POLK COUNTY HEALTH SERVICES

CENTRAL HEALTH AND WELLNESS CENTER

Client Orientation Information

Welcome to Polk County Behavioral Health. We offer services for mental health, substance use disorders, and problem gambling. It is our goal to help you Live Well. Here is a brief overview of what you can expect.

About Your First Appointment

The first appointment is called Intake. You will meet with a counselor and we will learn about the concerns that brought you here. We will ask you a lot of questions to understand your situation, and what your goals are. We will talk about what type of service and supports may help you reach your goals. Together we will make a plan. Your individual plan will be shared with you at the end of your appointment.

Find Your Fit

At your intake appointment, you can tell us what kind of counselor you want to work with. We will try our best to match you with the type of counselor that will meet your needs. If you want to work with someone different, you may speak with any staff member and ask about a better fit.

Length of Treatment

People get services for different lengths of time. At your intake appointment, your counselor will recommend the "level of care" based on the type of concerns you have and your individual need. We want you to ask questions. You may ask about changes to your plan any time during treatment. We want to help you meet your goals in a way that feels good to you.

Service & Supports That We May Recommend:

- Psychotherapy – Individual, Family
- Alcohol and/or Drug Counseling
- Problem Gambling Counseling
- Behavioral Health Treatment Groups
- Medication Management
- Case Management
- Skills Training
- Peer Support Services

About Our Staff

All of our staff are trained in trauma informed care. All providers you will work with have a certificate or license in their specific area of focus.

Crisis Services

Call our crisis line 24 hours a day, 7 days a week at the following numbers:	
Weekdays 8-5pm	503-623-9289
Evenings after 5pm / Weekends & Holidays	503-581-5535 or 1-800-560-5833

Walk in crisis support is available during normal business hours at any of our locations:

Dallas
182 SW Academy Street
Dallas, OR 97338

Monmouth
1310 Main Street East
Monmouth, OR 97361

West Salem
1520 Plaza Street NW
Salem, OR 97304

CLIENT RIGHTS

Clients of Polk County Behavioral Health have the right to receive care without discrimination due to age, race, ethnicity, gender, gender identity, gender presentation, sexual orientation, disability, religion, creed, national origin, familial or marital status, disability, or language spoken. As our client you have the right to safe, respectful and dignified care. You will receive services and care that are medically appropriate and within the bounds of what Polk County Behavioral Health offers.

1. Have all communications in a language that you can clearly understand
2. Receive a written copy of your rights and responsibilities
3. Be provided the opportunity to register to vote, upon request
4. Be notified in a timely manner of appointment cancellations
5. Receive a written notice when services are reduced, suspended or terminated
6. Expect that our employees will be sensitive to all clients' needs and feelings
7. Have access to and communicate privately with any public or private consumer rights program or advocate
8. Confidentiality and the right to consent to disclosure
9. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law.
10. Make a declaration for mental health treatment, when legally an adult, which is a legal document that allows you to plan now for a time when you may be unable to make your own mental health treatment decisions.
11. Participate in the development of a written Service Plan
12. Have family and guardian involvement in service planning and delivery
13. Receive a copy of the written Service Plan
14. Have all services explained to you, including expected outcomes and possible risks
15. Seek a second opinion
16. Choose from service and supports consistent with your assessment and your service plan and participate in periodic review and reassessment of service and support needs
17. Receive culturally competent services provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence
18. Refuse participation in experimentation
19. Discontinue treatment at any time without duress
20. Be free from seclusion and restraint
21. Know the name and qualifications of anyone who is involved in your care
22. Be referred to other services that are necessary for continuity of your care
23. Receive medication specific to the individual diagnosed clinical needs, including medications used to treat opioid dependence
24. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety
25. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation
26. Have religious freedom
27. Inspect your service record in accordance with ORS 179.505
28. Request and review a detailed explanation of charges and bills related to your care regardless of the source of payment.
29. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented
30. File grievances, including appealing decisions resulting from the grievance.

