Loving Helping Hands, Inc
5932 Hugh Howell Rd. Ste 203,Stone Mountain, GA 30087
770-383-2754 (o) ♦ 770-768-7397 (f)
www.lovinghelpinghands.com

CONSUMER INTAKE FORM

Full Legal Name:
_____ _____/_____ _____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Age: _____ Date of Birth: _____

Medicaid #_____ S.S.#: _____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____/_(____)_____/_____
(home) (work) (cell phone or other)

Telephone # _(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone or other)

E-mail address: _____

Gender: female _____ male _____

Are you (check one): Single _____ Married ____ Other _____

Partner's Name: _____

Occupation: _____
(circle) Full time/ Part time/Student/ Retired

Employer / School: ___ _____

Address: _____
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact _____
(Name) (Relationship)

_____ (_____)_____
(Day Phone) (Evening Phone)

Information listed on each form is updated yearly and remain valid until client is discharged from program or service is terminated. ***Revised 6/25/2013***

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Current Problem or Reason for Referral to LLH:

_____
_____
_____
_____
_____
_____
_____
_____

LHH Use Only

Intake information taken by (print name):_____

Date: _____

Referred by_____

Referral Date:_____

Medicaid current: Yes_____ No_____

Date Medicaid verified: _____

Assessment Scheduled: Yes_____ No_____

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CONSENT FOR TREATMENT

This form is to document that I_____ (☐legal guardian ☐ client), give my permission and consent to the therapist and the other employees/contractors of Loving Helping Hands, Inc., to provide treatment to myself. I understand that because of the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing. I understand that this therapist might or might not be providing an emergency service and I have been informed of whom to call in emergency or during weekend and evening hours. I understand that regular attendance will produce the maximum benefits but I am free to discontinue treatment at any time. If I decide to do so I will notify the therapist at least two weeks in advance so that effective planning for continued care could be implemented.

I understand that conversations with the therapist will almost always be confidential with the exception of situations mentioned in section 2. I further understand that therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has a legal responsibility to protect anyone I may be threaten with violence, harmful or dangerous actions (including those to myself) and may break confidentially of communication if such a situation arises. I understand that the therapist will make reasonable efforts to resolve these situations before breaking confidentiality.

I know of no reason that I should not undertake this therapy and I agree to participate fully and voluntarily. I have read and understood the following forms and that I agree to abide by its terms during our professional relationship: I authorize Loving Helping Hands, Inc. to advocate and appeal on my behalf if the Care Management Organization denies services for any reason.

I know of no reason that I should not undertake this therapy and I agree to participate fully and voluntarily.

BY SIGNING THIS FORM I AM ATESTING TO THE FACT I AM LEGALLY IN THE UNITED STATES

_____	_____	_____
Name of the Client (printed)	Signature	Date
_____	_____	_____
Legal Guardian (printed)	Signature	Date
_____	_____	_____
Staff Name (printed)	Signature	Date

USE THIS SPACE ONLY IF CLIENT/ LEGAL GUARDIAN REFUSES THE TREATMENT

I voluntarily refuse treatment and I am aware of legal and other implications related to my decision. I understand that I need to go though the new referral process if I desire to re-enter the program.

_____	_____	_____
Legal Guardian	Signature	Date
_____	_____	_____
Client	Signature	Date

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AUTHORIZATION FOR RELEASE OF INFORMATION
(Each agency must have a separate Authorization form)

Client's name (print) _____ Client's DOB ___/____/_____

I hereby request and authorize **Loving Helping Hands, Inc**. and their designed staff to share information with and to obtain copies of written reports/evaluations from the agencies mentioned below:

_____ County Court
_____ Department of Medicaid/Medicare Services
_____ County Department of Family & Children Ser.
_____ County Health Department
_____ Social Security Administration
_____ County Community Services Board

