Kolpia Counseling Services, a program of Options for Southern Oregon
611 Siskiyou Blvd. Ste 8 Ashland, OR 97520 P: (541)482-1718 F: (541)482-0964
836 E Main St. Ste 6 Medford, OR 97504 P: (541)500-8023 F: (541)500-8065

Client ID: _____

INTAKE AND CONSENT FORM

Client Profile

Legal Name of person seeking services:

_____
(Last, First, Middle Initial)

Name and relationship of person completing paperwork

_____

Last name at Birth:

_____

Date of Birth:

_____
(mm/dd/yyyy)

Preferred Name: _____

Preferred Pronoun(s): _____

Sex:
☐ Male ☐ Female ☐ Other: _____
☐ Don't know ☐ Prefer not to state

Gender Identity (optional):
☐ Female ☐ Male
☐ Transgender female
☐ Transgender male
☐ I use a different term: _____
☐ Don't know
☐ Prefer not to state

Preferred Language:

_____

Interpreter Needed?
☐ No
☐ Yes
☐ Language (list): _____
☐ ASL
☐ Other: _____

Physical Address: _____

_____

Mailing Address: _____
☐ Same as Physical _____

Are you Pregnant?
☐ Yes ☐ No
☐ Not Applicable ☐ Unknown

Driver's License Number:

_____
☐ None

Contact Information:
Home Phone: _____
Cell Phone: _____
Email: _____
Preferred Contact Method:
☐ Home ☐ Cell
Preferred Reminder Method:
☐ Text ☐ Voicemail

Referred By: _____

_____

Reason for Seeking Services today: _____

_____

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Client Profile: Personal Demographics

Employment Status (Check One):

☐ Full Time (35+ hours/week)
☐ Part Time (Less than 35 hours/week)
☐ Unemployed ☐ Retired
☐ Homemaker ☐ Disabled
☐ Student ☐ Volunteer/Other
☐ Unable to Work – Hospital Patient or Resident
☐Not in labor force

Do you want help finding work or a job?
☐ Yes ☐ No

Marital Status (Check One):
☐ Never Married ☐ Married
☐ Separated ☐ Divorced
☐ Widowed

Race and Ethnic information may not be used to discriminate against you and is voluntary.

Race (check one):
☐ White ☐ Alaska Native
☐ Asian ☐ American Indian
☐ Black/African America
☐ Native Hawaiian/Pacific Islander
☐ Two or more unspecified races
☐ Other single race

Ethnicity (check one):
☐ Mexican
☐ Cuban
☐ Puerto Rican
☐ Hispanic – other region
☐ Hispanic – No specific region
☐ Not Hispanic

Living Arrangement(check one):
☐ Transient/Homeless
☐ Foster Home
☐ Secure Residential Facility
☐ Residential Facility
☐ Jail
☐ Room and Board
☐ Supported Housing
☐ Supportive Housing Scattered
☐ Alcohol and Drug Free Housing
☐ Other Private Residence
☐ Private Residence – At Home
☐ Private Residence w/ Relative
☐ Private Residence w/ non-relative
☐ Oxford Home ☐ Prison

Client Profile: Personal Demographics

Education:
Highest Grade Completed: _____
☐ Currently a Student

Do you want help with school or training? (e.g. starting or completing job training, getting a high school diploma, GED, or an equivalent) ☐ Yes ☐ No

Veteran Status (Check One):

☐ Veteran w/ Current or former active duty military
☐ Current or former guard/reserve w/ active duty
☐ Current or former guard/reserve
☐ No Military Service

Tribal Affiliation (check one):
☐ None/Not Applicable
☐ Burns Paiute Tribe
☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw
☐ Confederated Tribes of Siletz
☐ Confederated Tribes of the Umatilla
☐ Confederated Tribes of Warm Springs
☐ Coquille Indian Tribe
☐ Cow Creek Band of Umpqua Indians
☐ Klamath Tribe
☐ Other

Legal Status (check one):

☐ 30 Day Civil Commitment
☐ 90 Day Civil Commitment
☐ 180 Day Civil Commitment
☐ Incarcerated
☐ Parole
☐ Probation
☐ Psychiatric Security Review Board (PSRB)
☐ Aid and Assist
☐ None
☐ DUII Conviction
☐ DUII Diversion
☐ Pre-Arrest Jail Diversion
☐ Post-Arrest Jail Diversion
☐ Guardianship (Court)
☐ Guardianship (Child Welfare)
☐ Juvenile Psychiatric Security Review Board(JPSRB)
☐ Involuntary Custody
☐ Unknown

Total Arrests in the last 30 days: _____ **Total Number of DUII Arrests in the last 30 days:** _____

