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Last Name:

First Name:

ID #

DOB:

**NUTRITION**

Number of Meals Eaten Daily:		Are you taking a food supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Names of supplements:	
Height:	Normal Weight:	Current Weight:	Do you have problems eating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:

**DO YOU HAVE, OR HAVE YOU EVER HAD THE FOLLOWING**

Symptom	Yes	No	Comments
Trouble with Vision			
Rash/Dark Spots			
Depression/Anxiety			
Sore Throat			
Stiff Neck			
Cough			
Short of Breath			
Chest Pains			
Ankle Swelling			
Nausea			
Vomiting			
Urinary Problems			
Trouble with Sex			
Problem with Period			
Vaginal Problems			
Fertility Problems			
Mother Took DES			
Joint Pain			
Arm/Leg Pain			
Leg Weakness			
Numbness/Tingling			
Headaches			
Fevers			
Diarrhea			
Weight Loss			
Night Sweats			
Enlarged Lymph Nodes			
Fatigue			
Weakness			
Memory Loss			
Trouble Concentrating			
Difficulty Walking			
Other			

**INFECTIONS**

Infection Name	Yes	No	Date	Comments
PCP				
MAI				
M. KAN				
KAPOSI'S SARCOMA				
CRYPTOCOCCUS				
HISTOPLASMOSIS				

Last Name:

First Name:

ID #

DOB:

**INFECTIONS (Continued)**

CANDIDIASIS

CMV RET. PNEUM. G.I.

CRYPTOSPORIDIUM

TOXOPLASMOSIS

HAIRY LEUKOPLAKIA

HERPES ZOSTER

HERPES SIMPLEX

EBHEPATITISV

SALMONELLA

SYPHILLIS

GONORREA

P.I.D.'S, RECURRING

PML

OTHER

**Surgeries:****Other Hospitalizations:****Chronic Medical Problems:****OB/GYN:**

Miscarriages:

Menarche:

Date of Last  
Pap:

P: G: AB:

**Contraceptives:**

Method Used/Now Using:

Other Methods Used:

Problems with Methods:

**Allergies:****Reactions:****Immunizations:** MMR Td FL Pneum. HBV**Childhood Diseases:** Measles Mumps Chicken Pox Other:

Current Medications:

**Miscellaneous:**

Exercise: (20 min. 3x week)

 Yes  No

Describe:

Seat Belt Use:

 Always  
 Occasionally  
 Never

Advance Directives Completed?

 Yes  
 No

Explained to Patient on Intake:

 Yes  
 No

Copy Given:

 Yes  
 No

Clinics/Hospitals/Private Physicians who provided HIV Treatment:

Last Name:

First Name:

ID #

DOB:

**INSURANCE**

DRIVERS LICENSE NUMBER	STATE	REFERRING DOCTOR	CHIEF COMPLAINT	DATE OF INJURY
CARRIER/PRIMARY	CASE MANAGER		CARRIER/SECONDARY	CASE MANAGER
ADDRESS			ADDRESS	
CITY	STATE	ZIP	CITY	STATE ZIP
PHONE	INSURANCE ID #		PHONE	INSURANCE ID #
GROUP NAME	GROUP #		GROUP NAME	GROUP #
GUARANTOR NAME			GUARANTOR NAME	
GUARANTOR ADDRESS			GUARANTOR ADDRESS	
CITY	STATE	ZIP	CITY	STATE ZIP
INSURED PATIENT ID #			INSURED PATIENT ID #	
INSURANCE UPDATES				

**ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF INFORMATION**

Please remember that to the extent permitted by law that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowance for certain procedures or services and others will pay a percentage of the charge. It is the patient's ultimate responsibility to pay for any deductible amount, coinsurance, co-payment or any other balance not paid for by your insurance company. When we are filing your claim, we will allow forty-five days from the billing date for the insurance carrier to process your claim and to make payment accordingly. If payment is not received within the time frame specified above, we will notify you to pay your account in full and to seek reimbursement directly from your insurance carrier. The billing of your insurance carrier is only done as a courtesy to the patient and does not dismiss the patient's responsibility for payment in full.

I certify that I have read and understand fully Care Resource's billing policy and agree to make payment-in-full and/or satisfactory payment arrangements when asked to do so as specified above. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record including information related to HIV infection. Furthermore, I hereby assign all medical and surgical benefits to which I am entitled, including Medicare, Medicaid, and Ryan White Part A, Private Insurance, Workers' Compensation and other health plans to Care Resource. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original copy. I understand that to the extent permitted by law, I am financially responsible for all charges whether or not paid by the insurance carrier. Should this account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

I authorize the release of any medical information (including HIV information and/or test results) necessary to process my claim(s) and to request payment of government benefits either to myself or to Care Resource (the assignee).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

Signature of Insured or Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name:

First Name:

ID #

DOB:

**In Depth Assessment Patient Questionnaire**

The in-depth assessment is a diagnostic tool for gathering information to establish or support a diagnosis, to establish eligibility for services, to provide a basis for the development or modification of a treatment plan or plan of care and to develop discharge criteria. By answering the following questions, you collaborate with the staff & therapist to determine how to meet your needs. Thank you for taking the time to complete this questionnaire. I acknowledge and accept home visits for the provision of certain program care or outreach.

I understand the purpose of this client questionnaire as stated above and give my consent for the staff & therapist to complete an in-depth assessment with me.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. Please describe in your own words, why you are seeking help today:

\_\_\_\_\_  
\_\_\_\_\_

2. Initial here (\_\_\_\_\_ initials) if you are willing to receive e-mail from care resource to keep up with happenings, events and new services at the agency. E-mail address: \_\_\_\_\_

3. Initial here (\_\_\_\_\_ initials) if you are willing to receive mail from care resource to keep up with happenings, events, new services at the agency. Address: \_\_\_\_\_

3. a. Initial here (\_\_\_\_\_ initials) if you would like to learn more about clinical trials at Care Resource. \_\_\_\_\_

b. Initial here (\_\_\_\_\_ initials) if you would like to volunteer at Care Resource. \_\_\_\_\_

c. Initial here (\_\_\_\_\_ initials) if you would be willing to be interviewed by the media regarding your HIV/AIDS status. (We frequently get requests from various media outlets to speak with our clients about their care; we would contact you first to see if you're willing to discuss your care with the television or newspaper reporter.) (Note: Items #2-3 have no impact on your ability to receive services at Care Resource) \_\_\_\_\_

4. How would you like to be contacted by the staff?

- Home phone \_\_\_\_\_ Message ok?  Yes  No
- Cell phone \_\_\_\_\_ Message ok?  Yes  No
- Other \_\_\_\_\_ Message ok?  Yes  No

Please List any special instructions for contact: \_\_\_\_\_

How did you learn about Care Resource?	
<input type="checkbox"/> Another Client	<input type="checkbox"/> Advertisement
<input type="checkbox"/> Self Referred	<input type="checkbox"/> Literature
<input type="checkbox"/> Other Provider	<input type="checkbox"/> Case Manager
<input type="checkbox"/> Clinic	<input type="checkbox"/> Hospital
<input type="checkbox"/> Other:	_____

5. In the event of an emergency, who may the staff contact? \_\_\_\_\_

- Emergency Contact Home phone \_\_\_\_\_ Message ok?  Yes  No
- Emergency Contact Cell phone \_\_\_\_\_ Message ok?  Yes  No
- Emergency Contact Other \_\_\_\_\_ Message ok?  Yes  No

Please List any special instructions for contact: \_\_\_\_\_

5. a. Is it ok to discuss your HIV status with your emergency contact?  No  Yes

6. How do you get where you need to go throughout the week? \_\_\_\_\_

- 7. a. I would like more information regarding a Living Will or Advanced Directive  No  Yes
- 7. b. I would like more information regarding a Mental Health Advanced Directive  No  Yes
- 7. c. Do you have any special needs? \_\_\_\_\_

Therapist initial when provided Date

8. From your perspective are there any services you need but are not currently receiving?  No  Yes, if yes, please explain: \_\_\_\_\_

9. Please describe some of your personal strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Do you currently have a stable place to live? Yes  No

2. Who do you live with most of the time? \_\_\_\_\_

3. How regular are your daily patterns?

- a. Eating: Very  Somewhat  Not at all
- b. Sleeping: Very  Somewhat  Not at all

Describe any recent changes: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ ID # \_\_\_\_\_ DOB: \_\_\_\_\_

4. How often do you eat away from home?  
Rarely/Never  Once a month  Once a week  2-4 times/week  At least once a day

**Personal Family History**

Where were you born? \_\_\_\_\_ Gender at Birth:  Male  Female  
Transgender:  No  Yes;  M to F or  F to M  
Primary Language: \_\_\_\_\_ Other Languages: \_\_\_\_\_

If born outside the U.S., please describe your immigration experience:  
\_\_\_\_\_  
\_\_\_\_\_

	Mother	Father	Oldest to Youngest brother/sister	brother/sister	brother/sister	brother/sister
Family Names:	_____	_____	_____	_____	_____	_____
Any mental illness?	_____	_____	_____	_____	_____	_____
Physical illness?	_____	_____	_____	_____	_____	_____
Death? (list year)	_____	_____	_____	_____	_____	_____
Substance Abuse?	_____	_____	_____	_____	_____	_____

2. Please describe what it was like growing up in your home: \_\_\_\_\_  
\_\_\_\_\_

3. Have you ever been married or partnered?  No  Yes , if yes, please list:

Name	Where	Dates	HIV?	Divorced?	Children, #, Gender, age?
a. _____	_____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____	_____

4. Please describe your experience with intimate relationships: \_\_\_\_\_  
\_\_\_\_\_

5. As a child, were you ever: <sup>1</sup>

	Hit	Slapped	Bruised	Burned	Sexually abused	Harmed
a. by an adult	_____	_____	_____	_____	_____	_____
b. by another child	_____	_____	_____	_____	_____	_____

6. As a child, did you ever:

	Hit	Slap	Bruise	Burn	Sexually abuse	Harm
a. an adult	_____	_____	_____	_____	_____	_____
b. another child	_____	_____	_____	_____	_____	_____

7. As an adult, were you ever: <sup>2</sup>

By Whom?	Hit	Slapped	Bruised	Burned	Sexually abused	Harmed
c. _____	_____	_____	_____	_____	_____	_____
d. _____	_____	_____	_____	_____	_____	_____

8. As an adult, did you ever:

Who?	Hit	Slap	Bruise	Burn	Sexually abuse	Harm
a. _____	_____	_____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____	_____	_____

<sup>1</sup> Alpert, E. J. (2002) Journal of General Internal Medicine Domestic Violence and Clinical Medicine: Learning from our Patients and From our Fears.