Private Provider_____
Hospital_____

CMO: ☐ Amerigroup
☐ Well Care
☐ Peach State

Psychiatrist/Physician:_____
Other: _____

Other_____
Other_____

Written information may include but is not limited to: **Psychological evaluation(s), Psychiatric evaluation(s), Drug/Alcohol assessments, Safety plans, all testing, recommendations, school records, medical records, and any other relevant or requested information** for the purpose of: sharing information to ensure better coordinate services and treatment from agencies involved.
I authorize these agencies to share information by phone, in person, fax and/or email contact. All information I hereby authorize to be obtained from this Agency, Department or Office will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:
☐ 9 months ☐ the period necessary to complete all transactions related to services provided to me.
I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____	_____	_____
Name of the Client (printed)	Signature	Date
_____	_____	_____
Parent or Legal Guardian (printed)	Signature	Date
_____	_____	_____
Staff Name (printed)	Signature	Date

USE THIS SPACE ONLY IF CLIENT/ PARENT/ LEGAL GUARDIAN WITHDRAWS CONSENT

_____	_____	_____
Parent or Legal Guardian	Signature	Date
_____	_____	_____
Client	Signature	Date

Information listed on each form is updated yearly and remain valid until client is discharged from program or service is terminated. ***Revised 6/25/2013***

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Hospital_____

CMO: ☐ Amerigroup
☐ Well Care
☐ Peach State

Psychiatrist/Physician:_____ Other_____
Other: _____
Other_____

Written information may include but is not limited to: **Psychological evaluation(s), Psychiatric evaluation(s), Drug/Alcohol assessments, Safety plans, all testing, recommendations, school records, medical records, and any other relevant or requested information** for the purpose of: sharing information to ensure better coordinate services and treatment from agencies involved.
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☐ 9 months ☐ the period necessary to complete all transactions related to services provided to me.
I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____	_____	_____
Name of the Client (printed)	Signature	Date
_____	_____	_____
Parent or Legal Guardian (printed)	Signature	Date
_____	_____	_____
Staff Name (printed)	Signature	Date

USE THIS SPACE ONLY IF CLIENT/ PARENT/ LEGAL GUARDIAN WITHDRAWS CONSENT

_____	_____	_____
Parent or Legal Guardian	Signature	Date
_____	_____	_____
Client	Signature	Date

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FACE TO FACE SCREENING: Please circle appropriate answer:

Mental Health

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

1. Serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? Yes No
2. Serious anxiety or tension (felt uptight, worried, and unable to relax)? Yes No
3. Being prescribed medication for psychological/emotional problem? Yes No
4. Thoughts of harming yourself and/or others? Yes No
5. Hallucinations (heard/seen things others don't hear or see)? Yes No
6. An Attempted suicide? Yes No

Substance Abuse

During the past 12 months have you:

1. Been preoccupied with drinking alcohol and/or using other drugs? Yes No
2. Tried to stop drinking alcohol and/or using other drugs, but couldn't? Yes No
3. Had problems caused by drinking/using drugs, and you kept using? Yes No
4. Need to drink and/or use more to get the same effect you used to? Yes No
5. Drunk alcohol and/or used other drugs more than you intended? Yes No
6. Experienced periods of time when your thinking speeds up and you have trouble keeping up with your thoughts? Yes No
7. Drunk alcohol and/or used other drugs to alter the way you feel? Yes No

Trauma

During the past year (12 months) have you:

1. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one? Yes No
2. Had periods of time where you felt that you could not trust family or friends? Yes No
3. Ever been afraid of your partner and/or a family member? Yes No
4. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened? Yes No

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Gambling

During the past year (12 months) have you:

1. Felt the need to bet more and more money? Yes No

2. Had to lie to people important to you about how much you gamble? Yes No

Are you currently taking any medications including over the counter? Yes No

If so, please list medications: _____

Do you have a mental health or substance abuse provider currently/past? Yes No

If yes, please list the name of Provider/Agency_____

_____

Staff Name (printed) **Staff Signature** **Date**

Disposition (agency only):

Referred for Assessment to list of providers: _____

Referred for Assessment with a scheduled appt:

_____

Date and Time of Appt _____ Clinician_____

*Give a copy to the patient to take with them to their assessment.

