OneEighty Client Demographics

Client Information

Client Name:_____Date of Birth _____

Address _____

City/State/Zip:_____Phone Number _____

County:_____ Social Security Number: _____

Email address (optional): _____

For reminders/appointments would you prefer: Text Call Email

Sex: _____ Gender Identity: _____ Marital Status: _____

Race Group: _____ Ethnicity Group: _____ Military Status: _____

Highest Level of Education: _____

Employment Status: _____ Source of income: _____

Emergency Contact Information (Optional)

Emergency Contact Name:_____

Relationship: _____ Emergency Phone: _____

Can we leave a message at your emergency phone? Yes or No

Client Signature:_____**Date:** _____

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OneEighty

Helping people change direction.

ACKNOWLEDGEMENT AND TREATMENT CONSENT FORM

Name: _____

I have received (and if appropriate legal guardian/custodian has received) a written packet of all the information as indicated below:

- Informed Consent
- Treatment Consent
- Telehealth Consent
- Electronic Health Record and Billing Consent
- Confidentiality
- Client Rights
- Client Abuse Policy
- Client Fee Policy
- Client Responsibilities
- Policy regarding provision of services to sensory impaired clients
- Client Grievance Procedure
- HIV/AIDS, Hepatitis B/C & Tuberculosis Brochure

My signature below is to confirm that:

- A staff member of OneEighty has been available to explain the information and to answer any questions regarding the above packet.
- I have read and understand the content of each of the above forms, and consent to the same.
- I understand that OneEighty uses security cameras in common areas. I acknowledge and agree that if I am in a common area, I may be recorded for the purpose of maintaining safety on the premises.
- **I understand that OneEighty** is a dynamic, integrated health system providing the following services: Addiction Services, Peer Support, Mental Health Services, Domestic Violence and Sexual Assault Services, Rape Crisis Center Services, Housing and Supportive Services and Prevention and Education Services. **I further understand that the staff members are trained to provide appropriate treatment and/or services as needed in this area.**
- **I agree to treatment or services as offered by OneEighty:**
  _____Myself _____ My Child (or person for whom I am legal guardian/custodian)

Client Signature: _____ Date: _____

(If needed)
Legal Guardian/Custodian: _____ Date: _____

Staff Signature: _____ Date: _____

Revised 9-2020

OneEighty
Client Financial Intake and Fee Agreement
(You are responsible for informing us of any financial changes)

Client Name: _____ **Date:**_____

Client Payment Type (please check all that apply):

_____Insurance (We need a copy of your insurance card)
_____Medicaid (If Medicaid only, proceed to bottom signature and we need a copy of your Medicaid card)
_____Medicare
_____ Self-Pay (If you are 100% self-pay only - no Medicaid/Ins/Sliding Fee - proceed to bottom signature)
_____Other (specify)_____

You will be charged 100% of the Fee Schedule until we receive copies of the following checked items:

❒ 2 most recent paystubs ❒ Insurance Card ❒ Medicaid Card
❒ Other: _____

Fill out this section if you have insurance and provide us with a copy of your card.

Insurance Information

Policy Holder: _____SS# _____

Policy Holder Date of Birth: _____ Relationship to Client: _____

By signing below, you are electing to have your insurance company billed first and asking them to pay us directly. This does not release you from financial responsibility for the services received. If your insurance company sends reimbursement directly to you, you are responsible for paying OneEighty directly. You are ultimately responsible for any portion of the bill not satisfied by your insurance company.

I, the undersigned, hereby authorize/request OneEighty, to disclose/receive information regarding diagnosis, treatment, and/or recommendation to/from my insurance company.

I hereby assign and authorize payment of medical benefits from my insurance company to OneEighty, 104 Spink Street, Wooster OH 44691 for services rendered by OneEighty.

_____
Policy Holder Signature Date

Income includes spouse income.

