San Luis Obispo Co Drug & Alcohol Services Programs

Triage Sheet

Today's Date: ______________

Full Name (First, Middle, & Last): ____
(Spell out middle name)

Date of Birth: ______________ **Social Security#:** ___________________________________

Referral Source: ______________________________ **DL# or ID#** _______________________

Substance(s) Used? (please check all that apply) Alcohol Fentanyl

Heroin Opiates Methamphetamine THC Benzodiazepines

Hallucinogens Other (fill in) ______________________________

Are you an IV user? .... Yes No

Have you experienced an overdose in the last 30 days? .... Yes No

Would you like a free Naloxone kit today? .... Yes No

*Please note, you can come in and obtain Naloxone training and kit in any of our 4 locations. You can also go to any CVS/ Walgreens and obtain Naloxone without a prescription.

Are you here for opiate withdrawal management/ suboxone? .... Yes No

Are you here for alcohol detox or for medication to stop drinking? Yes No

Have you had any suicide attempts in the past 30 days? .... Yes No

Do you have current thoughts about harming yourself? .... Yes No

Have you been in a Psychiatric In-Patient Unit or the CSU in the last 30-days? .... Yes No

Are you pregnant? Yes No Unknown **(If yes, due date ____________)**

How many days in the last 30 days have you had physical health problems? ______

Have you been to the ER or stayed overnight in the hospital in the past 30-days? .... Yes No

Have you been released from jail in the past 30 days? .... Yes No

Do you have transportation to treatment appointments? .... Yes No

Do you consider yourself homeless? .... Yes No

Client Name: ________________________________ Client MR# ________________

County of San Luis Obispo Behavioral Health

Client Information

Client MR#: ____________________ Social Security Number: ________________________

Prefix ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Client Name: ____
(First) (Middle) (Last)

Email: ____

Medicaid ID: ___________________ Medicare Beneficiary ID: ______________________

Phone Number #1: _________________ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Phone Number #2: _________________ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Street Address: ______________________________ City/State/Zip Code: _________________
Billing Address: ☐ Yes ☐ No If no, billing address: ___________________________________

Comments: List any special needs or considerations important to note about the client.

Client Aliases

Client Name: ____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: ____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: ____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

County of San Luis Obispo Behavioral Health

Client Information

Demographics

Date of Birth: ___________________ Sex: ☐ Male ☐ Female ☐ Not Listed

Marital Status:

☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Widowed
☐ Never Married ☐ Unknown

Gender Identity:

☐ Male ☐ Female ☐ Non-Binary ☐ Unsure/Questioning ☐ Other ☐ Transgender
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Prefer not to answer
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Unknown/Not Asked
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation:

☐ Heterosexual / Straight ☐ Lesbian (female) ☐ Gay (male) ☐ Bisexual ☐ Transgender
☐ Prefer not to answer ☐ Unsure / Questioning ☐ Declined to state ☐ Unknown/Not Asked

Pronoun: ☐ He ☐ She ☐ They ☐ Ze

Ethnicity:

☐ Amerasian ☐ American Native ☐ Asian Indian ☐ Black ☐ Cambodian ☐ Chinese
☐ Dominican ☐ Filipino ☐ Guamanian ☐ Hawaiian Native ☐ Hispanic/Latino ☐ Japanese
☐ Korean ☐ Laotian ☐ Mexican/Mexican American ☐ Multiple ☐ Not Hispanic or Latino
☐ Other Asian or Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Unknown

Race:

☐ Alaskan native ☐ American Indian ☐ Asian Indian ☐ Black/African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hmong ☐ Japanese ☐ Korean
☐ Laotian ☐ Mien ☐ Multiracial ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White/Caucasian ☐ Unknown ☐ Prefer not to answer

Primary Care Physician: ____

☐ Client does not have PCP

Financial Information

Financially Responsible: ☐ Yes ☐ No

Annual Household Income: $____________ # of Dependents: ______ # in Household: ______

Source of Income:
☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension ☐ Disability
☐ Other ☐ None ☐ Unknown ☐ Not collected

Living Arrangements:

