

Mid-Ohio Psychological Services, Inc.

Client Guidelines

(Revised 04/22/05)

This document (the Agreement) contains important information about the professional services and business policies you are going to receive. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you be provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before any additional sessions. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on this agency unless agency staff has taken action in reliance on it; if there are obligations imposed on this agency by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

SERVICES PROVIDED:

The treatment providers who work in this office are trained and legally qualified to provide a full range of psychological and/or counseling services to individual clients as well as to individuals who come at the request of public agencies. Services fall into five broad categories: **EVALUATION, COUNSELING, MEDICATION SERVICES, CSP (Case Management), AND DRUG AND ALCOHOL SERVICES (AOD Services).**

Mental Health Treatment is not easily described in general statements. It varies depending on the personalities of the treatment provider and client, and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Mental health treatment is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the treatment to be most successful, you will have to work on things we talk about both during our sessions and at home. For treatment to be successful, we must be able to talk openly and work together with trust. Although we cannot guarantee success, we promise that we will work with you to help you make the changes you wish to make, using methods designed to work with your special needs.

Mental health treatment may have benefits and risks. Since mental health treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health treatment has also been shown to have many benefits. Treatment often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Evaluations are done for a number of reasons. Often they are useful to guide us in counseling and medication services. They may also be requested by your physician, attorney, other professionals, or public agencies such as the court, Social Security, Children's Services, etc., so that the other party can make an informed decision about you. All clients must be evaluated prior to receiving other services offered by this agency.

Counseling services are designed to help you find solutions to the problems that brought you to treatment. Counseling may be provided in either individual or group settings depending on your particular needs.

Medication services may be appropriate in some cases and will be recommended by your counselor if he/she believes that you can benefit from this service. Once referred for medication services, you will see a psychiatrist who will work with your counselor and you in addressing your problems. Some clients may also benefit from Case Management Services. These services are designed to facilitate communication among various treatment providers and to ensure that you are getting your basic needs met.

If, through the evaluation process, it appears that you might benefit from drug and alcohol treatment, you will be referred to staff that have a scope of practice in this area. Once referred for drug and alcohol services, you will be seen by a qualified counselor who will work with you in addressing your chemical usage.

Please read the rest of this statement carefully; ask whatever questions you need to, and do not sign the agreement until you understand and can agree with no reservations.

APPOINTMENTS:

For counseling, we usually will want to see you once a week for 50 minutes each time. When you make an appointment, that time is set aside for you and no one else will use it. We make the best progress when we work together on a regular basis. If you are late, you will be seen only for the time remaining in that hour. ***If you must break an appointment, you must cancel at least 24 hours in advance, or a "no show" fee of \$35 will be charged. Most medical insurance companies, Medicaid and Medicare will not pay for missed appointments. You will be held responsible for this fee.*** Please do not cancel for any but the most important reasons.

For evaluations, the time will vary. You may be asked to come in to take some paper and pencil tests without the counselor being there, then there will be time for you to meet with the counselor for interview and/or further assessment with tests that only the counselor can administer. The counselor will review and evaluate all the results and write a report if one has been requested by the referring agency or professional; if no written report is needed, the counselor will go over the test results with you at your next meeting.

FEES:

Fees vary according to the time involved. A 50-minute counseling session is \$90, a two-hour group is \$80, diagnostic assessment sessions are \$135 per hour, CSP services are \$65 per hour, and medication review sessions are \$51.27 per fifteen minutes. For AOD services, assessment sessions are \$96 per hour, individual counseling is \$87 per hour, and group is \$38 per hour. **You are expected to pay at the beginning of each session.** Please discuss with our billing clerk any problems you may have meeting this requirement. Some or all of the fees for treatment services may be covered by your health insurance, Medicaid, or Medicare; please find out the details of your coverage from your insurance company. However, *you are responsible for payment, not the insurance company.*

If you become involved in legal proceedings that require agency participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if agency staff is called to testify by another party. You will be charged \$90 per hour for these activities. Insurance, Medicaid and Medicare do not pay for these services.