Self-Pay/Sliding Fee Scale Information

We offer a sliding fee scale for individuals who may not have the income or ability to pay the full fee. If you are interested in applying for assistance, please complete the following information and provide verification of income. You will be billed 100% of fees incurred for failure to provide proof of income.

Source of income: (Please check all that apply) ❒ Wages/Salary ❒ Alimony ❒ Savings/Invest ❒ SSI ❒ SSDI ❒ SS Retirement ❒ Child Support ❒ Family or Relative ❒ Disab/wComp ❒ Retirement Pension ❒ Gen Relief/Welfare ❒ Aid for Dep Child ❒ None ❒ Other

Gross Monthly Family Income: _____ #of people claimed on income tax_____

Your % of the fees will be: _____%.

If it is determined that you are eligible for Medicaid, your financial scholarship will expire in 90 days at which time you will be responsible for 100% of your fees unless you have enrolled with Medicaid.

1. If I am a self-pay client, I will pay my portion of the fee at the time of service, and if I am an insurance client and my insurance company does not pay 100% of the fee, I will pay the balance.
2. I understand that OneEighty will not refuse services for those who cannot pay, but if it has been determined I can pay, OneEighty will use various means to collect delinquent fees including collection agencies, withholding of recommendations and final discharges, and small claims court.

_____
Client Signature Date

_____
Responsible Party Signature Date

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION ABOUT PERSONS RECEIVING SERVICES FROM ONEEIGHTY

I, (Client name)_____, authorizes OneEighty to disclose to the Mental Health and Recovery Board of Wayne and Holmes Counties (ADAS/ADAMH), the Ohio Department of Behavioral Health, and/or Job and Family Services ("Departments") from whom I may be seeking funding for services, the information necessary to accomplish the following purposes:

- To enroll in SmartCare, which is the shared computer payment system used by CMH/ADAS/ADAMH Boards and the Departments.
- To determine my eligibility for publicly funded services
- To pay claims for services I receive
- To report information required by the ADAS/ADAMH Board and/or the Departments regarding characteristics of individuals seeking services and the services provided. I understand that the Board and Departments use the information in aggregate form of service planning and evaluation purposes

I understand that I must authorize disclosure of information necessary for payment purposes in order to receive behavioral health, alcohol, and drug addiction services. My treatment or payment for my services cannot be conditioned upon my giving authorization for any purpose other than payment.

If I am not receiving funding from the ADAS/ADAMH Boards and Departments, I am authorizing OneEighty to only disclose the following information:

- To report information, as required by the Ohio law, about reportable incidents that may occur while I am receiving services to the ADAS/ADAMH Board and Department(s)

I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire six (6) months after no longer receiving any services with OneEighty.

I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that OneEighty cannot control the use of this information once it has been disclosed.

_____ _____

Signature of Individual (Client) Date

_____ _____

Signature of Personal Representative Date

****

Explanation of efforts to obtain authorization, if signature is declined:

_____

_____

_____

_____ _____

Signature of Staff person attempting to obtain authorization Date

RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting the residency, with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced int eh residency guidelines. *

Adult

Client is an adult? Yes ☐ No ☐ **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Is Client a Minor? Yes ☐ No ☐	**Indicate if the child is in legal custody of the following (this is not the foster parent).** Parent ☐ CSB ☐ DYS ☐ Court ☐ Other ☐ (specify):
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Name: _____ Date: _____



Client Information Form- Adult

In a few words or sentences what help, or services do you need from OneEighty? How can we help you? _____

_____

Demographic Information

Gender:

Female Trans Female Male Trans Male Decline to answer Other

Pronouns:

She/Her/Hers He/Him/His They/Them/Theirs Ze Other

Date of Birth: _____ **SSN**: _____

Marital Status:

Single/Never Married Separated Married/Living together as Married
Divorced/Annulled Widowed

Race:

Alaska Native American Indian Asian Black/African American
Caucasian/White Native Hawaiian/Other Pacific Islander
Other single race Two or more races