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CLIENT RESPONSIBILITIES

As a client, or guardian, you have the right to know what we expect of you during treatment.

Provide Information

As a client or guardian, we ask that you:

- Provide accurate and complete information about current mental health concerns, past illnesses, hospitalization, medications, and other matters relating to your mental health
- Report any perceived risks in your care and any unexpected changes in your condition
- Provide feedback about your service needs and expectations
- Let us know of changes in address, phone number, or other requested information
- Let us know of changes in insurance

Respect and Consideration

As a client or guardian, we ask that you:

- Recognize and respect the rights of other clients, families, and staff. Threats, violence, or harassment of other patients or staff will not be tolerated
- Provide at least 24-hours notice when canceling appointments
- Be on time for your appointments, If you arrive more than 15 minutes late your appointment may be cancelled;
- Comply with Polk County's Tobacco-Free campus policy

Participate in Treatment

As a client or guardian, we ask that you:

- Participate in the development of mutually agreed-upon treatment plans
- Follow the care, treatment, and service plan developed
- Ask questions when you are unable to understand your care, treatment and services, or what you are expected to do
- Share your concerns about the proposed service plan and treatment recommendations
- Keep appointments with your provider(s)

Meet Financial Obligations

As a client or guardian, we ask that you:

- Please bring your insurance card at each visit
- If paying for services out-of-pocket, be prepared to pay amount due at the time of service
- Provide information about all insurance that is available to cover the expense of your services
- When requested by the billing department, provide copies of your insurance Explanation of Benefits (EOB)
- If you are uninsured, bring in documentation of eligibility for discounted services (sliding fee) in a timely manner
- Contact the Billing Department immediately to make payment arrangements if you have an outstanding bill.

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Notice of Privacy Practices

Most of us feel that health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive health information. This law, called the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA gives you rights over your health information including the right to get a copy of your information, make sure it is correct, and determine who has access.

Your Privacy Rights

- **Your Health Record:** In most cases, you have the right to view, receive a summary, or obtain elements from the USCDI designated record set, as per the 21st Century Cures Act (45 CFR 170.401). Copies of records may be provided to you or a third party that you identify in an electronic or paper format depending on your request and the technology in which the records are maintained. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Request Correction or Amendment to Your Records:** If you disagree with the contents of your health record, you may request an amendment. If we grant the amendment, we will notify you. If we deny the request because we believe the existing record is accurate and complete, we will give you specific reasons for the denial. If you continue to disagree, you may file a complaint with the Complaints Officer.
- **Right to Request an Accounting of all Disclosures:** You have the right to ask us for an accounting of the persons or programs to whom we have disclosed your protected health information. (This does not include disclosures for treatment, payment or health care operations, or to persons authorized by you.) The list will not include information provided directly to you or your family, or information that was sent with your authorization. You can request this type of list once per year.
- **Right to Request Limits on Uses or Disclosures of Your Information:** You have the right to ask that we limit how your information is used or shared. You must make the request in writing and tell us what information you want to limit and/or to whom you want the limits to apply. We are not required to agree to the limitation. You can request that the restrictions be ended in writing. You also have the right to restrict disclosures with respect to health care you paid for in full out of pocket.
- **Right to Revoke an Authorization:** If you are asked to sign an authorization to use or share information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared. Exception: Individuals receiving Alcohol & Drug services have the right to verbally revoke authorizations.
- **Right to Choose How We Communicate With You:** You have the right to ask that we share information with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. Or you may ask us to call you at a different phone number. Generally, you must make this request in writing. You do not have to explain why.
- **Right to File a Complaint:** You have the right to file a complaint if you do not agree with how we has used or shared your health information or if you disagree with our privacy practices in general.
- **Right to Receive or Decline a Paper Copy of this Notice:** You have the right to ask for a paper copy of this notice at any time.
- **Right to be notified of a Breach:** You have the right to be notified if we, or a business associate, discover a breach of your unsecured health information.