You will receive a monthly statement itemizing all charges and payments if you owe a balance. If there is a balance due, it must be paid in full. Accounts overdue by more than 60 days may be sent to a collection agency and may result in termination of treatment.

Misunderstandings about money can arise. If there are payment problems that have not been discussed, you and your counselor may become uncomfortable and your work together may suffer. Our contract is that the counselor helps you work on your problems and you pay for that service.

CONTACTING YOUR PROVIDER:

In order to provide quality services to clients during sessions, your treatment provider will not be available by phone in most circumstances. If you need to communicate with your treatment provider at times other than your regularly scheduled appointment, you may call the office (740) 687-0042 and leave a message. The agency receptionist will forward your message to the treatment provider who will determine if they will call you back or wait to discuss the issue at your next regularly scheduled appointment. The receptionist can work with you to make appointments or direct you to other agency staff to address most of your needs. Receptionists will be available to accept phone calls from 9 AM to 5PM weekdays. When a receptionist is not available to accept your phone calls, you may leave a voice mail and the receptionist will review these messages during the next regular business day. When your provider is not available for extended periods of time, any message that you might leave will be forwarded to their immediate supervisor or clinician who is providing “coverage” for them. If you are unable to reach agency staff and feel that you can’t wait for a return phone call, contact your family physician, nearest emergency room or call Emergency Services at (740) 687-TALK (687-8255).

CONFIDENTIALITY:

The law protects the privacy of all communications between a client and a mental health treatment provider. In most situations, agency staff can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA, the Ohio Department of Mental Health, and the Ohio Department of Alcohol and Drug Addiction Services. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Agency staff may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, agency staff make every effort to avoid revealing the identity of our clients. The other professionals are also legally bound to keep the information confidential. If you don't object, agency staff will not tell you about these consultations unless agency staff feel that it is important to our work together. Agency staff will note all consultations in your Clinical Record (which is called "PHI" in our Privacy Notice).
- You should be aware that this agency utilizes administrative staff that may have access to your records. In most cases, clinical staff need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- This agency also has contracts with Mental Health Boards. As required by HIPAA, this agency has a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where this agency is permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-patient privilege law. Agency staff cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order this agency to disclose information.

- If a government agency is requesting the information for health oversight activities, this agency may be required to provide it for them.
- If a client files a complaint or lawsuit against the agency or agency staff, we may disclose relevant information regarding that client in order to defend ourselves.
- If a patient files a worker's compensation claim, the patient must execute a release so that the agency may release the information, records or reports relevant to the claim.

There are some situations in which agency staff are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment.

- If agency staff know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires that agency staff file a report with the appropriate government agency, usually the Public Children Services Agency. Once such a report is filed, agency staff may be required to provide additional information.
- If agency staff have reasonable cause to believe that an elderly person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires that agency report such belief to the county Department of Job and Family Services. Once such a report is filed, agency staff may be required to provide additional information.
- If agency staff know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, agency staff must note that knowledge or belief and the basis for it in the patient's or client records.
- If agency staff believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and agency staff believe that disclosure of certain information may serve to protect that individual, then agency staff must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.
- We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or

other important officials. By law we cannot reveal when we have disclosed such information to the government.

If we are required to disclose information for any of the above situations, agency staff will make every effort to fully discuss it with you before taking any action and agency staff will limit their disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

If your unpaid bill must be referred to a collection agency or small claims court, your name, payment record, and last known address will be given to that agency.

Confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal law and regulations. Generally, the AOD program will not convey to a person outside the AOD program that a client attends or receives services from the program or disclose any information identifying a client as an alcohol or drug abuser unless: disclosure is expressly permitted in writing, the disclosure is allowed by court order, the disclosure is made to medical personnel in a medical emergency, or the disclosure is made to qualified personnel for research, audit or program evaluation. Violation of the Federal law and regulations by this program is a crime and suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. See 42 U.S.C. 290 DD-3 and 42 U.S.C. 290 EE-3 for Federal Laws and CFR Part 2 for Federal Regulations.

