Service	Receiving	Interested	Notes
Help obtaining identification	☐	☐	
Health Care	☐	☐	
Public Benefits	☐	☐	
Food/Clothing	☐	☐	
Education/Vocational Training	☐	☐	
Employment Assistance	☐	☐	
Emergency Shelter	☐	☐	
Housing	☐	☐	
Legal Assistance	☐	☐	
Mental Health Counseling	☐	☐	
Substance Abuse Treatment	☐	☐	
Transportation Assistance	☐	☐	
Other:	☐	☐	

Are you still interested in receiving services from the RNP? ☐Yes ☐No

If not, why? _____

Immediate Actions Taken: _____

PLEASE TAKE PHOTO OF REFERRAL and SET APPOINTMENT WITH INDIVIDUAL

Recovery Navigator Program Narrative Intake – to be completed within 30 days of intake

Living Situation

- In the past 30 days, where have you slept most frequently?

  ☐ Street/outside ☐ Vehicle ☐ Emergency shelter ☐ Transitional housing

  ☐ Permanent housing ☐ With family or friends/couch surfing

- During the last 30 days, how many nights have you spent in an emergency shelter? _____ (nights)

- If you are currently living in transitional or permanent housing, approximately how many months have you lived there? _____ (months)

  (☐ Check this box if the client has ALWAYS lived in permanent housing)

- If you are not currently living in permanent housing, when was the last time you had permanent housing? _____ (months ago)

- Overall, how safe do you feel your current housing situation is?

Not at all safe 0 ☐	Slightly safe 1 ☐	Moderately safe 2 ☐	Considerably safe 3 ☐	Extremely safe 4 ☐

- Overall, how satisfied are you with your current housing situation?

Not at all satisfied 0 ☐	Slightly satisfied 1 ☐	Moderately satisfied 2 ☐	Considerably satisfied 3 ☐	Extremely satisfied 4 ☐

Employment

- Approximately how many days were you paid for working during the past <u>30 days</u>? _____ days
  (Note: include under the table, paid sick days, and vacation)

- How many days have you experienced employment problems in the past <u>30 days</u>? _____ days
  (Note: include inability to find work, actively looking for work, or problems with current job in which job is jeopardized)

	Not at all 0	**Slightly 1**	**Moderately 2**	**Considerably 3**	**Extremely 4**
How troubled or bothered have you been by employment problems in the past 30 days?	☐	☐	☐	☐	☐

- For clients who are currently unemployed, or looking for a job, please answer the following questions:

	Not at all 0	**Slightly 1**	**Moderately 2**	**Considerably 3**	**Extremely 4**
How knowledgeable are you about where and how to look for a job?	☐	☐	☐	☐	☐
How comfortable are you writing a cover letter to apply for a job?	☐	☐	☐	☐	☐
How confident do you feel in your ability to interview for a job?	☐	☐	☐	☐	☐
How confident are you that a past boss/supervisor would recommend you for a future job?	☐	☐	☐	☐	☐

☐ N/A for above set of questions, check here if client is employed AND not looking for a new job

- What has been your usual employment status over the past <u>year</u>?

(Note: Response should represent the majority of the past year, not just the most recent. If there are equal times for more than one situation, select the most current of the situations.)

☐ Full-time (35+hours)
☐ Part-time
☐ Less than part-time/Temp Work
☐ Student
☐ Military Service
☐ Retired
☐ Disability
☐ Unemployed
☐ Medical/drug or alcohol/psychiatric treatment
☐ Jail/prison

- What type of work or training have you done before?

_____

_____

- What type of work or training would interest you?

