Ventura County Behavioral Health
Identification and Payer Financial Information
Client Information and Demographics

For Office Use Only

Admit Date: _____ Admit Time: _____ Circle One AM PM TYPE OF ADMISSION: ☐ First Admission ☐ Re-Admission ☐ Annual Data Entry ____

ADMITTING PRACTITIONER: Name: _____ Staff #: _____ Facility / Cerner MR#: _____

Client Information

Circle One
Dr. Mr. Mrs. Ms. Client's Last Name: _____ First Name: _____ MI: ____ Circle One Sr. Jr. III IV V VI

Date of Birth: MM/DD/YYYY SSN: ___ - ___ - ____ Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown

Client's Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone : _____ Work Phone: _____ Cell Phone: _____ Email: _____

COMMUNICATION PREFERENCE: ☐ Email ☐ Regular Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT: Office Use Only ROI acquired?: ☐ Yes ☐ No Name: _____ Relationship to client: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Email: _____

Where were you referred from?

___ Adolescent Probation	___ Family	___ O.P. Medical Provider - Non VCMC	___ Schools / Education
___ Alcohol & Drug Progs - Non VCBH	___ Hospital / ER - Non VCMC	___ O.P. Medical Provider - VCMC	___ Self
___ Comm Agencies & Counseling Ctrs	___ Hospital / ER - VCMC	___ Other / Unknown	___ VCBH Cont Provider
___ Community	___ Human Services Agcy	___ Psychiatric Facility - Private	___ VCBH O.P. Prog Adults
___ Courts/ Corrections/ Law Enforce	___ Human Services Agcy - PASS	___ Psychiatric Facility - VCMC	___ VCBH O.P. Prog YF
___ Crisis Services	___ Insurance Carriers / Progs	___ Residential Facility - Adult	

Living Arrangements (Where are you currently living?)

___ Adult residential facility, social rehabilitation facility, crisis residential, transitional residential, drug facility, alcohol facility	___ Inpatient psychiatric hospital, psychiatric health facility (PHF), or Veterans Affairs (VA) Hospital
___ Board and care facility	___ Justice related (juvenile hall, California Youth Authority home, or correctional facility, jail, etc.)
___ Community treatment facility	___ Mental health rehabilitation center (24-hour)
___ Foster family home	___ Other: _____
___ Group home (includes Levels 1-12 for children)	___ Residential treatment center (includes Levels 13-14 for children)
___ Homeless (no identifiable residence)	___ Skilled nursing facility /Intermediate care facility / Institute of Mental Disease
___ House /apartment (includes trailers, hotels, dorms, barracks, etc.)	___ State hospital
___ House/apartment & requiring daily support & supervision (applies to adults only)	___ Supported housing (applies to adults only
___ House/apartment & requiring some support w/daily living activities (applies to adults only)	___ Unknown /not reported

Do you experience any disability listed below? (If yes, please select up to 3)

___None ___Visual ___Hearing ___Speech ___Mobility ___Mental ___Developmentally Disabled ___Other: _____ Specify

Mixteco - Client

Are you Mixteco? ☐ Yes ☐ No

Military Veteran

☐ Yes ☐ No

Primary Language Spoken - Client

___ American Sign Language (ASL)					
___ Arabic	___ Farsi	___ Italian	___ Mien	___ Polish	___ Tagalog
___ Armenian	___ French	___ Japanese	___ Mixteco	___ Portuguese	___ Thai
___ Cambodian	___ Hebrew	___ Korean	___ Other Chinese Dialects	___ Russian	___ Turkish
___ Cantonese	___ Hmong	___ Lao	___ Other Non-English	___ Samoan	___ Vietnamese
___ English	___ Ilocano	___ Mandarin	___ Other Sign Language	___ Spanish	___ Unknown/Not Reported

Ethnic Origin

___ Cuban ___ Mexican/Mexican American___ Mixteco ___ Not Hispanic ___ Other Hispanic/Latino ___ Puerto Rican ___ Unknown

Religion - Client

What is your religious denomination, if any?: _____

Marital Status - Client

___ Single / Never Married ___ Married ___ Separated ___ Divorced / Annulled ___ Widowed ___ Unknown

Highest Level of Education - Client

___ None ___ 4 Years ___ 8 Years ___ 12 Years / GED ___ 16 Years ___ 20 Years or more ___ Vocational Ed
___ 2 Years ___ 5 Years ___ 9 Years ___ 13 Years ___ 17 Years ___ Other ___ Unknown/Not Reported
___ 1 Year ___ 6 Years ___ 10 Years ___ 14 Years ___ 18 Years ___ Preschool
___ 3 Years ___ 7 Years ___ 11 Years ___ 15 Years ___ 19 Years ___ Special Ed

