



Seven Counties Services

EPSDT Enrollment Packet Instructions

Please find following detailed instructions on how to complete the EPSDT Enrollment Packet. There are just a few simple forms, but completion is very important in order to continue with pursuing EPSDT services for your child.

- **Client Information Sheet**
 - Complete all information.
- **DSD Consent Form**
 - The Developmental Services Division of Seven Counties Services, Inc. requires consent prior to providing any kind of services to your child. Please fill out all areas indicated and sign and date.
 - Check the box for *Related Support Services*.
 - Fill in at least one emergency contact for your child's medical record
 - Initial regarding the grievance procedure
 - Sign at the Parent/Guardian line
 - At the very bottom, there is a section for Acknowledgement of Receipt of Notice. This is for you to sign that you have received a copy of the SCS Notice of Privacy Practices, which is attached.
- **SCS Notice of Privacy Practices**
 - Keep this form for your records.
- **Bill of Rights**
 - Keep this form for your records.
- **Grievance Procedure**
 - Sign one and Keep one of this form for your records.
- **Billing Verification Form**
 - Fill out all applicable areas and sign and date the bottom.
- **Freedom of Choice for EPSDT Service Providers**
 - Please contact your preferred service providers for your child. Once you have established which agencies you would like to use, indicate them in order of preference.
- **Therapy Providers with Seven Counties Services, Inc.**
 - This is a reference form for your records.
- **State Reporting Form**
 - Fill in client name, complete both pages of form and sign.
- **Physician Information**
 - Please fill out the areas highlighted in yellow only as completely as possible so that we may obtain orders necessary for EPSDT enrollment.
- **Email Release**
 - Indicate your email preference (or write N/A if not any) and sign at bottom
- **PCP Authorization to Disclose**
 - This gives us permission to communicate with your child's PCP to obtain script for therapy and needed records for the medical record at Centerstone. Please sign at the bottom.

Return all completed forms to the facility that provided it to you.

Incomplete packets will delay services until all original forms have been completed AND returned.

We look forward to working for you and your child!

Sincerely,

EPSDT Department

CLIENT INFORMATION SHEET

Date _____

Client Information

Last Name _____		First Name _____		Middle Name _____	
Social Security Number _____		Date of Birth ____ / ____ / ____		Sex <u>M / F</u>	
Street Address _____		Bldg #: _____		Apt #: _____	
City _____		State _____		Zip _____ County _____	
Home Phone _____		Cell Phone _____		May we leave voice mail? Please circle: <u>Home</u> <u>Cell</u>	

Client Marital Status: Single Married Divorced Widowed Cohabiting Separated

Client Employment Status: Full Time Part Time Laid Off Looking for Work Retired In Armed Forces Homemaker
 Student Pre-School/Child Disabled Resident of Institution

Client's highest grade level completed: Preschool Kindergarten Grade: _____ College: _____

Name of school currently attending: _____

Is there current involvement with the Department of Social Services? Yes / No

If yes, worker's name: _____ **Worker's Phone Number:** _____

Primary Source of Income for Client and Family in household (Complete all that apply)

*Please indicate combined gross amount (before taxes) per month where applicable for all incomes in household

<input type="checkbox"/> Wages/Salary	\$ _____	<input type="checkbox"/> Retirement/Pension	\$ _____
<input type="checkbox"/> Disability	\$ _____	<input type="checkbox"/> Other Sources	\$ _____
<input type="checkbox"/> Public Assistance	\$ _____	<input type="checkbox"/> None	

TOTAL GROSS ANNUAL HOUSEHOLD INCOME: \$ _____ **# OF PERSONS IN HOME:** _____

Responsible Party #1:	
Name: _____	
Relationship to client: _____	
Address (if different from client): _____	
Home #:	_____ May we leave voice mail? Yes / No
Cell #:	_____ May we leave voice mail? Yes / No
Work #:	_____ May we leave voice mail? Yes / No

Responsible Party #2:	
Name: _____	
Relationship to client: _____	
Address (if different from client): _____	
Home #:	_____ May we leave voice mail? Yes / No
Cell #:	_____ May we leave voice mail? Yes / No
Work #:	_____ May we leave voice mail? Yes / No

Private Insurance Information (if applicable) ** A copy of front and back of private insurance card must accompany this form.

