Application for Services

Today's Date: ________________ Who referred you to Cornerstone Counseling Center? ____________________________________

Client Name: ____ Date of Birth: ____________ Age: ___________
First Middle Last

Address: ____
Street Apt. # City State Zip code

SSN: ____________________________________ Email: ____

Phone Number: ______________________________ Alternate Phone Number (specify): ___________________________________

Is it okay to leave email and text reminders for appointments? ☐Yes ☐No Is it okay to leave a voicemail? ☐Yes ☐No

Preferred Language for therapy: _________________________ Religious Affiliation (optional): __________________________

FOR THE CLIENT NAMED ABOVE, PLEASE MARK THE FOLLOWING

Gender Expression: ☐ Male ☐ Female ☐ Transgender ☐ Other: ____________________________

Sexual Orientation: Which of the following would you consider yourself to be?
☐ Heterosexual (straight) ☐ Gay/ Lesbian ☐Bisexual ☐Other ____________

Race: ☐ American Indian ☐ African American ☐ Alaskan Native ☐ Other ____________
☐ Caucasian (White) ☐ Asian ☐ Native Hawaiian/ Pacific Islander

Ethnicity: Are you Hispanic? ☐ Yes ☐ No ☐ Refused If yes, please answer the questions below

☐ Central American ☐ Cuban ☐ Dominican ☐ Mexican
☐ Puerto Rican ☐ South American ☐ Not Hispanic

Marital Status: ☐ Single/never married ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Life Partner

Employment Status:
☐ Employed full-time ☐ Retired ☐ Unemployed, looking for work
☐ Employed part-time ☐ Homemaker ☐ Unemployed, not looking for work
☐ PT, looking for FT ☐ Student ☐ Unemployed, Disabled

Living Arrangement:
☐ Owned or rented house, apartment, or room
☐ Someone else's house, apartment, room
☐ Homeless (shelter, street, park, couch surfing)
☐ Detox/Inpatient/Residential Treatment
☐ Hospital (medical or psychiatric)
☐ Veteran's Home
☐ Other: ____________________
☐ Transitional Housing
☐ Group/Foster Home
☐ Correctional Facility
☐ Hotel/Motel
☐ Nursing Home
☐ Military Base

Education: Are you currently enrolled in school or a job training program? ☐Yes ☐No If yes, ☐Full time ☐Part time

Highest Level of Education Completed (whether or not you received a degree):

☐ Less than 6th Grade ☐ 11th grade ☐ GED
☐ 7th grade ☐ 12th grade ☐Some College _______ (# of years completed)
☐ 8th grade ☐ High School Diploma ☐Bachelor's Degree
☐ 9th grade ☐ Vocational/technical certification ☐Graduate Work/Degree
☐ 10th grade

Military: Have you ever served in the Armed Forces, the Reserves, or the National Guard? ☐Yes ☐No

VOA Cornerstone Counseling Center

CLIENT RIGHTS

(Client Copy)

Humane Treatment: Clients have the right to equal and humane treatment at all times and under all circumstances. Cornerstone Counseling Center will recognize and respect the individuality and dignity of each client. Relationships between Cornerstone Counseling Center staff and clients will be based on mutual acceptance, trust, and respect. You have the right to be free from seclusion and restraint if it is used to force, discipline, or retaliate or for convenience. No client will be denied treatment because of race, gender, sexual preference, creed, marital status, disability, national origin, or age.

Confidentiality: Cornerstone Counseling Center follows strict federal and state laws to maintain the confidentiality of your health information. You have the right to request information and confidential records, both current and closed. You have the right to refuse to grant authorization to release confidential information. Your services here will not be affected by your refusal to grant authorization.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations members of our agency are not required to obtain permission from you of actions which may result in breaching your confidentiality. The following are exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse or neglect of children, the elderly, and/or vulnerable and disabled individuals.
- Confidentiality does not apply to cases of potential self-harm, and/or threats to harm self and others.
- Confidentiality does not apply to cases involving possessions of illegal substances in a school zone.
- Confidentiality does not apply in cases where a minor child is a witness to domestic violence and/or a witness to illegal substance use.
- Confidentiality may not apply in cases involving a minor. In such cases, our agency may advise a parent, managing conservator, or guardian of a minor's consent of the treatment needed for the minor.