<sup>2</sup> National Library of Medicine (2007) "The reluctance of health care professionals to facilitate disclosure of domestic violence incidences with their patients, and vice-versa, is a contributing factor to the failure to recognize and assess the problem." Available at:

[http://www.nlm.nih.gov/archive/20040829/pubs/cbm/domestic\\_violence\\_assessment.html](http://www.nlm.nih.gov/archive/20040829/pubs/cbm/domestic_violence_assessment.html) on 12/13/2007

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

9. For question numbers 5-8 explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Do you have a pet?  No  Yes, Please list: \_\_\_\_\_

**Religious Beliefs**

Are you part of any organized religious activity?  No  Yes, Please list: \_\_\_\_\_

Do you hold important personal religious beliefs?  No  Yes, Please list:  
\_\_\_\_\_  
\_\_\_\_\_

**Culture**

Are you part of a cultural group?  No  Yes, Please list:  
\_\_\_\_\_

What cultural practices are important to you?  
\_\_\_\_\_  
\_\_\_\_\_

**Legal**

Have you ever been arrested?  No (proceed to Medical History)  
 Yes, please explain:

Charge	Date	Result
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Are you currently on probation?  No  Yes,  
If yes, provide probation officer: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Please list your probationary requirements so we might help you accomplish them:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History**

4. Medical Providers:	Name	Location	Phone	last visit date
Primary Care Physician	_____	_____	_____	_____
Psychiatrist	_____	_____	_____	_____
Therapist	_____	_____	_____	_____
Other	_____	_____	_____	_____
Other	_____	_____	_____	_____

5. Have you ever tested positive for Tuberculosis?  No  Yes  
6. Have you ever tested positive for Hepatitis?  No  Yes

Please list all medications you currently take:  
\_\_\_\_\_

Last Name:

First Name:

ID #

DOB:

(If you do not take any medications or supplements, then go to page 7 and answer question #10)

Drug Name	Why are you taking this medication	Number pills each time	Number times each day	Please describe restrictions with this drug, (with/without food)	When is the next refill date?
Supplements	Why are you taking this Supplement	Number pills each time	Number times each day	Please describe restrictions with this Supplement	

6. How closely do you follow your specific medication schedule over the last four days?

- Never                      Some of the time                      About half of the time                      Most of the time                      All of the time
- 

7. When was the last time you missed any of your medications?

- Within the past week                      1-2 weeks ago                      2-4 weeks ago                      1-3 months ago                      >3 months ago                      Never skip
- 

8. Please check the reason(s) below that may have contributed to missed medication doses in the last month (If you haven't missed any of your medications in the past month, please skip to question 9):

- Were away from home
- Were busy with other things?
- Simply forgot?
- Postponed a minute and then forgot
- Had too many pills to take
- Wanted to avoid side effects
- Did not want others to notice you taking medication
- Had a change in daily routine
- Felt like the drug was toxic/harmful
- Fell asleep/slept through dose time
- Felt sick or ill
- Felt depressed/overwhelmed
- Had problems taking pills at specified times (with meals)
- Ran out of pills
- Felt good
- Family responsibilities got in the way
- Changes on weekend got in the way
- Your housing/living situation got in the way
- Did not understand your provider's instruction
- Did not have access to food or water
- Did not have a safe or secure place to keep the medications
- Lost your medications
- Were under the influence of drugs or alcohol
- Taking too many pills
- The pills taste bad

Last Name:

First Name:

ID #

DOB:

9. The next sets of questions are about your feelings and opinions related to the medications that have been prescribed to you. How sure are you that:

	Extremely Sure	Somewhat Sure	Somewhat Unsure	Extremely Unsure
You're able to take the medications as directed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The medications have a positive effect on your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(If on Mental Health medications) If you don't take the medications exactly as instructed, the mental health condition will worsen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(If on HIV medications) If you don't take the medications exactly as instructed, the HIV in your body will become resistant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

a. Are you currently satisfied with your current regimen? Yes  No  If not, why? \_\_\_\_\_

b. Do you have everything you need to be able to follow the instruction for these medications? Please check

	Yes	No	N/A
A good place to store your medications at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A good place to store your medications away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food to eat with the medications, when needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enough drinking water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reminders (alarm clocks, watch, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c. Is there anything that you need that might help you with your medications? \_\_\_\_\_

d. On a scale of one to ten, how motivated are you to take your HIV medications?

Not Motivated					Very Motivated				
1	2	3	4	5	6	7	8	9	10

On a scale of one to ten, how motivated are you to take your Mental Health Medications?

Not Motivated					Very Motivated				
1	2	3	4	5	6	7	8	9	10

\* If you haven't taken your HIV or mental health medications as prescribed please answer the question below and if you have taken them as prescribed, please skip the question below.

e. On a scale of one to ten, how motivated are you to change the factors

influencing your adherence of HIV medications?

Not prepared to change					Already Changing				
1	2	3	4	5	6	7	8	9	10

influencing your adherence of Mental Health medications?

Last Name:

First Name:

ID #

DOB:

Not prepared to change

Already Changing

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

10. Please give a definition in your own words for the following list of words:

HIV \_\_\_\_\_

AIDS \_\_\_\_\_

Viral Load \_\_\_\_\_

CD4 \_\_\_\_\_

Drugs Classes \_\_\_\_\_

Resistance \_\_\_\_\_

Adherence \_\_\_\_\_

Have you taken any labs that relate to your HIV? Yes  No  (If no, skip to "Financial Eligibility")

11. What is your most recent Viral Load Number? \_\_\_\_\_

12. What is your most recent CD4 Count? \_\_\_\_\_

### Financial Eligibility

Do you have Health Insurance?

No, **if no**, does your employer offer insurance?  No  Yes

Yes, **if yes**, through your  current or  previous employer?

If from your previous employer, did you enroll in COBRA?

Yes Are you paying premiums yourself?  Yes  No

When does your COBRA coverage end? \_\_\_\_\_

No, **if no**, when you left your employer did your employer notify you of your Cobra Rights?

Yes, date: \_\_/\_\_/\_\_  No

Do  you or  someone else pay your co-payments/deductibles?

Do you have Medicaid Waiver (Project AIDS Care)?  Yes  No

### Are you enrolled in any of the following programs?

- ADAP (AIDS Drug Assistance Program)  No  Yes
- AICP (AIDS Insurance Continuation Program)  No  Yes
- TOPWA (Targeted Outreach for Pregnant Women Act)  No  Yes
- CMS (Children's Medical Services)  No  Yes
- WIC (Women, Infants & Children)  No  Yes
- HOPWA (Housing Opportunities for People with AIDS)  No  Yes
- HUD (Housing and Urban Development)  No  Yes
- TANF (Temporary Assistance to Needy Families)  No  Yes
- VA (Veteran's Administration)  No  Yes

### Do you want information?

- No  Yes
- No  Yes
- No  Yes
- No  Yes
- No  Yes
- No  Yes
- No  Yes
- No  Yes
- No  Yes

### Do you own or receive benefits from any of the following?

- Other Insurance  No  Yes, list: \_\_\_\_\_
- Private Disability Insurance  No  Yes, list: \_\_\_\_\_
- Trust Fund  No  Yes, list: \_\_\_\_\_
- Retirement Benefits  No  Yes, list: \_\_\_\_\_

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Created on 09/04/0906/04

Adapted by Care Resource 1/31/2009

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ ID # \_\_\_\_\_ DOB: \_\_\_\_\_

Income from Rental Property  No  Yes, list: \_\_\_\_\_  
Public or Private Assistance  No  Yes, list: \_\_\_\_\_  
Child Support Payments  No  Yes, list: \_\_\_\_\_  
Alimony  No  Yes, list: \_\_\_\_\_  
Financial Aid  No  Yes, list: \_\_\_\_\_  
Aid by any relative or friend  No  Yes, list: \_\_\_\_\_  
Other Monthly Assistance  No  Yes, list: \_\_\_\_\_

Education	Name	Years attended	Diploma?	Degree
High School:	_____	_____	_____	_____
College:	_____	_____	_____	_____
Graduate School:	_____	_____	_____	_____
Trade School:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

List any significant educational experiences you've enjoyed:

\_\_\_\_\_

Do you have any future plans involving education?

