# Intake/annual Checklist

**Please complete the following to see what forms need to be completed:**

*All highlighted fields must be completed for list to generate below.*

**Format:** Paper

| | |
|---|---|
| Age Group | Please Select |
| Substance Use Diagnosis | Please Select |
| HIV Diagnosis | Please Select |
| Insurance | Please Select |
| Has a Guardian | Please Select |
| Services Needed | Please Select |
| Visit Type | Please Select |
| Rendering SB&H Staff is Licensed | Please Select |
| **Recommended Steps** | |
| **Completed** | 0 |

| Intake Consents & Steps | Required (If Applicable) | Location | Completed |
|---|---|---|---|
| Consent Packet Acknowledgement | | Axiom/Excel | |
| SUD Release | | Axiom/Excel | |
| Advance Directives | | Axiom/Excel | |
| PCP ROI | | Axiom/Excel | |
| School ROI | | Axiom/Excel | |
| JPO ROI | | Axiom/Excel | |
| External BH provider ROI | | Axiom/Excel | |
| Family/Friends ROI | | Axiom/Excel | |
| Dual Enrollment- OTP specific | | Axiom/Excel | |
| Transport Authorization- youth specific | | Axiom/Excel | |
| Copy of Insurance Card | | Axiom - Scanned documents | |
| Private Pay Agreement | | Confluence | |
| Copy of Birth Certificate, Notice to Provider (DCS Only), or Proof of Guardianship | | Axiom - Scanned documents | |
| Copy of Member ID or Birth Certificate | | Axiom - Scanned documents | |
| Create Chart in Axiom | | Axiom - Scanned documents | |

| Screening Forms | Required? | Location | Completed |
|---|---|---|---|
| Cover Sheet | | Axiom/Excel | |
| Demographic [834] | | Axiom | |
| Adult Health Risk Assessment [HRA] | | Axiom/Excel | |
| Youth Health Risk Assessment [HRA] | | Axiom/Excel | |
| PCP Medical History Form | | Axiom/Paper | |
| Depression Screener [PHQ-9] | | Axiom/Paper | |
| Anxiety Screener [GAD-7] | | Axiom/Paper | |
| ADHD Screener | | Axiom/Paper | |

| Assessment Forms | Required? | Location | Completed |
|---|---|---|---|
| Engagement Session Note [Assessment] | | Axiom | |
| Substance Use Screener [ASAM] | | Axiom | |
| Service Plan | | Axiom | |
| Support & Safety Plan | | Axiom | |
| ART/CFT/Staffing Plan | | Axiom | |
| Developmental History Assessment | | Axiom | |
| Columbia-Suicide Serverity Rating Scale | | Axiom | |
| CALOCUS | | CALOCUS Portal | |
| Strength Needs Culture Discovery [SNCD] | | Axiom | |
| PCP Note 3.0 | | Axiom | |

| Wrap Up | Required? | Location | Completed |
|---|---|---|---|
| Overview of next steps | | Confluence | |
| PCP Communication | | Axiom | |
| Birth to 5 Observations Scheduled | | Axiom - scheduling | |
| Nursing Assessment Scheduled | | Axiom - scheduling | |
| Therapy Appointment Scheduled | | Axiom - scheduling | |
| Psych Eval Scheduled | | Axiom - scheduling | |
| PCP Visit Scheduled | | Axiom - scheduling | |
| Copies of Service Plan and Support & Safety Plan given to member | | Axiom | |
| Pend Engagement Session Note and Service Plan to BHP | | Axiom | |
| Document Closed | | Axiom | |

**Southwest Behavioral & Health Services**

Intake/Annual Consent Packet Acknowledgement

| Member's Name | SSN | DOB |
|---|---|---|

| Address, City, State Zip | Phone |
|---|---|

I have received a copy of the Southwest Behavioral and Health Services Consent Packet, summarized below. I understand each form as they have been presented to me and agree to expectations and guidelines. I have been offered the opportunity to review the below consent forms and understand that I have the ability to ask questions to my satisfaction as part of the SB&H intake process. I understand that a copy of this page will be placed in my clinical record to show that I received the contents of this document.

