Youthville

INTAKE PACKET CHECKLIST

All documents must be completed and signed by parent, SRS Social Worker or Child Welfare Contractor representative. If the information is incomplete, the client will not be scheduled for intake appointment until the documents are received.

- ☐ Youthville Child/Youth Intake Form (including Financial Agreement)
- ☐ Youthville HIPAA Acknowledgement & Attempt
- ☐ Youthville Client Rights and Responsibilities for Clinical Services form (the clinician will check the informed consent box on the form – page 2)
- ☐ Kansas Health Solutions Members Rights
- ☐ Professional Disclosure (complete physician consultation section, including the check box that the release was completed, or the waiver section)
- ☐ Youthville Authorization for Release of Information (2-3)
  - PCP (if the client does not have a PCP then the physician consultation waiver on the Professional Disclosure will suffice)
  - School
  - Last Mental Health treatment provider
- ☐ CINC petition
- ☐ Medicaid card
- ☐ SRS medical consent
- ☐ SRS YA 2300 (for children 5 and under, if available)
- ☐ Current safety plan(s), if applicable

Youthville
Family Consultation Service

560 N. Exposition
Wichita, KS 67203
(316) 264-8317
Fax (316) 264-0347

Child/Youth Intake Form

CHILD'S INFORMATION:

NAME: _____ FCS ID#: _____ KAECSES #: _____
First name Middle Initial Last Name

DOB: _____ AGE: _____ SS NUMBER: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

PHONE NUMBER: _____ _____
Home Cell

RACE/ETHNICITY OF CHILD

☐ African American/Black ☐ Caucasian/White ☐ Japanese ☐ Hispanic
☐ Asian ☐ Chinese ☐ Native American ☐ Biracial
☐ Hawaiian ☐ Vietnamese ☐ Other

Are there any communication barriers for the child or parent/guardian? _____ If so, please explain: _____

CAREGIVER INFORMATION:

☐ PARENT ☐ RELATIVE ☐ GUARDIAN ☐ RESOURCE PARENT

NAME: _____
Last name First Name Middle Initial

ADDRESS: (if different) _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

PHONE NUMBER: _____ _____ _____
Home Cell Work

Number of household members: _____

Are there any immediate family members in the military? _____ If so, have they served in combat? _____

Who is legally authorized to receive information about and make decisions regarding this child's care?

_____
Name and Relationship

CASE MANAGER/ PO: _____ AGENCY: _____ PHONE: _____ ☐ N/A

WHO REFERRED YOU TO OUR AGENCY: _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT FOR THIS CHILD: _____

IS TREATMENT COURT ORDERED? YES ☐ NO ☐

EMPLOYMENT INFORMATION:

☐ Full-time Student ☐ Part-time Student ☐ Employed ☐ N/A

Name of Employer: _____ Job Title: _____

LEGAL HISTORY:

Has the child been charged with a crime ☐ Yes ☐ No Is the child on probation? ☐ Yes ☐ No

If yes, please explain: _____

Child's Name:_____

SUBSTANCE USE HISTORY:

☐ NONE

☐ Alcohol ☐ Other substance use _____

Attended alcohol/drug abuse treatment: ☐Yes ☐No Has the child been told that they have an alcohol/drug problem: ☐Yes ☐No

GAMBLING HISTORY (PLEASE COMPLETE IF YOUR CHILD IS 12 YEARS OF AGE OR OLDER):

Are you seeking services for a gambling addiction: ☐ Yes ☐ No

If so, has the youth ever lied about their gambling: ☐ Yes ☐ No

If so, has the youth ever increased bets to get the same sense of action: ☐ Yes ☐ No

SCHOOL FUNCTIONING:

Current School:_____ ☐Elementary ☐Middle School ☐High School

Grade: _____ Teacher's Name:_____ School Phone Number:_____

Past / Present truancy Yes ☐ No ☐

Expulsions Yes ☐ No ☐ Number _____ Dates _____

Suspensions Yes ☐ No ☐ In school ☐ Out of school ☐ Number _____Dates _____

Asked to leave a daycare/preschool Yes ☐ No ☐ Number _____ Dates _____

☐ 504 Plan ☐ Special Education / IEP _____

SOCIAL, PLAY AND RECREATION: Describe the child's social, play and recreational interests:

_____

_____

PLACEMENT HISTORY: ☐ N/A

Type: Resource home, shelter, residential facility _____ Kinship home

Dates/length of stay: _____

Reason for moving: _____

Type: Resource home, shelter, residential facility _____ Kinship home

Dates/length of stay: _____

Reason for moving: _____

Please document additional placements on a separate page

CASE PLAN GOAL ☐ Reintegration ☐ Adoption ☐ Guardianship ☐ Maintenance at Home ☐ OPPLA ☐ NA

CONCURRENT CASE PLAN GOAL ☐ Adoption ☐ Guardianship ☐ OPPLA ☐ NA

MENTAL HEALTH HISTORY:

☐ No previous therapy

☐ Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Child's Name:_____

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized: ☐ Yes ☐ No ☐ N/A Multiple Hospitalizations: ☐ Yes _____

Last psychiatric facility _____ Date Admitted _____ Date Dismissed_____

Please document additional hospitalizations on a separate sheet

PRIMARY CARE PHYSICIAN (PCP):

NAME:_____ PHONE:_____

ADDRESS: _____

Visit/Checkup with PCP within the past 12 months: ☐ YES ☐ NO Regular preventative health screens: ☐ YES ☐ NO

CURRENTLY PRESCRIBED MEDICATIONS (Medication, dosage and prescribing physician):

_____

_____

Has the child been consistently taking these medications as prescribed ☐ YES ☐ NO

PATIENT MEDICAL/HEALTH: (Please check all that apply – past or current)

	PAST	OR CURRENT		PAST	OR CURRENT		PAST	OR CURRENT
ASTHMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	FREQUENT EAR INFECTIONS	☐	☐
HEART DISEASE	☐	☐	THYROID PROBLEMS	☐	☐	DENTAL PROBLEMS	☐	☐
CANCER	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS	☐	☐
SEIZURES	☐	☐	SIGNIFICANT WEIGHT GAIN/LOSS	☐	☐	HEPATITIS	☐	☐
DIABETES	☐	☐	SEASONAL ALLERGIES	☐	☐	GASTRO INTESTINAL PROBLEMS	☐	☐
HEAD INJURY	☐	☐	KIDNEY DISEASE	☐	☐	OTHER_____	☐	☐

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_____

History of hospitalization due to a medical condition: ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_____

Medication Allergies _____

NUTRITION: (Please check all that apply – past or current)

	PAST	OR CURRENT		PAST	OR CURRENT		PAST	OR CURRENT
INCREASED APPETITE	☐	☐	BINGE EATING	☐	☐	OTHER_____	☐	☐
DECREASED APPETITE	☐	☐						

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_____

Food Allergies _____

I have made myself throw-up after eating ☐ YES ☐ NO I do not eat a wide variety of healthy foods ☐ YES ☐ NO

PAIN:

	PAST	OR CURRENT	
CHRONIC PAIN	☐	☐	IF YES, PLEASE DESCRIBE: _____

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_____

I experience a decrease in my ability to function in life due to this pain ☐ YES ☐ NO

PSYCHIATRIC HISTORY:

	PAST	OR CURRENT		PAST	OR CURRENT		PAST	OR CURRENT
ADHD	☐	☐	ABUSE: SEXUAL	☐	☐	OTHER_____	☐	☐
ANXIETY	☐	☐	ABUSE: PHYSICAL	☐	☐			
DEPRESSION	☐	☐	EATING DISORDER	☐	☐			

Child's Name:_____

DEVELOPMENTAL HISTORY:

PREGNANCY: ☐ FULL TERM ☐ PREMATURE ☐ LATE DELIVERY: ☐ NORMAL DELIVERY ☐ C-SECTION

Problems during pregnancy_____

MILESTONES:

WALKING _____ MONTHS *TALKING* _____ MONTHS *TOILET TRAINED* _____ MONTHS

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for immediate family "2" for extended family)

___ Diabetes ___ Heart Disease ___ Anxiety ___ Psychiatric hospitalizations

___ Depression ___ Schizophrenia ___ Suicide attempts ___ Alcohol/drugs

___ ADHD ___ Bipolar Disorder ___ Antisocial behavior (difficulties – police/violence)

VISITATION ARRANGEMENTS:

Are there any custody/visitation arrangements? Please describe, noting any court orders:

_____

_____

FAMILY, CULTURE AND RELIGION: Describe the child's family, cultural and religious connections.