How We May Use Your Protected Health Information (PHI)

- **For Treatment**: We may use or share information with health care providers who are involved in your health care. For example, information may be shared to coordinate or manage your care.
- **For Payment:** We may use or disclose your information in order to bill and receive payment from you, your insurance company, or a third party payer for the services you received.
- **For Health Care Operations:** We are permitted to use your health care information for our business operations. For example, we may use information to review the quality of services you receive.
- **Identification:** We will also ask to take a photograph of you for identification purposes only. Photos will be maintained in your health record but will not be shared. If you do not want to have your photograph taken you will be asked to provide photo ID. Refusal will not prevent you from obtaining services.
- **In Organized Health Care Arrangements:** We may use and share health information with organizations we participate in on joint health care activities such as ensuring continuing care for you.
- **For Appointment Scheduling and Reminders:** We will ask you for permission to call to remind you about your appointments. We will use the contact number you provide. We will leave you a reminder message if you give us permission.
- **For Public Health Activities:** We shares information with Polk County Public Health that keeps and updates vital records, such as births, deaths and some communicable diseases.
- **For Health Oversight Activities:** We may use or disclose your information during inspections or in investigations of our service.
- **As Required by Law or for Law Enforcement:** We may disclose health care information for law enforcement

and other purposes information when required or permitted by federal or state law or by a court order.

- **For Abuse Reports and Investigations:** We are required by law to report suspected abuse and neglect to proper state authorities. This may result in PHI disclosure.
- **For Government Programs:** We may use and share information for public benefits under other government programs. For example, we may share your information to check eligibility for a nutrition program such as WIC.
- **For Coroners, Medical Examiners and Funeral Directors:** We may disclose information for the identification of a deceased person, and other activities permitted by law.
- **Business Associates:** We may disclose your health care information to third parties whom we contract with to perform business services for us, such as billing companies, quality assurance reviewers or translator service so it can perform a service on our behalf. We require that all business associates implement appropriate safeguards to protect your health care information.
- **Disaster relief:** If there is a disaster, we may disclose information about you to any agency helping in relief efforts.
- **Additional Protection:** In some instances, Oregon law provides additional privacy protections for HIV, substance abuse, mental health, and genetic testing.
- **Incidental disclosures:** Disclosures that are incidental to permitted or required uses or disclosures under HIPAA are permissible, so long as we implement safeguards to avoid such disclosures, and we limit the PHI exposed through these incidental disclosures.
- **To Avoid Harm and Special Government Activities:** We may share PHI with law enforcement or the US government in order to avoid a serious threat to the health or safety of any person, the public in general for protection of the President.
- **Inmates:** If you are an inmate of a jail or prison or in the custody of a police officer, we can give your PHI to that jail or officer so they can provide you health care, to protect your health or the health of someone else, for jail safety.
- **For Research:** We use PHI for public health studies and some reports. These studies and reports do not identify specific people.
- **For Fundraising:** We will not use any of your information for fundraising purposes.
- **For Workers Compensation:** We may disclose your health information to comply with laws for workers compensation or similar programs.
- **Sharing Your Information with Family, Friends and Others:** We may share health information with your family or other persons you have identified as involved in your medical or Behavioral Health care. You have the right to object to the sharing of this information.
- **Marketing**: We must obtain your authorization prior to using your health information to send you any marketing materials. We may however, provide you with marketing materials face-to-face or give you a gift of normal value without your authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without your authorization.

Other Laws Protect Your Health Information

Many of our programs have other federal and state laws to follow for the use and disclosure of your information such as **42 CFR Part 2,** which addresses alcohol and drug treatment. Sharing of this information will require your authorization.

For More Information and How to Contact Us

You may contact your Service Provider or PCBH Privacy Officer at any time if you have a question about this notice or need more information on how to use your rights.