☐ Consent for Evaluation and/or Treatment (SB&H Handbook)

**I hereby attest and acknowledge that I have read this entire consent for evaluation and/or treatment agreement and expressly declare, confirm and certify that I have the authority to execute this agreement on behalf of myself or applicable minor pursuant to any and all of the terms and conditions identified as expressed within this Agreement. I have had ample opportunity to review the contents of this Agreement and hereby authorize SBH to proceed based upon my authority to grant SBH the ability to evaluate and/or treat myself or applicable minor. I unequivocally expressed and represented my ability and authority to grant SBH the right to so proceed.**

☐ Informed Consent to Participate in Telepractice Services (SB&H Handbook)

☐ I agree ☐ I do not agree to participate in telepractice services

☐ Consent for Communication ☐ Email ☐ Voicemail ☐ Text Messages

☐ Attendance Guidelines Agreement (SB&H Handbook)

☐ Health Plan Member Handbook Acknowledgement (links in SB&H handbook)

☐ Payment Agreement: *I give my consent for SBH to bill my insurance carrier for services provided per the Notice of Privacy Practices referenced below. I elect to receive services with the understanding that I <u>may</u> be personally responsible to pay for the service being rendered to me.* (SB&H Handbook)

☐ SB&H Member Handbook Acknowledgement *(Program Responsibilities, List of Available Services at SB&H, Service Planning, Transition/Discharge Planning, Fees, Safety, SB&H Code of Ethics, SB&H Notice of Privacy Practices, AHCCCS Notice of Privacy Practices, Confidentiality of Substance Abuse Records, Rights of Persons Served, Additional Rights for Inpatient or Residential Treatment Facilities, Legal Rights for Persons with Serious Mental Illness, Notice to Persons with Serious Mental Illness, Notice to Individuals Receiving Substance Abuse Services, Grievance, Appeal and Complaint Policy and Procedure* ). **Bureau of Medical Facilities Licensing**: 602-364-3030; **Bureau of Behavioral Health Facilities Licensing**: 602-542-3422.

| Signature of Member | Date |
|---|---|
| Signature of Parent, Guardian, or authorized representative (when required) | Date |
| Witness (Staff) Signature | Date |

Member's Name: DOB:

Southwest Behavioral & Health Services

**Release of Information and Records Request Form**

Please check only **ONE** of the following options:

☐ Check here if you would like to **Release/Send** your records ☐ Check here if you would like to **Request** your records

☐ Check here if you would like to **both Release AND Request** your records

**How would you like to receive your records? Please select:** ☐ Mail ☐ Digital format via Mail (50 page minimum required) ☐ Email: _____

**Dates of Service (for records to be sent):** ☐ past 60 days ☐ past 90 days ☐ past year

☐ Other (list date range): _____ to _____

**I,** _____ _____ _____

Member's Name SSN DOB

_____ _____

Address, City, State, Zip Phone Number

**Authorize releases, and/or record requests as selected herein between:**

Southwest Behavioral & Health Services _____

Name of Healthcare Organization with Treatment Relationship Phone Number

_____ _____

Address, City, State, Zip Fax Number

**AND**

_____ _____

Name of Person and Agency (Recipient) Phone Number

_____ _____

Address, City, State, Zip Fax Number

**Notice to Recipient:** This information has been disclosed to you from records that Federal law protects. These records are not subject to redisclosure. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. I understand that if this information is released to the indicated third party, the third party may not follow the Federal privacy laws and my personal health information may be released by the third party. **Treatment, payment, and/or enrollment is not conditioned upon whether the member signs this consent.**

**Note:** Federal and state government rules require a separate authorization be completed for each of the following categories: Information on HIV/AIDS and other communicable diseases, and Alcohol/Substance Abuse Records.

