estonia

Ethiopia

Fiji

French Polynesia

Gabon

Gambia

Georgia

Ghana

Greenland

Guam

Guatemala

Guinea

Guinea-Bissau

Guyana

Haiti

Honduras

India

Indonesia

Iran (Islamic Republic of)

Iraq

Kazakhstan

Kenya

Kiribati

Kuwait

Kyrgyzstan

Lao People's Democratic Republic

Latvia

Lesotho

Liberia

Libya

Lithuania

Madagascar

Malawi

Malaysia

Maldives

Mali

Marshall Islands

Mauritania

Mauritius

Mexico

Micronesia (Federated States of)

Mongolia

Montenegro

Morocco

Mozambique

Myanmar

Namibia

Nauru

Nepal

Nicaragua

Niger

Nigeria

Northern Mariana Islands

Pakistan

Palau

Panama

Papua New Guinea

Paraguay

Peru

Philippines

Poland

Portugal

Qatar

Republic of Korea

Republic of Moldova

Romania

Russian Federation

Rwanda

Saint Vincent and the Grenadines

Sao Tome and Principe

Senegal

Serbia

Seychelles

Sierra Leone

Singapore

Solomon Islands

Somalia South Africa

South Sudan

Sri Lanka

Sudan

Suriname

Swaziland

Tajikistan

Thailand

Timor-Leste

Togo

Trinidad and Tobago

Tunisia

Turkmenistan

Tuvalu

Uganda

Ukraine

United Republic of Tanzania

Uruguay

Uzbekistan

Vanuatu

Venezuela (Bolivarian Republic of)

Viet Nam

Yemen

Zambia

Zimbabwe

*Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to:* [http://www.who.int/tb/country/data/profiles/en/](http://www.who.int/tb/country/data/profiles/en/%20)

Have you had frequent or prolonged visits\* to one or more of the countries or territories listed above with a high prevalence of TB disease (or regular contact with people who are from one of these countries)? (If yes, CHECK the countries or territories, above)

Yes[ ]  No[ ]

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facility or homeless shelter)?

Yes[ ]  No[ ]

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

Yes[ ]  No[ ]

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

Yes[ ]  No[ ]

Do you regularly use immunosuppressive medication, or have any of the following conditions: HIV, organ transplant recipient, diabetes, silicosis, cancer, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, 10% or more below ideal body weight?

Yes[ ]  No [ ]

**If the answer is YES to any of the above questions, screening with a PPD or IGRA is indicated.**

**[https://www.optumhealthslco.com/content/dam/ops-optslcty/slc/docs/home-page/PDF-UA\_SLCo\_English\_Member\_Handbook\_FINAL\_update%2010.2022\_a11y.pdf](https://www.optumhealthslco.com/content/dam/ops-optslcty/slc/docs/home-page/PDF-UA_SLCo_English_Member_Handbook_FINAL_update%2010.2022_a11y.pdf%22%20%5Co%20%22Medicaid%20Behavioral%20Health%20Services%20%20Member%20Handbook%20%28click%20link%29)**

**(Click link above to access Member Handbook)**

**PLEASE COMPLETE AFTER EVALUATION APPOINTMT**

**(Member’s Name)**Click or tap here to enter text.

**Member Acknowledgment Form**

I, have been offered a copy of the Medicaid Member Handbook. I have gotten it in the mail or was given a copy by my provider, or my provider has shown me where to find it online. I understand this handbook gives me information about my benefits. It also talks about my rights and responsibilities. My provider has shown me where the handbook describes how to access emergency services, transportation, and how to choose a provider. My provider has also shown me where the handbook instructs me how to file a grievance or appeal.

**I also understand that if I have been treated unfairly or discriminated against for any reason, I may file a complaint by contacting Optum Salt Lake County at:**

**1-877-370-8953.**

**My provider has reviewed these materials with me and answered my questions.**

**(PLESE INITIAL EACH ITEM WHEN THERAPIST HAS REVIEWED THEM WITH YOU)**

Click or tap here to enter text.**Emergency Services, (page 10)**

Click or tap here to enter text.**Transportation, (page 10)**

Click or tap here to enter text.**Choosing a Subcontractor, (page 8,9)**

Click or tap here to enter text.**Grievances, (page 17)**

Click or tap here to enter text.**Appeals, (page 15)**

Click or tap here to enter text.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Member Name**

Click or tap here to enter text.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Minor Signature**

Click or tap here to enter text.Click or tap here to enter text.

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**Member Signature/Legal Guardian Signature**

**Date**

Click or tap here to enter text.Click or tap here to enter text.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Interpreter Signature (if needed)**

**United Behavioral Health (UBH) under the brand name Optum®**

**Date**