\_\_\_\_\_

Do you have any problems learning? \_\_\_\_\_

### Work

Are you currently working?  Yes where? \_\_\_\_\_ Profession: \_\_\_\_\_  
How long at present employer? \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Do you have problems relating to your HIV status at work?  No  Yes

No **if no**, do you want to? Yes  no   
Are you receiving Unemployment?  No  Yes, amount? \_\_\_\_\_  
 Disabled since: \_\_\_\_\_ (date) amount disability? \_\_\_\_\_  
Profession: \_\_\_\_\_  
Are you receiving worker's compensation?  No  Yes; Amount: \_\_\_\_\_

Describe any significant successes you've enjoyed at work:

\_\_\_\_\_

\_\_\_\_\_

Are you able to make ends meet? yes  no  if no, explain: \_\_\_\_\_

\_\_\_\_\_

What is your Annual Income? \_\_\_\_\_ What type of proof of income do you have? \_\_\_\_\_

Please list income of all household family members:

\_\_\_\_\_

\_\_\_\_\_

What are your financial Assets? \_\_\_\_\_ What are your expenses? \_\_\_\_\_  
What type of proof do you have for Miami-Dade County Residency? (provide copy) \_\_\_\_\_

Last Name:

First Name:

ID #

DOB:

### Alcohol & Substance Use <sup>3</sup>

## A. Drinking History

Do you drink Alcohol?  No (Skip to "Drug History" on page 12)  
 Yes, please complete the questions below:

Are you ready at the present time to change your drinking? (Circle a number)

<b>1</b> Not at all ready to change	<b>2</b>	<b>3</b>	<b>4</b> Thinking about changing	<b>5</b>	<b>6</b>	<b>7</b> Preparing to change	<b>8</b>	<b>9</b>	<b>10</b> Actively working on or maintaining a change
--	----------	----------	-------------------------------------	----------	----------	---------------------------------	----------	----------	--

1. Age at 1st Use: \_\_\_\_\_ Age Regular Use Began: \_\_\_\_\_ Age Problematic Use Began: \_\_\_\_\_

2. Can you recall your first or first few drinking experience(s)?  yes  no

3. How does your body handle alcohol? \_\_\_\_\_

4. Does it take  small,  medium, or  large amounts of alcohol to make you drunk?

5. Have you experienced blackouts?  yes,  no if yes, explain: \_\_\_\_\_

6. Does it take  less,  more, or  the same amount of alcohol to produce intoxication as it did years ago?

7. Do you ever drink in the morning?  yes,  no

8. Do you ever drink alone?  yes,  no

9. Do you ever drink upon first awakening?  yes,  no

10. Do you drink at night to help you sleep?  yes,  no

11. Do you stock up and / or protect your supply of alcohol?  yes,  no

12. What happens to you emotionally when you drink (i.e., moody, irritated, numbing, etc.)? \_\_\_\_\_

13. If you are going out for the evening, do you have a few drinks before you leave home?  yes,  no

14. Have you ever been treated for alcoholism?  yes,  no

If yes, list when, where, length of stay and result:

When	City	Facility	How Long	Result
a. _____				
b. _____				
c. _____				
d. _____				

15. Have you ever attended AA, Al-Anon, Nar-Anon, NA or ACOA?  yes,  no *If yes*, describe your experience: \_\_\_\_\_

16. Have you ever felt you ought to cut down on your drinking?  yes,  no

17. Have people annoyed you by criticizing your drinking?  yes,  no

18. Have you felt bad or guilty about your drinking?  yes,  no

<sup>3</sup> U.S. Department of Health and Human Services Public Health Service Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment TIP 24: A Guide to Substance Abuse Services for Primary Care Clinicians. Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.45293> on 12/13/2007.

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19. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?  yes,  no

20. When you stop drinking or cut down on the amount, have you ever:

a. experienced internal or external shakes or tremors  yes  no

b. seen, heard, smelled or felt things that were not there?  yes  no

c. Had a seizure, convulsion, epileptic fit?  yes  no

21. Have you ever set limits on your drinking by doing any of the following:

a. Time of day  yes,  no

b. Switch from liquor to wine or beer  yes,  no

c. Amount to be consumed  yes,  no

d. Made promises to yourself about these restrictions  yes,  no

e. Have you ever broken them?  yes,  no

22. With whom do you do most of your drinking? \_\_\_\_\_

23. Have you ever injured yourself after drinking?  yes,  no If yes, explain: \_\_\_\_\_

24. How do you classify yourself as a drinker,  social,  heavy,  abuse,  or alcoholic?

Explain your answer:

25. Describe your pattern of drinking:

26. Current Use Level:

Amount (how much?): \_\_\_\_\_

Frequency (how often?): \_\_\_\_\_

Duration (how long at this level?): \_\_\_\_\_

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### B. Drug History (General)

27. Have you ever used drugs?  No (Skip to "Recreational/Leisure Activities" on page 14)

27 a. Have you ever been previously treated for a drug problem?  No

Yes **If yes**, list when, where, length of stay and result:

	When	City	Facility	How Long	Result
a.	_____				
b.	_____				
c.	_____				
d.	_____				

28. What happens to you emotionally when you use drugs?

\_\_\_\_\_  
\_\_\_\_\_

29. Have you ever received medication for nervousness, depression or weight loss?  no  yes, **If yes**, list:

\_\_\_\_\_

30. How do you classify yourself regarding your drug use? \_\_\_\_\_

31. Have you ever been ashamed of your conduct after using drugs?  no  yes, **If yes**, describe: \_\_\_\_\_

32. Have you ever had any drug related injuries?  no  yes, **If yes**, describe: \_\_\_\_\_

33. Have you ever used drugs/medications to help you sleep?  yes,  no **If yes**, explain: \_\_\_\_\_

34. Prior to seeking treatment today, what is the longest period of time you have been drug or medication free in the past year?

\_\_\_\_\_

35. Which drugs have you used? \_\_\_\_\_

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For Each Drug Used, Complete this Page (make additional copies as necessary)

Specific Drug: \_\_\_\_\_ Rank this drug by circling a number: 1 2 3 4 5

1= My favorite, 5 = least favorite

35. Are you ready at the present time to change your drug use related to this drug? (Circle a number)

<b>1</b> Not at all ready to change	<b>2</b>	<b>3</b>	<b>4</b> Thinking about changing	<b>5</b>	<b>6</b>	<b>7</b> Preparing to change	<b>8</b>	<b>9</b>	<b>10</b> Actively working on or maintaining a change
---	----------	----------	---	----------	----------	------------------------------------	----------	----------	--

36. Age at 1st Use: \_\_\_\_\_ Age Regular Use Began: \_\_\_\_\_ Age Problematic Use Began: \_\_\_\_\_

37. Can you recall your first use experience with this drug?  yes,  no

If yes, explain:

---



---

38. How does your body handle this drug?

---



---

39. Does it take  small,  medium, or  large amount to get you high?

40. Is the amount it takes to get you high  more,  less, or  the same amount to get you high as it did years ago?

41. What happens to you emotionally when you use this drug? \_\_\_\_\_

---



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42. Have you ever overdosed, experienced withdrawal or had an adverse reaction to this drug?  yes  no, If yes, explain:

43. Do you normally use this drug before:

- a. going out  yes  no
- b. Sexual Intimacy  yes  no
- c. Work, School  yes  no
- d. Other: \_\_\_\_\_

44. This drug helps me:

- handle stress
- handle anxiety
- handle boredom
- handle tiredness
- Other: \_\_\_\_\_

45. Describe your pattern of use for this drug:

46. Consumption level:

Amount (how much?): \_\_\_\_\_ Frequency (how often?): \_\_\_\_\_

Duration (how long at this level?): \_\_\_\_\_ Date of Last Use: \_\_\_\_\_

Method of use (snorting, oral, freebasing, Injection, other) \_\_\_\_\_

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**Recreational/Leisure Activities**

Please describe your recreational/leisure activities: \_\_\_\_\_

**Mental Health**

Have you ever been diagnosed with a mental illness?  No

Yes, please list: \_\_\_\_\_

Have you ever experienced mental health problems?  No

Yes, please list: \_\_\_\_\_

Have you ever received counseling before?  No

Yes, please list:

	Counselor	Location	Dates	Result
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Have you ever received mental health care in an inpatient facility?  No

Yes, please list:

	Counselor	Location	Dates	Result
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Have you ever attempted suicide?  No

Yes, please describe what happened:

\_\_\_\_\_

Have you ever had feelings you want to kill yourself or someone else?  No

Yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you currently feel you want to kill yourself or someone else?  No

Yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Are you having any problems with memory?  No  Yes, please describe:

\_\_\_\_\_

With concentration?  No  Yes, please describe: \_\_\_\_\_

**Sexual Health<sup>4</sup>**

Please describe your first consensual sexual experience:

\_\_\_\_\_

Describe your thoughts regarding your sexual life: \_\_\_\_\_

\_\_\_\_\_

<sup>4</sup> Centers for Disease Control (2007) Partnership for Health: A Brief Safer-Sex Intervention in HIV Clinics. Available at; [http://www.cdc.gov/hiv/topics/prev\\_prog/rep/packages/partnershipforhealth.htm](http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/partnershipforhealth.htm) on 12/13/2007.