PROFESSIONAL RECORDS:

The laws and standards of this profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your provider's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of \$1 per page for the first ten pages, 50 cents per page for pages 11 through 50, and 20 cents per page for pages in excess of fifty, plus a \$15 fee for records search, plus postage. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

CLIENT RIGHTS:

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about agency policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS:

Patients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless agency staff decide that such access would injure the child or we agree otherwise. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in mental health treatment is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment. For children 14 and over, it is our policy to request an agreement between the client and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

It is this agency's policy to attempt to engage both parental figures in their child's treatment unless parental rights have been terminated. Additionally, both parents may have access to view and/or request copies of the child's treatment record. If parental rights have been terminated, it is the responsibility of the parent who is seeking treatment for the child to provide documentation reflecting termination of parental rights.

MUTUAL RIGHTS AND RESPONSIBILITIES:

Your counselor is responsible for using your counseling time wisely and for developing and following a treatment plan that will help you deal with your problems. If your counselor believes that a problem would best be handled by another health care provider--a counselor, psychologist, specialists, or physician--a referral will be made. Your counselor will use available resources to help you.

You are responsible for cooperating with treatment and for trying to change those things that you and your counselor have identified to be changed. That means you must work on your problems both in counseling sessions and in daily life. You always have the right to ask for a change in treatment or to refuse treatment unless you are under court order. If you believe you are not being helped, please

tell your counselor so that changes can be made if possible. If you continue to feel you are not being helped, we will help you find another counselor.

Whenever you change your behavior, there are certain risks involved such as interpersonal strain, family conflicts, etc. Your counselor will make every effort to clarify these risks when they come up. When you enter into a counseling/psychotherapeutic relationship, you are almost certain to change your perceptions of the world and the way you interact with the people you encounter daily. These changes may result in emotional/interpersonal/economic difficulties and this is always a risk in participating in treatment. Sometimes, situations must get worse before they can get better. During diagnostic assessment, you may discover parts of your self that you are uncomfortable with and may have to admit to behaviors that embarrass you. Sometimes, this results in a drop in self-esteem and may make you feel worse. If you are participating in forensic services (court ordered services), you may deal with additional legal repercussions as the result of your participation in services provided by this agency. Your counselor will review with you the possible consequences of each intervention strategy. You have a right to refuse treatment at any time.

Based on each of our professions, we are bound by the professional and ethical standard of State law and our professions. That means we must respect your confidentiality (except for the situations noted above), we must provide the best service that we are capable of, work within the limits of our competencies, respect your rights and integrity, and act as far as we are able in your best interests. If you believe one or more of us has acted in an unprofessional or unethical manner, please tell your counselor so that the problem can be discussed and resolved. If you feel that the discussion has not helped, you should contact the Client's Rights Officer or any of the agencies listed on the *Client Rights Statement*.

If you would like to file a grievance and are a participant in the AOD program, you must do so in writing. The grievance must be dated and signed by the client and must include the date, time, description, and names of individuals involved in the incident/situation being grieved. The grievance is to be given to the Client's Rights Officer. MOPS will make a resolution decision on the grievance within 21 calendar days of receipt of the grievance. You have the option to file a grievance with outside organizations that include, but are not limited to, the agencies listed in the Client's Rights statement.

BILLING AND PAYMENTS:

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the agency to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If

such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT:

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. We will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, our billing staff will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your treatment.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract.

MEDICAID/SLIDING FEE CLIENTS:

To be eligible to receive public funds to help pay for the cost of your mental health services, you will need to sign a statement that allows the agency to give demographic and billing information to: The Fairfield County ADAMH (Alcohol, Drug and Mental Health) Board, Public-Private solutions hub, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Human Services, and MACSIS (Multi-Agency Community Services Information System) and process claims in compliance with state requirements. ORC 5199.61 (K) authorizes the development and operation of a community mental health information system, but prohibits the collection of information for the purpose of identifying clients by name except as necessary to validate appropriate reimbursement, therefore only a subset of MACSIS data will be collected in name identified form.

ALL INFORMATION COLLECTED FOR MACSIS WILL BE CONFIDENTIAL, consistent with state and federal law. Name identified information will only be used to pay for services received. Other information will be kept without your name attached. This information will not be available to any other sources or used for any other purposes. You have the right to review your records and notify the agency of errors in your record. Billing information will be kept for seven (7) years after you have received services, and only demographic information will be kept after that time.