_____

_____

Health & Behavioral Health

Type	Date Began	Date Ended	Type	Date Began	Date Ended
☐ Dental			☐ Developmental Disability		
☐ Head Injury			**HIV**		
☐ Hearing Impairment			☐ AIDS		
☐ Neurological Disability			☐ HIV		
☐ Speech Impairment			**Physical**		
☐ Vision Impairment			☐ Gout		
☐ Wounds/ Abscesses			☐ Mobility Impairment		
☐ Other Health Diagnosis			☐ Other Physical Impairment		

Chronic

Type	Date Began	Date Ended	Type	Date Began	Date Ended
☐ Arthritis			☐ Kidney Disease		
☐ Asthma			☐ Lupus		
☐ Cancer			☐ Memory Disorders/ Dementia		
☐ Cirrhosis			☐ Musculoskeletal Conditions		
☐ COPD			☐ Obesity		
☐ Diabetes			☐ Pain		
☐ Epilepsy/ Seizures			☐ Skin Conditions		
☐ Foot Conditions			☐ Thyroid		
☐ Gastrointestinal (including urinary)			☐ Tuberculosis (active)		
☐ Hepatitis C			☐ Tuberculosis (latent)		
☐ Hypertension			☐ Other Cardiovascular Condition		
☐ Insomnia			☐ Other Respiratory Condition		

Mental Health

Type	Date Began	Date Ended	Type	Date Began	Date Ended
☐ ADD/ADHD			☐ Personality Disorder		
☐ Anxiety Disorder			☐ Psychotic Disorder		
☐ Bipolar Disorder			☐ PTSD		
☐ Depressive Disorder			☐ Other MH Diagnosis		

Substance Use

- What role do drugs or alcohol have in your life?
  (Alleviate pain? Physical/emotional?)

_____

_____

- How much money would you say you spent during the last 30 days on:

  Alcohol? $ _____ Drugs? $ _____

  (NOTE: Only count actual money spent. What is the financial burden caused by drugs/alcohol? If client cannot recall past 30 days, it is okay to ask for an estimate based on a week or a day and multiple that number to get a 30 day estimate.)

- On a scale of 1 to 10 with 1 being not at all and 10 being extremely, how troubled or bothered have you been by alcohol and/or drug problems in the past 30 days?

  Alcohol 1 2 3 4 5 6 7 8 9 10

  Drugs 1 2 3 4 5 6 7 8 9 10

Childhood & Education

- Can you tell me a little bit about your childhood?

  (Did you have siblings? Who raised you? What was your relationship like with that person(s)? Foster care? Did you ever have concerns about your health or safety? Are you still in contact with your family, siblings, etc.?)

  _____

  _____

  _____

- Growing up, how did you do in school?

  (What did you enjoy about school? What did you find challenging? Individualized Education Plan? Learning/developmental disability? Did you repeat any grades?)

  _____

  _____

- Were you ever placed in a special education class while you were in school?

  ☐ Yes ☐ No

- Are you currently enrolled in any educational, vocational, or training programs (such as college, GED, ESL, or other professional courses)? ☐ Yes ☐ No

  ↳ If yes, approximately how many hours per week do you spend attending this program? _____ hours

- Do you have future plans to attend any educational, vocational, or training programs (including college, GED, ESL, or other professional courses)? ☐ Yes ☐ No

Legal History

- What is your current legal situation? What concerns, if any, do you have about these circumstances?

  _____

  _____

- Are you currently on probation? ☐ Y ☐ N

  Length of Probation: _____

  PO Name: _____

  Phone: _____ Location: _____

- Do you have any outstanding warrants? ☐ Y ☐ N

  Plan/Concerns: _____

  _____

- Have you ever been convicted of: (Please briefly describe and include dates)

  ☐ Assault/Domestic Violence ☐ Sex Offense ☐ Drug Offense

  ☐ Arson ☐ Meth Manufacturing

  _____

  _____

_____

Social History

- How would you describe your support system in the area?

_____

_____

- What does a typical day look like for you? What do you enjoy doing?

_____

_____

- Do you identify with any religious background or spiritual practice?

_____

_____

- Children: ☐ Yes ☐ No Are you a new or expecting parent? ☐ Yes ☐ No

  Notes on children (i.e. custody, # of dependent children):

_____

_____

- Have you had significant periods in which you have had experienced serious problems getting along with people in your life?