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<b>In the last 3 months, have you...</b>	<b>No</b>	<b>Yes</b>	<b>Not Sure</b>	<b>Have you...</b>	<b>No</b>	<b>Yes</b>	<b>Not Sure</b>
Been homeless?	<input type="checkbox"/>	<input type="checkbox"/>		Ever injected drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Been in alcohol or drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>		Ever been in alcohol or drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Had sex while high on drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>		Ever had sex against your will?	<input type="checkbox"/>	<input type="checkbox"/>	
Had sex to get money, drugs, shelter, etc.?	<input type="checkbox"/>	<input type="checkbox"/>		Ever had sex with other men (men only)	<input type="checkbox"/>	<input type="checkbox"/>	
Paid for sex with money or drugs?	<input type="checkbox"/>	<input type="checkbox"/>					
Had sex with a person who injects drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant now? (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had sex with a man who has sex with men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Been diagnosed with Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Been diagnosed with a sexually transmitted disease (e.g. Syphilis, Chlamydia, Gonorrhea, Hepatitis B?)  No  Yes  Not Sure

Been in the correctional system? (Probation, parole, secured detention, juvenile corrections etc.)  No  Yes  Not Sure

**In the past 3 months, have you had vaginal, oral, or anal sex?** No  Yes

**If yes, with a...**

Man?  No  Yes .....How many men? \_\_\_\_\_

Woman?  No  Yes .....How many women? \_\_\_\_\_

Transgender?  No  Yes .....How many transgender? \_\_\_\_\_

In the last 3 months, which types of sex have you had? If yes, about how often did you or your partner use condoms or barriers for each type of sex?

	<b>No</b>	<b>Yes</b>	<b>Always</b> (4 out of 4 times)	<b>Usually</b> (3 out of 4)	<b>Sometimes</b> (2 out of 4)	<b>Occasionally</b> (1 out of 4)	<b>Never</b> (0 out of 4)
4) Had vaginal sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performed anal sex? (top)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received anal sex? (bottom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performed oral sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received oral sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 3 months, have you had unprotected anal or vaginal sex with someone ...**  No  Yes If yes, how many partners? \_\_\_\_\_

Who was HIV positive (has HIV)?  No  Yes \_\_\_\_\_

Who was HIV negative?  No  Yes \_\_\_\_\_

Whose HIV status you didn't know?  No  Yes \_\_\_\_\_

**Do you have a spouse or main partner?** No  Yes

If yes, for how long? \_\_\_\_\_ years \_\_\_\_\_ months

Is your partner: HIV positive (has HIV)  HIV negative  I don't know

If you are HIV-positive, how long have you known about your HIV status? \_\_\_\_\_ years \_\_\_\_\_ months. If you are HIV-positive, are you receiving medical care for your HIV infection?  Yes  No  Not sure

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2009 HHS Federal Poverty Guidelines Annual Income Ranges (Gross Household Income) (Effective March 1, 2009 for Ryan White Part A & MAI Services in Miami-Dade County) **What is your yearly income?**

Family Size	A 0-100%	B 101-150%	C 151-200%	D 201-250%	E 251-300%	F 300-350%	G 351-400%
1	< or = to <input type="checkbox"/> \$10,830	<input type="checkbox"/> \$16,245	<input type="checkbox"/> \$21,660	<input type="checkbox"/> \$27,075	<input type="checkbox"/> \$32,490	<input type="checkbox"/> \$37,905	<input type="checkbox"/> \$43,320
2	< or = to <input type="checkbox"/> \$14,570	<input type="checkbox"/> \$21,855	<input type="checkbox"/> \$29,140	<input type="checkbox"/> \$36,425	<input type="checkbox"/> \$43,710	<input type="checkbox"/> \$50,995	<input type="checkbox"/> \$58,280
3	< or = to <input type="checkbox"/> \$18,310	<input type="checkbox"/> \$27,465	<input type="checkbox"/> \$36,620	<input type="checkbox"/> \$45,775	<input type="checkbox"/> \$54,930	<input type="checkbox"/> \$64,085	<input type="checkbox"/> \$73,240
4	< or = to <input type="checkbox"/> \$22,050	<input type="checkbox"/> \$33,075	<input type="checkbox"/> \$44,100	<input type="checkbox"/> \$55,125	<input type="checkbox"/> \$66,150	<input type="checkbox"/> \$77,175	<input type="checkbox"/> \$88,200
+1	<b>\$3,740</b>	<b>\$5,610</b>	<b>\$7,480</b>	<b>\$9,350</b>	<b>\$11,220</b>	<b>\$13,090</b>	<b>\$14,960</b>

All of the information I've provided in this questionnaire is true:

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Intake staff has forwarded information requested by the client to the appropriate Care Resource Department

Intake Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Medical Case Manager Assigned: \_\_\_\_\_

I have referred the client to the following resources based upon this assessment and included them in the Plan of Care:

**Ryan White Covered Services:**

- Case Management
- Other:
- Mental Health and Substance Abuse Counseling
- Inpatient Substance Abuse Counseling
- Comprehensive Risk Counseling Services
- Nutrition
- Dental
- Legal
- Food for Life Network
- Primary Care (Medical or Physician Referral)
- HIV/AIDS Education
- Prescription Drugs

**Community Services:**

- AIDS Drug Assistance Program
- Other:
- Pharmaceutical Company's Patient Assistance
- AIDS Insurance Continuation Program
- Medicaid Waiver Services
- Miami-Dade Transit
- Federal Emergency Management Agency
- Food Stamps
- Veteran's Administration
- HUD/Section 8/HOPWA/Homeless Services
- Social Security Disability

Case Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Case Manager

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Case Management Services Supervisor

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## Treatment Programs at Care Resource Orientation

Care Resource's Outpatient Treatment programs provide clinically competent services including individual, family and group counseling and educational sessions to individuals living with HIV/AIDS or at risk for HIV/AIDS and in many cases, suffering from co-occurring mental health disorders.

Care Resource's program therapists remain distinctively sensitive to the impact HIV/AIDS diagnosis, treatment and viral course have on individuals, couples and families. Incorporating HIV/AIDS education, treatment knowledge, adherence and risk reduction counseling allows clients to receive essential adjunct service from uniquely qualified staff.

Full time and per diem staff maintains registration and licensure in Clinical Social Work and Mental Health Counseling. Each therapist maintains at least 30 hours of continuing education every two years.

Referrals to Care Resource's Outpatient Therapy program are received directly from interested clients; the HIV/AIDS care system, Temporary Assistance to Needy Families program, community service organizations and family members. Entry into care involves a welcoming posture toward the client by all staff, no waiting list and thorough American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders diagnostic assessment as well as use of the American Society of Addictions Medicine's level of care determination. Individuals requiring alternate levels of care receive a choice of referrals into the appropriate service that can meet the individual client's need. Cooperative agreements maintained with detoxification, inpatient, partial hospitalization, day treatment and psychiatry services ensure rapid access to alternative levels of care and service. If after thorough assessment, outpatient individual counseling is the appropriate level of care, the client is presented with the results of the assessment and recommendation for care. Discussion of the specific benefits, alternatives and risks of treatment and informed consent ensues in order to ensure that entry into treatment is both voluntary and well informed. State program licensure requirements indicate the appropriate frequency of sessions must remain at a minimum of one session weekly. Fewer sessions must be clinically justified in writing by the therapist and entered into the client chart.

In addition to incorporating STI, HIV/AIDS and co-occurring disorder concerns into substance abuse outpatient treatment, the development of a client centered, individualized, strengths based treatment plan provides a roadmap for client and therapist to move toward enhanced function and sobriety. Individual therapy, education, groups and referrals commingle with additional services to meet client needs and treatment goals. Clients, for whom additional family members or significant relationships provide support toward accomplishing treatment objectives, are encouraged to incorporate their participation into treatment through couples or family therapy, education and/or support.

Abstinence, harm reduction, relapse prevention, increased knowledge of chemical dependency, support network development and maintenance and living substance free are some specific areas of therapeutic focus.

In addition, some Care Resource clients maintain goals relating to family preservation, economic self-sufficiency, and promotion of family responsibility in childcare and long-term relationship building.

Regular treatment plan reviews occur at least every thirty days or at points of significant change to ensure adequate progress and alteration of treatment addresses client needs. American Society of Addiction Medicine's Continued Stay Criteria helps guide clinicians in determining appropriate lengths of stay or changes in levels of care needs. Difficult or challenging client situations are staffed with the supervisor, or when another service is involved with the multidisciplinary team to ensure client's benefit from the collective experience and agency resources. All registered interns receive on-site supervision by licensed staff to ensure quality service provision and regular individual and group supervision.

Clients frequently disclose when relapse occurs. Subsequently, while urine testing is available, it is rarely necessary to determine client use or progress. Procedures aimed at maintaining the viability and veracity of collection samples guide therapists' use of testing to ensure that client directed reporting to third parties like probation or the department of children and families is accurate and actionable.

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Discharge planning involves eliciting behaviors indicative of change that once achieved indicate successful attainment of treatment goals. Incorporated into case planning, discharge planning allows the client to clearly understand when successful accomplishment of treatment objectives is achieved.

