FAMILY FIRST
MENTAL HEALTH

DEMOGRAPHIC INFORMATION/CONSENTS/CONTRACTS

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- MEDICAID CARD AND SOCIAL SECURITY CARD
- INTAKE INFORMATION AND CONSUMER INSURANCE VERIFICATION

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- PROGRAM PARTICIPANTS RIGHTS, COMPLAINT PROCEDURE, RESTRAINT POLICY
- HIPAA NOTICE OF PRIVACY PRACTICES
- AUTHORIZATION FOR THE DISCLOSURE & RECIPROCAL EXCHANGE OF PROTECTED INFORMATION
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- SERVICE NOTES
- GUARDIANSHIP PAPERWORK (if applicable)

SECTION 4:

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- MISC

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SECTION 1:

Face Sheet

Medical Card/ Social Security Card Intake

Information

Insurance Verification

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Home Face Sheet

Client Number:_____ ICD-10 Code: _____

Assessment Billing Date: _____ DOA: _____

Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

D.O.B.:_____ Gender: M / F Race/National Origin:_____

Medicaid #:_____

Eligibility Worker Name:_____ Contact Number: _____ (12 digits)

Previous services? □ YES □ NO If so, is the release form signed? □ YES □ NO

Primary Legal Guardian:_____ Relationship:_____

Address:_____

City: _____ _____
State:_____Zip:_____

Home: Cell:_____ Work:_____
_____

Other Caregiver:_____ Relationship:

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Legal Custody? □ YES □ NO If no, release form signed? □ YES □ NO

Address:_____

City:_____ State:_____ Zip:

DOA:

Home:_____ Cell:_____ Work:

Emergency Contact Information:

Name:_____ Relationship:_____

Address:_____ Phone: _____

City:_____ State:_____ Zip: _____

Verified Medicaid? YES NO Date Verified _____ By:

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Intake Information Form

Medical Record Number:		Today's Date:
Name and contact number of referral source:		
Client Name:		
Client Address:		
City:	State:	Zip:
Home Phone:	Work/Alternate Phone:	
DOB:	Social Security Number (Last 4 Only):	
Gender:	Age:	Best Time to Call:
Guardian Name:		Phone:
Guardian DOB:	Social Security Number:	
Guardian Address:		
Guardian City:	State:	Zip:
Next of Kin Name:		
Next of Kin Address:		
City:	State:	Zip:
Emergency Contact Name:		Phone:
Address:		
City:	State:	Zip:
Alternative Emergency Contact Phone Numbers:		
Primary Care Physician:		Phone:
Current/Past Mental Health Services? Y / N	Type/Provider:	
Prior/Current Diagnosis:		
Prior/Current Medications:		
INSURANCE INFORMATION (Required)		
Insurance Name:		
Cardholder's Name (as it appears on card):		
Cardmember's DOB:		SSN# (last 4 only):
Subscriber #:	Group #:	

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Insurance Company Phone Number (on reverse side of card):	
MCO or Impact Access: Y / N	Provider Phone # (on Medicaid card):

CONSUMER INSURANCE VERIFICATION

Consumer Name:		SSN (Last 4 Only):
DOB:	Sex: M / F	Married/Single/Divorced/Widow (circle)
Address:		
City:	State:	Zip:
Home/Cell Phone:	Email Address:	
Would you be interested in having communications sent to you via your email address? (Examples: appointment reminders, administrative updates and health bulletins). Yes No		
Employer Name:	Employer Phone Number:	
Employer Address:		
City:	State:	Zip:
Primary Care Physician:		Copay Amount: $
How did you hear about our Agency:		
Guarantor Name:		SSN:
Relationship to Patient: (please circle) Self Spouse Parent		DOB:
Address:		Ph #:
Employer Name:	Employer Phone Number:	
Employer Address:		
City:	State:	Zip:
Name:	Address:	
Home/Cell Phone:	Work Phone:	Relationship:
Plan Name:	I.D. Number:	
Address:	Group Number:	
Policy Holder:	Effective Date:	
Policy Holder SSN:	Policy Holder DOB:	Sex: M / F
Plan Name:	I.D. Number:	
Address:	Group Number:	
Policy Holder:	Effective Date:	
Policy Holder SSN:	Policy Holder DOB:	Sex: M / F
Plan Name:	I.D. Number:	
Address:	Group Number:	
Policy Holder:	Effective Date:	
Policy Holder SSN:	Policy Holder DOB:	Sex: M / F