Note: "Serious problem" means those that endangered the relationship. Also, a "problem" requires contact of some sort, either by telephone or in person	**In the past 30 days**		**In the past year**	
	No	**Yes**	**No**	**Yes**
Parents (mother or father)	☐	☐	☐	☐
Siblings	☐	☐	☐	☐
Sexual partner/spouse	☐	☐	☐	☐
Children	☐	☐	☐	☐
Other significant family (specify) _____	☐	☐	☐	☐
Close friends	☐	☐	☐	☐
Neighbors	☐	☐	☐	☐
Co-workers	☐	☐	☐	☐

Health & Wellbeing

- Do you have a primary care physician? If so, who and when did you last see them?

  _____

- When was the last time you saw a doctor/nurse? What was the purpose? How was the experience?
- _____
- Number of ER visits in the last year: _____
- Hospital inpatient days in the last year: _____
- Hospital admissions in the last year: _____
- Notes: _____

- Have you ever been a victim of a violent attack during homelessness? ☐ Y ☐ N

- Have you ever had any serious head injury/trauma?

  (Did you lose consciousness? Were you hospitalized? Was surgery required?)

  _____

- Do you currently have any pain or discomfort? Is it chronic or sporadic?

  _____

- Are you prescribed any medications? ☐ Y ☐ N

NAME:	DOSE:	PURPOSE:	DURATION:	PRESCRIBER:

- Have you been prescribed medications while in jail/prison? ☐ Y ☐ N
- How is your sleep? How many hours per day/night?

  _____

- Do you have vision or dental concerns?

  _____

- Do you have any of the following ongoing health issues and are you receiving care for this issue?

Health issues	Have this issue?		If yes, receiving care?	
	No	**Yes**	**No**	**Yes**
Kidney disease or dialysis	☐	☐	☐	☐
Liver disease or cirrhosis	☐	☐	☐	☐
Heart disease or history of heart attack	☐	☐	☐	☐
HIV+/AIDS	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Other	☐	☐	☐	☐
_____				
Other	☐	☐	☐	☐
_____				

- Do you have any concerns about your mental health?

  (Onset? When did you first receive tx? Previous diagnoses? Most recent diagnosis?)

  _____

  _____

- Has anyone ever told you that you have mental illness?

  _____

  _____

- Overall, how would you describe your mood?

  _____

  _____

- Have you ever been prescribed medication for mental health reasons?

NAME:	DOSE:	PURPOSE:	DURATION:	PRESCRIBER:	HELPFUL?
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

- Do you ever have thoughts about hurting yourself? About taking your own life?

  (How frequent are these thoughts? Have you ever attempted suicide? How many times? Most recent time?)

  _____

  _____

- Have you ever engaged in any self-harm (cutting, burning, etc.)?

  (In what way? How often? Does anything in particular trigger this behavior?)

  _____

  _____

- Have you been hospitalized to address these concerns (est. dates/places)?

  (What has that experience been like for you?)

  _____

  _____

- Do you ever have thoughts about hurting anyone else? Any plans to do so?

  _____

  _____

- In your life, have you ever had any experience that was incredibly frightening or traumatic?

  (Do thoughts of this event(s) affect your sleep? Nightmares? Do you try to avoid thinking about it? How?)

  _____

  _____

Conclusion

	Poor 1	**Fair 2**	**Good 3**	**Excellent 4**
Overall, how would you rate your current quality of life?	☐	☐	☐	☐

- Do you have any personal goals/plans you would like to work on in the coming 6 months? What would you like the RNP staff help you achieve?