☐ Dependent Living ☐ Homeless ☐ Independent Living ☐ Private residence – Independent
☐ On the streets or in a homeless shelter ☐ Private residence – Dependent ☐ Adult or child
☐ Jail or correctional facility ☐ Institutional setting ☐ 24-hour residential care
☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.) ☐ Group Home
☐ House or apartment, requiring some support with daily living activities (adults only)
☐ House or apartment, requiring daily support and supervision (adults only)
☐ Supported housing (adults only) ☐ Foster Family Home ☐ Residential Treatment Center
☐ Community Treatment Facility ☐ Board and Care ☐ Mental Health Rehabilitation Center
☐ Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility ☐ State Hospital ☐ Justice-related ☐ Other
☐ Inpatient Psychiatric Hospital, Inpatient Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital ☐ Homeless, no identifiable residence ☐ Unknown/Not Reported
☐ Skilled Nursing Facility/Intermediate Care Facility/Institution of Mental Disease

County of Residence: ________________ County of Financial Responsibility: ______________

Education/Employment:

Educational Status:
Currently Enrolled: ☐ Yes ☐ No Grade Level Enrolled: __________
Highest Grade Level Completed: _________________ Able to Read/Write: ☐ Yes ☐ No
☐ Able to read and write ☐ Able to read but not write ☐ Able to write but not read

Military Status: ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No

Employment Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed Seeking Work
☐ Unemployed Not Seeking Work ☐ Supported/Transitional Employment
☐ Homemaker ☐ Student ☐ Retired ☐ Disabled Not in Workforce ☐ Ages 0-5
☐ Volunteer Worker ☐ Resident/Inmate of Institution ☐ Other: ____________________

Criminal Justice Involvement:

☐ Probation ☐ Dept of Corrections ☐ Dept of Youth Services Commitment
☐ Jail ☐ Parole ☐ Not involved

Language:

Primary/Preferred Language: __________________________

☐ Client Does not Speak English ☐ Interpreter Services Needed

Hispanic Origin:

☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not of Hispanic Origin
☐ Prefer Not to Answer ☐ Unknown

Transportation Information

☐ Transportation Services Needed

Note any special needs accommodations (e.g. wheelchair, service animal, high rise)

Preferences

Communication Preference: ☐ Text Message ☐ Email ☐ Voice ☐ Do Not Send Any Notifications

Communication Phone Number: ______________________________

Days of the week: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri

County of San Luis Obispo Behavioral Health

Client Information

Contacts

Contact #1 Information: Relationship: ____________________

Name ____________________________________ Date of Birth: ____________________

First Last

Email Address: _______________________ Organization: ____________________

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: ______________________ Phone #2: _______________________

Address: ☐ Same as client

Street Address: _________________________________

City, State, Zip: _________________________________

Contact #2 Information: Relationship: ____________________

Name ____________________________________ Date of Birth: ____________________

First Last

Email Address: _______________________ Organization: ____________________

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: ______________________ Phone #2: _______________________

Address: ☐ Same as client

Street Address: _________________________________

City, State, Zip: _________________________________

County of San Luis Obispo Behavioral Health

Client Information

Contact #3 Information: Relationship: ____________________

Name ____________________________________ Date of Birth: ____________________
First Last

Email Address: ________________________ Organization: ____________________

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: ______________________ Phone #2: ______________________

Address: ☐ Same as client

Street Address: ________________________________

City, State, Zip: _________________________________

Contact #4 Information: Relationship: ____________________

Name ____________________________________ Date of Birth: ____________________
First Last

Email Address: ________________________ Organization: ____________________

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: ______________________ Phone #2: ______________________

Address: ☐ Same as client

Street Address: ________________________________

City, State, Zip: _________________________________

BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX (805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

Medical Providers:

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

☐Community Health Center ☐Private Community Physician ☐Hospital Emergency Rooms
☐Urgent Care Center ☐Pain Management Services ☐Specialty Medicine (i.e., Neurology, Cardiology, Endocrinology)
☐Dentists ☐Methadone Clinics

General Health Information

1. Date you last saw a Doctor / Nurse Practitioner / Physician Assistant:	2. What was the purpose of the visit?	3. Date of your last physical exam?

4. ☐ How many times have you visited an Emergency Room in the past 30 days?

5. ☐ How many days in past 30 have you stayed overnight in a hospital for physical health problems?

6. ☐ How many days in the past 30 have you experienced physical health problems?