_____

_____

BEREAVEMENT AND GRIEF: Has the child experienced grief and or loss? If so, describe how your family is supported socially, spiritually and culturally._____

_____

GENERAL FUNCTIONING: (Please check all that apply)

- ☐ Cheerful/happy mood most of the time
- ☐ Sad or tearful most of the time
- ☐ Feelings of hopelessness
- ☐ Withdrawn behaviors
- ☐ Difficulty thinking
- ☐ Under active/sluggish behavior
- ☐ Intentional self harm
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Sleepwalking
- ☐ Poor self-care/poor hygiene
- ☐ Nightmares
- ☐ Takes more than an hour to fall asleep
- ☐ Night waking for longer than 30 minutes
- ☐ Hard to wake up in the morning
- ☐ Unable to sleep in own bed through the night
- ☐ Extreme ups and downs in mood
- ☐ Irritability/anger
- ☐ Distinct periods of nonstop activity
- ☐ Exaggerated view of abilities
- ☐ Fast/rapid speech
- ☐ Feels rested after 3-4 hours sleep/ night
- ☐ Fearless/engaging in reckless activities
- ☐ Fearful of places, situations or people
- ☐ Worries about _____
- ☐ Wetting accidents
- ☐ Soiling Accidents
- ☐ Sexual inappropriate touching of others
- ☐ Sexual play with toys or objects
- ☐ Excessive masturbation
- ☐ Intentional vomiting/purging
- ☐ Difficulty concentrating
- ☐ Conflict with authority figures
- ☐ Stealing
- ☐ Physical cruelty to animals
- ☐ Physical aggression
- ☐ Verbal threats to harm others
- ☐ Threat to kill with intent /plan
- ☐ Lying
- ☐ Extreme conflict with siblings
- ☐ Running away
- ☐ Poor social skills
- ☐ Inability to complete tasks
- ☐ Inability to sustain attention
- ☐ Inability to remain seated
- ☐ Overactive/hyperactive behavior
- ☐ Easily distracted
- ☐ Hoarding food

WHEN DID THESE CONCERNS BEGIN? _____

_____

HOW OFTEN DO THESE OCCUR? _____

_____

Child's Name:__

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD?

_____

_____

CONSENT AND AUTHORIZATION

By signing below you are:

- Authorizing Youthville Family Consultation Service to provide the client with mental health services.
- Acknowledging that Youthville Family Consultation Service will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client (or parent or guardian if the client is under 18 years of age).
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.
- Acknowledging that you have signed a copy of the Financial Agreement & understand the terms of this agreement.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature X_____ Date_____

Must Be Signed by Client or by Parent or Guardian if Client is Under 18 Years of Age.

Youthville Family Consultation Service is an equal opportunity employer. Services are provided to people without regard to race, religion, color, sex, ancestry, national origin, handicap, age or political affiliation.

Youthville
Family Consultation Service

Financial Agreement

12/01/09

Client Information

Name: _____ Soc Security # _____

Date of Birth: _____

Responsible Party

Name: _____ Telephone: _____

Relationship to Client: _____ Cell Phone: _____

Address (if different from client): _____ Apt.#: _____

City, State: _____ Zip: _____

Billing Information

☐ No current health insurance coverage

☐ Insurance

☐ Employer EAP _____ (company)

☐ Medical Card # _____

☐ Medicare Card # _____

☐ Cenpatico Card # _____

Primary Insurance

Name (Policy Holder): _____ Soc Security #: _____

Address: _____ DOB: _____

Telephone #: _____ Cell Phone #: _____

Insurance Company: _____ Group/Plan #: _____

Policy ID #: _____ Employer: _____

Insurance Co. Phone #:

Secondary Insurance (if applicable)

Name (Policy Holder): _____ Soc Security #: _____

Address: _____ DOB: _____

Telephone #: _____ Cell Phone #: _____

Insurance Company: _____ Group/Plan #: _____

Policy ID #: _____ Employer: _____

Insurance Co. Phone #:

By signing this agreement you agree to and acknowledge each of the following conditions.