If you do not agree to sign this disclosure and authorization form, the Board may not be able to use public funds to pay for your services. Approximately 40% of Medicaid funding is supported through a local levy administered by the Fairfield County ADAMH Board (if you are a resident of another county, this amount is contributed by that county's mental health and recovery services board).

AUTHORIZATION FOR SERVICES:

I have read and understood the Client Guidelines (rev. 04/22/05), and have been given a copy for myself. I understand my rights and responsibilities and those of the counselor.

I have read and understand the above and authorize the disclosure of name identifying billing information to the Fairfield County ADAMH Board, Public-Private Solutions hub, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Human Services, and MACSIS (Multi-Agency Community Services Information System).

I agree to the conditions of this policy and give my informed consent for services for the following service(s) for myself:

- Diagnostic Assessment
- Forensic Services (not confidential)
- Outpatient counseling/psychotherapy
- Psychiatric Services (Medication/Somatic)
- Alcohol and Other Drug (AOD) Services
- CSP Services (Case Management)

Client's Signature

Counselor's Signature

Date

I agree to the conditions of this policy and give my informed consent for the above service(s) for the minor child, _____, and understand that the conditions of this policy apply to the child, but that as parent/legal guardian I am the only person who can consent to release information about the child's treatment.

Guardian's Signature

Date

CLIENT RIGHTS STATEMENT

rev. 2/21/2005

The Ohio Department of Mental Health [5122:2-1-02 (F)(1)(a)] requires that as a client of Mid-Ohio Psychological Services, Inc. you must be informed of patient/client rights. Therefore, it is necessary that you read the following and show your recognition of these rights by signing on the lines provided. Please feel free to ask questions if you have any doubts about any right or the meaning of the paper.

Services of Mid-Ohio Psychological Services, Inc. are available to anyone regardless of sex, age, religion, race, color, national origin or physical impairment. Persons from Fairfield County are given priority.

While you are receiving services at the Mid-Ohio Psychological Services, Inc. you have the following rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.
2. The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan.
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives.
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral. AOD clients have the right to receive a copy of one's own individualized treatment plan.
6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.
7. The right to freedom from unnecessary or excessive medication.
8. The right to freedom from unnecessary restraint or seclusion.
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan.
10. The right to be informed of any unusual or hazardous treatment procedures.
11. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs.
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.

13. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Administrative Code.
14. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear Treatment Reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an eminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Client shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records.
15. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
16. The right to receive an explanation of the reasons for denial of service.
17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.
18. The right to know the cost of services.
19. The right to be fully informed of all rights.
20. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.
21. The right to file a grievance.
22. The right to have oral and written instructions for filing a grievance.

If you have any questions concerning these rights or would like to file a grievance, you may contact the Client Rights Officer, Shawna Watts-Shumaker (Mid-Ohio Psychological Services, Inc., 624 East Main Street, Lancaster, Ohio 43130) during normal working hours (9:30 am to 5:30 pm) or by calling (740) 687-0024. The Client Rights Officer is responsible for accepting and overseeing the grievance process of any grievance filed by a client or other person or agency on behalf of a client. If the Client Rights Officer is the subject of the grievance or is unavailable, the alternative Client Rights Officer is Alice Grant and can be contacted as noted above.

Mid-Ohio Psychological Services is an agency which receives funds from the Ohio Department of Mental Health and the Fairfield County Mental Health and Recovery Services Board (FCMHRS) and as such is subject to audits by these entities. All information obtained in audits will be maintained as confidential as required by state and federal confidentiality regulations.

You may also seek additional help by contacting any of the following agencies.