7. ☐Yes ☐No Have you ever had surgery? If yes, please list:

8. ☐Yes ☐No Any other illness that requires frequent medical attention? If yes, please give details:

Allergies

9. ☐Yes ☐No Do you have any allergies? If yes, *what type of reaction did you have?* Fill out below-↓

Medication Allergies -

Food Allergies -

Other Allergies -

Medications

10. Please list any prescribed medications and over-the-counter medications you take regularly. (Include dosage and prescribing physician)

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

11. Which Pharmacy do you use?

12. Are you currently experiencing or do you have any of the following?

Yes No
☐ ☐ Swollen Ankles
☐ ☐ Jaundice
☐ ☐ Sinus Problems
☐ ☐ Bleeding Problems - Bruising Easily
☐ ☐ Joint Pain or Stiffness
☐ ☐ Difficulty Swallowing
☐ ☐ Chest Pain (Angina)
☐ ☐ Excessive Heartburn or Abdominal Pains
☐ ☐ Excessive Thirst
☐ ☐ Cough, Persistent or Bloody
☐ ☐ Chronic Back Pain
☐ ☐ Tooth or Gum Problems
☐ ☐ Nausea or Vomiting
☐ ☐ Diarrhea, Constipation, Blood in Stools
☐ ☐ Dizziness or fainting
☐ ☐ Frequent or Bloody Urination
☐ ☐ Rashes
☐ ☐ Blurred or Double Vision
☐ ☐ Fever

Yes No
☐ ☐ Seizures
☐ ☐ Headaches
☐ ☐ Weight Gain or Loss Recently
☐ ☐ Shortness of Breath
☐ ☐ Blood Transfusions
☐ ☐ Arthritis
☐ ☐ Stroke - If yes, give details: ____________________
☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure
☐ ☐ Artificial Joint
☐ ☐ Head Injury - If yes, give details: details: ____________________
☐ ☐ Cancer
☐ ☐ Chemotherapy/Radiation
☐ ☐ Diabetes
☐ ☐ Asthma, Emphysema, or Chronic Bronchitis
☐ ☐ Anemia
☐ ☐ Heart Attack or Heart Problem - If yes, please give details:

CLIENT NAME	CLIENT NUMBER

13. Women Only	
Yes No ☐ ☐ Are you pregnant? If yes, due date: ____ ☐ ☐ Are you breastfeeding? If yes, date of delivery: ____ ☐ ☐ Have you had any miscarriages or abortions? If yes, please give details: ____ ☐ ☐ Do you have difficult periods? If yes, please give details: ____ At what age did you start your first period? ____ Date of last period: ____	Yes No ☐ ☐ Have you experienced any domestic violence? ☐ ☐ Do you have pain with intercourse? ☐ ☐ Have you had an abnormal mammogram or lump? If yes, please give details: ____ ☐ ☐ Have you had an abnormal PAP smear? If yes, please give details: ____ Date of last GYN exam: ____

Communicable Diseases

14. ☐Yes ☐No Have you ever been tested for TB? (Tuberculosis)?
15. ☐Yes ☐No Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: ____

16. ☐Yes ☐No Have you been diagnosed with Hepatitis C? Date of last test: ____
17. ☐Yes ☐No Have you been tested for any other liver disease?

18. ☐Yes ☐No Have you been diagnosed with a Sexually Transmitted Disease (STD)? 19. ☐Yes ☐No Did you get treated?	Date of last STD Test?
20. ☐Yes ☐No Have you been tested for HIV? 21. ☐Yes ☐No Did you receive the test result?	Date of last HIV Test?

Mental Health

22. ☐Yes ☐No Have you ever been diagnosed with a mental illness? If yes, what was your diagnosis? ____
23. ☐Yes ☐No Did you receive treatment? If yes, please give details:

24. ☐ How many times in the last 30 days have you received outpatient emergency services for mental health needs?

25. ☐ How many days in the last 30 have you stayed 24 hours or more in a hospital or psychiatric health facility for mental health needs?

26. ☐Yes ☐No In the past 30 days have you taken prescribed medication for mental health needs, including medication for anxiety?

27. ☐Yes ☐No Past suicide attempts?	28. Date of last suicide attempt:	29. How many suicide attempts in your lifetime?

Alcohol and Other Drugs

30. Do you use the following substances and how frequently:	Daily	Often	Sometimes	Date last used
Alcohol→				
Other substances→				

31. ☐Yes ☐No Have you ever injected drugs?
32. ☐Yes ☐No Have you shared needles?
33. ☐Yes ☐No Have you shared cottons?