Policyholder's Name: _____	Policyholder Date of Birth: _____
Policyholder's SSN: _____	Policyholder Sex: <u>M / F</u>
Policyholder's relationship to client: _____	Policyholder's Employer: _____
Insurance Company Name: _____	Insurance ID Number: _____
Group Number: _____	Plan Number: _____

Medicaid Insurance Information (For All Clients)

Medicaid ID Number: _____

CONSENT FORM

I authorize Seven Counties Services to provide treatment to and/or obtain services for:

(Client name)

I understand that to promote quality of services, a team that may include a psychiatrist, psychologist, social worker, qualified mental health professional and/or qualified ID professional may review my treatment plan/service plan.

I further understand services may be stopped if I fail to follow the treatment recommendations or if I fail to pay for the services I receive.

If requested and applicable, I agree to provide written proof of the custody status of my child receiving treatment services.

I acknowledge Federal and State laws require the release of certain information in certain circumstances, including suspected child abuse, suspected adult abuse, and duty to warn of a threat of violence.

I acknowledge I have received and reviewed a copy of the Client Bill of Rights.

Client initials

Signatures:

Client or Parent / Guardian

Date

Witness/Staff

Date

Acknowledgement of Receipt of Notice

I have received a copy of the Seven Counties Services Notice of Privacy Practices.

Client Parent/Guardian Signature

Failure to obtain acknowledgment: Refusal to sign Other _____

CLIENT BILL OF RIGHTS

It is the policy of Seven Counties Services that all individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. These services will be directed toward health and habilitation, and will be provided in the least restrictive, community-based setting possible.

As an individual receiving services you have the following rights:

1. To be treated with consideration and respect for human dignity.
2. To receive quality treatment within our capabilities regardless of race, religion, sex, age, ethnic background mental and/or physical disabling condition, or ability to pay.
3. To be provided confidentiality and protection from any unwarranted disclosure regarding your treatment.
4. To receive information and services in a manner that you can understand and are respectful of cultural, spiritual and personal preferences.
5. To be involved in planning your treatment and to be informed about your treatment process.
6. To be provided information about emergency and crisis resources.
7. To be involved in your discharge and aftercare planning.
8. To be informed verbally and/or in writing about the benefits, risks and side effects of medication prescribed for you.
9. To refuse treatment to the extent permitted by the law and to be informed about the possible consequences of your action.
10. To expect continuity of care from one service to another, should you need another service.
11. To examine and receive an explanation about the bill for your services.
12. To review your record with your counselor or case manager and to receive a copy of your medical record to the extent permitted by law.
13. To request a different person to provide your services.
14. To request the opinion of a consultant at your own expense.
15. To bring an advocate to a grievance meeting.
16. To submit suggestions, recommendations and grievances regarding any aspect of your care at Seven Counties Services. To use the grievance procedure, call the **Ombudsman Line: 502-587-8240, Monday through Friday, 9:00 a.m. to 9:00 p.m.**, if you believe any of your rights have been violated.
17. To contact the Joint Commission with complaints. The Joint Commission is the national accrediting organization that sets standards of care that Seven Counties Services is committed to meeting. You may e-mail your complaint to complaint@jointcommission.org or call toll free 9:30 a.m. to 6:00 p.m. weekdays at 800-994-6610.

I have read these Bill of Rights above and received answers to any of my questions. My signature below indicates that I have received a copy of the Consent and Bill of Rights.

Client Signature

Date

CLIENT BILL OF RIGHTS

It is the policy of Seven Counties Services that all individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. These services will be directed toward health and habilitation, and will be provided in the least restrictive, community-based setting possible.