Ethnicity:

Cuban Hispanic-Specific Origin not given Mexican Not of Hispanic Origin
Puerto Rican Other Specific Hispanic

Living Situation:

Private Residence (rent or own) Friends or Family Home Foster Care
Homeless/lacking a permanent Residence Jail/Correctional Facility
Permanent Supportive Housing Residential Care/Group Home/ACF
Community Residence Temporary Housing Mental Health Institution
Nursing Home DD Licensed/Operated Facility Other Institution

Number of Children in the household under 18: _____

Current Life Stressors: Mark all that apply

Financial Family Job Health Issues Housing Difficulties
Legal Trouble Chronic Pain Grief/Loss Recent Trauma (i.e. victim of crime, abuse, natural disaster) Other: _____

Name: _____ Date: _____

Any Current Physical Disabilities/Limitations: Yes No
If yes, describe: _____

Do you need any assistive devices or interpreters to participate in services: Yes No
If yes, describe: _____

What is the best way to communicate (reminders, changes in schedule):
Phone call Text Message Email Other
Phone Number: _____ Email: _____

Would you like to list someone as an Emergency Contact: Yes No
If yes provide Name: _____ Relationship: _____
Phone number: _____

Health History

Primary Care Physician or Business name: _____
Date of last examination: _____

Medications currently being taken:

Name	Dose	How long Taken	Prescribing Physician	Effectiveness

Medications previously taken:

Name	Dose	How long Taken	Prescribing Physician	Effectiveness

Do you take any OTC (over the counter) medications? Yes No
If yes, what do you take: _____
_____

Allergies (drug or food): _____

Childbirth History (Skip if not applicable):

Currently Pregnant: Yes No 1st Trimester 2nd Trimester 3rd Trimester
If yes, are you receiving prenatal care or do you need assistance? _____

Childbirth within the last 5 years: Yes No **Total Number of births (live & still)**: ____

Name: _____ Date: _____

Physical Health Issues: Please indicate if you currently have, or have ever had, any of the following physical health issues. Select any that apply:

Anemia Arthritis Asthma Back Problems
Bronchitis/Emphysema Cataracts Cancer Diabetes
Hay fever/allergy Headaches Heart Disease Hearing loss
Hepatitis/Liver DX High Blood Pressure Kidney/Renal DX
Pneumonia Seizure/Epilepsy Sinus Problems Skin Disease
Stroke Thyroid Disease Tuberculosis Tumors
Ulcers Vascular Dx Vision Problems Other (complete next line)
List other significant Physical Health issues and date when occurring: _____

_____

Significant weight loss/gain in the last year: Yes No
If yes, how much change? Gained 10lbs gained 20lbs gained 30 or more lbs
lost 10lbs lost 20lbs lost 30 or more lbs

Hospitalizations in the last 3 years: Yes No
If yes, please complete:
Hospital name Location (City) Date(s) Reason
_____
_____

Emergency Room Visits in the last year: Yes No
If yes, please complete:
Hospital name Location (City) Date(s) Reason
_____

Do you currently use any of the following:
Tobacco Products: Yes No If yes, please complete the following:
What products: Cigarettes Chew Cigars Vape
How much used and length of use (#packs/#years): _____
Coffee, Tea, Cola: Yes No If yes, how much: _____

Have you previously used any tobacco products: Yes No
If yes, please explain: _____

Do you have any health concerns not listed on this form? Yes No
If yes, please explain: _____

Do you use any Complementary Health Practices (natural products, yoga, non-traditional healers, etc)? Yes No If yes, please explain: _____

Do you have any difficulties with Activities of Daily Life (bathing, dressing, obtaining meals)?
Yes No If yes, please explain: _____

OneEighty

Helping people change direction.