Employment Status - Client

___ Full Time- 35+ hrs/ wk, not incl
___ In The Armed Forces
___ Not In Labor Force- Homemaker
___ Not In Labor Force- Other Not Seeking Empl Past 30 Days
___ In The Armed Forces
___ Not In Labor Force-Retired
___ Not In Labor Force-Student
___ Not In Labor Force- MH, Developental Disability, Or A+D
___ Not In Labor Force- Other Disability
___ Part Time (1-15 hrs/ wk, not incl Armed Forces)
___ Part Time (16-32 hrs/ wk, not incl Armed Forces)
___ Unemployed-On Layoff from Job
___ Unemployed-Seeking Empl
___ Unknown

Occupation - Client

___ Admin Support, Clerical
___ Construction Trades
___ Executive, Admin, Mgmt
___ Extractive Occupations
___ Fabricator, Asblr, Hdwrkg
___ Farming, Forestry, Fishing
___ Handler, Eqpt Clnr, Helper, Labr
___ Machine Opr/Tender (except precision)
___ Mechanic & Repairs
___ Military Occupations
___ Never employed
___ Precision Production Occup
___ Preschool or Student
___ Private Household Business
___ Prod Insp, Tester, Sampler, Weigher
___ Prof Specialty Occup
___ Protective Services Occup
___ Sales Occup
___ Service Occup
___ Technician, Support Occup
___ Transp, Mtl Moving Occup
___ Unknown

Tobacco Smoker? - Client

___ Current every day smoker
___ Current some day smoker
___ Current status unknown
___ Former smoker
___ Heavy tobacco smoker
___ Light tobacco smoker
___ Never smoked
___ Smoker
___ Unknown if ever smoked

Parent/Guardian/Caregiver's Preferred Language Spoken

___ American Sign Language (ASL)
___ Arabic ___ Farsi ___ Italian ___ Mien ___ Polish ___ Tagalog
___ Armenian ___ French ___ Japanese ___ Mixteco ___ Portuguese ___ Thai
___ Cambodian ___ Hebrew ___ Korean ___ Other Chinese Dialects ___ Russian ___ Turkish
___ Cantonese ___ Hmong ___ Lao ___ Other Non-English ___ Samoan ___ Vietnamese
___ English ___ Ilocano ___ Mandarin ___ Other Sign Language ___ Spanish ___ Unknown/Not Reported

Alias (What other names have you used in the past?) - **Client**

Also known as #1: Last Name: _____ , First: _____ AKA #3: Last Name: _____ , First: _____
AKA # 2: Last Name: _____ , First: _____ AKA #4: Last Name: _____ , First: _____

ADP Clients Only - Client

Are you a client of Ventura County Behavioral Health - Mental Health? ☐ Yes ☐ No
If yes, your case manager's name: _____ Location: _____

ADP Female Clients Only - Client

Are you pregnant? ☐ Yes ☐ No ☐ Unknown If yes, when is your due date? _____
Under doctors care? ☐ Yes ☐ No

Informing Materials - Client

Client received A Guide To Medi-Cal Mental Health Services ? ☐ Yes ☐ No
Does client have an Advanced Directive? ☐ Yes ☐ No Was the client offered an Advanced Directive form? ☐ Yes ☐ No

Ventura County Behavioral Health	Identification and Payer Financial Information Part A	Name:
Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014		ID#:
		Site:

Client CSI Data

For Office Use Only Episode #: _____ Facility / Cerner MR#: _____ Admit Date: _____ Admit Time: _____ Circle One AM PM

Birth Name, Last: _____ First: _____ Middle: _____ **Suffix:** Sr. Jr. III IV V VI

Mother's First Name: _____ Fiscally Responsible County for Client: _____

Place of Birth - County: _____ State: _____ Country _____

CSI - Ethnicity

___ Not Hispanic or Latino ___ Unknown / Not Reported ___ Hispanic or Latino

Special Population - OFFICE USE ONLY

___ Assisted Outpatient Treatment Service(s) (AB 1421)
___ (AB 3632) Individualized Education Plan (IEP) Required Service(s)
County School : _____
Based on current residence
___ Governor's Homeless Initiative (GHI) Service(s)
___ No Special Population Services
___ Welfare-to-Work-Plan Specified Services