As an individual receiving services you have the following rights:

1. To be treated with consideration and respect for human dignity.
2. To receive quality treatment within our capabilities regardless of race, religion, sex, age, ethnic background mental and/or physical disabling condition, or ability to pay.
3. To be provided confidentiality and protection from any unwarranted disclosure regarding your treatment.
4. To receive information and services in a manner that you can understand and are respectful of cultural, spiritual and personal preferences.
5. To be involved in planning your treatment and to be informed about your treatment process.
6. To be provided information about emergency and crisis resources.
7. To be involved in your discharge and aftercare planning.
8. To be informed verbally and/or in writing about the benefits, risks and side effects of medication prescribed for you.
9. To refuse treatment to the extent permitted by the law and to be informed about the possible consequences of your action.
10. To expect continuity of care from one service to another, should you need another service.
11. To examine and receive an explanation about the bill for your services.
12. To review your record with your counselor or case manager and to receive a copy of your medical record to the extent permitted by law.
13. To request a different person to provide your services.
14. To request the opinion of a consultant at your own expense.
15. To bring an advocate to a grievance meeting.
16. To submit suggestions, recommendations and grievances regarding any aspect of your care at Seven Counties Services. To use the grievance procedure, call the **Ombudsman Line: 502-587-8240, Monday through Friday, 9:00 a.m. to 9:00 p.m.**, if you believe any of your rights have been violated.
17. To contact the Joint Commission with complaints. The Joint Commission is the national accrediting organization that sets standards of care that Seven Counties Services is committed to meeting. You may e-mail your complaint to complaint@jointcommission.org or call toll free 9:30 a.m. to 6:00 p.m. weekdays at 800-994-6610.

I have read these Bill of Rights above and received answers to any of my questions. My signature below indicates that I have received a copy of the Consent and Bill of Rights.

Client Signature

Date

Notice of Privacy Practices

PLEASE REVIEW IT CAREFULLY.

This notice describes how medical and behavioral health information about you may be used and disclosed and how you can get access to this information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

-
- | | |
|--|---|
| Get an electronic or paper copy of your medical record. | <ul style="list-style-type: none"> • You can ask to see or get an electronic or paper copy of your health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. In Kentucky, you are entitled to one free copy of your medical record. We may charge a reasonable, cost-based fee for second copies of your record. |
|--|---|
-
- | | |
|---|--|
| Ask us to correct your medical record. | <ul style="list-style-type: none"> • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days. |
|---|--|
-
- | | |
|--|--|
| Request confidential communications | <ul style="list-style-type: none"> • You can ask us to contact you in a specific way (for example, at home or office by phone) or to send mail to a different address. • We will say “yes” to all reasonable requests. |
|--|--|
-
- | | |
|---|--|
| Ask us to limit what we use or share | <ul style="list-style-type: none"> • You can ask us not to use or share certain health information for treatment, payment, or our operations. <ul style="list-style-type: none"> • We are not required to agree to your request, and we may say “no” if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. <ul style="list-style-type: none"> • We will say “yes” unless a law requires us to share that information. |
|---|--|
-
- | | |
|---|---|
| Get a list of those with whom we’ve shared information | <ul style="list-style-type: none"> • You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
|---|---|
-
- | | |
|--|--|
| Get a copy of this privacy notice | <ul style="list-style-type: none"> • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
|--|--|

YOUR RIGHTS continued

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on this page.
- You can file a complaint with the U. S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/orc/privacy/hipaa/complaints/.
- You can file a complaint on the Ombudsman line at 502-587-8240.
- You can file a complaint with the Privacy Officer at 502-589-8600.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to

- Share information with your family, close friends, or others involved in your care.
We will ask you to sign an authorization to release form to these people.
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.
- Seven Counties does not create or maintain a facility directory.

In these cases we never share your information unless you give us written permission

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES and DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways. We are not required to obtain your authorization to use your health information in these ways.