34. ☐ How many days in the past 30 have you injected drugs?	Last time injected drugs:

35. ☐Yes ☐No Have you ever used SLO Co. Needle Exchange?

36. ☐Yes ☐No Are you in withdrawal today? If yes, list from what substance(s)?

37. ☐Yes ☐No Seizures, delirium tremens? If yes, please give details:

38. ☐Yes ☐No Have you had blackouts? If yes, please give details:

39. ☐Yes ☐No Are you currently smoking / ingesting marijuana? → ☐Yes ☐No Medical Marijuana Card?	Date last smoked/ingested marijuana:
40. ☐Yes ☐No Have you ever overdosed on alcohol or other drugs?	If Yes, please give details:

41. ☐Yes ☐No Do you currently use any tobacco products (cigarettes, electronic cigarettes, chew)?

To the best of my knowledge the above information is accurate and true, and I will inform my provider of changes in my health or medications:

Client Signature:	**Date:**
Staff Signature:	**Date:**
CLIENT NAME	**CLIENT NUMBER**

County of San Luis Obispo Behavioral Health

Coordinated Care Consent

Client Name: ____________________ Client ID: ____________

Authorization for the Disclosure of Health and Other Personal Information

By signing this form below, you will allow certain organizations and individuals to use and share your health and other personal information for purposes related to your treatment and care. They will be able to share your information through an electronic health record system maintained by the California Mental Health Services Authority called SmartCare.

1. Who will share my information if I sign? By signing, your information may be shared by and with any of the following that provide services to you ("your providers") and which are connected to SmartCare:

- Health care providers, such as doctors, hospitals, and pharmacies.
- Mental health providers and substance use disorder providers.
- School-based providers, such as nurses, social workers, and counselors.
- California county health care agencies.
- Housing providers, that is, nonprofits that help people find a home.
- Any jails or prisons that provides services to you while you're incarcerated.
- Any child welfare agencies that are actively involved in your or your child's case.
- Your providers also include any health insurers that provide you with coverage, including any of your mental health plans.

2. Will my providers be able to use and share my information for any reason?

No, your providers can only use and share your information for limited purposes. Your providers may use and share your information to provide you with medical or behavioral health care, to coordinate your care, to determine how much should be paid for services provided to you, or to improve the quality of care.

3. What types of information about me may be shared if I sign? Your providers may share the following types of information about you:

- Medical information, such as information about illnesses, injuries, medical treatments, allergies, medications, X-rays, blood tests, and your HIV status.
- Behavioral health information, such as any mental health conditions or alcohol or drug use disorders you may have, which could include information on your substance use history and medications, diagnoses, and drug test results.
- School services information, such as an Individualized Education Program, and any records of medical or behavioral health services provided in schools.
- Housing service information maintained in a Homeless Management Information System, which describes services provided to some people without homes.
- Incarceration information including, if you are incarcerated, when you are scheduled to be released.
- Child welfare records, including any family reunification or maintenance plan.

4. Can I obtain a list of providers who saw my information?

Yes, can obtain a list of providers that have received some types of your information by contacting County of San Luis Obispo Central Health Information at (805) 781-4724

5. Can my providers who receive my information share it with others?

Yes, but only if permitted by state and federal laws. In some cases your information may no longer be subject to federal privacy laws once it is shared.

6. When does my consent expire?

Your providers will be able to access your information for 10 years after the date you sign, unless you revoke your consent earlier.

County of San Luis Obispo Behavioral Health

Coordinated Care Consent

Client Name: ____________________ Client ID: ____________

Authorization for the Disclosure of Health and Other Personal Information Cont'd

7. Can I change my mind and revoke my consent later?
Yes, you have a right to revoke this form at any time. If you want to revoke, you should contact County of San Luis Obispo Central Health Information at 805-781-4724. If you revoke, your providers still may keep any information they received about you prior to the date of revocation.

8. If I am a parent or guardian, can I sign on behalf of my child?

Yes, you may do so by including your name as the "Legal Representative" of your child and by signing the last line. Your child should also sign the first line if your child is 12 or older. If you sign on behalf of a child, the form will expire when your child turns 18.

9. Do I have to sign this?

No, signing this form is voluntary, and declining to sign this form will not impact your ability to get medical care, health insurance, or any government benefits. If you don't sign, some of your providers still may have a right to obtain some of your information under the law.