Legal Class - OFFICE USE ONLY

___ 14-Day Intensive Treatment
___ 72-Hr Evaluation & Treatment for Adults
___ 72-Hr Evaluation & Treatment for Children
___ Additional 14-Day Hold
___ Additional 180-Day Hold
___ Additional 30 Day Hold
___ Charges and/or convictions pending
___ Determination of competency to stand trial
___ Determination of sexual psychopathy & related legal categories
___ Found "not guilty by reason of insanity" or "guilty but insane"
___ Other involuntary civil status
___ Other involuntary criminal status
___ Transfer from correctional facilities
___ Unknown / Not Reported
___ Voluntary

Admission Necessity Code - OFFICE USE ONLY

___ Emergency ___ Planned (Prior Authorization) ___ Unknown / Not Reported

Issues Affecting Mental Health - OFFICE USE ONLY

Current Substance Abuse: ☐ Yes ☐ No ☐ Unknown
Developmental Disabilities: ☐ Yes ☐ No ☐ Unknown
Physical Health Disorders: ☐ Yes ☐ No ☐ Unknown

Conservatorship / Court Status - OFFICE USE ONLY

___ Murphy ___ Lanterman-Petris-Short ___ Juvenile Court, Dependent of the Court-300 ___ Not Applicable
___ Probate ___ Temporary Conservatorship ___ Juvenile Court, Ward - Status Offender-601 ___ Unknown / Not Reported
___ P.C. 2974 ___ Rep Payee w/o Conservatorship ___ Juvenile Court, Ward - Juvenile Offender-602

Preferred Language Spoken - Client

___ American Sign Language (ASL)

___ Arabic	___ Farsi	___ Italian	___ Mien	___ Polish	___ Tagalog
___ Armenian	___ French	___ Japanese	___ Mixteco	___ Portuguese	___ Thai
___ Cambodian	___ Hebrew	___ Korean	___ Other Chinese Dialects	___ Russian	___ Turkish
___ Cantonese	___ Hmong	___ Lao	___ Other Non-English	___ Samoan	___ Vietnamese
___ English	___ Ilocano	___ Mandarin	___ Other Sign Language	___ Spanish	___ Unknown/Not Reported

Race (Check up to 5, if needed) - Client

___ American Indian / Alaska Native	___ Chinese	___ Japanese	___ Native Hawaiian	___ Samoan
___ Asian Indian	___ Filipino	___ Korean	___ Other	___ Unk / Not Reported
___ Black or African American	___ Guamanian	___ Laotian	___ Other Asian	___ Vietnamese
___ Cambodian	___ Hmong	___ Mien	___ Other Pacific Islander	___ White / Caucasian

Client is Primary Caregiver for:

Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time? _____
Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time? _____

Additional Emergency Contact Information - OFFICE USE ONLY

EMERGENCY CONTACT:
Name: _____ Relationship to client: _____ Phone #: _____
Name: _____ Relationship to client: _____ Phone #: _____
Name: _____ Relationship to client: _____ Phone #: _____

Ventura County Behavioral Health
Payer Financial Information

For Office Use Only
Admit Date: _____
Admit Time: _____
Family #: _____

Client Last Name: _____ First: _____ MI: ____ Phone #: _____
Person Responsible for Payment Last Name: _____ First: _____ MI: ____ Phone #: _____
Mailing Address: _____ Apt # _____ City _____ State _____ Zip _____

Medi-Cal, Medicare

Medi-Cal #: _____ Medi-Care #: _____
Issue Date: MM/DD/YYYY Part A Effective Date: MM/DD/YYYY Part B Effective Date: MM/DD/YYYY

Primary Insurance

Insurance Company Name: _____ Pre-Authorization Required: ☐ Yes ☐ No
Mailing Address: _____ Ste #: _____ City: _____ State: _____ Zip: _____
Group #: _____ Effective Date: MM/DD/YYYY Policy #: _____
Insured Name: _____ Insured SSN: _____
Insured Employer: _____
Client's Relationship to Insured: _____ Worker's Comp? ☐ Yes ☐ No