1. Fairfield County ADAMH Board
 1560 Sheridan Drive
 Lancaster, Ohio 43130
 (740) 654-0829 Fax (740) 654-7621

2. Ohio Department of Mental Health
 Client Advocacy Coordinator
 30 East Board Street, 8th Floor
 Columbus, Ohio 43266-0414
 (614) 466-2333 Fax (614) 466-1571

3. State of Ohio Psychology Board
 77 South High Street, Suite 1830
 Columbus, Ohio 43215-6108
 (614) 466-8808 Fax 614-728-7081

4. Ohio Legal Rights Service
 8 East Long Street, 5th Floor
 Columbus, Ohio 43266-0523
 1-800-282-9181 or (614) 466-7264

5. State of Ohio Counselor and Social Worker and Marriage and Family Therapist Board
 77 South High Street, 16th Floor
 Columbus, Ohio 43215-6108
 (614) 466-0912 Fax 614-728-7790

6. Ohio Department of Alcohol and Drug Addiction Services
 Two Nationwide Plaza
 280 North High Street, 12th Floor
 Columbus, Ohio 43215-2537
 (614) 466-3445 Fax (614) 752-8645 TDD (614) 644-9140

7. Lisa Simeone, Regional Manager
 Office for Civil Rights
 U.S. Dept. of Health & Human Services
 233 N. Michigan Ave., Suite 240
 Chicago, Ill. 60601
 (312) 886-2359 Fax (312) 886-1807 TDD (312)353-5693

8. Ohio Medical Board
77 South High Street, 17th Floor
Columbus, Ohio 43266-0315
(800) 554-7717 or (614) 466-3934
9. Attorney General's Office
Health Care Fraud Unit
101 E. Town Street, 5th Floor
Columbus, Ohio 43215
(614) 466-0722 Fax (614) 644-9973
10. Nursing Education & Nurse Registration Board
77 South High Street, 17th Floor
Columbus, Ohio 43266-0316
(614) 466-3947
11. Vocational Rehabilitation Client Assistance Program
30 East Broad Street, Suite 1201
Columbus, Ohio
1 800-228-5405 Fax (614) 752-4197

CLIENT RIGHTS STATEMENT

I have read and understand the Client Rights Statement (rev. 2/21/2005) and have been given a copy for myself.

Client's Signature: _____

Parent/Legal Guardian's Signature: _____

Counselor's Signature: _____

Date: _____

PRIVACY NOTICE FORM

(rev 4/14/03)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

This agency may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when staff of this agency provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when staff consult with another health care provider, such as your family physician or another mental health provider.
 - *Payment* is when this agency obtains reimbursement for your healthcare. Examples of payment are when staff disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within this agency such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of this agency, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Agency staff may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when agency staff are asked for information for purposes outside of treatment, payment and health care operations, agency staff will obtain an authorization from you before releasing this information. Agency staff will also need to obtain an authorization before releasing your psychotherapy notes.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) agency staff have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Agency staff may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in the staff's professional capacity, staff know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, staff are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.
- **Elder Abuse:** If agency staff have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, staff are required by law to immediately report such belief to the County Department of Job and Family Services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and agency staff will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If agency staff believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, agency staff may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to agency staff an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and agency staff believe you have the intent and ability to carry out the threat, then agency staff are required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Worker's Compensation:** If you file a worker's compensation claim, agency staff may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, agency staff are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, agency staff will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in agency mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Agency staff may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, agency staff will discuss with you the details of the request process. It may take several days to arrange for the inspection of your records and/or to copy your records. A fee may be associated with the copying of your records.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Agency staff may deny your request. On your request, agency staff will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, agency staff will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from this agency upon request, even if you have agreed to receive the notice electronically.

Mental Health Provider's Duties:

- Agency staff are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- Agency staff reserve the right to change the privacy policies and practices described in this notice. Unless agency staff notify you of such changes, however, agency staff are required to abide by the terms currently in effect.
- If agency staff revise these policies and procedures, the new policies and procedures will be posted on the agency web site: www.mopsohio.com

V. Questions and Complaints

If you have questions about this notice, disagree with a decision agency staff make about access to your records, or have other concerns about your privacy rights, you may contact the client's rights officer listed in the "Client Guidelines" form.

