

Service	Receiving	Interested	Notes
Help obtaining identification	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care	<input type="checkbox"/>	<input type="checkbox"/>	
Public Benefits	<input type="checkbox"/>	<input type="checkbox"/>	
Food/Clothing	<input type="checkbox"/>	<input type="checkbox"/>	
Education/Vocational Training	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency Shelter	<input type="checkbox"/>	<input type="checkbox"/>	
Housing	<input type="checkbox"/>	<input type="checkbox"/>	
Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse Treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

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 <input type="checkbox"/>	Slightly safe 1 <input type="checkbox"/>	Moderately safe 2 <input type="checkbox"/>	Considerably safe 3 <input type="checkbox"/>	Extremely safe 4 <input type="checkbox"/>
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- Overall, how satisfied are you with your current housing situation?

Not at all satisfied 0 <input type="checkbox"/>	Slightly satisfied 1 <input type="checkbox"/>	Moderately satisfied 2 <input type="checkbox"/>	Considerably satisfied 3 <input type="checkbox"/>	Extremely satisfied 4 <input type="checkbox"/>
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Employment

- Approximately how many days were you paid for working during the past 30 days? _____ days
(Note: include under the table, paid sick days, and vacation)
- How many days have you experienced employment problems in the past 30 days? _____ 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How comfortable are you writing a cover letter to apply for a job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How confident do you feel in your ability to interview for a job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How confident are you that a past boss/supervisor would recommend you for a future job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 year?

(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.)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Full-time (35+hours) | <input type="checkbox"/> Part-time |
| <input type="checkbox"/> Less than part-time/Temp Work | <input type="checkbox"/> Student |
| <input type="checkbox"/> Military Service | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Medical/drug or alcohol/psychiatric treatment | <input type="checkbox"/> 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
<input type="checkbox"/> Dental			<input type="checkbox"/> Developmental Disability		
<input type="checkbox"/> Head Injury			HIV		
<input type="checkbox"/> Hearing Impairment			<input type="checkbox"/> AIDS		
<input type="checkbox"/> Neurological Disability			<input type="checkbox"/> HIV		
<input type="checkbox"/> Speech Impairment			Physical		
<input type="checkbox"/> Vision Impairment			<input type="checkbox"/> Gout		
<input type="checkbox"/> Wounds/ Abscesses			<input type="checkbox"/> Mobility Impairment		
<input type="checkbox"/> Other Health Diagnosis			<input type="checkbox"/> Other Physical Impairment		

Chronic

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

Mental Health

Type	Date Began	Date Ended	Type	Date Began	Date Ended
<input type="checkbox"/> ADD/ADHD			<input type="checkbox"/> Personality Disorder		
<input type="checkbox"/> Anxiety Disorder			<input type="checkbox"/> Psychotic Disorder		
<input type="checkbox"/> Bipolar Disorder			<input type="checkbox"/> PTSD		
<input type="checkbox"/> Depressive Disorder			<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other significant family (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease or cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or history of heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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?
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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 <input type="checkbox"/>	Ambivalent <input type="checkbox"/>	Not interested <input type="checkbox"/>
Hygiene	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Tracking Level	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>

Protective Factors/Strengths

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

LEAD New Client Checklist – Paper Forms

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

Screening Forms

LEAD Screening	<input type="checkbox"/>
LEAD Program Consent	<input type="checkbox"/>
LEAD OWG ROI	<input type="checkbox"/>
Photo	<input type="checkbox"/>

Intake/Registration Forms

HMIS Consent/Revocation	<input type="checkbox"/>
HMIS Profile	<input type="checkbox"/>
HIPAA Disclosure	<input type="checkbox"/>
Reach Grievance Policy	<input type="checkbox"/>
Reach Grievance Form	<input type="checkbox"/>
Reach Orientation Contract	<input type="checkbox"/>
Reach Client Rights	<input type="checkbox"/>
REACH ROIs	<input type="checkbox"/>
LEAD Intake part 1	<input type="checkbox"/>

To be completed within 30 days:

LEAD Intake part 2	<input type="checkbox"/>
Reach Individual Service Plan	<input type="checkbox"/>
Reach Self Care Plan	<input type="checkbox"/>
VI-SPDAT	<input type="checkbox"/>

Ongoing Documentation:

Proof of ID/SSN	<input type="checkbox"/>
Disability Documentation	<input type="checkbox"/>
Chronic Homelessness Documentation	<input type="checkbox"/>
Proof of Income	<input type="checkbox"/>
LEAD Rental Assistance Agreement	<input type="checkbox"/>
Rental Assistance Authorization	<input type="checkbox"/>
Motel Agreement	<input type="checkbox"/>
Motel Assistance Authorization	<input type="checkbox"/>

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

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:		
	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If outside, are you staying in a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Demographics:

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

Veteran/Military Status:

Is client a U.S. Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Year Entered Military Service:	Years separated from military status:	Theater of Operations: <input type="checkbox"/> World War II <input type="checkbox"/> Korean War <input type="checkbox"/> Vietnam War <input type="checkbox"/> Persian Gulf War (Desert Storm) <input type="checkbox"/> Afghanistan (Enduring Freedom) <input type="checkbox"/> Iraq (Iraqi Freedom) <input type="checkbox"/> Iraq (New Dawn) <input type="checkbox"/> Other Peacekeeping Operations or Military Interventions
Branch of the Military:	Discharge Status:		
Is client a spouse/partner or dependent minor of a veteran? <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Dependent Minor <input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Physically Disability	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Developmental Disability	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Chronic Health Condition	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Mental Health Problem	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Substance Abuse <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Domestic Violence Victim/Survivor	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> X
Have you been a victim of domestic violence in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How long ago did client's most recent experience occur?				
<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 – 6 months <input type="checkbox"/> 6 months to 1 year				
<input type="checkbox"/> 1 year or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused				

Current Income:

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

Current Non-Cash Benefits:

<u>Benefit Source</u>	<u>Receiving?</u>	
Food Stamps (SNAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
WIC Nutrition Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Veteran's Administration Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
TANF Child Care services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
TANF transportation services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other TANF-funded services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Source:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Insurance:		
<u>Insurance Provider</u>	<u>Receiving?</u>	
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	
State Children's Health Insurance Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	
VA Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer-Provided Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Private Pay Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
State Health Insurance for Adults	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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



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: _____