Treat You

- We can use your health information and share it with other professionals

Examples: Your health information will be shared among your

	<p>who are treating you.</p> <ul style="list-style-type: none"> We can use and disclose your health information about you to provide, coordinate or manage your care and related services. 	<p>treatment team. We will share your information with outside agencies performing services relating to your treatment, such as lab work, or to pharmacies to fill your prescriptions.</p>
Run our Organization	<ul style="list-style-type: none"> We can use and share your health information to run our practice, improve your care, and contact you when necessary. 	<p><i>Examples:</i> We use health information about you to manage your treatment and services. We will use your information to contact you to remind you that you have an appointment with us.</p>
Bill for your services	<ul style="list-style-type: none"> We can use and share your health information to bill and get payment from health plans or other entities. 	<p><i>Examples:</i> We give information about you to your health insurance plan so it will pay for your services.</p>

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	<p>We can share health information about you for certain situations such as:</p> <ul style="list-style-type: none"> Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone’s health or safety.
Do research	<p>We can use or share your information for health research.</p>
Comply with the law	<p>We may disclose health information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.</p>
Respond to lawsuits and legal actions	<p>We can share health information about you in response to a court order.</p>
Work with a medical examiner or funeral director	<p>We may share health information with a coroner, medical examiner, or funeral director when an individual dies.</p>
Respond to organ and tissue donation requests	<p>We may share health information about you with organ procurement organizations.</p>
Address workers’ compensation, law enforcement and other government requests	<p>We may use or share health information about you:</p> <ul style="list-style-type: none"> For workers’ compensation claims For specific law enforcement purposes or to a correctional institution if you are an inmate With health oversight agencies for activities authorized by law For special government functions such as military, national security and presidential protective services.

CONFIDENTIALITY OF SUBSTANCE ABUSE RECORDS

Seven Counties Services offers programs for substance use disorder treatment. We are required to comply with federal regulations (42 CFR, Part 2) that place strict limitations on how drug or alcohol treatment information may be used or disclosed. For these

programs, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

- You authorize the disclosure in writing
- The disclosure is permitted by a court order
- The disclosure is made to medical personnel in a medical emergency
- The disclosure is to a qualified personnel for research, audit or program evaluation purposes
- A situation exists that requires a mandatory report be made to the proper authorities, to report suspected child abuse or neglect or threats to commit a crime on the premises against another person
- Communication is between a program or an entity having administrative control over the program
- An agreement with a Qualified Service Organization exist that authorized the Part 2 health information to be shared

Suspected violations may be reported to the United States Attorney in the district where the violation occurs. For more information see: Title 42 of the Code of Federal Regulations (C.F.R.), Part 2 – regulations governing confidentiality of alcohol and drug abuse patient records or the Seven Counties Services Privacy Officer.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site at www.sevencounties.org

This notice of Privacy Practices applies to the following organization:

Seven Counties Services, 10101 Linn Station Rd., Ste. 600, Louisville, KY 40223

www.Sevencounties.org

Privacy Officer contact information: phone 502-589-8600

Effective Date of Notice: 10-2013

revised 1-2-20

RE: _____
Individual Receiving Waiver Services

ADDENDUM TO THE SEVEN COUNTIES SERVICES
GRIEVANCE PROCEDURE

SPECIFIC TO WAIVER RECIPIENTS

Grievance Procedure

Program Level:	Request a meeting to discuss the grievance with case manager or service staff. If resolution is not possible, request in writing a meeting with program supervisor to problem solve and resolve grievance.
DS Human Rights:	If issue resolution is not attained, one can request in writing a hearing before the Human Committee: Rights Committee
Ombudsman:	Call the Seven Counties Services Ombudsman, which will bring the issue to the attention of the Chief Executive Officer. If necessary, the CEO can channel the concerns for policy decision to the Board of Directors.

