Please Attach A Copy Of Your IDs and Insurance Cards

Please Complete All Forms, Front and Back

IN HOME
Clinical & Casework Services, Incorporated
Est. 1994

1711 Church Street
Suite D
Norfolk, VA 23504

Office (757) 623-8985
Fax (757) 623-4516
Email: ihccs1711@gmail.com

Orientation Checklist for Mental Health Skill Building

- ☐ Freedom of Choice
- ☐ The mission of the provider or service
- ☐ Service confidentiality practices and protections for individuals receiving services
- ☐ Privacy Rights (uses and disclosures of mental health information)
- ☐ Human rights policies and protections and instructions on how to report violations
- ☐ Opportunities for participation in services and discharge planning
- ☐ The provider's grievance procedure
- ☐ Service guidelines including criteria for admission to and discharge or transfer from services
- ☐ Hours and days of operation
- ☐ Availability of after-hours service
- ☐ Any charges or fees due from the individual

I, _____, hereby acknowledge that I have received an orientation to services and that the information indicated above has been explained to me so that I understand it.

Signed: _____
(Parent, Guardian, Authorized Representative, if applicable)

Date: _____

Signed: _____
(Witness / Relationship)

Date: _____

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CLIENT REFERRAL FORM

Date: _____

Prospective Client Name: _____ Phone Number _____

Parent/Guardian Name: _____ Email: _____

Address: _____ D.O.B____/____/____ Age:_____

Gender: _____ Social Security Number: _____

Insurance Plan Name: _____ Insurance Name: _____

Member ID# _____ Member ID#_____

Referred By: _____ Agency: _____ Phone: _____

Concerns:

_____

_____

_____

_____

_____

Requested Service(s): Check all that apply:

SERVICE REQUESTED			
☐ Outpatient	☐ Benny's Place	☐ MHSB	☐ Intensive In-Home

FOR OFFICE USE ONLY:

Insurance Verification# _____ Co-Pay _____

Service Weeks/Units Available _____

(HMO/PPO) Insurance Authorization # _____ Co-Pay/Deduct _____

(HMO/PPO) Weeks/Units available _____

Self-Pay Amount: _____

Assessment Scheduled with _____ Date scheduled _____

Packet Mailed: ☐ YES ☐ NO

Completed By _____

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INTAKE REQUEST FOR SERVICES

Name of Identified Client (Last, First, Middle) _____ Date of Request _____

Street Address _____ Apt # _____ Home telephone _____

City _____ State _____ Zip _____ Work/Cell Telephone _____

Gender _____ Ethnicity _____ Age _____ Date of Birth _____ Social Security Number _____

Marital Status _____ Legal Status (Parole, Probation, etc.) _____

Names of Parent(s)/Emergency Contact _____ Telephone _____ Relationship _____

Referring Agency _____ Referring Agent _____

Street Address/Suite _____ Telephone _____

City _____ State _____ Zip _____

SERVICE REQUESTED

☐ Outpatient ☐ Benny's Place ☐ MHSB ☐ Intensive In-Home

Client Identification Number: _____

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INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber's Name: _____ Client's Name: _____ Carrier: _____ Insurance ID #: _____ Group #: _____ Client's Relationship to Subscriber: _____	Subscriber's Name: _____ Client's Name: _____ Carrier: _____ Insurance ID #: _____ Group #: _____ Client's Relationship to Subscriber: _____
Person Responsible for portion not covered by Insurance: _____	
Tricare Only	
Sponsor's Social Security #: _____ Branch of Service: _____ Duty Station: _____ Authorization #: _____	☐ Active ☐ Retired ☐ Deceased Rank/Rate: _____ # of Sessions Authorized: _____

STATEMENT OF AGREEMENT

IN HOME CLINICAL AND CASEWORK SERVICES, INC. believes in enhancing the confidential relationship between client and therapist. Therefore, we request that you discuss all financial arrangements and appointment hours directly with your therapist, and that you make all payments directly to your therapist. Because appointment hours are reserved for you, you will be charged for missed appointments, a charge which is NOT covered by insurance, unless ample advance notice is given (**24 hours**). The charge of failing to keep or cancel an appointment is $40.00. The patient is responsible for supplying correct insurance information, any necessary insurance forms, and for payment of any personal portion within 25 days of receiving a monthly bill. An interest charge of 1.5% per month will be charged for balances over 30 days. Patient agrees to pay all costs of collection, including reasonable attorney's fee. I have read the above office policy and agree to comply with its terms as presented. My signature below also constitutes authorization for my insurance company to make payments directly to In Home Clinical and Casework Services, Inc. and /or Bernard N. Curry, PhD, LCSW, to release information to my insurance company in order to process our claims.