The program is small and specialized to meet the needs of two specific groups: to those impacted by HIV/AIDS and to those participating in Temporary Assistance to Needy Families Programming. Serving approximately 30 persons yearly, sessions generally occur once weekly for a period of 6 months on average. Groups at Care Resource include an HIV support and treatment group meeting on Thursdays at 6:00 PM in our second floor conference room, while attendance in AA/NA/AI-anon is encouraged. Contact your therapist for referral to the groups or check on line for contact information at [www.careresource.org](http://www.careresource.org).

Mental Health concerns and Substance Use can impact the spread of HIV and sexually transmitted infections. We recommend all participants receive HIV testing (if status is unknown), regular TB screening and regular STI testing if sexually active to ensure that your health needs are adequately met and you help reduce the spread of these infections within our community by receiving prompt adequate treatment.

For HIV testing, simply come in during office hours sign in and wait for your rapid test (about 30 minutes). For Sexually transmitted infections screening, if you see your doctor here, ask for the full sexually transmitted infections assessment or go to either the health department or Planned Parenthood at the following locations

**Health Department information (free depending on income):**

<a href="#">Miami Dade CHD-Downtown Clinic</a>	1350 NW 14th St.	Miami	305-547-5588
<a href="#">Little Haiti Health Center</a>	300 NE 80 Terrace	Miami	305-325-3567
<a href="#">MDCH - P.E.T. CENTER</a>	615 Collins Avenue	Miami Beach	305-535-5540x107
<a href="#">Miami Dade CHD- West Perrine Health Center</a>	18255 Homestead Avenue	Miami-Dade	305-256-6315

**Planned Parenthood (call for pricing):**

North Miami Health Center	681 N.E. 125th St.	Miami	(305) 895-7756
Kendall Health Center	11440 S.W. 88th St., Suite 109		(786) 263-0001
<a href="#">Jean Shehan Family Planning Clinic</a> 3	119A SW 22nd Street		(305) 285-5535

**Infection Control (Universal Precautions)**

Care Resource Therapy Program practices universal precautions to prevent the spread of pathogenic organisms. This means that employees are required and clients are encouraged to wash hands after using the restroom, all specimens are handled as potentially infectious material and policy and procedure govern the handling of all potentially infectious material.

**Fees**

**For individuals who do not qualify for publicly funded programs** or who wish to pay privately, Counseling fees are charged on a sliding scale designed to accommodate a client's ability to pay for needed services.

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**Psychosocial Counseling Sliding Scale:**

Fee	Family Size	A	B	C	D	E	F
		< 100%	101-150%	151-200%	201-250%	251-300%	>300% and up
	% of Fee due	0%	20%	40%	60%	80%	100%

**Summary:**

	100%	80%	60%	40%	20%
In-Depth Assessment (new patient)	\$195.00	\$156.00	\$117.00	\$78.00	\$39.00
In-Depth Assessment (Established patient)	\$150.00	\$120.00	\$90.00	\$60.00	\$30.00
Individual/Family Therapy	\$75.00	\$60.00	\$45.00	\$30.00	\$15.00
Group	\$25.00	\$20.00	\$15.00	\$10.00	\$5.00
Clinic Visit	\$25.00	\$20.00	\$15.00	\$10.00	\$5.00
Treatment Plan Development	\$150.00	\$120.00	\$90.00	\$60.00	\$30.00
Treatment Plan Reviews	\$75.00	\$60.00	\$45.00	\$30.00	\$15.00

**Access to Information**

You have access to your information that a therapist deems would not by its disclosure injure you in some way. Access for review is available by written request. Access to copies of your information requires a written request and payment of a copy fee.

If you have a legal guardian, your legal guardian may have access to your information and may participate in treatment planning.

**Partner Notification Program**

The Florida Department of Health provides free and confidential partner notification to those who may have been exposed to HIV or other sexually transmitted infections (STI). You simply give them the contact information of the individual who has been exposed and they do the rest. The notified individual gets the opportunity to be tested and receive early treatment, possibly avoiding life threatening conditions from untreated HIV or other STIs. Want to use a confidential e-mail service to notify partner's who've been exposed? [www.inspot.org/florida](http://www.inspot.org/florida)

**Confidentiality Agreement**

**Who You See Here;  
What You Hear Here;  
When You Leave Here;  
Let it Stay Here!**

Confidentiality entails the responsibility to safeguard clients from unauthorized disclosures of information. As you are aware, clinicians are bound by strong ethical and legal rules regarding confidentiality. Your issues will be held confidential within the clinical staff of Care Resource with the following exceptions: (1) You are a threat to yourself or to

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others (for example, you are suicidal or homicidal), (2) Your clinician knows or suspects you are abusing a minor child, or vulnerable adult, (3) This agency, or a representative thereof, is under court order, such as a subpoena or deposition.

As a client of Care Resource, you are expected to abide by certain rules of confidentiality. Clients must feel safe in knowing that their statements and presence as members of Care Resource will not be disclosed except as expressed herein. The foundation of confidentiality allows each client to fully explore his or hers own feelings in a safe environment without fear of retribution or negative consequences upon returning to the world outside of Care Resource. Some clients do not want family members or other friends to know that they are receiving services from Care Resource. We must respect those wishes.

You are expected to protect the confidentiality of other Care Resource clients. This means, specifically, that you are not to disclose the identity of any client outside of Care Resource. You are not to discuss anything that is learned about another client at Care Resource. These rules are rigidly enforced to protect you and other clients of Care Resource.

## Limits to Your Confidentiality

It is important for you to know that there are limits to the confidentiality of your information. This means that access to information in your case file is possible when required by law and/or regulation. Examples of these limits to confidentiality are as follows:

- Your case file may be subject to review when ordered by a judge.
- If we believe you intend to harm yourself or someone else, it is our ethical and professional duty to inform others, as the circumstance requires.
- In situations of suspected child or vulnerable adult abuse, it is required that we report this to the appropriate authorities.
- Other professionals associated with your care may have access to information on record in your case file without your written consent.
- During a medical emergency, we will disclose information that will assist emergency personnel in treatment.
- You may request in writing to see your record.
- You may consent in writing to disclose parts of your record to someone else.
- Your information may be disclosed to law enforcement when a crime is committed on the premises or against a member of staff.
- Payers have access to your information for the purpose of oversight, quality review, utilization review and public health reporting.
- You may be seen in group therapy. If so, you and every other member of the group will be told that anything discussed is private. This includes the names of group members of any problems they discussed in group. This is not to be talked about with anyone outside the group. Confidentiality will exist only to the extent that each patient trusts and respects every other member of the group. Violation of this confidentiality is grounds for dismissal from the program.

## Statement of Client Rights

As a client of Care Resource, you have many rights. We always want to make sure you are valued and served in the most professional manner. Here's what you can expect:

1. I have the right to respectful treatment by staff.
2. I have the right to services, provided without discrimination because of race, age, religion, nationality, origin, sex, sexual orientation, disability or economic status.
3. I have the right to confidentiality (privacy) except when there is danger to others or myself.
4. I have the right to assignment to a professional clinician.
5. I have the right to actively participate in the development and review of an individualized treatment plan. This includes the right to know and meet with the professional staff members responsible for my care, to know their professional qualification and to know their staff person.

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6. I have the right to the least restrictive type of treatment that can meet my needs.
7. I have the right to pursue a complaint through the written grievance procedure provided at intake.
8. I have the right to understand the services that Care Resource provides including my rights and responsibilities as a client before receiving services from Care Resource.
9. I have the right to be referred to appropriate services and agencies when my needs are beyond what can be provided at Care Resource.
10. I have the right to give informed consent or to refuse treatment and to be advised of the consequences of such refusal.
11. I have the right to a humane and safe environment giving me reasonable protection from harm and appropriate privacy with regard to my personal needs.
12. I have the right to request a therapist change (if receiving individual therapy). I understand that changes of therapist will be made only after consultation with the Psychosocial Services Manager and the therapist assigned to me.

### Statement of Client Responsibilities

As a client of Care Resource, you have many responsibilities too. We always want to make sure you understand your responsibilities and accept the credit for your success in treatment. Here's what we expect from you:

1. I am responsible for maintaining the confidentiality of other clients.
2. I am responsible for following the Psychosocial Services treatment Program Rules.
3. I am responsible for the grievance procedure as outlined in the Client Grievance Procedure for any problem or concern.
4. I am responsible for informing therapist/case managers at the agencies from which I receive services, that I am also receiving services from Care Resource. I understand that coordination of services between agencies is to my benefit.
5. I will treat all Care Resource staff, volunteers, and clients respectfully. I will not be verbally or physically abusive.
6. I am responsible for following the treatment plan that I have developed with my therapist/case manager.
7. I am responsible for keeping all scheduled appointments (case management, individual and group therapy). I will give 24 hours notice if I need to miss an appointment and reschedule the appointment with my therapist and/or case manager.
8. I will attempt to remain drug and alcohol free while on the premises of Care Resource.
9. I am responsible for providing my therapist with an update of any changes in my status (physical, financial, emotional).
10. I am responsible for providing my own transportation whenever possible. If unable to provide my own transportation; I will contact my primary care manager for available resources.

### Grievance Procedures

**Care Resource** will work with you to try to resolve all complaints BEFORE they become grievances. As a **Care Resource** client, you have the right to submit a complaint or grievance at any time, and have the right to expect a prompt response. Remember to file a grievance only when you have exhausted all other means of resolving your problem.