10. Can I have a copy of this form?

Yes, you have a right to obtain a copy of this form.

By signing below, I consent to the disclosure of my information as described in this form. Further, by including my phone number below, I consent to the receipt of texts or calls to communicate with me about my consent and how my information may be shared (standard message and data rates may apply).

Client Information

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________________ Email: ______________________

Contact: ______________________ Relation: ______________________

Client Phone #: ____________________ ☐ DNC ☐ DNLM

Client Alt. Phone #: ______________ ☐ DNC ☐ DNLM

Client Address: ______________________________________
____

Billing ☐ ______________________________________

County of San Luis Obispo Behavioral Health
Coordinated Care Consent

Client Name: ____________________ Client ID: ____________

Authorization for the Disclosure of Health and Other Personal Information Cont'd

I give consent for sharing of information across all services within the San Luis Obispo County Behavioral Health network.

☐ Yes ☐ No

Start Date: __________________ Expiration Date: __________________

Client Identified Restrictions

Restricted Staff: ______________________________
____
____
____

Details on any other restrictions of sharing my data. This will prompt a review by the County of San Luis Obispo Behavioral Health Privacy Officer. This does not guarantee the restriction of this data as specified in the text.

Client Signature: ______________________________ Date: _____________

Parent/Guardian Signature: ______________________ Date: _____________

Relationship to Client: ________________________

Staff Signature: ______________________________ Date: _____________

County of San Luis Obispo Behavioral Health
Consent To Treat

Client Name: ____________________________ Client ID: ________________

Start Date: ________________ End Date: ______________

Purpose

I would like services for myself or my child from The County of San Luis Obispo Behavioral Health and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

My Rights

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

Privacy Practices

I acknowledge I have been offered a copy of County of San Luis Obispo Behavioral Health's Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others. I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

Services

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

Risks and Benefits of Services

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment.

Client Name: ____________________ Client ID: _____________

I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.

I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.

I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary

I understand participation in behavioral health services is voluntary, except for certain situations where County of San Luis Obispo Behavioral Health is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships.

I understand that even if a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services that are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

Eligibility for Services

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure.

Client Name: ____________________ Client ID: _____________

I understand that County of San Luis Obispo Behavioral Health may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies

I understand providers are generally available during regular county business hours, which are 8am - 5pm, except during county holidays. I understand that some programs have different hours of availability. For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with County of San Luis Obispo Behavioral Health's after-hours telephone service. For urgent or crisis situations, I or my child can contact: County of San Luis Obispo Behavioral Health's Crisis Line at: 1-800-838-1381.

For emergencies, I understand my family or I should call 911.

Change of Clinician/Provider

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance

I understand County of San Luis Obispo Behavioral Health will ask me to provide my financial information on annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

I understand any private insurance will be billed by County of San Luis Obispo Behavioral Health before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

Client Name: ____________________ Client ID: ____________

Additional Documents for Medi-Cal Clients

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries.

Complaints and Grievances

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from County of San Luis Obispo Behavioral Health and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

Complaints to the Licensure Board

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Informed Consent

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.

Client Signature: ____ Date: ________________

Parent/Guardian Signature: ______________________________ Date: ________________

Relationship to Client: ____________________________________

County of San Luis Obispo Behavioral Health

Consent for Text Communication

Client Name: ______________________________ Client ID #: ____________

I hereby agree to receive communication through text message (SMS) under the terms of this consent form. I understand that:

• If my phone number changes, I should inform The County of San Luis Obispo as soon as possible. I understand that if I don't inform The County of San Luis Obispo, providers may continue to text my previous number under this consent, which may result in a breach of confidentiality.

• When using my own personal electronic device, The County of San Luis Obispo does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.

• Texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular message will be read and responded to within any particular period of time.

• Providers will use reasonable means to maintain security and confidentiality of text information sent and received. Providers and The County of San Luis Obispo are not liable for any breach of confidentiality caused by the client or any third party.

• I may be charged fees for the sending and receipt of texts by my cell phone carrier.

• I have the right to opt out of the receipt of text messages any time by replying "STOP" to any message I receive from The County of San Luis Obispo or my provider.

• Depending on the service I use for text messaging, the messages sent may not be encrypted and therefore could potentially be intercepted by other people, and I agree to accept that risk by engaging in text messaging.