In addition to the Seven Counties Services Grievance procedure, the following organizations may be contacted to assist in the resolution of issues/concerns related to those receiving services from Seven Counties Services waiver programs:

- Protection and Advocacy (P & A): 1-800-372-2988
- The Arc of Kentucky: 1-800-281-1272
- Adult Protective Services (Jefferson Co): (502) 595-4803
- Child Protective Services (Jefferson Co): (502) 595-4550
- APS & CPS: Bullitt, Henry, Shelby, Spencer, Trimble & Oldham Counties: 1-888-403-5090
- Department for Medicaid Services: (502) 564-5560
- Legal Aid: (502) 584-1254

Signature of Client or Legal Guardian (as applicable)

Date

RE: _____
 Individual Receiving Waiver Services

ADDENDUM TO THE SEVEN COUNTIES SERVICES
 GRIEVANCE PROCEDURE

SPECIFIC TO WAIVER RECIPIENTS

Grievance Procedure

Program Level:	Request a meeting to discuss the grievance with case manager or service staff. If resolution is not possible, request in writing a meeting with program supervisor to problem solve and resolve grievance.
DS Human Rights:	If issue resolution is not attained, one can request in writing a hearing before the Human Committee: Rights Committee
Ombudsman:	Call the Seven Counties Services Ombudsman, which will bring the issue to the attention of the Chief Executive Officer. If necessary, the CEO can channel the concerns for policy decision to the Board of Directors.

In addition to the Seven Counties Services Grievance procedure, the following organizations may be contacted to assist in the resolution of issues/concerns related to those receiving services from Seven Counties Services waiver programs:

- Protection and Advocacy (P & A): 1-800-372-2988
- The Arc of Kentucky: 1-800-281-1272
- Adult Protective Services (Jefferson Co): (502) 595-4803
- Child Protective Services (Jefferson Co): (502) 595-4550
- APS & CPS: Bullitt, Henry, Shelby, Spencer, Trimble & Oldham Counties: 1-888-403-5090
- Department for Medicaid Services: (502) 564-5560
- Legal Aid: (502) 584-1254

 Signature of Client or Legal Guardian (as applicable)

 Date

BILLING NOTIFICATION

Client Name: _____ **Client ID#:** _____

SELF PAY (State Subsidized Funding)

(Attach proof of Income to this form). Annual Household Income _____

CERTIFICATION OF FISCAL INFORMATION/FINANCIAL RESPONSIBILITY

I certify that my fiscal information has been declared accurately and completely, and hereby give Seven Counties Services, Inc. permission to verify the stated income. Further, I agree to pay the account in accordance with the stated fees.

Self-Pay Fee Schedule (based on annual household income)

_____	_____	_____	_____	_____
Eval/Individual/Family	Group	MD/ARNP Initial Eval Or Psychotherapy	MD/ARNP Med Check Or RN Illness Mgt	*RS _____

MEDICAID OR KCHIP

I understand that I am financially responsible for all services not covered by Medicaid. I agree to inform Seven Counties Services, Inc. immediately upon loss of Medicaid eligibility. I understand that I am financially responsible for any service received after loss of Medicaid eligibility. *RS _____

INSURANCE and MEDICARE WAIVER AND ASSIGNMENT OF PAYMENT

I hereby authorize Seven Counties Services, Inc. to contact my employer and/or insurance provider to confirm eligibility and benefits payable under the policy. I also authorize Seven Counties Services, Inc. to release medical records it maintains, if my insurance provider or Medicare requests such information. I hereby assign payment directly to Seven Counties Services, Inc. for any insurance or Medicare benefits otherwise payable to me but not to exceed Seven Counties Services, Inc. regular charges. **I understand that I am financially responsible for my co-payments and insurance and/or Medicare deductible amounts and all charges not covered by the insurance carrier or Medicare. I further agree that should I receive an insurance or Medicare check for my services at Seven Counties Services, Inc., I will immediately sign it over to Seven Counties Services, Inc.**

INSURANCE or MEDICARE COPAYMENT:

_____	_____	_____	_____
Eval/Individual/Family	Group	MD/ARNP Initial Eval Or Psychotherapy	MD/ARNP Med Check Or RN Illness Mgt

INSURANCE or MEDICARE DEDUCTIBLE: _____ *RS _____

*RS - Rate Schedule

PAYMENT DUE: I understand that all fees are due and payable at the time of service.

MISSED APPOINTMENTS: I agree to notify Seven Counties Services, Inc., 24 hours in advance to cancel an appointment.