Secondary Insurance Company

Insurance Company Name: _____ Pre-Authorization Required: ☐ Yes ☐ No
Mailing Address: _____ Ste #: _____ City: _____ State: _____ Zip: _____
Group #: _____ Effective Date: MM/DD/YYYY Policy #: _____
Insured Name: _____ Insured SSN: _____
Insured Employer: _____
Client's Relationship to Insured: _____ Worker's Comp? ☐ Yes ☐ No

Financial Liability

Dependents (No. of persons (family group) dependent upon income)? _____
Income: (Enter Clients / Responsible Persons income received monthly)

Employment Income: $ _____ SSA: $ _____ Other: $ _____
Unemployment Income: $ _____ SSI: $ _____
State Disability Insurance: $ _____ VA Benefits: $ _____ Total Income: $ _____

Uniform Method of Determining Ability to Pay (UMDAP)

Office Use Only UMDAP Start Date: MM/DD/YYYY UMDAP End Date: MM/DD/YYYY

Responsible Person's Monthly Income		Responsible Person's Assets		Responsible Person's Monthly Expenses	
Self:	$	Savings:	$	Court Ordered:	$
Spouse:	$	Bank Balances:	$	Child Care:	$
Other:	$	Market Value of Stocks:	$	Dependent Care:	$
County Use Only Calculated UMDAP $		Market Value of Bonds:	$	Medical Expenses:	$
		Market Value of Mutual Funds:	$	Retirement:	$
		Market Value of Other:	$		

	Age	Gender	Client	Head of Household	Family Member in Household	Family Member Out of Household	Extended Family Member
Last Name, First , MI: _____	_____	_____	☐	☐	☐	☐	☐
Last Name, First , MI: _____	_____	_____	☐	☐	☐	☐	☐
Last Name, First , MI: _____	_____	_____	☐	☐	☐	☐	☐

Ventura County Behavioral Health	Identification and Payer Financial Information Part B	Name:
Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014		ID#:
		Site:

Release of Information/Authorization to Pay

All clients are responsible for the cost of services received from Ventura County Behavioral Health (VCBH). We will bill your insurance company for you. Clients are expected, at minimum, to pay all applicable deductible, co-payments, and any other non-covered client portions at the time of service. You are responsible for providing your insurance information. Please bring all insurance cards with you to your first visit. Failure to present the proper insurance information may result in you incurring full responsibility for payment of all services rendered.

If you are a new client, or, if there are changes in your insurance coverage, you will go through our insurance verification process. We will verify what benefits, if any, are available to you through your insurance plan. Please note that verification of benefits does not guarantee payment from any insurance company.

I understand that I am financially responsible for all services not covered by school based services related to the Individual Education Plan (IEP) or my insurance. If I become ineligible for services at any time during my treatment, I understand that I will be responsible for charges or my Uniform Method of Determining Ability to Pay (UMDAP), whichever is less.

I understand and accept that I am financially responsible for all services provided by Ventura County Behavioral Health. I authorize Ventura County Behavioral Health to release to my insurance company any medical information necessary for the processing of a claim. I permit a copy of this authorization to be used in the place of the original.

- ✔ Ask us to explain if you don't understand why you may have to pay for services.
- ✔ Ask us how much these items or services will cost you.

Payment Agreement (Client or Parent/Guardian must initial and sign payment agreement)

Calculated Annual UMDAP.....	$

I agree to pay my annual cost today or at my next visit. Payer Initials _____

I agree to pay $_____ every _____ and to pay any remaining balance on my last visit to VCBH....

....Payer Initials _____

_____

Signature of Client or Legally Authorized Representative Date

_____

Signature of VCBH Representative Date

Ventura County Behavioral Health	Identification and Payer Financial Information Part B	Name:
Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014		ID#:
		Site:

NEW DAWN
COUNSELING & CONSULTING

INFORMED CONSENT FOR TELEHEALTH SERVICES

In order to meet your needs during these times, New Dawn Counseling and Consulting, Inc. will be providing TeleHealth services. By signing this form, you are agreeing to receive telehealth services during this period.