• I am under no obligation to communicate with The County of San Luis Obispo or my providers via text message, and if I have any concerns about communicating via texts I should not do so.

Client Signature: ______________________________ Date: ______________

Parent/Guardian Signature: ______________________ Date: ______________

Relationship to Client: __________________________

Staff Signature: ______________________________ Date: ______________

County of San Luis Obispo Behavioral Health

Consent for Email Communication

Client Name: ____________________ Client #: ______________________

I hereby agree to receive emails from The County of San Luis Obispo and its contracted mental health and substance use disorder providers for any purposes related to my treatment, the coordination of my care, or reimbursement for my care, in accordance with the terms of this consent form. I acknowledge and understand that:

- If my email address changes, I should inform The County of San Luis Obispo as soon as possible. I understand that if I don't inform The County of San Luis Obispo, providers may continue to email my previous address under this consent, which may result in a breach of confidentiality.

- When using my own personal electronic device, The County of San Luis Obispo does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.

- Email is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular message will be read and responded to within any particular period of time.

- Email is not inherently secure and may be intercepted by a third party. Providers will use reasonable means to maintain security and confidentiality of email information sent and received. Providers and The County of San Luis Obispo are not liable for any breach of confidentiality caused by the client or any third party.

- Email messages from me will be treated as confidential information and may be included in my medical record.

- Depending on the service I use for emails, the messages sent may not be encrypted and therefore could potentially be intercepted by other people, and I agree to accept that risk by sending emails.

- I am under no obligation to communicate with The County of San Luis Obispo or my providers via email, and if I have any concerns about communicating via email I should not do so.

Start Date: ____________________ End Date: ____________________

Client Signature: ________________________________ Date: ________________

Parent/Guardian Signature: __________________________ Date: ________________

Relationship: __________________________

Staff Signature: ________________________________ Date: ________________

County of San Luis Obispo Behavioral Health

Consent for Telehealth

Client Name: ____________________ Client ID #: ____________

Consent For Telehealth

Start Date: ____________________ End Date: __________________

I hereby agree to receive services utilizing telehealth and agree that this is an acceptable mode of delivering health care related services to me under the terms of this consent form. I understand and agree to the following statements regarding Telehealth:

- Telehealth services include the use of video teleconferencing solutions to provide services to a client via electronic interactive audio and video telecommunication from a distant location. Telehealth services are considered face-to-face because the client is visually present. I understand that that my provider will not be physically in my presence.
- Telehealth services will be provided to me for purposes of evaluation, diagnosis, management, and treatment.
- The treating provider performing the examination or treatment will keep a record of the consultation in my electronic healthcare record.
- All the information discussed via telehealth is held to the same privacy standards as that of an in-person appointment.
- Should I feel for whatever reason telehealth is not a comfortable means of conducting my treatment sessions, I have the right to withdraw consent for telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with telehealth, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- When using my own personal electronic device, The County of San Luis Obispo does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.

Client Name: ______________________ Client ID #: __________

- All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Audio/visual recording may be allowed with a separate written consent. Such recordings are for staff training purposes only, are not part of the medical record, and are destroyed after intended use.
- Although my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency, I understand that my provider will be unable to render in-person emergency assistance if I experience a crisis during a telehealth session.

Client Signature: ______________________ Date: ______________

Parent/Guardian Signature: ______________________ Date: ______________

Relationship to Client: ______________________

Staff Signature: ______________________ Date: ______________

County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name______________________ **Birth Date:** ______________ **Client ID** ___________

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

By signing this form below, I am allowing County of San Luis Obispo Health Agency to disclose my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

☒ Organization/Provider ☐ Contact ☒ Release To ☒ Obtain From

Initial whom we can release to or obtain from:			
	SLO County Social Services		Sierra Mental Wellness Group
	SLO County Sheriff (Bailiff)		Family Care Network
	SLO County Counsel		Seneca Center
	SLO County Superior Court		Child Development Center
	Testing Laboratories		Wilshire Foundation Community Services
	School		Bryan's House
	CAPSLO Direct SVCS/Parent Education		Wellpath
	Pharmacy:		Residential Care Facilities
	Probation		Tri-Counties Regional Center
	Parole		Transitions Mental Health Association
	Court Appointed Special Advocates (CASA)		Physician/Clinic (Name):
	Attorney(s):		Other:
	5-Cities Homeless Coalition		Other:
	Foster Parent:		Other:
	Veterans' Service Officer		Other:
	Crestwood Behavioral Health		Other:
	Recovery Residences		Other:
	San Luis Obispo Mental Health Services		Other:

County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name____________________ **Date of Birth:** ____________ **Client ID** __________

Contact Type ☒ Organization/Provider ☐ Personal Contact

Purpose of Disclosure

☐ Process insurance/third party claims (Substance Abuse Remittance Only)

☒ Care Coordination

☐ HIE (Health Information Exchange)

☐ Other ____

Expiration

If nothing marked – one (1) year from date signed

☐ 1 time disclosure ☐ 6 months ☐ End of agency treatment

Start Date _______________ **End Date** _______________

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available

Type: ☐ MH ☒ SUD

☒ All records ☐ Acknowledgement of treatment ☐ Billing &/OR insurance information
☐ Intake/admission information ☐ Psychological Evaluation(s) reports
☐ Medications prescribed ☐ Discharge summary/plan ☐ Progress Review /Summary
☐ Screening assessment(s) ☐ AAPS Eligibility Documents ☐ School Records/Reports/IEPs
☐ Medical History, Lab results, Immunization Records ☐ Treatment plan(s)
☐ Progress Notes ☐ Legal Documents ☐ Other __________

Records Start Date __________________________ Records End Date __________________________

Client Name____________________ **Date of Birth:** ____________ **Client ID** __________

Restrictions

____

Terms

- - The recipient(s) of my confidential information may share it with others if they are permitted to do so under federal and state law. I understand that in some cases my information may no longer be subject to privacy laws once it is shared.
- I have a right to revoke this form at any time by contacting County of San Luis Obispo Health Agency. I understand that if I revoke, the recipient(s) of my information may keep the information that they received about me prior to the date I revoked.
- Signing this form is voluntary, and that declining to sign this form will not impact my ability to get medical care, health insurance, or any government benefits.
- Even if I don't sign this form, the recipient(s) may have a right to obtain my confidential information under applicable law.

Signing for a Child:

I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form on the last line. If my child is 12 or older, my child should also sign on the first line.

By checking these boxes, I agree that I have read, understand, and agree to these terms.

☑ NOTICE TO CLIENT: Signing this form is voluntary and not required to receive services with the County Behavior Health Services. I understand.

☑ ACCESS TO MY RECORD: I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. I understand I can also review my records with my therapist by making an appointment. This request can take 30 days to complete, and charges will apply.

Agency Contact Information

County of San Luis Obispo Central Health Information at **805-781-4724**

Program________________________ **Attention**________________

Address____

City_________________________ **State**_____ **Zip Code**______________

Phone Number____________________

County of San Luis Obispo Behavioral Health

Multi-Party Release of Information

Client Name____________________ **Date of Birth:** ____________ **Client ID** __________

Copy Given to Client ☐ Yes ☐ Declined a copy Agency Staff __________________________

ID verified by ☐ driver's license ☐ other picture ID ☐ Known to Agency

Additional Information –

The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

☒ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☒ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Client Signature ______________________________________ Date _______________

Parent/Guardian Signature _____________________________ Date _______________

Relationship ____

Staff Signature _______________________________________ Date _______________

County of San Luis Obispo Behavioral Health

Release of Information

Client Name____________________ **Date of Birth** ____________ **Client ID** __________

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

By signing this form below, I am allowing County of San Luis Obispo Health Agency to disclose my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

☒ Organization/Provider ☐ Contact ☐ Release To ☐ Obtain From

Release To/Obtain From Medi-Cal

____

Contact Type ☒ Organization/Provider ☐ Personal Contact

Purpose of Disclosure

☒ Process insurance/third party claims (Substance Abuse Remittance Only)

☐ Care Coordination

☐ HIE (Health Information Exchange)

☐ Other ______________________________

County of San Luis Obispo Behavioral Health
Release of Information

Client Name____________________ **Date of Birth** ___________ **Client ID** __________

Expiration

If nothing marked – one (1) year from date signed

☐ 1 time disclosure ☐ 6 months ☐ End of agency treatment

Start Date ________________ **End Date** _________________

Information to be used or disclosed:

The information that can be disclosed under this authorization includes the following, if available