Signature of Client, Parent or Legal Guardian

Date

Signature of Seven Counties Services Staff

Date

Client Name / ID Number _____

Request for Electronic Communications – Email and/or Text messaging

As a client of Seven Counties Services you have the right to request we communicate with you by electronic mail (email) or text messaging.

I understand that by signing this form, I am agreeing to be contacted by Seven Counties Services employees by text messaging and/or email, as indicated below.

I will not expect Seven Counties Services to pay any of my text messaging/email charges or fees.

Text Messaging – Text messaging is limited to the permitted purposes indicated in the box below.

PERMITTED PURPOSE(S) OF TEXT MESSAGING:				
1. Appointment Reminders	_____	Yes	_____	No
2. Appointment Confirmation	_____	Yes	_____	No
3. Medication Reminders	_____	Yes	_____	No

Mark "yes" or "no" for each texting purpose.

Authorized Text Messaging number: (_____) _____ - _____

Email My current e-mail address _____

I understand that by signing this form I have read and/or understand the following:

- Seven Counties Services staff are only permitted to send me a text message for one of the reasons listed above.
- I will only text message or email Seven Counties Services staff during normal business hours when the employee is known to be on duty. I will use other methods to contact employees in any other circumstance.
- Text messaging and/or email will not be used to contact Seven Counties Services employees in case of an emergency because employees are not always able to respond quickly.
- Text messaging is always at risk of being read by others, and cannot be sent in a way so that others cannot read it while it is being sent.
- Deleting a text or email on my device does not mean it is permanently erased from the device or records kept by my provider.
- An e-mail message is not a private communication between me and my service provider.
- E-mail messages have inherent privacy risks; to avoid misaddressing an e-mail double check the fields prior to sending the e-mail to ensure the e-mail is addressed to the intended person.
- A telephone call or scheduled face-to-face discussion should be used when the content of an email is complex.
- Your e-mail message and any and all responses to it may become part of your legal health record and will be subject to be viewed by others on your treatment team and/or released for treatment, payment or healthcare operations per established procedures.
- Failure to follow these procedures will result in termination of texting/e-mail communications with Seven Counties Services staff.
- I may end this authorization at any time by signing a Withdrawal of Agreement for Electronic Communication. After withdrawing my authorization, a new form must be signed to make changes in the permitted purpose, text number or email address.

I have read the information regarding text messaging and/or e-mail above and have been given the opportunity to ask questions.. I authorize Seven Counties Services to communicate with me by text messaging and/or e-mail, as indicated above, regarding the client named above.

Signature _____ Date _____

Witness _____ Date _____

Consent to Transport, Emergency Medical Attention, & Photograph

Participant Name: _____

ID# _____

CONSENT TO TRANSPORT

I give permission for an employee/volunteer/agent of Seven Counties Services, Inc. to transport me/my child/ward in the employee's/volunteer's/agent's personal car or Seven Counties Services, Inc. vehicle on trips.

I **DO NOT** give permission for an employee/volunteer/agent of Seven Counties Services, Inc. to transport me/my child/ward in the employee's/volunteer's/agent's personal car or Seven Counties Services, Inc. vehicle on trips.

CONSENT FOR EMERGENCY MEDICAL ATTENTION

I give my consent for an employee/volunteer/agent of Seven Counties Services, Inc. to obtain medical attention for me/my child/ward if this becomes necessary while under his/her supervision and, under these circumstances, I agree to assume financial responsibility for any medical treatment rendered. I understand that in the event of an emergency illness or injury, the family will be notified as soon as possible. I release Seven Counties Services, Inc. and its agents and employees from any liability arising from or connected with the activities to which this consent relates.

I **DO NOT** give my consent for an employee/volunteer/agent of Seven Counties Services, Inc. to obtain medical attention for me/my child/ward if this becomes necessary while under his/her supervision and, under these circumstances, I agree to assume financial responsibility for any medical treatment rendered. I understand that in the event of an emergency illness or injury, the family will be notified as soon as possible. I release Seven Counties Services Inc. and its agents and employees from any liability arising from or connected with the activities to which this consent relates.