Polk County Behavioral Health
Compliance Officer
182 SW Academy Street
Dallas, OR 97338
Phone: 503.623.9289

State of Oregon Department of Human Services
Governor's Advocacy Office
500 Summer St. NE, E17
Salem, Oregon 97301
Phone: 1-800-442-5238

State of Oregon department of Human Services
Privacy Officer
500 Summer Street NE, E24
Salem, Oregon 97301
Phone: 1-800-442-5238 or 503-945-5780

Office for Civil Rights
Medical Privacy Complaints Division
U.S. Department of Health and Human Services
200 Independence Ave. SW HHH Building, Room 509H
Washington DC 20201
Phone: 866.627.6648

How to File a Complaint or Report a Suspected Problem

You may contact us or any of the departments as listed above if you want to file a complaint or to report a problem with how PCBH has used or shared information about you. The services we provide you will not be affected by any complaints you make. PCBH cannot retaliate against you for filing a complaint, cooperating in an investigation or refusing to agree to something that you believe to be unlawful.

Duration of This Notice

We may change the terms of this notice at any time. Any changes will apply to information we already have, as well as any information we may receive in the future. A copy of the new notice will be posted at each or our sites and provided as required by Law. You may ask for a copy of the current notice anytime you visit a PCBH site or you may request we send you a copy electronically or by mail.

COMPLAINTS AND GRIEVANCES

Client complaints and grievances are used as an important source of information for continuously improving services. As per Oregon Administrative Rule 309-019-0215, every client or their guardian has the right to submit complaints verbally, or in writing. If you have a problem with access, service, clinical care, contact with staff, quality of care, or your rights, please let us know.

Complaints Process:
Polk County Behavioral Health accepts complaints and grievances in writing or telephone. To make a complaint verbally you may speak with any staff member or specifically ask to speak with the Complaints Officer. To submit a complaint in writing, you may ask any staff member for a complaint form *(FORM: BHQA001 Client Complaint Form)*

Polk County Behavioral Health
Attn: Complaints Officer
182 SW Academy St
Dallas, OR 97338
503-623-9289

You will receive an initial response to your complaint within three business days and a resolution decision within five business days. If additional time is needed to gather information, you will be notified with an explanation. In these circumstances, the resolution decision may be delayed up to 30 days.

Expedited Review:
If the matter of the complaint is likely to cause harm to you before the complaints process is complete, client or guardian may request an expedited review. Expedited complaints will be reviewed within 48 hours of receipt of the complaint and a written response including information about the appeals process will be issued.

Appeals:
If you are unsatisfied with the resolution of your complaint, you may file an appeal within 60 calendar days from the date you received a decision. The Health

Services Director will review appeals and a decision will be offered. Expedited Appeal

Notice:
Persons making a complaint or grievance, supporting witnesses or staff members shall not be subject to retaliation for making a report or being interviewed about a complaint. Retaliation may include but is not limited to dismissal or harassment, reduction in services, wages, or benefits, or basing service or a performance review on the action.

Persons making a complaint or grievance are immune from any civil or criminal liability with respect to the making or content of a complaint made in good faith.

Additional Resources for Complaints and Grievances:

Oregon Health Authority
If you are not satisfied with your experience AND have filed a complaint, but your complaint was not resolved you can submit a complaint to Oregon Health Authority Addictions and Mental Health Division by calling **503-945-5763 or 1-800-273-0557** or submitting a form online using OHA 8001.

Member of PacificSource Marion & Polk CCO
If you have a complaint about your health plan, benefits or care, you can call, write or visit PacificSource at:

(503) 210-2515 or (800) 431-4135
TTY (800) 735-2900

PacificSource Community Solutions
Attn: Appeals and Grievances
PO Box 5729 Bend, Oregon 97708
Fax: (541) 322-6424.