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I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to our agency. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date:

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SECTION 2: CONSENTS

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Consent for Behavior Health Treatment

Client Name: _____ Record Number: _____

I, _____ hereby voluntarily consent to evaluation and/or treatment by Family First Mental health. I understand that this evaluation/treatment may include the referral to an outpatient therapist/psychiatrist for a psychiatric interview and/or monitoring of medications, referral to a psychologist for psychological testing, individual, family, or group counseling, mentoring or other mental health and substance abuse services. I reserve the right to withdraw this consent to any time. In addition, I reserve the right to refuse at any time services or treatment is offered.

Notice to Consumer

It is the policy of Family First Mental health that as a consumer in our agency, you shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared between treatment agencies for quality of care. You may be asked to sign a Consent for Release of Information, should the need arise to share confidential information. Provision of services will not be contingent upon signature of this release. The consumer of legally responsible person shall give consents for Release of Confidential Information voluntarily. Information may also be shared with appropriate agencies as necessary to protect your safety and welfare as well as that of other individuals (see Release of Information). Records of your treatment are contained in a locking system.

Confidentiality

Federal law and regulations protect the confidentiality of client records maintained by this program. Generally, the program may not say to person outside the program that a consumer attends the program, or disclose any information identifying as a client in treatment.

UNLESS:

[1] The consumer consents in writing; [2] the disclosure is allowed by court order; [3] the disclosure is to personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 USC 290dd-3 and USC 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations).

Services Admissions

If I am here for behavior health services this is to verify that I have been offered referral for counseling, testing, a medical evaluation, and/or treatment for tuberculosis and other cont. diseases.

_____

Signature of Consumer/ Guardian Date

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Signature of Intake Coordinator Date

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Freedom of Choice

This form should be completed after eligibility determination has been made by all consumers of Family First Mental Health.

I, _____ ., have been informed of the services available to me or my child. I understand I have a right to choose the provider of choice and assistance with transferring would be offered if I do not choose to stay with our agency.

As long as I maintain eligibility for services, I will continue to have the opportunity to choose between providers. I understand that I have the right to refuse services. Refusal of services does not prevent me from receiving other services for which I may qualify.

By signing, I am confirming I have been orientated about Freedom of Choice.

Client Signature_____ Date

FILL OUT ONLY IF CONSUMER WANTS ADDITIONAL INFORMATION

By signing below, I am requesting names of other providers in the area providing the same services.

Name of Company Provided: _____

Client Signature_____ Date

Staff Signature_____ Date

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PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

Every program participant at our agency has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. Family First Mental Health Services (FFMHS) is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

Program Participant Rights: As a participant in programming, you have the right to:

- Be fully informed about the course of your care and decisions that may affect your treatment
- Revoke your consent for treatment at any time
- Timely and accurate information to assist you in making sound decisions about your treatment
- Be fully involved as an active participant in decisions pertaining to your treatment
- Have an individual identified in writing that will direct and coordinate your treatment
- Request a change in individual directing and coordinating our treatment, if you so desire
- Receive services in an environment that is free of all fom1s of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
- Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
- File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
- Have family members, friends or others involved in your treatment with your consent and approval
- Receive services that comply with all applicable federal and state laws, rules and regulations
- File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit
- To request a transfer to another program if you believe you are not receiving care that meets your needs and preferences.
- You may also have additional rights afforded to you based on federal, state, and local regulations. Your service coordinator will advise you of any additional rights that you may have.