Right to be informed: You have the right to take part in treatment decisions regarding your mental health care services, including the right to refuse treatment. You have the right to have program expectations and program fees explained to you. You have the right to be informed of possible reasons for involuntary termination from our program services, including but not limited to the following behaviors: threats of harm/violence, engaging in acts of harm/violence, dealing substances on our property, and violating confidentiality. You may be re-admitted to treatment 30 days after an involuntary termination from our program conditional upon your compliance with program expectations. These cases will be discussed with the treatment team and decided on an individual basis.

Other client rights:

- You have the right to get information on the Prepaid Mental Health Plan in a language and format that is easily understood.
- Our agency is a safe zone. Weapons and violence of any kind are prohibited. Clients will be treated in the least restrictive manner which is consistent with treatment needs.
- You have the right to utilize communication tools, including phone, mail, and email. These services are limited to communicating with lawyers, counselors or family members. You also have the right to have communication sent to you as long as all federal privacy laws are followed.

Grievance Procedure for Client:

If for any reason you feel you are not receiving adequate or appropriate services from our agency or that your rights have been violated, you have the right to file a grievance in writing to the Division Director. At this time, you have the right to receive all information needed to file a complaint with Medicaid. You may also request a hearing with the Department of Human Services. The agency must provide a fair and proper hearing of your complaints. The hearing will comply with the guidelines of the State of Utah in regard to civil rights, notifications and fair hearings.

Please see other side for Client Responsibilities

VOA Cornerstone Counseling Center

CLIENT RESPONSIBILITIES

As a Client you are expected to:

1. Respect the property, comfort, and confidentiality of clients and staff. This includes not talking about the content of the group or identifying the members of the group.
2. Arrive promptly for your appointment. You are expected to cancel at least 24 hours in advance if you are unable to make a scheduled appointment. You may be billed for the session if you fail to do so. If you are more than 15 minutes late for your session you may be billed for the session and may not be seen for your appointment.
3. Pay your fees at the time of service. If you have insurance, you are expected to provide the agency with the necessary information. Service may be denied if payment is not received.
4. Tell your therapist and front office staff if you have any changes in your financial situation, insurance, home or work address, or telephone numbers.
5. Do your part to keep VOA, Utah a safe zone - be aware that weapons, violence, or threats of violence towards staff or any other person are not allowed on agency grounds.
6. Follow the Utah Clean Air Act - smoking is not allowed within 25 feet of any entrances at our agency.
7. Be aware that any client who is under the influence or in possession of alcohol or drugs may not receive services.
8. Make arrangements for child care unless a different agreement has been made between you and your therapist – remember we have free onsite childcare for your use during group and individual sessions.
9. Inform us immediately any time visitation rights have been changed and/or revoked (parental rights/custody). As an agency we are required to keep record of this.
10. Discuss any dissatisfaction with your therapist concerning services received.

Failure to follow these responsibilities may result in police intervention and/or immediate discharge from the program.

Please keep this copy for yourself. If you have any questions or concerns about its contents, please ask the intake therapist as you review this form in session. Please sign on the following page to acknowledge you have read and understand the above Client Rights and Responsibilities.

Client Name: ____ Date of Birth: ______________________ Age: ______________

Emergency Contact: ____
Name Relationship

____
Phone Number Address

Can we contact you in 1 year regarding the effectiveness of the services provides? ☐Yes ☐No

CLIENT RIGHTS & RESPONSIBILITIES

I hereby acknowledge that I been provided a copy of and agree to Volunteers of America Utah - Cornerstone Counseling Center's Client Rights and Responsibilities, including the grievance policy and confidentiality agreement. I understand that it is my responsibility to read this document and to ask about anything that is unclear.

____
Client Signature Today's Date

CONSENT FOR TREATMENT

I, _____________________________________, herby agree to enter treatment at Volunteers of America Utah - Cornerstone Counseling Center. I understand this application and anything else I tell Cornerstone personnel will be kept confidential, with the exceptions listed in the Confidentiality Policy (Client Rights & Responsibilities) and the Fee Form, which I have signed.

____
Client Signature Today's Date

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided access to Volunteers of America Cornerstone Counseling Center's Notice of HIPAA Privacy Practices and can request a hard copy at any time. I understand that it is my responsibility to read this document and to ask about anything that is unclear.