_____

_____

_____

_____

_____

Care Manager Impressions

Motivation for Care Management	Interested ☐	Ambivalent ☐	Not interested ☐
Hygiene	Good ☐	Fair ☐	Poor ☐
Tracking Level	Good ☐	Fair ☐	Poor ☐

Protective Factors/Strengths

☐	Married/committed partner and/or children:
☐	Presence of positive social support from spouse, family and/or close friends:
☐	Problem solving skills and history of healthy coping skills:
☐	Active participation/interest in BH treatment:
☐	Understands the risks of drug use and takes steps to reduce negative consequences:
☐	Presence of hopefulness, as client is able to identify ways of coping and options for future:
☐	Religious/Spiritual commitment:
☐	Life satisfaction:
☐	Future orientated with good insight of needs and goals:
☐	Ct is a strong self-advocate, can express needs and ask for help:
☐	Ct exhibits resiliency, learning and growing from past experiences:
☐	Ct has a high level of health literacy (knows and addresses health needs):
☐	Other:

LEAD New Client Checklist – Paper Forms

Case Manager	Intake/Registration Date
Client Name	REACH Client ID #

Screening Forms

LEAD Screening	☐
LEAD Program Consent	☐
LEAD OWG ROI	☐
Photo	☐

Intake/Registration Forms

HMIS Consent/Revocation	☐
HMIS Profile	☐
HIPAA Disclosure	☐
Reach Grievance Policy	☐
Reach Grievance Form	☐
Reach Orientation Contract	☐
Reach Client Rights	☐
REACH ROIs	☐
LEAD Intake part 1	☐

To be completed within 30 days:

LEAD Intake part 2	☐
Reach Individual Service Plan	☐
Reach Self Care Plan	☐
VI-SPDAT	☐

Ongoing Documentation:

Proof of ID/SSN	☐
Disability Documentation	☐
Chronic Homelessness Documentation	☐
Proof of Income	☐
LEAD Rental Assistance Agreement	☐
Rental Assistance Authorization	☐
Motel Agreement	☐
Motel Assistance Authorization	☐

LEAD New Client Checklist – Agency Information-Enter within 3 days of completing Intake

1. DAP Documentation
    - ☐ Code BH Screening Full
    - ☐ Enter Intake into Agency
    - ☐ Add Program Registration w/date of intake

☐ Set status for client

☐ Give copy of HMIS paperwork to Screening/Outreach Coordinator

Use HMIS Profile and LEAD Intake to input data

2. Required Records
    - ☐Income/Benefits/Insurance
    - ☐ Education Level
    - ☐ Employment Status
    - ☐ Living Situation
3. Client Info
    - ☐ Client Phone
    - ☐ Substances Used
    - ☐ Health/Behavioral Health Conditions
    - ☐ Medical Record
    - ☐ Verify Demographic Information
        - ☐ Check date of birth
        - ☐ Gender
        - ☐ Race
        - ☐ Social Security Number
        - ☐ Veteran Status
4. Other Info
    - Consents/Documentation – Required
        - ☐ HMIS/Safe Harbor Consent/Revocation
        - ☐ HIPAA
        - ☐ Grievance
        - ☐ Reach Orientation
    - Consents/Documentation – If applicable
        - ☐ Additional ROIs
        - ☐ Media Release
    - Add Client ID Numbers – Add an ID – any that apply
        - ☐ DOC
        - ☐ Provider One
        - ☐ Driver's License Number
        - ☐ Tribal Enrollment
5. Scroll down for the following:
    - ☐ Add VISPDAT
    - ☐ Add Marital Status
    - ☐ Add Client Self-Care Plan

King County Homeless Management Information System (HMIS)
Client Consent for Data Collection and Release of Information

What is the HMIS?
The HMIS is a data system that stores information about homelessness services. Bitfocus, Inc. manages the HMIS for King County. The purpose of the HMIS is to improve services that support people who are homeless to get housing, and to have better access to those services, while meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

What is the purpose of this form?
With this form, you can give permission to have information about you collected and shared with Partner Agencies that help King County provide housing and services. A current list of Partner Agencies is at http://kingcounty.hmis.cc/participating-agencies/

BY SIGNING THIS FORM, I AUTHORIZE King County and Bitfocus to share HMIS information with Partner Agencies. The HMIS information shared will be used to help me get housing and services. It will also be used to help evaluate the quality of housing and service programs. I understand that the Partner Agencies may change over time.