If you believe that your privacy rights have been violated and wish to file a complaint with this agency, you may send your written complaint to:

Client Right's Officer
Mid-Ohio Psychological Services
624 East Main Street
Lancaster, Ohio 43130

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Agency staff will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

This agency reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Agency staff will provide you with a revised notice by posting these changes to the agency web site.

Privacy Notice Acknowledgement:

I acknowledge that I have been given a copy of the “Privacy Notice” (rev. 4/14/03) and understand these rights and responsibilities. I understand that if I have any questions about these issues that I can discuss them with my clinician or the agency’s Client Right’s Officer.

Client Signature

Date:

Clinician Signature

Date:

**MID-OHIO PSYCHOLOGICAL SERVICES, INC.
CLIENT SELF-REPORT PSYCHO-SOCIAL INTAKE
(Adult Form)**

Client Name: _____ Date: _____

Social Security Number: _____ Phone: _____

Case Manage Name/Agency) _____

Legal Status: Parole [] Probation [] Pending Case [] None []

Who sent you to this agency: _____

BIOGRAPHICAL INFORMATION

Gender _____ Date of Birth _____ Age _____

Race/Ethnic _____ County of Residence _____

Permanent address _____

Contact in Case of Emergency _____ Phone# _____

FAMILY & SOCIAL INFORMATION

Current Marital Status: _____ Length of time: _____

Number and date of Previous Marriages and names of spouses: _____

Names and ages of your children and name of their other parent _____

Community Interest/Involvement _____

Religious/Spiritual Involvement _____

Legal System Involvement _____

EDUCATIONAL & OCCUPATIONAL HISTORY

Highest grade completed in school: _____ **School** _____

Were you ever in special classes (explain): _____

Extracurricular Activities: _____

Current Occupation/Means of Support _____

Work History:

Date:	Employer	Type Work	How Terminated
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Military History:

Branch	Years Service	Type of Discharge
_____	_____	_____

Other Sources of Income: _____

ABUSE HISTORY

Have you ever been physically abused (describe): _____

Have you ever been sexually abused (describe): _____

Have you ever been mentally abused (describe): _____

Have you ever been neglected (describe): _____

HAVE YOU EVER USED THE FOLLOWING :	PLEASE CHECK	HOW OFTEN DO YOU USE?	WHEN DID YOU LAST USE:
ALCOHOL			
POT			
SPEED			
COCAINE			
DOWNS			
ACID			
HEROIN			
INHALANTS			
TOBACCO			
CAFFEINE			

Do you have any other addictions (i.e., Gambling, Food) _____

MENTAL HEALTH HISTORY

Have you ever seen a counselor before (describe): _____

Have you ever been in a psychiatric hospital (describe): _____

Have you ever had hallucinations (describe): _____

Have you ever attempted suicide (describe): _____

Why are you seeking counseling at the present time (Please give details): _____

=====

Reviewed by Clinical Director: Yes No

Assigned to: _____

Type of Payment: _____

Physical Health Assessment

Legal Name _____ Date _____

Name you prefer _____ Age _____

Birth date _____ Male Female

Race: White Black Asian Am. Indian Hispanic Other _____

Name of family physician or clinic: _____

Address: _____

Date last seen by physician: _____

Date of last physical: _____

Are you currently under a physician's treatment? Yes No

Condition(s) you are being treated for _____

List all medications you are currently taking or have discontinued within the last month (30 days) for physical and/or emotional reasons. Include birth control pills and over the counter medications:

None taken

Name of Medication	Dosage	How Often Taken	Who told you to take this medication?	How long have you taken it?	Is it a Prescription Medication?

Who administers these medications to you?

Self
 Other: _____

What other kinds of medications have you taken in the past?