Follow the steps outlined below if you feel that you have been unfairly treated or if you feel the services you are receiving do not meet your standards.

1. Tell the staff member providing you services that you need an appointment to talk about the problem or concern you are having regarding **Care Resource** services. You may be asked to write down your problem or concern.
2. If you and the staff member providing services to you cannot agree on a solution, you may request a meeting with the supervisor of the unit-either by asking the staff member to set an appointment, or you may contact him/her directly to set an appointment. The supervisor will help you and the staff member resolve the problem.

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3. If the supervisor cannot help you and the staff member work out a solution with which you are comfortable, you may present your complaint formally as a grievance and allow the supervisor to investigate the grievance and get feedback from the department manager. You should expect a response to your grievance within **five** business days, sooner if possible.
4. If you are not satisfied with the resolution of the grievance, you may pursue your grievance at the next level in the organization. In such cases, you may ask the supervisor to arrange an appointment with the department manager, or you may arrange the appointment yourself.
5. If **Care Resource** cannot resolve your grievance in a manner that you consider reasonable and fair, you have the right to bring your grievance to an external review body for a resolution:

**In Dade County Contact:**

- a. For Ryan White Care Act Part A clients Miami-Dade County: 305 375-4742
- b. For Medicaid or State funded Services like ARTAS or TANF: Florida Local Advocacy Council: 1-800-342-0825
- c. For Counseling Clients, further pursuit of a grievance depends upon which entity pays for your care or which entity governs the behavior or your therapist. Some of the most common payers include: SFAN Quality Assurance Coordinator at (305) 585-5241, Ryan White Part A Substance Abuse and Mental Health Miami-Dade County at 305 375-4742;
- d. Any abuse/neglect of a vulnerable person: 1800-96A-BUSE

**In Broward County contact:**

- a. Broward County Part A Grantee's Office at (954) 327-8750

**Assurances:**

- (1) I have read the client Grievances Procedures and have received a copy. The procedure has been explained to me, and I understand its contents.
- (2) I have been informed, that if I am not satisfied after receiving the results of the internal grievance procedure at **Care Resource**, I may bring my grievance directly to Miami-Dade County (for Ryan White Part A Clients) (305) 573-4002, or to the South Florida AIDS Network Quality Assurance Coordinator (for Counseling clients) (305) 584-5241. I also have been informed, that if I feel I have been abused by staff and/or the agency, I may contact the Florida Department of Children and Families at (800) 96a-buse or For Medicaid or State funded Services like ARTAS or TANF: Florida Local Advocacy Council - contact: 1-800-342-0825.
- (3) In the event that I choose to file a grievance against **Care Resource**, I give my consent to release any confidential information related to my specific grievance from my confidential records. I understand that the information voluntarily supplied on the **Care Resource** grievance form or any other method of communication will be used to investigate the complaint. This consent to release confidential information will expire 90 days after **Care Resource** receives the notification of grievance filed. I understand that I may withdraw my complaint and stop the grievance procedures at any time.
- (4) I am assured that filing a grievance does not preclude my receipt of any services for which I am eligible, nor will it hinder my access from any of these eligible services.

**Treatment Program Rules**

Agreement to participate in, and abide by, the following rules and regulations established by the Psychosocial Services Department of Care Resource is required to access services here.

1. I will not illegally possess, use, sell, give away, or receive drugs, alcohol, or other illegal substances while on or near the premises of Care Resource.

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2. I will not engage in overt sexual behavior toward staff, clients, volunteers, or others on or near the premises of Care Resource.
3. An Individual Treatment Contract negotiated by myself and therapist and/or case manager will be initiated in writing, and my therapist and/or case manager and myself will sign any change in the treatment contract.
4. I will attempt to be alcohol/drug free for 24 hours before and at the time of my appointment.
5. I will notify my therapist and /or case manager 24 hours in advance of cancellation of an appointment.
6. I understand that more than 3 consecutive absences may result in termination from the program, unless approved by my therapist and/or case manager.
7. I will abide by the rules or confidentiality as defined by the Agreement of Confidentiality.
8. I will not engage in violent behavior nor make verbal or physical threats of violence toward staff, clients, volunteers, or property on the premises or near Care Resource.

### **NOTICE OF PRIVACY PRACTICES**

Effective Date: 05/19/2008

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

1. YOUR RIGHTS WITH RESPECT TO YOUR CONFIDENTIAL INFORMATION:

- a. To review, copy (\*including paper copy) and receive information;
- b. To request the right to amend your information if incorrect (although we are not required to do so);
- c. To receive an accounting of non-routine or non authorized disclosures of your information for 6 years;
- d. To request a restriction on certain uses and disclosures of your information (although we are not required to do so);
- e. To file a complaint if you believe your rights have been violated\*; and
- f. To receive confidential communications.

*To request information about your rights to health information, complete and submit a written request to the: Medical Care & Research Services Manager: 3510 Biscayne Blvd, #300, Miami FL 33137 or Medical Care Services Supervisor: 830 East Oakland Park Blvd. Suite 121, Ft. Lauderdale, FL 33334*

2. THE FOLLOWING ARE VARIOUS USES AND DISCLOSURES OF YOUR CONFIDENTIAL PATIENT INFORMATION THAT MAY BE USED BY PHYSICIAN (NO specific medical consent is required):

- a. For your Medical care:
  - i. For example, your health care team may share your medical information including their observations, in order to determine how you are responding to treatment, and to communicate with specialist.
  - ii. For example, we may use your health care information to contact you regarding an appointment.
- b. To bill for your medical services
  - i. For example, a bill may be sent to your insurance company, which contains your diagnosis, procedure performed and supplies used.
- c. For our operational services
  - i. For example, your information may be used in connection with quality improvement activities in order to improve the quality and effectiveness we provide.
  - ii. For example, our business associates may need to access your confidential information so they can perform the job we ask them to do. Business associates include accreditation agencies, laboratories, state hospital associations, our attorneys and accountants.

3. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MAKE UNLESS YOU OBJECT:

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- a. To family and friends involved in your care;
- b. With respect to treatment alternatives or other health related benefits which may be of interest to you;
- c. Fundraising activities; and
- d. Appointment reminders.

If you have an objections to the uses and disclosures mentioned above, you must complete a written request to the: Medical Care & Research Services Manager; 3150 Biscayne, Blvd., #300, Miami, FL 33137 or Medical Care Services Supervisor; 830 East Oakland Park Blvd., Suite 121, Ft. Lauderdale, FL: 33334.

4. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MUST MAKE (without your consent):
  - a. When required by state or federal law;
  - b. To state and federal public health authorities for disease prevention;
  - c. To protective service agencies authorized to receive reports of abuse, neglect and domestic violence;
  - d. To governmental oversight agencies;
  - e. When required pursuant to a court order;
  - f. For law enforcement purposes;
  - g. To a coroner, medical examiner, or funeral director for the purposes of carrying out their duties;
  - h. Pursuant to established research protocols (IRB or Privacy Board approval);
  - i. When required to avert a serious threat to health or safety;
  - j. In connection with worker's compensation programs;
  - k. Lawsuits and similar proceedings; and
  - l. National Security & Intelligence Agencies.

Any other uses other than what is described above are prohibited unless you give specific authorization. You have the right to revoke such authorization at any time in writing except to the extent we have already relied on it.

5. OUR DUTIES:
  - a. We are required to maintain the confidentiality of your medical information and to provide you with notice of our legal duties and privacy practices.
  - b. We are required to abide by the terms of this notice
  - c. We reserve the right to change the terms of this Notice and post the new notice when it becomes effective
6. \*RIGHT TO COMPLAIN:
  - a. If you believe your rights identified in this Notice have been violated, you may complain to the Medical Care & Research Services Manager or Medical Care Services Supervisor, if you are here to receive medical care. If you are here to receive Psychosocial Services, you may complain to the Psychosocial Services Manager. Contact our office at 305-576-1234 and request a complaint form to file a complaint. All complaints must be submitted in writing.
  - b. If you are unhappy with how your complaint was handled, you may contact the Secretary of Health and Human Services.
  - c. The law prohibits any retaliation for filing a complaint.

7. FOR FURTHER INFORMATION:

You may contact the privacy officer at 3510 Biscayne, BLD Suite 300, Miami, FL 33137 or call 305-576-1234 extension 301, for any further information with respect to this policy. In addition, you may refer to the Grievance procedures referred to earlier in this attached document.

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**Affirmations:**

\_\_\_ I HAVE READ and understand THE STATEMENT OF CLIENT'S RIGHTS.

\_\_\_ I HAVE READ, understand and AGREE TO ACCEPT THE RESPONSIBILITIES OF A CLIENT AT CARE RESOURCE AS LISTED IN THE STATEMENT OF RESPONSIBILITIES.

\_\_\_ I have read and understand that noncompliance with the program rules will result in immediate case review by the staff, and may result in my discharge from the program. Further, noncompliance with Rules No. 7 or 8 will result in immediate discharge from Care Resource.

\_\_\_ I have read and understand Care Resource maintains the Client Agreement to Confidentiality with me to ensure my Confidentiality and the confidentiality of others. I agree to uphold these standards at all times in my participation in all Care Resource programs. I understand that any breach the confidentiality of a Care Resource client will result in a meeting with my counselor and Manager of Psychosocial Services who will terminate all services to me.