1. The information provided regarding insurance coverage is accurate.
2. The client or you, as the client's parent or guardian, are responsible for payment for fees for professional services.
3. If the client is covered by an insurance policy and if Youthville Family Consultation Service agrees to bill that insurance company for services rendered to the client, you are responsible for completing any required preauthorization of services and for all applicable co-payments, deductibles, coinsurance, and non-allowable charges.
4. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
5. There is a higher fee for your first appointment than on-going appointments.
6. A no show appointment (failure to cancel 24 hours prior) will require full payment of your fee before being rescheduled.
7. If your insurance company denies, refuses, or fails to make payments for the services rendered, Youthville Family Consultation Service will notify you in writing and require immediate payment of all sums due.
8. ~~Insufficient fund checks will be assessed a $30.00 charge.~~
9. You may be liable for a client obligation under Medicaid and will be required to pay any such obligation in full.
10. You are responsible for notifying Youthville Family Consultation Service of any changes in name, address, telephone number or insurance coverage.
11. By signing this agreement, you agree to allow Youthville Family Consultation Service to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
12. In order to meet the needs of all clients, Youthville Family Consultation Service will necessarily discontinue treatment for a client who NO SHOWS or cancels appointments frequently. For further questions, discuss this policy with the assigned therapist.
13. Non-payment for services could result in your account being turned over to our collection agency and/or termination of services. Our collection agency will assess you costs of collection including related court, legal, and/or attorney fees. Services that have been terminated for non-payment will not be re-opened without payment in full of all account balances.

ASSIGNMENT OF BENEFITS

I authorize benefits payable under the above named insurance contract to be paid directly to the provider, (Youthville Family Consultation Service). A copy of this form shall be considered as valid as the original form.

Signature X_____ Date_____

I understand I am responsible for any balance remaining after insurance and write-offs.

Signature X_____ Date_____

For Office Use Only	
☐ Copy of Insurance Card, Front & Back	☐ Copy of this document to Parent/Guardian/Policy Holder
☐ Copy of this document and copy of insurance card to the client file.	
☐ Original document and copy of insurance card to Finance.	

Youthville
Family Consultation Service

Client Rights & Responsibilities for Clinical Services

Youthville respects you and your family, and our goal is to protect your rights as a client. Honoring these rights is an important part of respecting and caring for you as a whole person. We value you and your family's role in making decisions about your care.

We will provide care in a manner intended to be respectful of your personal values and beliefs and sensitive to cultural, racial, religious and other differences. We will not discriminate on the basis of race, color, religion, age, sex, sexual orientation, national origin, or disability. You are important to us and we want to work with you to provide the best care possible.

Client Rights & Responsibilities

- Clients will receive treatment in the least restrictive, most appropriate manner.
- Clients will always be treated with dignity and respect and never subjected to verbal or physical abuse or exploitation.
- Clients will receive an explanation of the potential benefits and any known side effects or other risks associated with all medications that are prescribed by the agency.
- Clients will receive an explanation of the potential benefits and any known adverse consequences or risks associated with any type of treatment that is included in their treatment plan.
- Clients will not be subjected to any type of treatment, technique, intervention, or practice, including the use of any type of restraint or seclusion, performed solely as a means of coercion, discipline, or retaliation, or for the convenience of staff.
- Clients will be provided information about alternative treatments the agency provides, even if this is not the recommended treatment of the assigned clinician.
- Clients receiving treatment voluntarily may refuse any treatment or medication.
- Clients receiving treatment involuntarily will be informed that there may be consequences to the client if they fail or refuse to comply with any portion of the treatment plan.
- Clients may refuse participation in any experimental treatment or research project. Clients will never be forcibly subjected to treatment without the client's knowledge and express consent.
- Clients have the right to participate in developing their treatment plan, including the right to request changes regarding specific services or providers.
- Clients may receive additional mental health services from providers not employed by Youthville although information should be provided to ensure coordination of treatment.
- Clients may choose to have another individual accompany them in their contacts with Youthville. This right will be limited if the clinician believes this would interfere with confidentiality or treatment, or would be unduly disruptive to the agency's operation.
- Clients have the right to expect that Youthville staff will safeguard information regarding the client's previous or current participation in mental health treatment.
- Clients may exercise their rights through the use of advance directives, a living will, a durable power of attorney or powers associated with a custodianship.
- Clients will be informed of all services fees, payment requirements, and potential consequences for non-payment. Clients will be provided with treatment options and/or referral to a provider in their area should the agency decide to terminate treatment prior to completion for any reason. If an emergency situation exists, sufficient services will be provided to clients until transfer can be made to another provider.
- Children will not be left unsupervised in the lobby. A client child will not be dropped-off.