Allergies:

Allergies to Medication Yes No

If yes, which medications: _____

Type of reaction: _____

Other allergies (food, environment, etc) _____

Type of reaction: _____

FEMALES:

Are you currently pregnant? Yes No How far along? _____

Breast-feeding? Yes No

Have you ever had an abortion? Yes No How many? _____

Have you ever had a miscarriage? Yes No How many? _____

Is your menstrual cycle Regular Irregular

MALES & FEMALES:

Height _____ Weight _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

Do you use street drugs? Yes No How much? _____

What
kind? _____

Have you ever abused prescription medications? Yes No

Describe: _____

Do you drink coffee or other caffeine products? Yes No

How much? _____

Have you ever been sexually abused? Yes No

Describe Briefly:

Have you ever been physically abused? Yes No

Describe Briefly:

Are you sexually active? Yes No

Are you having any difficulties performing sexually? Yes No

Explain:

Aids to daily living:

Glasses/Contact lens Hearing Aid Dentures/Partial Prosthetics

Other significant medical information or observations: _____

Significant medical history in your biological family (ie. History of psychiatric problems, chronic medical problems, etc)._____

List past surgeries/injuries/hospitalizations and dates:

Describe any physical or developmental disabilities that you may have (ie. Were you ever in special education classes, have you ever had a significant physical injury, are you on SSD?):

In the last year, how many times have you:

- | | |
|---|--------------------------------|
| _____ Been to the hospital | _____ Seen your regular doctor |
| _____ Been to the emergency room | _____ Been to a dentist |
| _____ Received services at an outpatient clinic | |

Please mark the following with a (P) if you have had any problems with the following in the past and with a (C) if you currently have problems with the condition :

- | | | | |
|------------------------|--------------------------------|--------------------------------------|------------------------------|
| __ AIDS | __ Bronchitis | __ Nerve Problems | __ Gall Bladder Disease |
| __ HIV+ | __ Blackouts | __ Heart Failure | __ Migraine Headaches |
| __ Cancer | __ Cataracts | __ Liver Disease | __ Kidney Disease/
Stones |
| __ Stroke | __ Jaundice | __ Low Blood Pressure | __ Alcohol/Drug Abuse |
| __ Asthma | __ Diabetes | __ High Blood Pressure | __ Psychiatric Problems |
| __ Anemia | __ Hepatitis | __ Seizures/Epilepsy | __ Panic Attacks |
| __ Ulcers | __ Pneumonia | __ Arthritis | __ Gonorrhea/Syphilis |
| __ Colitis | __ Thyroid/Goiter | __ Rheumatic Fever | __ Herpes/Venereal |
| __ Glaucoma | __ Heart Attack | __ Urine Infections | __ Warts/Crabs |
| __ Vision
Problems | __ Emphysema | __ Frequent Cough | __ Poor Circulation |
| __ Over
Weight | __ Tuberculosis | __ Bleeding Tendencies | __ Chest Pains |
| __ Memory
Problems | __ Dizziness | __ Loss of Bladder/
Bowel Control | __ Palpitations |
| __ Weight
Loss/Gain | __ Blood Disease | __ Sinus Problems | __ Poor Appetite |
| __ Back Pain | __ Rashes or
Skin Condition | __ Colostomy/Urostomy | __ Overeating |
| __ Numbness | __ Nightmares | __ Hallucinations | __ Constipation |
| | __ Confusion | __ Difficulty Sleeping | __ Diarrhea |
| | __ Hard of Hearing/
Deaf | __ Muscle Weakness | __ Impotency/Frigidity |

_____	_____
Client Signature	Date

Client refused to complete this form. _____
Staff Initials Date

Client refused to sign release to gather medial information _____
Staff Initials Date

Staff use only	
Physical exam warranted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If pregnant, was an effort made to ensure prenatal care? (Explain on back of form) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the client sign a release to communicate with and/or obtain a PHA from a physician: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician referral made to: _____	
Other instructions/concerns: _____ _____ _____	
_____	_____
Signature of RN or Physician	Date

BILLING AUTHORIZATION

Client Name: _____ Sex: M F
(Last) (First) (Middle Initial)

Address: _____

County of Origin: _____ County of Residence: _____

Home Phone (_____) _____ Business Phone (_____) _____

Date of Birth: _____ Age: _____ SS#: _____

Employer: _____

Guardian's Name: _____

Address: _____

Who Referred You: _____

Monthly Household Income: _____

Family Size: _____ List Family Members: _____

INSURANCE INFORMATION

Answer each item completely and provide a completed claim form at your earliest convenience. A copy of your Medicaid Card must be furnished monthly.