_____ _____

Client or Legal Guardian Date

Do not write below this line- For therapist to complete and sign, prior to initial session:

Y____ N____

Fee Arrangement: Client Portion: $_____, Insurance Portion $_____ per session

Adjustment $ _____Therapist Signature:_____

Date: _____, 20 _____

CURRENT SITUATION SUMMARIZED

AREAS OF CONCERN

DESIRED GOALS

I, _____, request that I/the above referenced client be provided the indicated services under the In Home Clinical and Casework Services Program.

Requestor _____ Date _____

FOR OFFICE USE ONLY:

Admitted? Yes____ NO____ Date_____ Refused/Date _____

Reason _____

Signature of IHCCS Representative _____

Client Identification Number: _____

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EMERGENCY MEDICAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Emergency Contact (Authorized Representative)

_____ (____) _____
Name (Last, First) Telephone

_____ (____) - _____
Street Address Telephone

_____ _____ _____
City State Zip

Primary Care Physician

_____ (____) - _____
Name (Last, First) Telephone

_____ (____) - _____
Street Address Fax

_____ _____ _____
City State Zip

Insurance

Insurance Company: _____

Insurance ID #: _____ Group #: _____

Continue on reverse side

Medical Information

For the Following Questions please circle yes or no, if you select yes please explain.

Do you have medication and or food allergies: Yes / No

Yes, Explain:_____

Do you have a history of Substance Abuse: Yes / No

Yes, Explain:_____

Do you have any significant medical problems or conditions: Yes / No

Yes, Explain:_____

Do you have any significant ambulatory or sensory problems: Yes / No

Yes, Explain:_____

Do you have any special communication needs: Yes / No

Yes, Explain:_____

Do you have any Advance Medical Directives (i.e., living will/special medical power of attorney):

Yes / No

Yes, Explain:_____

Current Medications		
Medication Name	**Dosage/Frequency**	**Prescribing Doctor**

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Physical Form

I have discussed _____, undergoing a physical exam including vision, and TB Test with the staff of IHCCS, Inc.

☐ I/my child have/had a physical exam within the past year. The date was _____.

☐ I/my child have/has not had a physical exam within the past year. However, I intend to schedule a physical exam ASAP and will provide IHCCS, Inc. with a copy of the results.

☐ (*MHS/PSR clients only*) I have had a TB Test within the past year (copy of results will need to be provided) The date was _____.

☐ (*MHS/PSR clients only*) I have not had a TB test within the past year. However, I intend to schedule a physical exam ASAP and will provide IHCCS, Inc. with a copy of the exam results.

☐ I/my child have/had a vision exam within the past year. The date was _____.

☐ I/my child have/has not had a vision exam within the past year. However, I intened to schedule a physcial exam ASAP and will provide IHCCS, Inc. with a copy of the exam results.

_____ _____
Client/Guardian Date

_____ _____
Witness Date

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CONSENT FOR TREATMENT

The consent and authorization of the undersigned is hereby given to the **In Home Clinical and Casework Services, Inc. (IHCCS, Inc)**: program and to clinicians and case managers attending:

_____
Name of Client

1. To render to the client such treatment considered therapeutically necessary.

2. To release information communicated to or learned by **IHCCS, Inc.** only through a **"Release of Information"** form signed by the client and/or his/her legal guardian, if applicable.

3. I understand that a relationship with a physician and/or other professionals not employed by **IHCCS, Inc** is independent and will be billed separately.