Disability Rights Oregon
503-243-2081
511 SW 10th Avenue, Suite 200
Portland, OR 97205
www.droregon.org

The Governor's Advocacy Office
Governor's Advocacy Office
500 Summer Street N.E., E-17
Salem, OR 97310-1097
Fax: 503-378-6532
Email: GAO.CR@state.or.us

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Acknowledgment of Orientation Documents and Consent for Treatment

Acknowledgement of Orientation Packet:

By signing this form, you acknowledge you have received or declined a copy of the following information from Polk County Behavioral Health. We encourage you to review all documents in the Orientation Packet carefully. If you have declined a paper copy, you may visit our website at **https://www.co.polk.or.us/bh** to review materials online. The Orientation Packet contains the following information:

- Overview of Services
- Client Rights and Responsibilities
- Information about Complaints and Grievances
- Notice of Privacy Practices

_____ I received a paper copy of the Orientation Packet

_____ I declined a paper copy of the Orientation Packet, but have reviewed all documents.

Consent for Treatment

By agreeing to receive services from Polk County Behavioral Health, I acknowledge the risks and benefits of treatment include, but are not limited to, the following:

Benefits

- Determining my strengths and goals for treatment
- Choosing which goals are priorities and working with my therapist in deciding how to reach those goals
- Having the opportunity to become more independent
- Enjoying increased satisfaction with the quality of my life
- Developing a personalized plan to address safety or crisis situations
- Experiencing an increase in positive responses to difficult situations
- Improving my coping abilities and reducing my stress
- Improving my personal relationships

Risks

- Experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness
- Being in touch with painful emotions, sometimes for the first time, which may temporarily lead to feeling worse
- Recalling or talking about unpleasant aspects of my life, which can bring up uncomfortable feelings
- Personal growth sometimes requires changes that may be uncomfortable or unexpected
- Significant others may notice the changes I make; my relationships with others may be affected by the changes I make
- I may not achieve my desired level of improvement.

I understand that I have the right to refuse or stop treatment at any time. I understand that refusal or stopping treatment may have an effect on my condition, it may worsen, stay the same, or get better. I give permission to Polk County Behavioral Health to provide treatment and services to me, my child, or the person I am the legal guardian of.

_____ _____ _____

Print Name of Client | Print Name of Legal Guardian if applicable | Date

FOR OFFICE USE ONLY Client ID: _____

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FINANCIAL AGREEMENT AND CONSENT

I agree to be financially responsible and pay for the services that are not fully covered by insurance. I understand that the law allows Polk County Behavioral Health to collect from me the amount owing.

Note: Polk County Behavioral Health serves students (school-aged youth age 5-21 yrs old) through the Central Health and Wellness Center even if they don't have insurance or can't pay. We will bill Oregon Health Plan or other insurance but students will not be charged.

I authorize Polk County Behavioral Health to use, disclose and communicate both verbally and in writing my health information, including substance use and mental health information to and from my health insurance company or other entity responsible for my medical bills for the purpose of eligibility, payment, audit and health care operations.

I hereby assign Polk County Behavioral Health all monies to which I am entitled from insurance for services received.

_____	_____	_____
Print Name of Client	Signature: ☐Client -or- ☐Legal Guardian	Date

FOR OFFICE USE ONLY Client ID: _____

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Behavioral Health Registration

Please fill out the following information for the person who will be receiving Mental Health or Addiction Services. If you require assistance completing any of the forms please let an office staff know. Thank you!

WHAT SERVICES ARE YOU SEEKING?

☐ Mental Health Counseling ☐ Alcohol & Drug Treatment ☐ Problem Gambling Counseling ☐ Other _____

CLIENT INFORMATION

Last Name	First Name	MI	Social Security No.	Date of Birth	☐ Male ☐ Female ☐ Other
Street Address	City	State	Zip Code		Home Phone ☐ YES ☐ NO Leave messages?
Mailing Address (if different from above)	City	State	Zip Code		Cell Phone ☐ YES ☐ NO Leave messages?
ODL/Oregon DMV# (required if seeking DUII related services)	How would you like to receive appointment reminders? ☐ TEXT ☐ PHONE ☐ EMAIL				Email