Medicaid/Medicare Number: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____ SS#: _____

Subscriber's Employer: _____

Group Name/Number: _____ Subscriber ID: _____

Responsible Party's Name & Address: _____

(Our office will bill your insurance carrier directly for all services unless other arrangements have been made. The responsible party will also receive a bill and is responsible for any unpaid balance. Client's or responsible party's signature authorizes release of information as may be necessary to the insurance carrier for processing of insurance claims. Signature also authorizes payment of insurance benefits to be made directly to the supplier of the services.)

Signed _____ Date _____

Print Name: _____

8. Your personal safety?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

9. The neighborhood in which you live?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

10. Your housing/living arrangements?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

11. Your health in general?

- Terrible
- Mostly dissatisfied
- Equally satisfied/dissatisfied
- Mostly satisfied
- Very pleased

12. How often do you have the opportunity to spend time with people you really like?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

Part 2
These next few items ask you about your health and medications <i>within the past 6 months.</i>

13. How often does your physical condition interfere with your day-to-day functioning?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

14. Concerns about my medications (such as side effects, dosage, type of medication) are addressed:

- Never
- Seldom/rarely
- Sometimes
- Often
- Always
- Not applicable/no medications

The next two items deal with how you have been treated by other people.

15. I have been treated with dignity and respect at this agency.

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

16. How often do you feel worried by people's reactions to the problems that brought you to the agency?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

Part 3
The following questions ask you about how much you were distressed or bothered by some things <i>during the last seven days.</i> Please mark the answer that best describes how you feel.

During the past 7 days, about how much were you distressed or bothered by:

17. Nervousness or shakiness inside

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

18. Being suddenly scared for no reason

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

19. Feeling fearful

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

20. Feeling tense or keyed up

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

21. Spells of terror or panic

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

22. Feeling so restless you couldn't sit still

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

23. Heavy feelings in arms or legs

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

24. Feeling afraid to go out of your home alone

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

25. Feeling of worthlessness

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

26. Feeling lonely even when you are with people

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

27. Feeling weak in parts of your body

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

28. Feeling blue

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

29. Feeling lonely

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

30. Feeling no interest in things

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

31. Feeling afraid in open spaces or on the streets

- Not at all
- A little bit
- Some
- Quite a bit
- Extremely

32. How often can you tell when mental or emotional problems are about to occur?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

33. When you can tell, how often can you take care of the problems before they become worse?

- Never
- Seldom/rarely
- Sometimes
- Often
- Always

Part 4

Please tell us some things about yourself.

34. What was the last school grade you completed?

- Less than 1st grade
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- High school diploma/GED
- Trade/Tech school
- Some college
- 2 yr college/Associate degree
- 4 yr college/Undergraduate degree
- Graduate school courses
- Graduate degree
- Post-graduate studies
- Further special studies

35. Race (check all that apply):

- White
- Native American/Pacific Islander
- Black/African-American
- Hispanic/Latino
- Asian
- Other_____

36. What is your marital status?

- Never married
- Married
- Separated
- Divorced
- Widowed
- Living together

37. What is your current living situation?

- Your own house/apartment
- Friend's home
- Relative's home
- Supervised group living
- Supervised apartment
- Boarding home
- Crisis residential
- Child foster care
- Adult foster care
- Intermediate care facility
- Skilled nursing facility
- Respite care
- MR intermediate care facility
- Licensed MR facility
- State MR institution
- State MH institution
- Hospital
- Correctional facility
- Homeless
- Rest home
- Other_____

38. What is your employment status?

- Employed full time
- Employed part time
- Sheltered employment
- Unemployed
- Homemaker
- Retired
- Disabled
- Inmate of institution

39. Are you in treatment because you want to be?

- Yes
- No

Please stop here. Thanks!!

MACSIS 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 residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? <input type="checkbox"/> Yes <input type="checkbox"/> 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

Client is a Minor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate if child is in legal custody of the following (this is not the foster parent). <input type="checkbox"/> Parent <input type="checkbox"/> CSB <input type="checkbox"/> DYS <input type="checkbox"/> Court <input type="checkbox"/> 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.