You have the right to have confidential care and treatment records as protected by K.S.A. 1986 Supp. 65-5601 to 65-5605. Within Youthville Family Consultation Service information about you may be exchanged as needed for our staff to do their jobs. Information may also be exchanged during professional consultation; during internal or contracted supervision of our staff, students, or volunteers; or with referring agencies (such as SRS). The staff may also consult with other members of the treatment team regarding your care and treatment. Representatives of licensing and accreditation organizations will have access to your record for the purpose of reviewing and evaluating Youthville Family Consultation Service compliance with licensing and accreditation regulations and standards. Our staff has an ethical responsibility to report certain information to the appropriate people or agencies when they believe that you are a serious danger to yourself or to others, and this information can be reported with or without your permission. In case of suspected physical, mental, or sexual abuse or neglect of a child, the staff is required by law to report information to the proper authorities with or without your permission. A court of law can order your records without your permission. Under no circumstances, other than stated above, may any staff member communicate any information about you without your knowledge and written consent. Your records are confidential, and the information is for professional use and may only be sent to other people or organizations with your written consent.

Grievances

Clients, client representatives, families, volunteers, relatives, colleagues, etc. have the right to have their concerns listened to in a manner that is respectful and timely. The expression of a complaint or grievance will in no way compromise or interfere with the services and care provided to the client, family, relative, volunteer, etc. All complaints or grievances will be taken seriously, addressed, and the staff involved will document any steps taken. The Family Stakeholder Liaison will complete the investigation within 30 days of receipt of the privacy grievance or complaint or within 90 days of receipt for general grievances. When a client's health condition requires it, the review period may be expedited. The complainant will be notified of the grievance disposition by phone whenever possible and by mail. Notification will occur within 30 days of receipt of the privacy grievance or complaint or within 90 days of receipt for general grievances. In some instances, the complainant will be notified of the right to file a grievance with the State after exhausting the agency grievance process. Grievances, including those involving the use or disclosure of protected health information, access to protected health information, or other privacy concerns, should be directed to the Privacy Officer. To file a complaint or grievance call the Here to Hear line at 1-800-593-1950, ext. 350 or email privacyofficer@youthville.org.

_____ _____

Responsible Party's Signature Date

By signing this form I acknowledge that I understand the information above and have received a copy of the informed consent.

_____

Print Client's Name

Youthville Notice of Privacy Practices – Client Summary

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

We understand that treatment/health information about you is personal. Youthville employees are committed to protecting your treatment/health information and privacy.

We will use your information to provide care and treatment, create a record of the care and services you receive, bill your insurance in a timely fashion if applicable, and operate our facility in a diligent manner.

We will safeguard your information and share it only with those who need or are entitled to know it. We will obtain your permission for other use or disclosure.

You may ask to see, change, restrict, or obtain a copy of your information and file a formal complaint if we fail to assure your privacy or information confidentiality.

For more details, please read this Notice of Privacy Practices.

Youthville provides treatment/health care to our clients in partnership with other professionals and organizations. Our privacy practices guide:

- Any treatment/health care professional that treats you at any of our locations.
- All departments or units of our organization, including all off-campus units or departments.
- All staff or volunteers of our organization.
- Any business associate of Youthville with whom we need to share your treatment/health information.

We are required by law to:

- Keep treatment/health information about you private.
- Provide you this notice of our legal duties and privacy practices with respect to treatment/health information about you.
- Follow the most stringent state and/or federal law.
- Abide by our currently published Notice of Privacy Practices.

We may change our policies at any time. Changes will apply to treatment/health information we already have. When we make a significant change in our policies, we will change our notice and post the new notice in our offices, in our living units, and on our Web site at www.youthville.org. You can receive a copy of the current notice at any time. You will be offered a copy of the current notice at the time you are first provided care by Youthville. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose treatment/health information about you.

- If you are a client receiving services with multiple providers within Youthville, we can share your current, past, and/or future treatment/health information with those other Youthville providers (including, but not limited to Resource Parents, Therapists, Chemical Dependency Counselors, Permanency Specialists, and Foster Care Workers).
- We may use and disclose treatment/health information about you for **treatment** (example, sending treatment/health information about you to a specialist as part of a referral), **to obtain payment for treatment** (example, sending billing information to your insurance company or Medicaid), and **to support our health care operations** (example, using client information to improve quality of care).
- We may use and disclose treatment/health information about you **without** your prior authorization for several other reasons. Subject to certain requirement, we may give out treatment/health information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections,**

national security, and emergencies. We also disclose treatment/health information when required by law, such as in response to **valid judicial or administrative orders.**

- We may also contact you for appointment reminders, or tell you about or recommend possible treatment options, alternative, health-related benefits or services that may be of interest to you.
- We may disclose treatment/health information about you to a friend or family member whom you designate to be involved in your care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of treatment/health information.

- In any other situation not involving routine care, financial and insurance matters or organizational operations, we will ask for your written authorization before using or disclosing treatment/health information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decisions.