I understand that I have the rights with respect to telehealth:

1. I understand that Telehealth can include communication through the internet, phone call, email, videoconferencing, voicemail, and at times text messaging your counselor.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. New Dawn Counseling will utilize secure, encrypted audio/video transmission software to deliver TeleHealth.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
6. I understand that my consent is required to forward my personally identifiable information to a third party.
7. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
8. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an

emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

9. The following information pertains specifically to videoconferencing and phone sessions:
    a. Due to sensitive material that is covered in each session, please be alone in the room, unless otherwise agreed upon with your mental health provider.
    b. Please do not call your counselor via videoconferencing while you are driving or if you are in a public area
    c. Please call your counselor immediately if you are running late
    d. Please dress as if you are going to an in-person appointment.
    e. Please have sessions in a room with minimal distractions (No texting, emailing, internet surfing, or engage in any other activities while you are engaged in your session).
    f. Please make sure all electronics are turned off while in session (TV, radio, ipods, stereos)
    g. No smoking, vaping or use of tobacco products during sessions.
    h. Please do not attend while under the influence of alcohol or other substances
    i. Please make sure to have your devices fully charged prior to your scheduled appointment.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.
I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.
I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Choose one of the following:
O Yes, I would like to consent for Telehealth Services
O No, I do not consent for Telehealth Services
O I do not have a camera and consent to Phone Sessions (does not apply to insurance and private pay clients)

_____ O I do not have an email _____
Email Phone

_____ _____
Client's Name Parent or Guardian's name

_____ _____
Client's or Parent Signature Date

New Dawn Counseling Center

Consent for Mental Health Services

1. Mental Health Services may include assessment, diagnostic services, crisis intervention, supported employment, supported housing, rehabilitation services, linkage services, individual, group or family therapy, or medication. Services are provided by qualified staff members of the New Dawn Counseling Center. (Qualified staff include both licensed and unlicensed staff)

2. You will be informed in a separate consent form about any medication recommended for use as part of the mental health services.

3. You will be expected to pay all or some of the costs of services received, **if applicable.** The amount you pay is dependent upon your ability to pay based on your income and family size.

4. All information and records obtained in the course of services shall remain confidential and will not be released without your written consent except under one or more of the following conditions:

   a. If you are a minor, to your parent or guardian.

   b. If you are a ward of the court, to the court.

   c. If you are an L.P.S. conservatee, to the conservator.

   d. To government law agencies to protect the lives of federal and state elective constitutional officers and their families.

   e. To the courts, as necessary to the administration of justice.

   f. To prevent bodily harm to another person (Tarasoff vs. Regents of University of California, 1976).

   g. When child abuse is observed or suspected (Penal Code Section 11161.5).

   h. When older/dependent adult abuse is observed or suspected (Welfare and Institutions Code Section 15630).

5. You have the right to freedom of choice when requesting mental health services.

6. You have a right to refuse or stop mental health services at any time unless you are identified in 4a, b, or c above.

I have read the above, agree to accept services and acknowledge that I have received a copy of this agreement.

Client_____ Witness_____

Print Name & Tilte: _____

Parent, Guardian, Conservator_____ Date_____

New Dawn Counseling & Consulting

Confidential Patient Information Welfare & Institutions Code 5328 And Evidence Code 1014

Revised 07/12/16 AG

Consent for Mental Health Services

Name

ID #

Site

New Dawn Counseling Center

Acknowledgement of Notice of Privacy Practices, Consumer Guide and Crisis Prevention Plan

These materials do not, and are not intended to, constitute legal advice and do not necessarily reflect the opinions of legal counsel. The users may consult their own legal counselors to guide them with regard to the use of the law and of these documents.

Client Name____

I hereby acknowledge that I have received: (Check all that apply)

❒ The Notice of Privacy Practices Statement ______ (please initial)

❒ The VCBH Consumer Guide______ (please initial)

❒ Crisis Prevention Plan ______ (please initial)

Signature ______________________________________ Date ___________

❒Parent ❒Guardian ❒Self ❒Other

- -

Reconocimiento Del Aviso De Las Practicas De Privacidad, Guía Del Consumo, Y Plan De Prevención de Crisis.

Esta información en el no constituye asesoramiento jurídico. Así como no es un substituto para consejo legal u otro consejo profesional. Los usuarios deben consultar sus propios consejeros legales para guiarlos con respecto al uso de la ley y de estos documentos.