**Keep a copy for the medical record.

ADDITIONAL NOTES

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CLIENT RIGHTS

Clients of Loving Helping Hands possess the following rights:

- The rights to receive appropriate service.
- The right to be protected from harm, physical, and sexual abuse at the facility as well as in the community.
- The right to an individualized service/treatment plan
- The right to participate, in a manner appropriate to client's condition, in the development and periodic review of service or rehabilitation plan.
- The right to be told in appropriate terms and language, the content and objective of service or rehabilitation, the nature and significant possible negative effects of service or rehabilitation. The right to obtain the name, title, and role of the staff members who are directly responsible for carrying out the client's service or rehabilitation.
- The right of the client to have access to his/her service or rehabilitation records.
- The right, with written permission, for the client's attorney to have access to his/her records.
- The right to refuse medication.
- The right to refuse to participate in physically intrusive research.
- The right, prior to admission, to an explanation of client's rights in terms and language that he/she can understand and to have a list of the client's rights posted in a prominent place in the facility.
- The right, prior to admission, to an explanation in terms and language that the client can understand of admission and discharge policies.
- The right, prior to admission, to an explanation of the client's rights in terms and language that the client can understand, at the charges and fees that he/she will be requested to pay.
- The right to aftercare program.
- The right to file a grievance if the client is not satisfied with the service or rehabilitation that he/she receives.

I_____, have been informed of the client rights and grievance policy.

_____ _____

Client Signature ***Date***

_____ _____

Staff Signature ***Date***

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GRIEVANCE POLICY & PROCEDURE

Policy

Loving Helping Hands has a system to provide a fair, efficient and complete mechanism for receiving, investigating and resolving all client complaints/grievances. Clients who believe their rights have been violated can file complaints/grievances.

Purpose

To assure that all clients are provided with the highest level of care

Definitions

Grievance - A written or oral statement, alleging that an:

1. Individual's rights have been unfairly limited or violated.
2. Individual has been abused, neglected, or mistreated; or staff has acted in an illegal or improper manner with respect a student.

Procedure for filing a Complaint

The following steps are to be followed by staff in handling a complaint:

1. Client shall make a verbal complaint to their assigned Direct Care Counselor. If the complaint can be handled to the satisfaction of the complainer by the staff to which it is made, the process can end there.

2. If the client is unable to resolve the grievance via a verbal complaint, they may request a grievance form, which is then reviewed by the Direct Care Counselor's immediate supervisor.

3. The Direct Care Counselor's Supervisor will make copies of the complaint/grievance form and give one copy to the Program Director and place one copy in the client's file. At anytime the client can ask for a staff member to assist in this process.

4. The Direct Care Counselor's Supervisor will investigate within 3 business days and report his/her findings to the Program Director.

5. If the grievance is unable to be resolved within five working days it will be referred to Grievance Review Committee. (The Grievance Review Committee consists of the Director, Direct Care Counselor, and the Direct Care Counselor's Supervisor). The Grievance Review Committee will discuss the grievance and will notify in writing within 3 workdays thereafter the action to be taken in this matter.

6. The Grievance Review Committee may recommend an interagency meeting to explore other courses of action as deemed appropriate.

7. A copy of the grievance and its findings will be forwarded to the client's medical records.

8. If the client is unable to resolve the grievance via the steps above, they can contact the DHR.

Client Name: _____

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DISCHARGE PROCEDURES

Social Security Number:	- -
Medical Assistance Number:	
Gender:	☐ Male ☐ Female
Date of Birth	/ /
Race	☐ **African-American** ☐ **Caucasian** ☐ **Hispanic** ☐ **Bi-Racial** ☐ **Other** _____
Age:	
Does Client have children:	☐ Yes ☐ No
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Loving Helping Hands and the Direct Care Counselor are committed to provide quality services. To provide a high quality of service, it is essential that you understand our policy for termination of services when they are no longer required or needed.

Termination of program services shall, whenever possible, be a collaborative effort between you, your family, therapist, Loving Helping Hands appointed staff member, and treatment team. Together, they will develop a Discharge Plan formulating your needs and assisting you with the necessary referrals for service, Rehabilitation Assessment and Community Support.

A decision to terminate program services may be recommended by service team if you fail to comply with service goals.

If you are unable to attend services due to hospitalization or other temporary reason, your file will remain open until you are able to return to service.

Program services may be terminated by the request of legal guardian.

Program services may be terminated if you present a threat to the health or safety of Loving Helping Hands staff and community member surrounding you.