Your rights regarding treatment/health information about you.

- In most cases, you have the right to look at or get a copy of treatment/health information that we use to make decisions about your care, after you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, if it is not part of the medical information maintained by us, or if we determine that your record is accurate. You may appeal, in writing, a decision by us not to amend the record.
- You have the right to a list of those instances where we have disclosed treatment/health information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the amount before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that treatment/health information about you be communicated to you in a confidential manner (such as sending mail to an address other than your home) by notifying us in writing of the specific way or location to communicate with you.
- You may request in writing that we not use or disclose treatment/health information about you for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request, but we are not legally required to accept it. We will inform you of our decision on your request.

Complaints

- If you wish to file a complaint because you feel that your privacy rights may have been violated or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below).
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.
- Under no circumstances will you be penalized or retaliated against for filing a complaint.

Katie Herzberg
Privacy Officer
Youthville
4505 East 47th Street South
Wichita, KS 67210
Voice Phone: 316.529.9100 ext 8113
FAX: 316.529.9351
E-mail: kherzberg@youthville.org

Region VII Office of Civil Rights
U.S. Department of Health & Human Services
601 E. 12th Street, Room 248
Kansas City, MO 64106
Voice Phone: 816.426.7278
FAX: 816.426.3686
TDD: 816.426.7065

Effective Date: April 14, 2003 – Revised 082510

Youthville Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received a copy of the Youthville Notice of Privacy Practices. I understand if I am a client receiving services from multiple providers within Youthville that my current, past, and/or present treatment/health information can be shared with those other Youthville providers (including, but not limited to Resource Parents, Therapists, Chemical Dependency Counselors, Permanency Specialists, and Foster Care Workers).

Name (Please Print)

Signature Date

If you have a child (minor) being served, cared for, or treated by Youthville, please provide their names below.

Name (Please Print) Name (Please Print)

Name (Please Print) Name (Please Print)

Name (Please Print) Name (Please Print)

Name (Please Print) Name (Please Print)

Office Use Only

Attempt to Obtain Acknowledgment

If, after efforts have been made to obtain an acknowledgment, one has not or cannot be obtained, complete the following information:

Client Information: Enter the client or clients' name in the spaces above, leaving the signature portion blank.

Today's Date:		Staff Completing:	
Did the client receive a copy of the Privacy Notice [ ] Yes [ ] No			
Describe attempts made to obtain acknowledgment:			
Reason Acknowledgement was not obtained:			

Are you a victim of a violent crime? If so you are not alone. You have the right to be treated with courtesy, compassion and with respect for their dignity and privacy. You have the right to receive information regarding resources available to you.

The Kansas Crime Victims Compensation Board provides victims with financial help for loss of earnings and out of pocket expenses for injuries endured as a direct result of violent crime. Crime victims may be eligible to receive financial help for costs by simply completing an application. Once your application has been completed and filed, your claim will be assigned to an investigator for further processing, and then onto the Board for a final decision. You will be notified by postal mail in regards to the approval or denial of your claim. A crime victim may receive up to $25,000 in compensation. Funeral expenses are limited to $5,000. Cost for reasonable medical care, mental health counseling or other services necessary as a result of the injury may be included. In the event of the death of the victim, reasonable medical expenses and the partial cost of funeral, burial, or cremation is also reimbursable.

Crime victims are not alone at Family Consultation Service (FCS). The FCS staff can provide you with a Crime Victims Eligibility Form, Application, and other helpful resources available to victims and witnesses of crime. Knowing what to expect, how the criminal justice system works, and what resources are available to you can help offer comfort and support during an otherwise unfortunate time in your life.

PCP

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

FCS ID # _____ KAECSES # _____

Client Last Name	First Name	MI	Date of Birth	SSN

I, _____, the client or authorized representative, authorize
(Identification may be required to complete this form)

YOUTHVILLE to:

RELEASE the following written information:
(Please initial each applicable item)

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ ~~Psychological Evaluation Report~~
_____ Discharge Summary
_____ Progress Review(s)
(* See Next Page.)
_____ Hospitalization Screening
_____ Progress Notes: FROM _____ TO _____
_____ Medical _____
_____ Other: _____
_____ Other: _____
_____ Other: _____
_____ Other: _____

OBTAIN the following written information:
(Please initial each applicable item)

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ ~~Psychological Evaluation Report~~
_____ Discharge Summary
_____ Progress Review(s)
_____ Alcohol and Drug Treatment Information
_____ Hospitalization Screening
_____ Progress Notes: FROM: _____ TO: _____
_____ Medical Reports _____
_____ Legal Reports _____
_____ Education Reports _____
_____ Other: _____
_____ Other: _____

I authorize communication with the person or agency listed below in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above–named client's treatment. (Please initial all that apply.)