**What kind information would you like released and/or requested as selected herein? Check all that apply:**

| | | |
|---|---|---|
| ☐ Clinical Assessment | ☐ Psychiatric Evaluation | ☐ Medications |
| ☐ Clinical Services Notes | ☐ Treatment/Service Plans | ☐ Test Results/Labs |
| ☐ Discharge Summary | ☐ Substance Use Information | ☐ AIDS/HIV Information |
| ☐ Psychological Assessment | ☐ Verbal disclosure of treatment information | ☐ School Records |

☐ Other (Please specify i.e. billing records, treatment summary, etc): _____

**Purpose for Release/Request:** _____

**A purpose for the request/disclosure** is required for all 3rd party releases only. This section identifies to the authorized party and signer why the records are being requested and/or what the records will be used for. The purpose is not required when members are requesting their own records. **I understand** that at anytime, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

**Authorization will expire:**

☐ 1 Year From this Date

☐ Other: _____ (Enter Date, no greater than 1 year)

_____ _____

Signature of Member/Guardian/Authorized representative Date

_____ _____

Other Required Signature (If Applicable) Witness (if Member is unable to sign)

*If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required.

SOUTHWEST
BEHAVIORAL&HEALTH SERVICES
IMPACTING PEOPLE, IMPROVING COMMUNITIES

**Southwest Behavioral & Health Services Cover Sheet**

Member's Name | Member SS# | DOB

Address, City, State Zip | Phone | Email

Gender: ☐ Gender Variant ☐ Male ☐ Female ☐ Intersex ☐ Questioning ☐ Transgender ☐ Decline to answer

Race: ☐ American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Caucasion ☐ Native Hawaiian ☐ Decline to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to answer

Primary Language | Preferred Language

**Insurance Coverage:** *Attach a copy of medicaid, medicare, commercial and other insurance cards*

☐ Medicaid ☐ Medicare ☐ Private (Self-pay) ☐ TriCare ☐ Blue Cross ☐ HMO ☐ Other

Insurance Co. | Insurance ID# | Policy#

**Special Needs:**

| | | | |
|---|---|---|---|
| Interpreter (spoken) | ☐ No | ☐ Yes, specify language | |
| Translator (written) | ☐ No | ☐ Yes, specify language | |
| Mobility Assistance | ☐ No | ☐ Yes, identify assistance needed | |
| Visual Impairment Assistance | ☐ No | ☐ Yes, identify assistance needed | |
| Hearing Impairment Assistance | ☐ No | ☐ Yes, identify assistance needed | |
| Need Childcare Arrangements | ☐ No | ☐ Yes, identify need | |

Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. ↓

**Key Contacts:** ☐ No ☐ Yes

If applicable, select custody arrangement ☐ Sole ☐ Joint ☐ Ward of Court (DCS) or Legal Guardian

**Parent/Legal Guardian(s):** Phone

*Must provide current legal document* Phone

Phone

Phone

**Emergency Contact:** Phone

*Complete ROI* Address

**PCP/Physician:** Phone Fax

*Complete PCP ROI* Address

**Dentist:** Phone Fax

**Other Healthcare Specialist(s):** Phone Fax

*(e.g. Mental health, substance use, OBGYN, neuro, pain, naturopath, etc)* Address

Phone Fax

Address

**Pharmacy:** Address

**Other Key Contacts:** *(e.g. school, probation/parole officer, other involved agencies [DDD/DCS], significant other, neighbors, family)*

Name: Relationship:

Phone: Fax:

Name: Relationship:

Phone: Fax:

**Southwest Behavioral & Health Services Youth Health Risk Assessment**

| Member's Name | Member SS# | DOB |
|---|---|---|
| | | |

| Address, City, State Zip | Phone | Email |
|---|---|---|
| | | |

**Substance Related Disorders Screening** ☐ Adult (18+) ☐ Youth (0-17) As appropriate, ask the youth these questions

| | | |
|---|---|---|
| Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? | ☐ No | ☐ Yes |
| Do you ever use alcohol or drugs while you are by yourself alone? | ☐ No | ☐ Yes |
| Do you ever forget things you did while using alcohol or drugs? | ☐ No | ☐ Yes |
| Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs? | ☐ No | ☐ Yes |
| Do your family or friends ever tell you that you should cut down on your drinking or drug use? | ☐ No | ☐ Yes |
| Have you ever gotten into trouble while you were using alcohol or drugs? | ☐ No | ☐ Yes |

Who in your family uses alchohol or other substances?