4. I agree to undergo Drug/Alcohol testing as requested by the qualified mental health professional.

5. I agree to fully participate in all scheduled treatment and support groups and individual sessions.

6. I agree to be transported within the parameters of services and as deemed necessary by the **IHCCS, Inc** staff.

7. I promise to pay/guarantee payment of the replacement cost, plus a reasonable surcharge, for all furniture or other property that may be broken or damaged by the patient (client).

8. I consent to have a photograph/video of my likeness kept in my permanent record without limitation in case I should become missing or fall to unexpected harm.

IT IS UNDERSTOOD AND AGREED THAT I WILL PARTICIPATE **IN ALL ASPECTS OF** THE IN HOME CLINICAL AND CASEWORK SERVICES PROGRAM.

_____ _____
Client Date

_____ _____
Parent or Legal Guardian Date

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Notice of Freedom of Choice/Selection of Provider

☐ Client and/or guardian were advised that they meet eligibility criteria and are eligible for
- ☐ Intensive In-home services
- ☐ Mental Health Skill Building
- ☐ Psychosocial Rehabilitation Services

and have freedom of choice regarding providers of that service. Client and/or guardian were given a list of other Medicaid approved providers.

☐ Client and/or guardian choose **In Home Clinical & Casework Services, Inc.**

☐ Client and/or guardian elect to have services provided by **another provider.**

☐ Client and/or guardian were advised that any decision that affects the individual's receipt of Medicaid-covered service may be appealed to DMAS. They were notified of the right to a hearing and the procedure for requesting a hearing.

☐ Client and/or guardian were advised that they do not meet criteria and are not eligible for
- ☐ Intensive In-Home services
- ☐ Mental Health Skill Building
- ☐ Psychosocial Rehabilitation Services

_____ _____
Signature of Staff Date

_____ _____
Client/Guardian Signature Date

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ACKNOWLEDGEMENT
OF
YOUR RIGHTS

☐ Member was provided a copy of the Human Rights policy and the policy has been read and explained to member so that they understand them. Member has also been informed of the role of the Regional Advocate and how to contact this person.

_____ _____
Signed (Parent, Guardian, Authorized Representative, if applicable) Date

_____ _____
Signed (Witness / Relationship) Date

☐ Member refused copy.

Member is unable/unwilling to sign that she/he understands the rights.

_____ _____
Staff Name Witness / Relationship

_____ _____
Date Date

YOUR HUMAN RIGHTS

As a client of this program you have certain rights which are set out in the Rules and Regulations to Assure the Rights of Clients of In Home Clinical and Casework Services Programs. Also, there is a written policy which sets out what this program must do to comply with the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Behavioral Health and Developmental Services. A summary of your rights is set out below.

1. RIGHT TO NOTIFICATION

You must be informed of your rights every six (6) months while in the program, and you have a right to see and get a copy of the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Behavioral Health and Developmental Services and the Policy upon request. Also, you must be told what the program's rules of conduct are, and you have a right to have a copy.

2. RIGHT TO REQUEST CONSULT

You have the right to request the option of a consultant at your expense or to request an in-house review of your individual treatment Plan.

3. RIGHT TO TREATMENT

You have the right to receive prompt evaluation and treatment. IHCCS cannot deny services to you solely on the basis of your race, national origin, sex, age, religion or handicap. If you think you have been discriminated against by the IHCCS Program, you can contact any program employee.

4. RIGHT TO CONFIDENTIALITY

Your records will be released only with your consent or the consent of your authorized representative or by court order, except in emergencies or as otherwise required or permitted by law.

You have the right to inspect and to have copies made of your records at your own expense (current rate is $.50 per page), except where it would be harmful to you. In that situation, a lawyer, doctor or psychologist you choose can see the records on your behalf. If you feel there are mistakes in your record, you can ask to have them corrected, and if the staff does not change what you think is an error, you can place your statement about the error in your record.

You have the right to not be the subject of experimental or investigation research without prior written informed consent by you or that of your guardian.

5. RIGHT TO CONSENT

A treatment or service which presents a "significant risk", that is, one that might cause some injury or have a serious side effect may not be administered unless you or your authorized representative first give informed consent to it.