For Minor Children

Parent Name (*please print*) _____

Parent Name (*please print*) _____

CLIENT INSURANCE INFORMATION

Oregon Health Plan (OHP) ID #	Health Plan Name			
Medicare ID #	Coverage Part A ☐ Part B ☐ Part D ☐			
Name of Additional Health Insurance Plan	Group No.	ID#	Insurance Phone Number:	
Responsible Party (if different than insured)	Relationship	Date of Birth	Social Security No.	Phone Number
Is additional insurance through: ☐ Employer ☐ Self-purchased ☐ Absent Parent ☐ Other				

MEDICAL INFORMATION

INDICATE SERVICES YOU HAVE RECEIVED IN THE PAST *Please indicate if we may request these records?*

		ROI for Records Request:
☐ Mental Health Counseling	Provided By: _____	☐ YES ☐ NO
☐ Med. Management	Provided By: _____	☐ YES ☐ NO
☐ A&D Treatment	Provided By: _____	☐ YES ☐ NO
☐ Gambling Treatment	Provided By: _____	☐ YES ☐ NO

PRIMARY CARE PROVIDER (PCP) Do you have a Primary Care Provider? ☐ YES ☐ NO

Dr. Name: _____ Clinic Name/Location: _____

MEDICATIONS/ALLERGIES

Do you have any Allergies to Medication? If yes, please list: ☐YES ☐NO

If you are currently being prescribed any of the following medications, please mark all that apply:

Medication	Prescriber
☐ Abilify/aripiprazole	
☐ Clozaril, Frazalco/clozapine	
☐ Geodon/ziprasidone	
☐ Haldol/haloperidol	
☐ Invega/pallperidone	
☐ Risperdal/risperidone	
☐ Seroquel/quetiapine	
☐ Zyprexa/olanzapine	

Medication	Prescriber
BENZODIAZAPINES:	
☐ Ativan/loraepam	
☐ Klonopin/clonazepam	
☐ Valium/diazepam	
☐ Xanax/alpraolam	
☐ Librium/chlordiazepoxide	

Medication	Prescriber
STIMULANT DRUGS:	
☐ Adderall	
☐ Adderall XR	
☐ Concerta	
☐ Dexedrine	
☐ Dexedrine spansule	
☐ Daytrana	
☐ Metadate CD	
☐ Metadate ER	
☐ Methylin ER	
☐ Ritalin	
☐ Ritalin LA	
☐ Ritalin SR	
☐ Vyvanse	
☐ Quillivant XR	

Medication	Prescriber
OTHER:	
☐ Vicodin	
☐ Oxycontin	
☐ Fentanyl/Duragesic/Fentora	
☐ Lorcet/Lortab/Norco	
☐ Hydromorphone/Dilaudid	
☐ Meperidine/Demerol	
☐ Methadone/Dolophine	
☐ Morphine/MS Contin	
☐ Oxycodone	
☐ Oxyfast/Roxicodone	
☐ Targiniq ER	
☐ Percocet	
☐ Tramadal	
☐ Suboxone	

Other prescribed drugs not on this list:

Are you Pregnant? ☐ YES ☐NO

Do you use Tobacco? ☐ YES ☐NO

Do you now or have you ever used IV Drugs? ☐YES ☐NO

Have you used non-prescribed drugs or alcohol in the past 90 days? ☐YES ☐NO

Please tell us if you have previously completed an Advance Directive and if so, who has a copy on file?

☐ NO - I have not completed an Advance Directive

☐YES - I have a completed an Advance Directive and it is on file with:

☐ PCP (Name):

☐ Hospital (Name):

☐ Family, Attorney or Personal Representative (Name):

DEMOGRAPHIC INFORMATION *Because we are a Medicaid provider, we are required to ask the following questions.*

1. Client last name at birth? _____

2. What is your Primary Language? _____

3. Do you need an interpreter? ☐ NO ☐ Hearing Impaired ☐ Foreign Language _____

4. Is the client a veteran? ☐ YES, Current or Former Guard/Reserve Military ☐ NO, but Current or Former Guard/Reserve Military ☐ YES, Current or Former Active Duty Military ☐ NO