_____ _____

Client Signature ***Date***

_____ _____

Staff Signature ***Date***

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HIPPA
NOTICE OF PRIVACY PRACTICES
Georgia Department of Human Resources

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 and related federal regulations. If you have questions about this Notice please contact the Legal Services Office at the address below.

The Department of Human Resources is an agency of the State of Georgia responsible for numerous programs that deal with medical and other confidential information. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where more stringent disclosure requirements do not apply, this Notice of Privacy Practices describes how the department may use and disclose your protected health information for treatment, payment, health care operations and for certain other purposes. This notice also describes your rights to access and control your protected health information, and provides information about your right to make a complaint if you believe the Department has improperly used or disclosed your "protected health information." Protected health information is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to abide by the terms of the Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. Upon request, the Department will provide you with a revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Office, or in person at any facility where you receive services from the Department.

1. USES AND DICLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by the department, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist obtaining payment of your health care bills.
TREATMENT: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

PAYMENT: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays foe health care services such as; making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

HEALTH CARE OPERATIONS: The department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. The Department may use a sign-in sheet at the registration desk at any facility where services are provided. You may be asked to provide your name and other necessary information, and you may be called by name in the waiting room when a staff member is ready to see you, and your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke in writing at any time, except as permitted or required by law as described below.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT: The Department may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

OTHERS INVOLVED IN YOUR HEALTH CARE: Unless you object, the Department may disclose to a member of your family, a relative, a close friend or any other person your identity, protected health information related to that person's involvement in your health care. The Department may use or disclose protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care of your location, general condition or death. The Department may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. Objections may be made orally or in writing.

PERMITTED OR REQUIRED USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT: The Department may use or disclose your protected health information without your authorization when required to do so by law; for public health

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purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner, medical examiner or funeral director; for certain approved research purposes; to prevent or lessen a threat to health or safety; and to law enforcement authorities for identification or apprehension of an individual.

REQUIRED USES AND DISCLOSURES: Under the law, the Department must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Department's compliance with the requirements of the Privacy Rule at 45 OFR Sections 164.500.et.seq.

2. YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION: Upon written request, you may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the department uses for making medical and other decisions about you. A reasonable, cost based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information.

YOU HAVE THE RIGHT TO REQUEST RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION: You may ask in writing that the Department not use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your case. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law, if the Department does agree to the requested restriction the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION: Upon written request, the Department will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact. The Department will not request an explanation from you as to the basis for the request.

YOU MAY HAVE THE RIGHT TO REQUEST AMENDMENT OF YOUR PROTECTED HEALTH INFORMATION: If the department created your protected health information, you may request in writing an amendment of that information for as long as it is maintained by the Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES THE DEPARTMENT HAS MADE OF YOUR PROTECTED HEALTH INFORMATION: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures the Department made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. Upon written request, you have the right to receive legally specified information regarding disclosures occurring after April 14, 2003, subject to certain exceptions, restrictions and limitations.

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE DEPARTMENT, Upon request. All written requests regarding your rights as set forth above should be sent to the legal Services Office at the address shown in Section 3 below.

3. COMPLAINTS

You may complain to the Department and to the Secretary of Health and Human Services. If you believe your privacy rights have been violated. You may file a complaint by notifying the Legal Services Office in writing of the basis for your complaint. The Department will not retaliate against you for filing a complaint. You may contact the Legal Services Office by telephone at (404) 656-4421, facsimile (404) 657-1123, or by mail to 2 Peachtree Street NW, Room 29.21, Atlanta, GA 30303-3142 for further information about the complaint process or this notice. Please sign a copy of this Notice of Privacy Practices for the Department's records.

I have received a copy of this Notice on the date indicated below.

_____ _____

Signature Date

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Insurance Verification Form

Client name: _____

Date of birth: _____

Current insurance carries:

- ☐ **Medicaid – ID #_____**
- ☐ **Amerigroup – ID #_____**
- ☐ **Cenpatico Behavioral Health – ID #_____**
- ☐ **Wellcare – ID #_____**
- ☐ **Private Insurance/Name/ #_____**
- ☐ **Uninsured**

Additional insurance:

Insurance company name: _____

Policy name (parent's name): _____