The information to be collected and shared includes:

- Name, birthday, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use, and daily living information
- Housing Information
- Use of crisis services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by Partner Agencies
- Results from assessments
- My photograph or other likeness (if included)

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- King County, Bitfocus and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review their privacy policies.
- There is a small risk of a security breach, and someone might obtain my information and use it inappropriately.
- If I have questions about my privacy rights, my HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at (206) 444-4001 x2.
- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 7 years from my last HMIS recorded activity.

- I may revoke this Consent earlier at any time in writing to:

  Bitfocus, Inc.
  ATTN: King County HMIS
  548 Market St #60866
  San Francisco, CA 94104-5401

- The revocation will take effect upon receipt, except to the extent others have already acted under this Consent.

- My HMIS information may be viewed by auditors or funders who review work of the Partner Agencies, including HUD, The Department of Veteran Affairs, The Department of Health and Human Services, and The Washington State Department of Commerce. I understand that the list of auditors and funders may change over time.

- My HMIS information may be shared to coordinate referral and placement for housing and services.

- My HMIS information may be further shared by the Partner Agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.

- My HMIS information will be combined with other information from the Washington State Department of Social and Health Services (DSHS) to help evaluate the quality of social services.

- My HMIS information may be used for research; however, my identity will remain private.

Important: Personal information is not entered in HMIS for people who are 1) receiving services from domestic violence agencies; 2) fleeing or in danger from domestic violence, dating violence, sexual assault or stalking situation; or 3) have revealed information about being HIV positive or having AIDS. If one of these situations applies to you, **DO NOT** agree to have your personal identifying information collected.

SIGNATURE:

_____ _____

Signature of Patient/Client or Representative: Date

_____

PRINTED NAME

For Agency Use Only:

Client Opted Out (Refused Consent) _____ (Staff/Agency Initials)

_____ _____

Witness Staff & Agency) *Date*

Client Revocation of Consent

I revoke my permission to share personally identifying information about me and/or my dependent children under age 18 in the King County Homeless Management Information System (HMIS).

Identifying information to be removed from the system:

(Please check any of the information below to be removed from HMIS)

- ❑ My First and Last Name
- ❑ My Social Security Number
- ❑ My Day and Month of Birth
- ❑ My Last Permanent Address
- ❑ My Phone Number
- ❑ My Ethnicity
- ❑ My Race

If Applicable: Identifying information of minor children to be removed from the system:

(Please check any of the information below to be removed from HMIS)

- ❑ Child's First and Last Name
- ❑ Child's Social Security Number
- ❑ Child's Day and Month of Birth
- ❑ Child's Last Permanent Address
- ❑ Child's Phone Number
- ❑ Child's Ethnicity
- ❑ Child's Race

Insert child/children's name(s):

_____
_____
_____
_____
_____
_____

All non-identifying information will remain in the system:

Gender
Year of Birth
Any other non-identifying information
Education
Program Entry/Exit Answers

I understand that I will continue to receive the same services from HMIS-participating agencies, whether I allow them to enter identifying personal information about me into the HMIS or not.

_____ _____ _____
Client Signature (Parent/Guardian) Date Relationship to Client

_____
Printed Name of Client (Please Print Clearly)

_____ _____
Agency Witness Signature Date

_____
Printed Name of Agency Witness

Homelessness Management Information System (HMIS) Profile

LAW ENFORCEMENT ASSISTED DIVERSION (LEAD) FORM USE

Complete required form for EACH Household Member

Identification (Full Legal Name and Unique Identification):

First Name:	Middle Name:	Last Name:	Social Security Number:

Date of Birth:	Is client head of household	If "No", name of head of household	Relationship to head of household:
	☐ Yes ☐ No		

Residence Prior to Program Entry:

Residence the night before program entry:	Residence City the night before program entry:	Length of stay at this residence:

Approximate date of continuously homeless immediately prior to project entry:	Episodes of homelessness in last 3 years:	Continuously homeless for at least 1 year?
	☐ 1 ☐ 2 ☐ 3 ☐ 4+	☐ Yes ☐ No