_____ **VERBAL COMMUNICATION** _____ **FAX COMMUNICATION**
_____ **EMAIL COMMUNICATION** _____ **US MAIL**

TO / FROM – NAME / AGENCY _____

ADDRESS: _____

CITY, STATE, ZIP: _____

_____
Client or Authorized Representative Signature Date Relationship to Client

_____
Witness Date

****THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE**

PCP

Client Name_____

RESTRICTIONS – The information indicated will be disclosed unless there are specific restrictions noted here:_____

_____

THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

_____ Evaluation / Treatment Planning ____ Case Coordination ____Legal Proceedings

_____ School Placement or Assessment ____ Other _____

- I understand that under state and federal confidentiality provisions only the information specified can be released to the specified person or agency. (CFR-42, part 2 , KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)
- I also understand that Youthville cannot ensure that the recipient will maintain confidentiality of this information I have authorized to be released.
- I also understand that this authorization will be honored unless revoked verbally or in writing. Verbal revocation must be followed by written verification within 24 hours. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify Youthville. (KAR 30-60-47(b)(7), AAPS Standards for Licensure/Certification, Chapter 7,1.a.(7), and CFR-42, part 2)
- I also understand that this authorization will expire (Select One **): (KAR 30-60-47(b)(6), CFR-42, part 2)

☐ Maximally, one year from this date (i.e., date of signature below).

OR ☐ On the following date: _____ (MM/DD/YY).

OR ☐ Upon the following specific event: (Please describe.) _____

_____

** Note: If neither a specific date or a specific event is selected this Authorization will automatically expire 90 days after discharge from Youthville or one year from the date of the signature below, whichever comes first. *

- I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information. (CFR 42, part 2)
- I understand that this authorization is voluntary and that Youthville can not condition treatment on whether I sign the authorization, (with limited exceptions relating to research-related treatment and an authorization requested by a health plan prior to enrollment for eligibility and enrollment determinations).
- I verify that I have been given the chance to ask and receive answers to questions.

* This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**** A photo static copy of this Authorization shall be considered as valid as the original. ****

School

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

FCS ID # _____ KAECSES # _____

Client Last Name	First Name	MI	Date of Birth	SSN

I, _____, the client or authorized representative, authorize
(Identification may be required to complete this form)

YOUTHVILLE to:

RELEASE the following written information:
(Please initial each applicable item)

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_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Progress Review(s)
(* See Next Page.)
_____ Hospitalization Screening
_____ Progress Notes: FROM _____ TO _____
_____ Medical _____
_____ Other: _____
_____ Other: _____
_____ Other: _____
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(Please initial each applicable item)

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_____ **VERBAL COMMUNICATION** _____ **FAX COMMUNICATION**
_____ **EMAIL COMMUNICATION** _____ **US MAIL**

TO / FROM – NAME / AGENCY _____

ADDRESS: _____

CITY, STATE, ZIP: _____

_____
Client or Authorized Representative Signature Date Relationship to Client

_____
Witness Date

****THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE**

School

Client Name_____

RESTRICTIONS – The information indicated will be disclosed unless there are specific restrictions noted here:_____

_____

THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

_____ Evaluation / Treatment Planning _____ Case Coordination _____Legal Proceedings

_____ School Placement or Assessment _____ Other _____

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Previous Mental Health Provider

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

FCS ID # _____ KAECSES # _____

Client Last Name	First Name	MI	Date of Birth	SSN

I, _____, the client or authorized representative, authorize
(Identification may be required to complete this form)

YOUTHVILLE to:

RELEASE the following written information:
(Please initial each applicable item)

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
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(* See Next Page.)
_____ Hospitalization Screening
_____ Progress Notes: FROM _____ TO _____
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_____ Other: _____
_____ Other: _____
_____ Other: _____
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OBTAIN the following written information:
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_____ **VERBAL COMMUNICATION** _____ **FAX COMMUNICATION**
_____ **EMAIL COMMUNICATION** _____ **US MAIL**

TO / FROM – NAME / AGENCY _____

ADDRESS: _____

CITY, STATE, ZIP: _____

_____
Client or Authorized Representative Signature Date Relationship to Client

_____
Witness Date

****THIS DOCUMENT IS NOT VALID UNLESS THE INFORMATION IS COMPLETE ON REVERSE SIDE**

Previous Mental Health Provider

Client Name_____

RESTRICTIONS – The information indicated will be disclosed unless there are specific restrictions noted here:_____

_____

THE PURPOSE OR NEED FOR THE DISCLOSURE (Initial all that apply)

_____ Evaluation / Treatment Planning _____ Case Coordination _____Legal Proceedings

_____ School Placement or Assessment _____ Other _____

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OR ☐ On the following date: _____ (MM/DD/YY).