5. What is the highest grade complete by client? _____ If currently a student, what school does client attend? _____

6. What is client's county of residence? ☐ Polk ☐ Marion ☐ Other _____

7. What is client's marital status? (*If living as married, please check married)*

☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

8.What is client's employment? (mark all that apply)

☐ Full Time (35 or more hours) ☐ Part Time (Less than 35 hours) ☐ Unemployed (Looking for work or on layoff) ☐ Homemaker ☐ Student
☐ Retired ☐ Disabled (Unable to work for physical or psychological reasons) ☐ Hospital Patient or Resident of Other Institutions
☐ Other Reported Classification (e.g. volunteers) ☐ Sheltered/Non-Competitive Employment (Jobs in segregated settings for a specific population, intended to provide training and experience)
☐ Not in Labor Force (Not actively looking for work)

8a. Are you interested in receiving information about how to find employment? ☐ YES ☐ NO

9. What is the primary source of income/support for client or parent of client?

☐ Wages/Salary ☐ Public Assistance ☐ Disability/SSDI ☐ Retirement/Pension/SSI ☐ Other ☐ None

10. Estimated Gross Monthly Household Income: _____ ☐ No Income ☐ Refuse to Answer

11. What is the total number of people dependent upon household income? _____

12. How many children ages 0-17 that are dependent upon the household income? _____

13. What is the client's living arrangement?

☐ Transient/Homeless
☐ Foster Home
☐ Residential Facility
☐ Jail
☐ Prison
☐ Room & Board
☐ Supported Housing
☐ Supportive Housing (scattered site)
☐ Supportive Housing (congregate setting)
☐ Alcohol and Drug Free Housing
☐ Oxford Home
☐ Other Private Residence
☐ Other
☐ Private Residence (at home)
☐ Private Residence (with Relatives)
☐ Private Residence (with non-relative)
☐ Residential Facility (SUD)
☐ Residential Facility (BRS)
☐ Residential Facility (CSEC)
☐ Residential Facility (PRTS)
☐ Residential Facility (SCIP/SAIP)
☐ Residential Facility (SRTF or YAT)
☐ Residential Facility (RTH or YAT)
☐ Secure Residential (SRTF Adult)
☐ Residential Sub-Acute Care Facility

14. Please list the number of: Arrests in the past month (not including DUII Arrests): _____
Arrests in your lifetime (not including DUII Arrests): _____
DUII Arrests in the past month: _____
DUII Arrests in your lifetime: _____

15. Which of the following best describes client's:

Race? *Mark all that apply*
☐ White ☐ Alaska Native ☐ American Indian ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Single Race

Ethnicity?
☐ Not of Hispanic Origin ☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Other Specific Hispanic _____

Tribal Affiliation ? *Mark all that apply*
☐ Not Applicable
☐ Conf. Tribe of Grand Ronde
☐ Conf. Tribe of Warm Springs
☐ Klamath Tribes
☐ Burns Paiute
☐ Conf. Tribe of Siletz
☐ Coquille Indian Tribe
☐ Other _____
☐ Conf. Tribe Coos, Lower Ump & Siuslaw
☐ Conf. Tribe of Umatilla
☐ Cow Creek/Ump Indians

16. Who Referred You To Us? *(mark all that apply)*

☐ Self
☐ Family/Friend
☐ Doctor, Nurse, or Physician
☐ Crisis Helpline
☐ Media, Internet Advocacy
☐ Group
☐ School
☐ DD Services
☐ Aging & Disability
☐ ADES
☐ Police or Sheriff
☐ Parole
☐ Probation
☐ Employer
☐ Employment Services
☐ Vocational Rehabilitation
☐ Attorney
☐ Child Welfare
☐ Health Plan/CCO
☐ Jail
☐ State Prison
☐ Federal Prison
☐ State Psychiatric
☐ Facility PSRB Board
☐ Municipal Court Justice
☐ Court
☐ Circuit Court
☐ Federal Court
☐ None
☐ Other _____

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RECEIVED BY: _____ CLIENT ID#: _____