____
Client Signature Today's Date

UNDERSTANDING OF EVACUATION PLAN

1. Keep Calm.
2. Evacuate to the nearest safe exit.
3. Everyone will meet on the North end of the East parking lot (East of the dumpsters).
4. Please follow instructions given to you by Volunteers of America Utah - Cornerstone Counseling Center staff if you are in session. Staff will lead clients to the nearest exit and out to the emergency meeting spot.
5. Once the building has been evacuated clients and staff will be accounted for. At this time agency management will implement any Safety Protocols and Emergency Response Procedures.

I, _____________________________________ have read and understand the instructions regarding the emergency procedures for this agency. I also understand that I can request a copy of the evaluation plan at any time.

____
Intake Therapist Signature when reviewed with client Today's Date

Client Name: ____________________Date:______________

MEDICAID ELIGIBILITY

Client Name: ____________________Date:______________

Please answer yes or no to the following questions.

________ Are you a legal resident or US citizen?
________ Do you have any children under the age of 18?
________ Are you currently pregnant?
________ Do you have a physical or mental disability that is not related to substance abuse?
________ Do you want to apply for Medicaid?
________ I am currently Medicaid eligible

OPTUM CLIENT RIGHTS ACKNOWLEDGEMENT FORM

I,__________________________________, hereby acknowledge that I have read and understand the Optum client rights. I also acknowledge that a copy of the Optum client rights was offered to me.

______________________________ ____ ________________

Printed Member Name **Member Signature/ Legal Guardian Signature** **Date**

MEMBER ACKNOWLEDGEMENT

I, ____________________________, hereby acknowledge that I have been offered/received a Medicaid Member
Name of Consumer
Handbook and Provider Directory (either in the mail or from my provider). I understand that the purpose of the handbook is to unsure I have information about my benefits, rights and responsibilities. The handbook also provides information on how to receive covered services, access to emergency services, transportation, and how to choose a provider. The handbook also addresses procedures for filing grievances and appeals.

I also understand that if I have been treated unfairly or discriminated against for any reason, I may file a complaint by contacting OptumHealth at: 1-877-370-8953.

My provider has reviewed these materials with me and answered my questions.

______________________________ ____ ________________

Printed Member Name **Member Signature/ Legal Guardian Signature** **Date**

TAM MEDICAID ELIGIBILITY SCREENING

1. Is the patient between 19 and 64? ☐Yes ☐No

If **yes** continue to question to, if no, patient is not eligible.

2. Has the patient been homeless for at least a year or has had at least four episodes of homelessness in the past three years? ☐Yes ☐No

If **yes**, continue to question three, if no, patient is not eligible.

3. Does the patient have dependents under the age of 19? ☐Yes ☐No

If yes, patient is not eligible. If **no**, continue to the next question.

4. Does the patient have less than $50.25 income in the past month (67.70 for household of two)? ☐Yes ☐No

If **yes**, please schedule patient with Medicaid Specialist, if no, no further action is needed.

If the patient is eligible, please send their information via email to the Medicaid Specialist for follow-up. In order to share their information with Medicaid Specialist, please have them sign a release of information for the Medicaid Specialist.

Client Questionnaire

Client Name: ______________________________ DOB: _________

Briefly describe why you are seeking counseling services at this time: ____

____

School/Employer: _______________________________________ Length of time at school/employment _________________________

Do you currently have a protective order? Y / N Are you currently involved with DCFS? Y / N

Are you currently on probation/parole? Y / N Do you have any pending charges? Y/N

Number of Arrests in the last 30 days __________ Number of Arrests in the last 6 months ______

While you were growing up, during your first 18 years of life: (Circle Yes or No)

1. Did a parent or other adult in the household often ...

Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

Yes No

2. Did a parent or other adult in the household often ...

Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

Yes No

3. Did an adult or person at least 5 years older than you ever...

Touch or fondle you or have you touch their body in a sexual way? Or try to or actually have oral, anal, or vaginal sex with you?

Yes No

4. Did you often feel that ...

No one in your family loved you or thought you were important or special oryYour family didn't look out for each other, feel close to each other, or support each other?