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Client ID: _____

	Total Arrests in Lifetime: _____ Total Number of DUII Arrests in Lifetime: _____

Client Profile: Financial	Options will provide mental health services to all contracted Oregon Health Plan members and other Josephine/Jackson County residents for a reasonable fee. Fees may be adjusted based on your ability to pay based on our sliding fee scale. No one will be turned away for the inability to pay. Our fee is adjusted based on household income and the number of dependents in the household. Fees may be further reduced if it is determined by Management that such fees will cause an undue hardship, interfere with, or prevent a person from receiving medically necessary services. If you have questions regarding our charges, please discuss them with the Intake Coordinator. If you are covered by OHP for medical or mental health care at the time services are provided, you will not be charged for those services unless there is a required co-payment. If you have a limited benefit package (Med only-QMB), you may be charged for services not covered by OHP or Medicare (Sliding fee schedule applies). If your OHP coverage terminates, you will be charged based on the sliding fee scale. If you have no insurance coverage, you are financially responsible for charges incurred for services provided to you. These charges will be based on the sliding fee schedule which is available by request. If you are covered by private health insurance or Medicare, and that coverage DOES NOT pay the fees for the services provided, you are financially responsible for these charges based on the sliding fee schedule. If your private health insurance company directly reimburses you for the service, you are required to provide that payment to Options. If not, you are liable for total dollar amount in full. If you do not have health insurance, please ask the front desk for information on OHP and the Federal Health Care Market Place. Income below 138% of poverty may qualify you for OHP.	
	Source of Income (Please check and list amount): ☐ Wages/Salary $_____/mo ☐ Retirement/Pension/Social Security $_____/mo ☐ Other (Alimony/Child Support/Care of Foster Child) $_____/mo ☐ Unknown $_____/mo ☐ Public Assistance $_____/mo ☐ Disability/Social Security Disability $_____/mo ☐ None/No source of Income	Household Income Information: Annual Gross Household Income $_____ Number of Child Dependents: _____ Total Number of Household Dependents: _____

—	Please check all that apply:

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☐ AllCare: 740 SE 7th Street, Grants Pass, OR 97527; (541)-471-4106, Fax (541) 471-4128
☐ Jackson Care Connect: 33 N Central Avenue, Medford, OR 97501; (855) 722-8208, Fax (503) 416-3723
☐ Medicaid Open Card/Other (card number): _____
☐ Medicare Card Number: _____
☐Veterans Administration Card Number: _____
☐ Private Insurance Name: _____ ID #: _____Group #: _____
☐ None/No Insurance

Family/ Contacts

Responsible Party (Parent or Legal Guardian):
Relationship: ☐ DHS Guardianship ☐ Guardian ☐ Other: _____

Name: _____ **Phone #**: _____ **DOB:** _____

Street Address: _____
_____

Emergency Contact:

☐ Same as Responsible Party (skip fields below)

Relationship: _____

Name: _____ **Phone #**: _____ **DOB:** _____

Street Address: _____
_____

Allergies

Allergy: _____ **Reaction**: _____ **Severity**: ☐ Severe ☐ Moderate ☐ Mild
Allergy: _____ **Reaction**: _____ **Severity**: ☐ Severe ☐ Moderate ☐ Mild
Allergy: _____ **Reaction**: _____ **Severity**: ☐ Severe ☐ Moderate ☐ Mild
Allergy: _____ **Reaction**: _____ **Severity**: ☐ Severe ☐ Moderate ☐ Mild

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Client ID: _____

External Providers	
	Primary Care Provider Name: _____ Phone Number: _____ Pharmacy Name: _____ Phone Number: _____ Dentist Name/Office: _____ Phone Number: _____

Consent for Treatment	
	<u>The Following Information has been made available to me (Please check all)</u> ☐ The Notice of Privacy Practices regarding my privacy rights. ☐ A description of my rights and responsibilities and consent for treatment at Options. ☐ Information regarding my right to file grievances, including appealing decisions resulting from a grievance. ☐ The community referral sheet for Tobacco Cessation, if interested. ☐ Information (if legally an adult) regarding the Declaration of Mental Health and Advance Directive. ☐ I have been given the opportunity to register to vote (if legally an adult). ☐ An explanation of fees. ☐ I can receive a hard copy of all of the forms discussed in this notice.
	<u>I agree to/Authorize the following: (Please check all)</u> ☐ I authorize and request that payment for services provided to me by Options for Southern Oregon, Inc. payable under my insurance benefits be made directly to Options for Southern Oregon, Inc. Also, I authorize Options for Southern Oregon, Inc. to release any billing information necessary to pursue payment. ☐ I agree to inform Options if my insurance changes and will complete a fee agreement upon changes. ☐ I have been informed of and agree to follow the attendance expectations for treatment. ☐ Weapons are not allowed within any Options facilities. ☐ I have been informed and agree to the use of text messaging for appointments and understand the risks and guidelines. ☐ I authorize the use of Telehealth in the course of my diagnosis and treatment. I understand that Telehealth involves the communication of my medical information, both orally and/or visually, to Options providers that are located offsite. Options will do everything reasonable to prevent disrupted or distorted technical failures and will take reasonable measures to prevent unauthorized access, but problems may occur.

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You must give voluntary consent before you receive services. You have the right to refuse treatment. You also have the right to participate in the development and review of a service plan, to be informed of your diagnoses, to receive an explanation of any prescribed medications and possible side effects, and to withdraw your consent to treatment. The above Informed Consent for Treatment and Services has been explained to me and I agree to receive services from Options for Southern Oregon.

_____
Individual Signature/Guardian/DHS Caseworker

_____ _____
Print name of person signing above Date

_____ _____
Options for Southern Oregon Staff Signature Date