\_\_\_ I hereby authorize Care Resource, its staff and volunteers to provide me, directly or through other agencies or individuals, such available services for which I am eligible.

Statement

Signature

I have received a copy of the Care Resource Grievance Procedure. \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of the Client Agreement to Confidentiality \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of the Program Rules \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of my Rights and Responsibilities with Care Resource \_\_\_\_\_ Date: \_\_\_\_\_

I have been given written materials about my right to accept/refuse treatments \_\_\_\_\_ Date: \_\_\_\_\_

I have been given a copy of the Notice of Privacy Practices \_\_\_\_\_ Date: \_\_\_\_\_

I have been informed of my right to formulate Advanced Directives including a Florida Living Will, Health Care Surrogate and Living Will for Mental Health Care \_\_\_\_\_ Date: \_\_\_\_\_

I understand that the terms of any Advanced Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. \_\_\_\_\_ Date: \_\_\_\_\_

Please check and sign one of the following:

I **HAVE** executed an Advanced Directive (Living Will, Designation of a Health Care Surrogate or Advanced Directive for Mental Health) \_\_\_\_\_ Date: \_\_\_\_\_

**-or-**

I **HAVE NOT** executed an Advanced Directive (Living Will, Designation of a Health Care Surrogate or Advanced Directive for Mental Health) \_\_\_\_\_ Date: \_\_\_\_\_

Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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## LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs<sup>5</sup>

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

### What is a Living Will?

Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

### What is the difference between a Living Will and a legal will?

A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death, and appoints a personal representative or revokes or revises another will.

### How do I make my Living Will effective?

Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

### After I sign a Living Will, what is next?

Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

### What is a Health Care Surrogate?

Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

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<sup>5</sup> The Florida Bar and the Florida Medical Association accessed and available at:

<http://www.floridabar.org/tfb/flabarwe.nsf/840090c16eedaf0085256b61000928dc/b954f12053a410ec85256e28005bd4a0>  
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### **How do I designate a Health Care Surrogate?**

Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

### **Can I have more than one Health Care Surrogate?**

The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

### **Can the Living Will and the Health Care Surrogate designation be revoked?**

Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

### **Where can I go to obtain legal advice on this issue?**

If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

*This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.*

### **The above in Spanish:**

#### **Preguntas Frecuentes Acerca de los Instructivos Avanzados de Salud y Testamentos en Vivos**

El Cuerpo Legislativo de la Florida ha reconocido que todos adultos capaces tienen los derechos de predeterminación con respecto a sus decisiones acerca de su salud, incluyendo el derecho de escoger o denegar tratamiento de salud o intervención quirúrgica que sólo sirven para prolongar la vida cuando existe un estado de salud fatal. Pero, este derecho es sujeto a ciertos intereses de la sociedad, como la protección de la vida y la protección de normas de conductas éticas en la profesión médica. Para asegurar que este derecho no se ha perdido por incapacidad física o mental, el cuerpo de la Legislatura ha establecido un procedimiento bajo Capítulo 765 de los Estatutos de la Florida que permiten los individuos.

#### **¿Que es un Testamento en Vivo (en inglés—Living Will)?**

Cada adulto capaz tiene el derecho de hacer una declaración escrito conocido como "Living Will." El documento tiene como objetivo dar instrucciones acerca de la prohibición de la intervención quirúrgica que prolongan la vida para individuos que sufren de saludes fatales. El formulario sugerido se ha proporcionado por el Cuerpo Legislativo bajo los Estatutos de la Florida en la sección 765.303. En la Florida, la definición de "intervención quirúrgica que prolongan la vida" se ha extendido por el Cuerpo Legislativo para incluir la provisión de comida y agua para pacientes que sufren de saludes fatales.

#### **Cuál es la diferencia entre un Testamento en Vivo (Living Will) y un Testamento Legal (Legal Will)?**

Un Testamento en Vida no debe confundirse con un Testamento regular el cual dispone de los activos de una persona tras su muerte y designa sucesores o revoca un testamento otorgado válidamente con anterioridad.

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### **¿Cómo valido mi Testamento en Vivo?**

Bajo la ley de la Florida, un Testamento en Vivo debe ser firmado por su otorgante en presencia de dos testigos, un testigo no puede ser esposa o pariente del otorgante. Si el otorgante no tenga la capacidad física de firmar el Testamento en Vivo, un testigo puede firmar en la presencia y a la dirección del otorgante. La Florida dar la palabra a un Testamento en Vivo que hubo firmado en otro estado si el Testamento en Vivo hubiere firmado de conformidad con las leyes este estado o de conformidad con las leyes de la Florida.

### **¿Después de firmo un Testamento en Vida, que pasa?**

Después de firmar un Testamento en Vivo es la responsabilidad del otorgante avisar al médico de este documento. Es importante proporcionar una copia del Testamento en Vivo al su médico y el hospital para colocarlo en su historial médico.

### **¿Que es un Health Care Surrogate?**

Cualquier adulto capaz puede designar un sustituto para la toma de decisiones de salud cuando no pueda hacer decisiones por usted mismo. Cuando el otorgante está incapacitado, el sustituto tiene la responsabilidad de consultar con los médicos en seguida. El sustituto da permiso a los médicos y hace decisiones sobre el tratamiento de salud del otorgante que son iguales a las decisiones que haría el otorgante si era capaz de hacerlos. Si no hay información de lo que habría elegido el otorgante, el sustituto puede considerar el mejor interés del otorgante mientras decidiendo cómo tratar a él. El formulario sugerido se ha proporcionado por el Cuerpo Legislativo bajo los Estatutos de la Florida en la sección 765.303.

### **¿Cómo designo un sustituto para la toma de decisiones de salud (en inglés-Health Care Surrogate)?**

Bajo las leyes de la Florida, la designación de Health Care Surrogate debe ser elegido por un documento escrito, y debe ser firmado en la presencia de dos testigos; uno de los testigos no puede ser esposa o pariente del otorgante. La persona designada como Health Care Surrogate no puede ser un testigo para la firma del documento.

### **¿Puedo tener más que un sustituto para la toma de decisiones de salud (en inglés-Health Care Surrogate)?**

El Otorgante puede designar otro sustituto. El otro sustituto puede tomar las decisiones de salud si el sustituto original no quiera o no pueda cumplir con sus responsabilidades. Si el otorgante no tenga la capacidad física para firmar al designación, él puede dirigir que otra persona firmarlo en la presencia de testigos. Una copia precisa tiene que ser proporcionado al Sustituto (Health Care Surrogate). A menos que la designación declara una fecha de caducidad, la designación permanece válida hasta que es revocado por el otorgante.

### **¿Puede ser revocado el Testamento en Vivo y el sustituto para la toma de decisiones de salud (Health Care Surrogate)?**

El Testamento en Vivo y el sustituto para la toma de decisiones de salud pueden ser revocado por el otorgante con tanta frecuencia-- con una carta firmado y fechado; por la destrucción física del documento original; por una declaración verbal de su intención de revocarlo; por un documento nuevo ejecutado que es diferente que el documento original. Es muy importante informar al médico que el Living Will y la Designación de Health Care Surrogate han sido revocados.

### **¿Dónde puedo recibir consejo legal acerca de este asunto?**

Si necesita consejo legal, llame a su abogado. Si no haya contratado a un abogado, llame al Servicio de Referencia de un Abogado del Colegio de Abogados de la Florida 1-800-342-8011, o servicios de referencia de abogado de los colegios de abogados locales en la Florida o las oficinas locales de ayuda jurídica en las páginas amarillas de la guía telefónica.

*Esta información ha sido preparado por la Comité de Ley de Protección de los Consumidores y La Oficina de Información Público del Colegio de Abogados de la Florida y se publica por cortesía del Colegio de Abogados de la Florida y la Asociación Médica de la Florida.*

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*Suggested form of a Living Will, Florida Statutes Section 765.303*

# Living Will

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ 2\_\_\_\_\_, I \_\_\_\_\_ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

- \_\_\_\_\_ (initial) I have a terminal condition.
- or \_\_\_\_\_ (initial) I have an end stage condition.
- or \_\_\_\_\_ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed): \_\_\_\_\_

Witness _____	Witness _____
Street Address _____	Street Address _____
City, State& Zip _____	City, State & Zip _____
Phone _____	Phone _____

*The principal's failure to designate a surrogate shall not invalidate the living will.*

*— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —*

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*Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203*

# Designation of Health Care Surrogate

Name \_\_\_\_\_

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name \_\_\_\_\_

Name \_\_\_\_\_

Signed: \_\_\_\_\_

Witnesses  
1. \_\_\_\_\_  
2. \_\_\_\_\_

*At least one witness must not be a husband or wife or a blood relative of the principal.*

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

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# Mental Health Advance Directive<sup>6</sup>

If you believe you may be hospitalized for mental health care in the future and that your doctor may think you aren't able to make good decisions about your mental health treatment, completion of a mental health advance directive will help make your treatment preferences known. It is important that you decide NOW what types of mental health treatment you do or do not want and to appoint a friend or family member to make the mental health care decisions that you want carried out. You can use the following advance directive for mental health to direct your future care.