Liability Waiver for Clients Riding in Company or Employee Vehicles

I, _____, hereby acknowledge and agree to the following terms and conditions regarding riding in a company or employee vehicle:

1. I understand riding in a company or employee vehicle is not a requirement of receiving services from OneEighty. There is an exception related to residential clients (Pathway and WRTC) as described below in item 4.
2. Transportation options may be presented by OneEighty from time to time for client convenience. If I am presented with the option for transportation by OneEighty, I have the free will to voluntarily accept it or reject it and instead choose my own transportation option independent of OneEighty.
3. Prior to accepting a transportation option presented by OneEighty, I understand that whenever I ride in any vehicle there are inherent risks, including but not limited to accidents, injury, property damage, and other unforeseen incidents.
4. For their safety, program supervision requirements, and as part of their treatment plans, residential clients (Pathway and WRTC) are required to be transported by OneEighty staff between the residential sites, main office and local 12-step meetings.
5. Prior to accepting a transportation option presented by OneEighty, I acknowledge I am assuming the risks associated with riding in the company or employee vehicle, and I hereby release, waive, discharge, and covenant not to sue OneEighty, its employees, agents, affiliates, successors, and assigns from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me while riding in the company or employee vehicle.
6. In addition, in the event I choose to ride in a company or employee vehicle, I agree to always comply with all applicable laws, regulations, and safety precautions while being provided transportation.

I have carefully read and fully understand the contents of this liability waiver. I voluntarily agree to its terms and sign it of my own free will.

Signature: _____

Date: _____

Printed Name: _____

OneEighty

CONSENT FOR THE RELEASE OF INFORMATION

Client Name: _____ **Date of Birth:** _____

I, _____ **, hereby consent to communication from**

Select one or both

OneEighty, Inc. and between OneEighty, Inc. and ____ Treating Providers

____ Health plans, third-party payors, and individuals & entities helping to operate this program

Purpose and need for disclosure :

____ Treatment, payment, or healthcare operations

Information to be released:

____ Information related to treatment, payment, or healthcare operations

Amount of information to be disclosed:

____ Information covering the most recent admission (except SUD counseling notes and psychotherapy notes)
____ All information including SUD counseling notes
____ All information including Psychotherapy notes
____ Other: _____

I understand that this consent will remain in effect until:

____ 90 days post end of treatment, billing, and related operations

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that OneEighty, Inc. cannot control the above entity's use of the information. I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information FOR ANY OTHER PURPOSE.

_____ _____
Signature of Client **Date**

_____ _____
If appropriate, signature of Parent/Guardian/Personal Representative (with description of relationship and authority to act on behalf of client. Required for all minors) **Date**

_____ _____
Signature of Staff **Date**

REVOCATION: This authorization is subject to revocation at any time except to the extent the program or person who is making the disclosure has already acted in reliance upon it. The consent can be revoked either verbally or in writing.
I hereby revoke consent in writing verbally Time if verbally revoked:_____ Date:_____
Signature of client/parent/guardian or staff witness to verbal revocation: _____

Initial one

Client given copy:_____ **Client declined copy:** _____
(Client initials) (Client initials)

Prohibition against re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol/drug abuse or mentally ill client.

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Name: _____ ***Date:*** _____

Patient Health Questionnaire (PHQ–9)

1. Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score: _____

2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Name: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Name: _____ Date:_____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Name:_____

Brief Biosocial Gambling Screen - BBGS

Overview

Brief screens can help people decide whether to seek formal evaluation of their gambling behavior. The 3-item BBGS is based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria for **gambling disorder**.

Scoring

A "**yes**" response to **any single item** indicates potential gambling-related problems and the need for additional evaluation.

1. During the past 12 months, have you become restless irritable or anxious when trying to stop/cut down on gambling?
   ◯ Yes ◯ No

2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?
   ◯ Yes ◯ No

3. During the past 12 months did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?
   ◯ Yes ◯ No

www.icrg.org www.divisiononaddiction.org

Call, Text 1-800-GAMBLER or chat www.HelpMyGamblingProblem.org