Nombre del Cliente ____

Yo reconozco por este medio que he recibido: (verifique todo que aplica)

❒ El Aviso de la Declaración de las Prácticas de Privacidad_______ (Por favor de inicial)

❒ El Guía del Consumo de VCBH_______ (Por favor de inicial)

❒ Plan de Prevención de Crisis _______ (Por favor de inicial)

Firma ____ Fecha ___________

❒ Padre ❒Guardián ❒Yo Mismo ❒ Otro

Youth & Families Crisis Prevention Plan

A. Identifying Information:

Clinician Name/ Clinic:_____ Phone:_____

Physician's Name:_____ Phone:_____

❑CFS Case manager ❑602 P.O.:_____ Phone:_____

B. Reason for Referral/Problem Description:_____

_____

C. Current Meds:_____

D. Plan (check all that apply)

❑ *Call 911 immediately if the client:*

- Is having a medical emergency
- Is physically assaultive or destroying property
- Experiencing a cognitive disturbance (i.e., disoriented, unresponsive, hallucinating, etc.)
- Has obtained a weapon
- Imminent risk of harm to self or others

❑ *Go to the nearest emergency room if the client is safe to transport & needs urgent medical attention, including but not limited to:*

- Physical injury
- Medication side effects outside of clinic hours
- Medical complications
- Running out of medication outside of clinic hours

❑ *Call the Crisis Team 1-866-431-2478 if the client is 0 to 20 years old and is:*

- Threatening to hurt self
- Engaging in out of control/escalating behavior
- Returning from psychiatric hospitalization
- Threatening to hurt others or destroy property
- Engaging in other dangerous or risky behaviors

❑ *Call the Home Access Team (HAT; (805)384-1555) if the client is 0 to 18 years old and is not a danger to self or others, but is displaying unmanageable behavior, including but not limited to:*

- Continued non-compliant behavior
- Verbally abusive
- Refusing to take medications
- Threatening to run away
- Refusing to go to school

*Or if parent needs additional support to manage youth

E. Referral Out

- Crisis Team Referral: Fax 1) this form, 2) a current risk assessment, 3) the front page of the PFI, and a 4) Current Release of information to Crisis Team at (805)482-0973.
- HAT/Parent Partner Referral: Fax the documents above and the client MTP, with Parent Partner Support added as a service, to HAT at (805)384-1080.

SAVE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.

Attach Label Here

New Dawn Counseling & Consulting, Inc.

Clinician: _____

Insurance Disclaimer

To whom it may concern:

To the best of my knowledge, I can attest that my child,_____

(Print child's name)

is covered under Medi-Cal and does not have any other insurance coverage.

_____ _____

Signature Date

_____ _____

Print Your Name Relationship to Client

La Renuncia del Seguro Medico

A quien corresponda:

Yo declaro según mi conocimiento, y puedo atestiguar que mi niño/a,

_____ está cubierto bajo Medí-Cal y no tiene cualquier otra

(Imprima el nombre del niño/a)

cobertura de seguro medico

_____ _____

Firma Fecha

_____ _____

Imprima Su Nombre Relación al Cliente

New Dawn Counseling & Consulting, Inc.

EPSDT ATTENDANCE CONTRACT

New Dawn makes every effort to provide quality services to our clients. In order to ensure the ongoing success of our counseling programs, client and/or a responsible adult must understand and agree to our attendance expectations. Regular attendance at scheduled appointments is critical to therapy being effective.

1. I understand that counseling is a commitment and that this commitment may last anywhere from 3 months to a year, depending on the severity of symptoms. I will cooperate with the therapist to set an appointment time that is mutually agreed upon.

2. I understand that the client must attend the first 5 counseling sessions without fail. The only cancellation accepted will be for illness; accompanied by a doctor's note.

3. I understand that I am responsible for getting the client to the scheduled session ON TIME.

4. If I need to cancel/reschedule, I will call the therapist at least 24 hours before the appointment time. If I agree to have the client seen at school, I will notify the therapist, in advance, if the client will not be available due to a field trip, testing, illness or other school related reason.

5. After attending the first 5 sessions, I understand that if the client misses or I am late in canceling two sessions in a row, I will lose my scheduled appointment time.

6. I understand that continued inconsistency in attendance will be grounds for discharge.

I have read and understand the 'EPSDT Attendance Contract' and agree to its terms and conditions.

_____	_____	_____
Client's Name	Client's Signature (if applicable)	Date
_____	_____	_____
Print Name of Responsible Adult	Signature	Date
_____	_____	
Signature of Witness to Above	Date	