- Read each section of the form carefully and talk about your choices with your case manager, doctor, or other trusted persons.
- The person you choose to be your health care surrogate and alternate must be a competent person who is at least 18 years old, whose civil rights have not been taken away. The person you choose should not be a mental health professional, an employee of a facility which might provide services to you, an employee of the Department of Children and Family Services, or a member of the Local Advocacy Council.
- Make sure your surrogate understands your wishes and is willing to take the responsibility.
- You and your surrogate (and a back up alternate surrogate if you wish) should sign the form in front of two witnesses.
- Have copies made and give them to your surrogate, your case manager, your doctor, the hospital or crisis unit at which you are most likely to be taken, your family, and anyone else who might be involved in your care. Discuss your choices with each of them.

You can change your advance directive at anytime you are competent to do so. If you travel, be sure to take a copy of the advance directive with you. Your advance directive will not take effect unless a physician decides that you are incompetent to make your own treatment decisions. If you are in a psychiatric facility, you will have an attorney appointed to represent your interests and will have a hearing in front of a judge or hearing master. A health care surrogate is not authorized to consent to treatment for a person on voluntary status.

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily execute this mental health advance directive to assure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decisions for myself. If a guardian or other decision-maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes and it should be given the greatest possible legal weight and respect. If the surrogate (s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care surrogate to make certain treatment decisions for me. My surrogate is also authorized to apply for public benefits to defray the cost of my health care, to release information to appropriate persons, and to authorize my transfer from a health care facility.

My Mental Health Care Surrogate is:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

I, \_\_\_\_\_, mental health care surrogate designated by \_\_\_\_\_, hereby accept the designation.

Signature of the Mental Health Care Surrogate: \_\_\_\_\_  
Date: \_\_\_\_\_

<sup>6</sup> State of Florida (2002) Baker Act Handbook and User Reference Guide. Accessed and available 2/2/9 at: <http://www.namigainesville.org/images/Psychiatric%20Advanced%20Directive.pdf>

Last Name:

First Name:

ID #

DOB:

If the person named above is unavailable to serve as my mental health care surrogate, I hereby appoint and want immediate notification of my alternate mental healthcare surrogate as follows:

Name of Alternate: \_\_\_\_\_

Address: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

I, \_\_\_\_\_, alternate mental health care surrogate designated by \_\_\_\_\_, hereby accept the designation.

Signature of the Alternate Mental Health Care Surrogate: \_\_\_\_\_

Date: \_\_\_\_\_

Complete the following or Initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health care surrogate full power and authority to make mental health care decisions for me. This includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have stated in this advance directive. If I have not expressed a choice in this advance directive, I authorize my surrogate to make the decision my surrogate determines is the decision I would make if I were competent to do so. \_\_\_\_ Yes \_\_\_\_no

B. My choice of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24 hour care, I would prefer to receive this care in this/these facilities:

Facility: \_\_\_\_\_

Facility: \_\_\_\_\_

2. I do not wish to be placed in the following facilities for psychiatric care for the reasons I have listed:

Facility/Reason: \_\_\_\_\_

Facility/Reason: \_\_\_\_\_

C. My choice of a treating physician is:

First choice of physician: \_\_\_\_\_

Second choice of physician: \_\_\_\_\_

I do not wish to be treated by the following physicians:

Name of physician: \_\_\_\_\_

Name of physician: \_\_\_\_\_

D. My wishes regarding confidentiality of my admission to a facility and my treatment while there are as follows:

1. \_\_\_\_ my representative may be notified of my involuntary admission \_\_\_\_ Yes \_\_\_\_ No

2. \_\_\_\_ any person who seeks to contact me while I am in a facility may be told I am there. \_\_\_\_ Yes \_\_\_\_ No

3. \_\_\_\_ I consent to release of information about my condition and treatment plan \_\_\_\_ Yes \_\_\_\_ No

To the following persons: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_ I do not consent to release of information about my admission or treatment to anyone unless I give specific consent at the time of the request or as otherwise allowed by law \_\_\_\_ Yes \_\_\_\_ No

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health treatment, I have initialed one of the following, which represents my wishes:

1. \_\_\_\_ I consent to the medications that Dr. \_\_\_\_\_ recommends.

Last Name:

First Name:

ID #

DOB:

2. \_\_\_\_\_ I consent to the medications agreed to by my mental health care surrogate, after consulting with my treating physician and any other individuals my surrogate may think appropriate, with the exceptions found in #3 below.

3. \_\_\_\_\_ I specifically do not consent and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents: (list name of drug and reason for refusal):

4. \_\_\_\_\_ I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

5. I have the following other preferences about my psychiatric medications:

F. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:

1. \_\_\_\_\_ my surrogate may not consent to ECT without express court approval.

2. \_\_\_\_\_ I authorize my surrogate to consent to ECT.

3. Other instructions and wishes regarding ECT are as follows:

G. If during a stay in a psychiatric facility, my behavior requires an emergency intervention; my wishes regarding which form of emergency interventions should be made in the following order (fill in numbers, giving 1 to your first choice, 2 to your second and so on until each has a number). If an intervention you prefer is not listed, write it in after "other" and give it a number.

\_\_\_\_\_ Seclusion                      \_\_\_\_\_ Medication in pill form                      \_\_\_\_\_ Physical restraints  
\_\_\_\_\_ Medication in liquid form                      \_\_\_\_\_ Medication by injection                      \_\_\_\_\_ other:  
\_\_\_\_\_ Both Seclusion and Physical Restraints                      \_\_\_\_\_

H. Florida law prohibits a mental health surrogate from consenting to experimental treatments that have not been approved by a federally approved institutional review board without my prior written consent or the express approval of the court.

\_\_\_\_\_ I consent to my participation in experimental drug studies or drug trials.

\_\_\_\_\_ I do not wish to participate in experimental drug studies or drug trials.

I. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Other instructions I wish to give about my mental health care are (use additional pages if needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Name:

First Name:

ID #

DOB:

By signing here, I indicate that I fully understand that this advance directive will permit my mental health care surrogate to make decisions and to provide, withhold, or withdraw consent for my mental health treatment.

Printed name (Declarant): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This advance directive was signed by \_\_\_\_\_ in our presence. At his/her request, we have signed our names below as witnesses. We declare that at the time this advance directive was signed, the Declarant, according to our best knowledge and belief was of sound mind and under no constraint or undue influence. We further declare that we are both adults, are not designated in this advance directive as the mental health care surrogate and at least one of us is neither the person's spouse nor blood relative.

Dated at: \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(County and State) (Day) (Month) (Year)

Witness signatures:

Witness 1:

Witness 2:

\_\_\_\_\_  
Signature of Witness 1

\_\_\_\_\_  
Signature of Witness 2

\_\_\_\_\_  
Printed Name of Witness 1

\_\_\_\_\_  
Printed Name of Witness 2

\_\_\_\_\_  
Home Address of Witness 1

\_\_\_\_\_  
Home Address of Witness 2

\_\_\_\_\_  
City, State, Zip Code of Witness 1

\_\_\_\_\_  
City, State, Zip Code of Witness 2

Last Name:

First Name:

ID #

DOB:

<b>Agency: Care Resource</b>		<b>Outreach Encounter Form</b>	
Date _____	Encounter Time _____	To _____	Total Units _____
# of Units _____	OFFE 10179 _____	OTEC 10181 _____	Location _____
<b>Personal &amp; Demographic Data</b>		CIS _____	Primary Language _____
DOB _____	Name _____	SS# _____	M ___ F ___ Age _____
African American ___	Haitian ___	Hispanic ___	White, on-Hispanic ___
Other _____			
<b>HIV Assessment</b>			
Tested for HIV? If Yes _____		How long ago? _____	Positive ___ Negative ___
If No (Client never tested, no results or test negative) _____		Would you like to test today? _____	Did not get results Yes ___ No ___
If not today, would you like to talk about testing at a future date? _____		Yes ___ No ___	Date _____
<b>Assessment and Referrals (HIV+ Clients)</b>		<b>Referral to: (list provider name)</b>	
When did you test positive? _____		Medical Doctor _____	
Do you have a Doctor? _____		Case Management _____	
If Yes ___ Who? _____		Substance Abuse _____	
Where do you receive care? JM ___ VA ___ Private ___		Other _____	
Clinic _____ Other _____		<b>Took client to: (list location)</b>	
Do you see your doctor regularly? Y ___ N ___		Medical Doctor _____	
Date of next appointment? _____		Case Management _____	
Last time you saw a Doctor? _____		Substance Abuse _____	
If No ___ Why not? _____		Other _____	
Would you like to see a doctor? Y ___ N ___		<b>Follow up date:</b>	
Do you have a case manager? Y ___ N ___		Medical Doctor _____	
Last time you saw case manager? _____		Case Management _____	
		Substance Abuse _____	
		Other _____	
<b>HIV Test Referral (Client is not HIV+)</b>		Follow up: ___Y ___N Date _____	
Written referral given? Y ___ N ___ To: _____		Post Test Counseling provided? _____	
Taken to site? Y ___ N ___		___Y ___N	
Pretest Counseling? Y ___ N ___ Consent signed? Y ___ N ___		Test Result: ___Positive ___Negative	
Risk Behavior IDU ___ MSM ___ Heterosexual ___ Homosexual ___ Sex worker ___		Referral if Positive to:	
Follow up Contact Information Follow up date: _____		___Medical Care _____	
Name: _____		___Case Management _____	
Address: _____		___Other _____	
City _____ Phone _____		Referral follow up date: _____	

Outreach Worker \_\_\_\_\_ Client Signature \_\_\_\_\_

Progress Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_