ROI Type: ☐ MH ☒ SUD

☒ All records ☐ Acknowledgement of treatment ☐ Billing &/OR insurance information
☐ Intake/admission information ☐ Psychological Evaluation(s) reports
☐ Medications prescribed ☐ Discharge summary/plan ☐ Progress Review /Summary
☐ Screening assessment(s) ☐ AAPS Eligibility Documents ☐ School Records/Reports/IEPs
☐ Medical History, Lab results, Immunization Records ☐ Treatment plan(s)
☐ Progress Notes ☐ Legal Documents ☐ Other ___________

Records Start Date __________________________ Records End Date __________________________

Restrictions:

____

____

____

Client Name____________________ **Date of Birth** ___________ **Client ID** __________

Terms. I understand:

- The recipient(s) of my confidential information may share it with others if they are permitted to do so under federal and state law. I understand that in some cases my information may no longer be subject to privacy laws once it is shared.
- I have a right to revoke this form at any time by contacting County of San Luis Obispo Health Agency. I understand that if I revoke, the recipient(s) of my information may keep the information that they received about me prior to the date I revoked.
- Signing this form is voluntary, and that declining to sign this form will not impact my ability to get medical care, health insurance, or any government benefits.
- Even if I don't sign this form, the recipient(s) may have a right to obtain my confidential information under applicable law.

Signing for a Child:
I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form on the last line. If my child is 12 or older, my child should also sign on the first line.

■ **NOTICE TO CLIENT:** By signing below, I consent to the disclosure of my information as described in this form. Further, by including my phone number below, I consent to the receipt of texts or calls to communicate with me about my consent and how my information may be shared (standard message and data rates may apply).

■ **ACCESS TO MY RECORD:** I have a right to obtain a copy of this form. I understand I should ask the person who presented this form to me for a copy.

Agency Contact Information:
County of San Luis Obispo Central Health Information at **805-781-4724**

Program_______________________ **Attention**_______________

Address____

City________________________ **State**_____ **Zip Code**_____________

Phone Number___________________

County of San Luis Obispo Behavioral Health
Release of Information

Client Name________________ **Date of Birth** __________ **Client ID** __________

Copy Given to Client ☐ Yes ☐ Declined a copy Agency Staff ____________________

ID verified by ☐ driver's license ☐ other picture ID ☐ Known to Agency

Additional Information:
The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

☒ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.
☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease:

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.
☒ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Client Signature ____________________________ Date __________

Parent/Guardian Signature ____________________ Date __________

Relationship ______________________________

Staff Signature ____________________________ Date __________

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT

CLIENT COST EXPLANATION AND AGREEMENT

Your provider will explain the cost of services to you. In some cases, you must pay a reasonable fee for the services you receive. Contact your provider or the Billing office at (805) 781-4702 right away if:

- You are unable to pay your fee
- Your income/the number of people dependent on your income change
- You get (or lose) private insurance
- **You get (or lose) Medi-Cal**

☐ **Full Scope Medi-Cal (May include Medi-Medi)**
We accept Full Scope Medi-Cal as payment in full if **you remain eligible**. If you lose your Medi-Cal, you must pay for your services. Please let your provider know as soon as possible so we can help you regain your Medi-Cal or set fees.

☐ **Other Funding Sources (8500)**
County Referrals: AB109, Probation, Superior Court, Department of Social Services (DSS), Child Welfare Services, Family Treatment Court, Youth Treatment Services, School Referrals and Driving Under the Influence (DUI) Program Referrals. Drug and Alcohol Services receives grant money or is contracted by other agencies to provide services at no cost to you while you are enrolled in specific programs. If you also have Medi-Cal in San Luis Obispo, your Medi-Cal will be billed first.

☐ **Share of Cost (SOC) Medi-Cal (May include Medi-Medi)**
Some types of Medi-Cal have a monthly Share of Cost that you must pay before Medi-Cal covers the cost of treatment. The services you receive from every provider apply toward your Share of Cost. Call the Billing Office at 781-4702 to learn about how we help with your Share of Cost or talk to your Eligibility Technician at Department of Social Services to see if you qualify for full scope Medi-Cal, which has no Share of Cost.

Your monthly Share of Cost is: $_______________

Client Name:____ Client Number: _________________

Annual period begins __________and ends: __________

My signature below confirms my understanding of the cost of services.

Client or Responsible
Person's Signature: ____ Date: __________

Staff Witness Signature: ____ Date: __________