If outside, are you staying in a vehicle? ☐ Yes ☐ No

Last Permanent Housing: (record the city, state, and zip code of the apartment, room, or house where the client last lived for 90 days or more; emergency shelters & transitional homes, etc. NOT to be included)

City, State, and Zip Code of last Permanent Address:	
Was the last permanent address in UNINCORPORATED King County?	Was last permanent address within a city limit?
☐ Yes ☐ No	☐ Yes ☐ No

Demographics:

Ethnicity:		Race (Check all that apply):	
☐ Hispanic ☐ Non-Hispanic		☐ American Indian/Alaska Native	☐ Asian
Gender (self-reported by client:		☐ Black/African American	☐ White
☐ Female	☐ Transgender male to female	☐ Native Hawaiian/Other Pacific Islander	
☐ Male	☐ Transgender female to male	☐ Client doesn't know	☐ Client refused
☐ Other:	☐ Client refused		
Primary Language:		Ability to understand English:	
		☐ Yes ☐ No ☐ Interpreter needed	

Veteran/Military Status:

Is client a U.S. Veteran? ☐ Yes ☐ No	Year Entered Military Service:	Years separated from military status:	Theater of Operations: ☐ World War II ☐ Korean War ☐ Vietnam War ☐ Persian Gulf War (Desert Storm) ☐ Afghanistan (Enduring Freedom) ☐ Iraq (Iraqi Freedom) ☐ Iraq (New Dawn) ☐ Other Peacekeeping Operations or Military Interventions
Branch of the Military:	Discharge Status:		
Is client a spouse/partner or dependent minor of a veteran? ☐ Spouse/Partner ☐ Dependent Minor ☐ No			

Disability Types and Services: Physical disability, developmental disability, chronic health, and mental illness require written verification from a state licensed health care provider.

Use This Key for Answers Below:
Y - Yes
N - No
DK – Client Doesn't Know
X – Client Refused

	Diagnosed with: Client is currently diagnosed with disability listed	Long-term disability: Expected to be long-continued & indefinite duration and substantially impairs ability to live independently	Documentation: Documentation of the disability and severity on file	Services/Treatment: Currently receiving services treatment for this disability
Disabling Condition	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Physically Disability	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Developmental Disability	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Chronic Health Condition	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Mental Health Problem	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Substance Abuse ☐ Alcohol ☐ Drugs ☐ Both	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X
Domestic Violence Victim/Survivor	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X	☐ Y ☐ N ☐ DK ☐ X

Have you been a victim of domestic violence in the past year? ☐ Yes ☐ No

Are you currently fleeing? ☐ Yes ☐ No

How long ago did client's most recent experience occur?

☐ Within the past 3 months ☐ 3 – 6 months ☐ 6 months to 1 year
☐ 1 year or more ☐ Client doesn't know ☐ Client refused

Current Income:

Income Source	Receiving?	Amount	Date Started
Earned Income	☐ Yes ☐ No	$	
Unemployment Insurance	☐ Yes ☐ No	$	
Supplemental Security Income (SSI)	☐ Yes ☐ No	$	
Social Security Disability Income (SSDI)	☐ Yes ☐ No	$	
Private disability insurance	☐ Yes ☐ No	$	
TANF	☐ Yes ☐ No	$	
Disability Lifeline/General Assistance (DL/GAU)	☐ Yes ☐ No	$	
Retirement income from Social Security (SSA)	☐ Yes ☐ No	$	
VA Service-Connected Disability Compensation	☐ Yes ☐ No	$	
VA Non-Service-Connected Disability Compensation	☐ Yes ☐ No	$	
Pension from a former job	☐ Yes ☐ No	$	
Child support	☐ Yes ☐ No	$	
Alimony or other spousal support	☐ Yes ☐ No	$	
Other Source:	☐ Yes ☐ No	$	

Current Non-Cash Benefits:

Benefit Source	Receiving?	
Food Stamps (SNAP)	☐ Yes ☐ No	
WIC Nutrition Program	☐ Yes ☐ No	
Veteran's Administration Medical Services	☐ Yes ☐ No	
TANF Child Care services	☐ Yes ☐ No	
TANF transportation services	☐ Yes ☐ No	
Other TANF-funded services	☐ Yes ☐ No	
Other Source:	☐ Yes ☐ No	

Health Insurance:		
Insurance Provider	**Receiving?**	
Medicaid	☐ Yes ☐ No	
Medicare	☐ Yes ☐ No	
State Children's Health Insurance Program	☐ Yes ☐ No	
VA Medical Services	☐ Yes ☐ No	
Employer-Provided Health Insurance	☐ Yes ☐ No	
Health Insurance obtained through COBRA	☐ Yes ☐ No	
Private Pay Health Insurance	☐ Yes ☐ No	
State Health Insurance for Adults	☐ Yes ☐ No	

Agency Representative: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

GENERAL INFORMATION: Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Evergreen Treatment Services may not disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Generally, you must sign a written consent before Evergreen Treatment Services REACH Program can share information for any purpose. Written consent (with some exceptions) may be revoked either verbally or in writing. Under certain circumstances, federal law permits Evergreen Treatment Services to disclose information without your written permission:

1. MEDICAL EMERGENCY: To help in the event of an emergency medical situation.

2. COURT ORDER: As required by the document.

3. CHILD ABUSE OR NEGLECT: ETS is required to report to Child Protective Services any situation in reasonable cause is suspected in an incident of child abuse or neglect, including sexual abuse (RCW 26.44).

4. THREATS OF HARM: Threats to harm self or someone else.

5. CRIME RELATED TO ETS: ETS will disclose information to law enforcement about a crime or threat against our property or personnel.

6. RESEARCH & AUDIT: For research, audit or evaluations.

7. QUALIFIED SERVICE ORGANIZATION AGREEMENT: When ETS has a formal agreement with an organization / business associate.

YOUR RIGHTS: Under HIPAA you have the right to inspect and copy your own health information maintained by Evergreen Treatment Services, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Evergreen Treatment Services records, and to request and receive an accounting of disclosures of your health related information made by Evergreen Treatment Services during the six years prior to your request. You also have the right to receive a paper copy of this notice.

EVERGREEN TREATMENT SERVICES DUTIES: Evergreen Treatment Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Evergreen Treatment Services is required by law to abide by the terms of this notice. Evergreen Treatment Services reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains.

COMPLAINTS AND REPORTING VIOLATIONS: You may complain to Evergreen Treatment Services and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

I Hereby Acknowledge that I Received this Notice of Privacy Practices

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Signature of Client | Printed Name of Client | Date | Witness Signature

REACH & LEAD Client Grievance Policy

Clients in the REACH & LEAD Programs have the right to request that their case managers, the REACH Co-Directors, and/or the LEAD Program Manager review case management decisions that affect them.

If a client is dissatisfied by a case manager decision, or the way a case manager has treated him or her, he or she should discuss his or her concerns directly with the case manager involved. If such a discussion fails to resolve the problem, the client can ask his or her case manager to schedule a meeting with the REACH Co-Directors, or the LEAD Program Manager.

If the client wishes to appeal the decision, he or she should write a letter describing the situation and the reason for the appeal. The REACH Co-Directors will consult with the ETS Executive Director and will respond with a decision to the client in writing.

I have read and received a copy of the REACH & LEAD Grievance Policy.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

REACH
forging trust. fostering change.

ADDRESS
2133 3rd Avenue, #116
Seattle, WA 98121

TELEPHONE
(206) 432-3574

FAX
(206) 432-3575

EMAIL
mail@etsreach.org

Client Grievance

If you prefer to file a grievance verbally, please talk with your case manager.

Client Name: _____

Client ID Number: _____

Briefly explain the nature of the grievance:

_____

_____

_____

_____

_____

_____

Please list an appropriate resolution to your grievance:

_____

_____

_____

_____

_____

_____

_____

If you have additional comment(s), please use the back of this paper.

Signature: _____ Date: _____