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_____

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Youthville
Family Consultation Service

Kansas Health Solutions Member Rights

02-20-08

- **Receive Information.** Each Member has the right to receive information about Kansas Health Solutions, our policies and procedures, our services, our practitioners and providers, and the Members rights and responsibilities.
- **Copy of medical records.** Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected as specified in 45 CFR part 164.
- **Free exercise of rights.** Each Member is free to exercise his or her rights, and that the exercise of these rights does not adversely affect the way the Member is treated by Kansas Health Solutions and the provider.
- **Freedom to change providers.** Kansas Health Solutions shall not impose any limitation on the Member's freedom to change mental health solutions.

Kansas Health Solutions Members have the additional right and responsibilities:

- To choose his/her provider
- To ask for a therapist who understands his/her language and culture
- To receive needed services at convenient times and places
- To obtain access to services within the specified access standards
- To treat others with consideration and respect
- To be at appointments on time
- To call if he/she must cancel
- To be part of the treatment team by telling your doctor or therapist about symptoms and to as questions
- To tell the doctor or therapist if you do not agree with recommendations
- To tell the doctor or therapist when/if you want to end treatment
- To take medications as prescribed and to tell the doctor if there is a problem
- To carry his/her insurance cards
- To tell the provider if they have other insurance
- To follow plans and instructions for care that they have agreed on with providers

Second Opinions

Another important right Kansas Health Solutions Members need to know about is the right to request a second opinion. Members can request a second opinion from a licensed mental health professional within Kansas Health Solutions' network.

Kansas Health Solutions will provide for a second opinion from an appropriate behavioral health care professional within the network or arrange for the Member to get one outside the network at no cost to the Member.

Grievances

Members or their designated representative (e.g. family member, friend, lawyer, or other person) as specified by the Member in writing, may file a grievance either orally or in written form with Kansas Health Solutions and any provider. A Member has 180 days from the occurrence to file a grievance. Members or their representatives can contact the Kansas Health Solutions Ombudsman for assistance in completing forms and any other procedural steps. To file a grievance contact the toll free number 1-866-547-0222.

Member Contact Information

Kansas Health Solutions, LLC.
720 SW Jackson, Suite 310
Topeka, KS 66603
1-785-575-9393
www.kansashealthsolutions.org

_____ _____
Responsible Party's Signature Date

Signature indicates having read this document and understanding of rights & responsibilities as a consumer of Youthville Family Consultation Service.

_____
Print Client Name

Youthville

Professional Disclosure

07/10/08

Client Name: Date of Birth:

FCS Client #: KAECSES #: Clinician's Name:

Disclosure:

License of the Provider:

- ☐ Licensed Master's Social Worker
- ☐ Licensed Marriage & Family Therapist
- ☐ Licensed Master's Level Psychologist
- ☐ Licensed Professional Counselor
- ☐ Licensed Psychologist
- ☐ Licensed Specialist Clinical Social Worker
- ☐ Licensed Clinical Marriage & Family Therapist
- ☐ Licensed Clinical Psychotherapist
- ☐ Licensed Clinical Professional Counselor

Client was informed of the clinician's training, job title, license, level of education, and scope of practice (i.e., ability to diagnose, treat, prescribe medication, and perform surgery). Documentation of client's understanding of such disclosure shall be placed in the client's case file. Please be advised that certain mental disorders can have medical or biological origins, and that you should consult with a physician.

Client's Signature

Clinician Signature, Credentials Date

Physician Consultation:

In Kansas, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of such consultation is to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms. The client/parent/legal guardian may also choose to waive such consultation. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived.

Physician's Name _____ Location: _____ Phone Number _____

Client/Parent/Legal Guardian Signature Relationship

Clinician Signature, Credentials Date

☐ Release Completed

Waiver of Consultation:

Medical consultation for the above named client is hereby waived.

Signature of Client/Parent/Legal Guardian Relationship Date