Yes No

5. Did you often feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No

6. Were your parents ever separated or divorced?

Yes No

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No

10. Did a household member go to prison?

Yes No

VOA Cornerstone Counseling Center

Medical History Questionnaire

Name: ______________________________________Date:_________________ Age:__________ DOB:______________________

Do you have a primary care doctor? Y / N Doctor's Name: ____

When is the last time you were seen by a doctor? ______________________ Height: ______________ Weight: ______________

Have you had any recent changes in your weight: Y / N If yes, circle one: Gain / Loss

How many times have you been to the ER in the last year for:

Physical health concerns? _____ Mental health concerns? ___

In the past year, how many days have you stayed in a hospital for:

Physical health reasons? ______ Mental health reasons? ___

Do you use tobacco products (chew, cigarette, e-cig, vaping)? Y / N Age of 1st use? _____

How often do you smoke? ☐ Less than 1 pack a day? ☐ 1-2 packs a day ☐ More?

Are you interested in quitting? Y / N

If female, are you currently on birth control? Y / N Are you pregnant? Y / N Due date: ___________ Date of LMP:___________

Please check all current and past conditions:

☐ Heart problems	☐ Vision problems	☐ Stomach problems	☐ Unconsciousness
☐ High blood pressure	☐ Diabetes	☐ STIs	☐ Hepatitis C
☐ Stroke	☐ Hearing problems	☐ Thyroid problems	☐ Cancer
☐ Liver problems	☐ Tuberculosis	☐ Drug/Alcohol problems	☐ Kidney problems
☐ Musculoskeletal problems	☐ HIV positive	☐ Hyperactivity as a child	☐ Learning difficulties as a child

Have you ever been unconscious, had a head injury, or experienced a black-out? Y / N

Please explain and/or list other illnesses or health concerns that you may have: ____

____

____

Please list any injury, surgery, and/or hospitalizations below:

NATURE OF PROBLEM	DATE	HOSPITAL

How would you rate your overall health right now?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Refused

Please list all medications you are currently taking and/or have taken in recent weeks, including medications for depression, anxiety or other psychiatric problems. Please indicate if they were helpful or not.

MEDICATION	DOSAGE & FREQUENCY	START DATE	DOCTOR'S NAME	HELPFUL?

Are you taking your medications as prescribed? Y / N

Do you have any drug allergies? Y / N If yes, list ____

Are you on any Medication Assisted Treatment (i.e. Suboxone, Methadone, Vivitrol) Y / N If yes, explain _____________________

Please check the substances you have used in your lifetime below. Please include both prescribed and non-prescribed substances.

☐ Tobacco products (cigarettes, chewing tobacco, cigars)
☐ Alcoholic beverages (beer, wine, liquor)
☐ Cannabis (marijuana, pot, dabs, CBD oil)
☐ Cocaine (coke, crack, etc.)
☐ Prescription stimulants (Ritalin, Adderall, Concerta, Vyvance, diet pills)
☐ Methamphetamine (speed, crystal)
☐ Inhalants (nitrous oxide, glue, gas, paint thinner, whippets, etc.)
☐ Benzodiazepines (Xanax, Valium, Klonopin, Ativan, Librium, Rohypnol)
☐ Spice or Bath Salts
☐ Hallucinogens (LSD/Acid, PCP, mushrooms, Special K, ecstasy)
☐ Heroin and other street opioids
☐ Prescription opioids (oxycodone, Percocet, fentanyl, hydrocodone, Vicodin, methadone, suboxone)
☐ OTHER (GHB, Tranquilizers, muscle relaxors, soma)
☐ OVER THE COUNTER (no doz, red devils, minithins, robitussen, coridcidin, etc.)

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor

about an emotional problem?. . . . . Yes No

2. Have you ever felt you needed help with your emotional problems, or have you had people

tell you that you should get help for your emotional problems?. . . . . .Yes No

3. Have you ever been advised to take medication for anxiety, depression, hearing voices,

or for any other emotional problem?. . . . . .Yes No

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for

psychiatric reasons?. . . . . .Yes No

5. Have you ever heard voices no one else could hear or seen objects or things which others

could not see?. . . . . .Yes No

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most

activities, had trouble concentrating and making decisions, or thought about killing yourself?. . . . . .Yes No

(b) Did you ever attempt to kill yourself?. . . . . Yes No

7. Have you ever had nightmares or flashbacks as a result of being involved in some

traumatic/terrible event?

For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?. . . . . .Yes No

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?. . . . . Yes No

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?. . . . . .Yes No

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?. . . . . .Yes No

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?. . . . . Yes No

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?. . . . . Yes No

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything?. . . . . .Yes No

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint?. . . . .
Yes No

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.. . . . . Yes No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling?. . . . . .Yes No

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?. . . . . Yes No

Document is in the public domain. Duplicating this material for personal or group use is permissible.