6. RIGHT TO DIGNITY

You have the right to be called by your preferred or legal name, to be protected from abuse, and to request help in applying for services or benefits for which you are entitled. You have a right to a safe, sanitary and humane environment and confidential telephone communications. You will be treated with dignity and respect at all times.

7. RIGHT TO LEAST RESTRICTIVE ALTERNATIVE

IHCCS does not place any restrictions on clients other than those noted under general rules of conduct.

8. RIGHT TO COMPENSATION

IHCCS does not require or engage clients in the performance of compensatable work.

9. RIGHT TO RETAIN CERTAIN LEGAL RIGHTS

When you enter this program you still keep your basic legal rights, including the right to enter into contracts, to register and vote; to marry or divorc to make a will; to use the courts, etc.

10. RIGHT TO REFUSE TREATMENT

You have the right to accept medical care or to refuse treatment to the extent permitted by law. You have the right to be informed of the medical consequences of any treatment refusal.

11. TREATMENT PLANNING

You will actively and knowingly participate in your treatment plan formulation and any subsequent revisions. You will be given an explanation of your diagnosis, nature of illness, and planned course of treatment.

12. RIGHT TO HEARINGS AND APPEALS

If you believe any of your rights or ethics regarding your treatment have been violated, you may file a complaint with any staff member or your primary counselor. You may appeal the decision to the Director.

13 ASSISTANCE BY REGIONAL ADVOCATE

The state has appointed a Regional Advocate to assist clients and to make sure programs recognize client's rights. The advocate will assist you in making, resolving or appealing complaints about rights violations. You can contact the Regional Advocate yourself and ask for help or the staff will help you make the contact.

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ACKNOWLEDGEMENT OF YOUR RIGHTS

☐ Member was provided a copy of the HIPAA policy and the policy has been read and explained to member so that they understand them.

Signed (Parent, Guardian, Authorized Representative, if applicable) _____ Date _____

Signed (Witness / Relationship) _____ Date _____

☐ Member refused copy.

Member is unable/unwilling to sign that she/he understands the rights.

Staff Name _____ Witness / Relationship _____

Date _____ Date _____

In Home Clinical and Casework Services, Inc.

NOTICE OF PRIVACY PRACTICES

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

THE PRIVACY OF YOUR MENTAL HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your MENTAL HEALTH information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your MENTAL HEALTH information. We must follow the privacy practices that are described in this notice, while it is in effect. This notice takes effect May 6, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted applicable by law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all MENTAL HEALTH information that we maintain, including MENTAL HEALTH information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION

We use and disclose MENTAL HEALTH information about you for treatment, payment, and MENTAL HEALTH care operations. For example:

Treatment: We may use or disclose your MENTAL HEALTH information to a physician or other MENTAL HEALTH care provider providing treatment to you.

Payment: We may use and disclose your MENTAL HEALTH information to obtain payment for services we provide to you

Mental Healthcare Operations: We may use and disclose your MENTAL HEALTH information in connection with our MENTAL HEALTH care operations. MENTAL HEALTH care operations include quality assessment and improvement activities, reviewing the competence or qualifications of MENTAL HEALTH care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your MENTAL HEALTH information for your treatment, payment or MENTAL HEALTH care operations, you may give us written authorization to use your MENTAL HEALTH information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your MENTAL HEALTH information for any reason except those described in this notice.

To your Family and Friends: We must disclose your MENTAL HEALTH information to you, as described in the Patient Rights section of this notice. We may disclose your MENTAL HEALTH information to a family member, friend, or other person to the extent necessary to help with your MENTAL HEALTH care or with payment for your MENTAL HEALTH care, but only if you agree that we may do so.

Persons involved in care: We may use or disclose MENTAL HEALTH information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use of disclosure of your MENTAL HEALTH information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose MENTAL HEALTH information based on a determination using our professional judgement disclosing only MENTAL HEALTH information that is directly relevant to the person's involvement in your MENTAL HEALTH CARE.

Marketing Mental Health Related Services: We will not use your MENTAL HEALTH information for marketing communications without your written authorization.