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PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT
FAMILY FIRST MENTAL HEALTH SERVICES

Program Participant Responsibilities: As a program participant of our agency, you have the responsibility to:

- Refrain from all forms of physical violence or abuse toward other program participants, staff, or visitors
- Refrain from abusive language, disruptive behavior or overt sexual conduct
- Refrain from loitering outside the organization's facilities
- Refrain from bringing any type of weapon into the organization's facilities or property
- Refrain from bringing any illicit (illegal) drug or alcohol onto the organization's property
- Refrain from using illicit drugs or alcohol while participating in services provided by the organization
- Use tobacco only in designated areas
- Attend all services required by the organization to meet agreed upon goals.
- Notify any outside treatment provider (Physician, case worker, counselor, etc.) of participation in services, should your treatment impact, or compromise, the provision of those services
- Treat other program participants, staff, and visitors in a respectable manner.

Client Signature:_____Date: _____

Provided By:_____Date: _____

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CONSUMER COMPLAINT PROCEDURE

Consumer's Name**:**_____

Here at Family First Mental Health. We are concerned about any problems you may experience with this program. To address any problem(s), we need to be made aware of them. Therefore, we have set up a Complaint Procedure that we request you to use. If you have a problem with the services that you or your child are receiving or if you believe that any of your or your child's rights have been violated, please report your concern by:

1. First letting your/ your child's Counselor and/or the program manager know the problem. While you can tell your complaint to him/ her verbally, if possible, we suggest that you put your complaint in writing. Unless the program manager or designee is on vacation, you should have a response to your complaint within five (5) working days.
2. The program manager or designee must investigate all alleged violations or complaints. This investigation may result from an external complaint or the agency's policy to investigate certain situations. These situations include but are not limited to: Peer-to-Peer aggression, Elopement and/or alleged mistreatment by Family First Mental Health Services Staff. These situations are investigated to ensure our staff is following established protocol to maintain the safety of program Clients. The program manager or designee will conduct individual interviews with all Clients and staff involved in the incident. Based on the findings, the program manager or designee will resolve the complaint and take any disciplinary actions warranted. You will be notified of the findings of any investigation pertaining to you or your child.
3. If you are not satisfied with the Program Manager or designee's response, you may take your complaint to the Local Human Rights Committee either in writing or by requesting to appear in person at their meeting. This committee may be contacted through the Human Rights Advocate.
4. You maintain the right to seek other avenues beyond the Local Human Rights Committee that may be available, and you deem it appropriate to handle any complaint you may have with service provision.

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

FFMH Staff Signature Date

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RESTRAINT POLICY

Family First Mental Health employees will not use physical restraints on any consumer in our service. FFMH will use alternatives to physical restraints (Crisis Prevention Intervention) 1hrough de-escalation techniques when a consumer becomes uncontrollable during service.

FFMH protocol is for the guardian to inform the FFMH case manager of all levels of incidents. If the consumer becomes a danger to himself, the guardian will be instructed to call 9-1-1.

FFMH is required to document all incidents that occur while the consumer is in our service as an internal incident report and/or critical incident report depending upon the severity of the situation.

Signature of Consumer/Guardian	Date
FFMH Representative	Date

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Family First Mental Health
HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 10/01/2023

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

The terms of this Notice of Privacy Practices ('Notice') apply to Family First Mental Health, its affiliates and its employees. Family First Mental Health will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Family First Mental Health. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses anddisclosures of your protected health information as necessary for payment purposes. During the normal course of business operations. we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your

payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services. etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

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Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations:
- If we suspect child abuse or neglect: if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events. product defects, or to participate in product recalls:
- To your employer when we have provided health care to you at the request of your employer
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request:
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities: and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: **(1) to** carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) lo medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however. such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost *to* prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide lo a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures; Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged

a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests. must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Infonnation: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do. however, have theright to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and theprotected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Family First Mental Health in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally. any restriction by communicating your desire to do so Jo the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Compliance Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

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For Further **Information:** If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice. you may contact the Family First Mental Health Compliance Officer by phone at 708-852-5259 or at the following address: 1010 W lake Street, Oak Park, IL. 60301

This notice of Privacy Practices is also available at on our Family First Mental Health website at www.familyfirstmentalhealth.com

Client Receipt by signature:

Client Name: _____

Client Signature: _____ Date: _____

FAMILY FIRST
MENTAL HEALTH

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

NAME:_____ DOB:_____

I, _____, hereby give my consent for Family First Mental Health to

☐ Release to and/or ☐ obtain information from:

NAME_____ AGENCY_____

ADDRESS _____ CITY/STATE

PHONE_____ FAX

This information is being released/obtained for the purpose of

INFORMATION REQUESTED:

☐ Assessments	☐ Psychological
☐ Individualized Education Plan	☐ Medical History and Physical
☐ Social History	☐ Immunization Record
☐ Progress Notes	☐ Grades
☐ Psychiatric Evaluations	☐ Attendance / Disciplinary Records
☐ Discharge Summaries	☐ Monthly Update
☐ Written / Verbal Correspondence	☐ Admission Note
☐ Education Evaluation	☐ Other:

I was informed of the information requested / released and the benefits of its release

Parent / Legal Guardian Signature Date

_____ _____

Witness / Family First Mental Health Staff Signature Date

ANY INDIVIDUAL OR AGENCY RECEIVING THISCONFIDENTIAL INFORMATION SHALLNOT DISCLOSE THIS INFORMATION TO ANY THIRD PARTY UNLESS THE INDIVIDUAL CONSENTS OR UNLESS THE LAW ALLOWS OR REQUIRES FURTHER DISCLOSURE WITHOUT CONSENT.

ALL BLANK AREAS ON THIS FORM MUST BE COMPLETED PRIOR TO PARENT/AR SIGNATURE. PHOTO COPY OF THIS

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COMPLETED RELEASE IS CONSIDERED AS VALID AS ORIGINAL. DURATION OR CONSENT SHALL BE NO LONGER THAN 90 DAYS AFTER TERMINATION OR ONE YEAR. WHICHEVER IS SOONER. THE CLIENT, PARENT OR AR MAY TERMINATE THIS AUTHORIZATION TO RELEASE INFORMATION AT ANY TIME.

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RECEIPT OF CONSUMER HANDBOOK

l acknowledge that I have received a copy of the Consumer Handbook at Orientation and that **l** have had the opportunity to ask questions.

_____ _____

Guardian/Consumer Signature Date

_____ _____

Family First Mental Health Staff Signature Date

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MEDIA AND PHOTO CONSENT

I, _____(guardian/consumer) hereby authorize Family First Mental Health to make use of the following (check all boxes authorized by this consent):

☐ Audio-Visual recordings of consumer

☐ Photograph of consumer's image

☐ Photographs and related stories about consumer for Family First Mental Health's website, and/or Social Media

OR

☐ I **decline** any authorization of audio-visual recordings and photographic imaging of consumer.

_____I understand that this authorization will be time-limited until I am discharged from the program and that I have the right to change or revoke this consent at any time.

_____I understand that any media that is put into use, under the authorization of this consent, can continue to be used at the discretion of Family First Mental Health unless a written revocation of such use is provided and signed by myself or my parent/guardian (if applicable).

_____Family First Mental Health may use monitoring equipment within the service environment for safety purposes. The use of monitoring equipment is always prohibited in bathrooms/bedrooms.

_____

Client signature Date

_____

Signature of Parent/Guardian (if applicable) Date

_____

FFMH Representative Date

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INSERT ALL CORRESPONDENCE

- **FAX COVER SHEETS**
- **LETTERS**
- **DIRECTIVES**
- **COPIES OF E-MAILS, ETC.**

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SECTION 3:

SERVICE NOTES

GUARDIANSHIP PAPERWORK

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SERVICE NOTES

☐ Service Plan Development Notes/ Team Meetings

☐ CM Notes

☐ Family / Community Support Notes

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NOTES

1. **NOTES ARE TO BE FILED IN CHRONOLOGICAL ORDER WITH THE MOST RECENT ON TOP.**
2. **ALL NOTES ARE TO BE APPROVED/SIGNED/DATED.**
3. **SAMPLE NOTE FORMS ARE AVAILABLE IN SUPPLEMENTAL DOCUMENTATION.**
4. **DOCUMENTATION MUST BE TYPED OR LEGIBLY WRITTEN IN BLACK INK, LEGIBLE AND ABBREVIATIONS DECIPHERABLE.**
5. **USE OF CORRECTION FLUID OR TAPE IS PROHIBITED. SEE ILLINOIS DSS PROVIDER MANUAL FOR CORRECTIVE ACTIONS, IF NECESSARY.**
6. **IF ABBREVIATIONS ARE USED, THE PROVIDER MUST MAINTAIN A LIST OF ABBREVIATIONS AND THEIR MEANINGS.**
7. **REFERENCE INDIVIDUALS BY FULL NAME, TITLE & AGENCY OR PROVIDER AFFILIATION AT LEAST ONCE IN EACH NOTE.**
8. **NOTES MUST BE ENTERED INTO THE AYM SYSTEM WITHIN 24 HOURS OF SERVICE.**

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SECTION 3

INSERT GUARDIANSHIP PAPERWORK

FROM LEGAL GUARDIAN (if applicable)

Example: DSS, Custodial Parent, Grandparent(s) who have legal custody

☐NOT APPLICABLE

Signature:_____Title_____

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SECTION 4

PART 1:

☐ Behavioral Screening ☐ CGAS ☐ GAF ☐ OTHER:

PART 2:

☐ IM+CANS (Lifespan, Caregiver and Health Risk Assessment) and Updates

PART 3:

☐ Consumer Medication Identification Log and Medication Administration Record (MAR)

PART 4:

☐ IM+CANS Personal Health Survey

PART 5:

☐ Substance Abuse Assessment (as applicable)

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PART 1:

INSERT COMPLETED
BEHAVIORAL SCREENING TOOL,
WORKSHEETS AND OUTCOMES

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PART 2:

INSERT IM+CANS, Updates and Reviews

(Lifespan CANS, Caregiver CANS and Health Risk Assessment CANS)

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PART 3:

Consumer Medication Log and Medication Administration Record (MAR)

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CONSUMER MEDICATION IDENTIFICATION LOG

	NAME OF MEDICATION	PRESCRIBING PHYSICIAN	PRESCRIBED DOSAGE	FORM	FREQUENCY	EFFECTIVE DATE	DISCONTINUE DATE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

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Consumer medications must be identified at intake and any changes/additions/deletions noted above.

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PART 4:

IM+CANS Personal Health Survey

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PART 5:

INSERT SUBSTANCE ABUSE ASSESSMENT

(If non-applicable, please indicate below)

☐**NOT APPLICABLE**

Signature:_____Title:

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SECTION 5:

ACCOUNTING OF DISCLOSURES

MISCELLANEOUS

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AUTHORIZATIONS/COLLABORATION

☐ Authorizations / Miscellaneous Collaboration

☐ Service Authorizaton Form for Legal Guardian

☐ Outpatient Notes

☐ Physician Notes Collaboration

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Accounting of Disclosures of Individually Identifying Health Information

			COMPLETE THIS SECTION WHEN SHARING IIHI WITH OUTSIDE ENTITY		
Date of Disclosure	**Purpose or reason for review or sharing information (specify if written request is on file)**	**What IIHI information are you reviewing or sharing?**	**Method of transmitting information (fax, e-mail, mail, verbal)**	**When you share information with an outside entity provide Name:**	**Signature**
Example: 01/01/25	Audit	Audit	n/a	n/a	J.Jones
Example: 01/01/25	Written request for copy of ITP	ITP	e-mail	Jane Doe	J. Jones

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Date:

Consumer/ Parent Name:

Address:

Dear:

l hope that this letter finds you doing well. It has come to our attention here at Family First Mental Health that we have not heard from you in a while. In order for your Case to remain open with us, it is a requirement that you must be actively receiving and participating in treatment consistently. Please contact us within **ten business days,** to schedule an appointment if you are still interested in our services.

If we do not hear from you by _____,we will close your case record at that time. If you decide later that you would like to continue services, simply give us a call at the number below and we will assist you with starting services again.

Sincerely,

FAMILY FIRST MENTAL HEALTH

_____

Signature

Name:_____Credentials:_____ Phone Number:_____