Please list any history and treatment of behavioral health or substance use issues that your family members have had:

**Youth Health Risk Screening Questionnaire**

Have you been diagnosed with diabetes or asthma? ☐ No ☐ Yes

If yes, what medications are you taking for this?

Check the symptoms the youth experiences regularly:

☐ Headaches ☐ Dizziness ☐ Nausea/Vomiting ☐ Persistent cough or wheezing
☐ Extreme Fatigue ☐ Blurry Vision ☐ Over/Under Weight ☐ Other:

| | | |
|---|---|---|
| Does the youth eat a poor diet? | ☐ No | ☐ Yes |
| Is the youth sedentary or minimally active? | ☐ No | ☐ Yes |
| Is the youth up to date on immunizations? | ☐ No | ☐ Yes |
| Does the youth use tobacco or are they exposed to second hand smoke? | ☐ No | ☐ Yes |

If yes, what and how often?

☐ Vape ☐ Cigarettes ☐ Chew ☐ Other:
☐ Daily ☐ Weekly ☐ Occasionally ☐ Other:

**Health History (Please include all medical, dental, and behavioral health history)**

| | | | | | |
|---|---|---|---|---|---|
| ☐ PCP on file | Date of last Physical Visit | | Current health issues | | |
| | Any Allergies? | ☐ No ☐ Yes | Please Specify | | |
| ☐ Dentist on file | Date of last Dental Visit | | Current oral issues | | |
| ☐ Other: | Date of last Visit | | Other health issues | | |
| ☐ Other: | Date of last Visit | | Other health issues | | |

**Untreated physical and/or behavioral needs can impact overall health and negatively impact progress toward Goals.**

**A PCP appointment is recommended for further evaluation.**

| | | |
|---|---|---|
| Would you like help with the above or other physical health needs? | ☐ No | ☐ Yes |

Return to Intake Checklist

# Transportation Authorization and Release of Liability

I , _____ (name of parent or legal guardian). Herein referred to as Legal Guardian, residing at _____ (address) hereby affirm that I am the parent or legal guardian of _____ (full name of minor), whose AHCCCS ID is _____ and date of birth is _____, herein referred to as Minor.

Minor is _____ (age) years old. Upon completion and signing of this form, I hereby provide my limited consent for Minor to be transported for the purpose of _____ (include purpose of transportation), herein referred to as Purpose. The Minor may be transported for this Purpose from _____ (start date of authorization) to _____ (end date of authorization; cannot be more than 3 months after the start date of the authorization).

Minor will be transported without the presence of their Legal Guardian.

By providing this authorization and release of liability, I represent that Minor is capable of being transported without the presence of their Legal Guardian and will comply with all safety rules and regulations communicated by the driver. I understand if Minor does not follow the rules, the Minor may no longer be transported without a Legal Guardian. I agree to ensure that Minor will be ready for their pickup for their trip and will be able to get themselves to the specific pickup location at the scheduled time.

**I agree to inform the AHCCCS enrolled provider within 48 hours if for any reason I cease being the Legal Guardian of Minor and agree to provide the name and contact information for the newly designated Legal Guardian. I agree to inform the AHCCCS enrolled provider immediately in the event that I no longer consent to Minor receiving non-emergency transportation for medical necessary services. I agree to provide an updated signed Transportation Authorization and Release of Liability form 3 months after the date of signature below to continue the authorization for the Purpose outlined above. I may ask at any time, in writing, that this authorization be canceled.**

Upon execution of this authorization and release for transportation of a Minor, I hereby release AHCCCS and the AHCCCS contracted health plan, its employees, officers, agents, and subcontractors from any and all liability, causes of action, or claims in connection with the transportation.

If any of the above information should change, the Legal Guardian is responsible for providing an updated Authorization and Release of Liability Form.

_____ _____
Signature of Legal Guaridan Date

_____ _____
Printed Name of Legal Guadian Date