CONSENT TO PHOTOGRAPH

I give my permission for Seven Counties Services, Inc. to photograph me/my child/ward for identification purposes. I understand that the photograph will be kept with other identifying information and used for treatment purposes.

I **DO NOT** give my permission for Seven Counties Services, Inc. to photograph me/my child/ward for identification purposes. I understand that the photograph will be kept with other identifying information and used for treatment purposes.

Participant/Guardian Signature

Date

Witness/Staff

Date



EPSDT Provider List

Agency	Phone Number	Occupational Therapy	Physical Therapy	Speech Therapy
Children's Therapy Center 13010 Eastgate Parkway, Suite 101 Louisville, KY 40223 (Off English Station Road near Academy Sports)	502.244.1210	✓		✓
Green Hill Therapy 1410 Long Run Road, 40245 (Shelbyville past Valhalla, towards Simpsonville)	502.244.8011	✓ Hippo therapy	✓ Hippo therapy Aqua therapy	
Independence at Heart (Kerrie Johnson)	502.387.4254	✓ Offers In-Home		
Spalding en-Tech 845 South 3 rd Street, 40203 (Downtown between Breckinridge & Kentucky)	502.585.9911	✓		✓
TheraPLACE Learning Center 4121 Shelbyville Road, 40207 (off Thierman Lane, close to Trinity High School)	502.653.9657	✓ Aqua therapy	✓ Aqua therapy	✓
Upside Therapeutics Facility in Fisherville, but Community Based options are available	502.494.5732	✓ In-Community Hippo therapy		



Seven Counties Services

3717 Taylorsville Road
Louisville, KY 40220
Office: (502) 459-5292 Ext. 7190
Fax: (502) 287.0647

EPSDT Freedom of Choice
Service Provider List

Client Name: _____ **SCS ID#:** _____

The EPSDT program offers people freedom to choose from any and all service providers available. Attached is a list of the providers in our region that have elected to provide EPSDT services. Please indicate below the providers of your choice according to preference for each discipline. Prior to completing this form, please ensure you have communicated with your chosen provider that an EPSDT spot has been confirmed in the desired therapy discipline. Also keep in mind that there is always the possibility that your child may have to utilize more than one provider.

Discipline Requested

Provider Choices

Occupational Therapy	1 st Choice: _____
	2 nd Choice: _____
	3 rd Choice: _____
Physical Therapy	1 st Choice: _____
	2 nd Choice: _____
	3 rd Choice: _____
Speech Therapy	1 st Choice: _____
	2 nd Choice: _____
	3 rd Choice: _____

Parent/Guardian Signature

Date

STATE REPORTING FORM

Client Name _____	ID Number _____	Client Review Date _____
<p>SSI or SSDI</p> <p><input type="radio"/> No Receives None</p> <p><input type="radio"/> Yes, SSI Only</p> <p><input type="radio"/> Yes, SSDI Only</p> <p><input type="radio"/> Yes, Both SSI and SSDI</p> <p><input type="radio"/> Yes, TANF Only</p> <p><input type="radio"/> Yes, TANF and SSDI</p> <p>DCBS Involvement</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>State Guardianship</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>School Attendance Status</p> <p><input type="radio"/> No</p> <p><input type="radio"/> No, School/College on Break</p> <p><input type="radio"/> Yes, Public/Private/Home/Cotlege</p> <p><input type="radio"/> Yes, Special Education</p> <p>Living Arrangements</p> <p><input type="radio"/> Alcohol/Drug treatment facility</p> <p><input type="radio"/> Boarding home</p> <p><input type="radio"/> Family care home</p> <p><input type="radio"/> Foster care</p> <p><input type="radio"/> Homeless /uninhabitable dwelling</p> <p><input type="radio"/> Hotel/motel</p> <p><input type="radio"/> ICF/MR Private facility</p> <p><input type="radio"/> ICF/MR State facility</p> <p><input type="radio"/> Jail /prison - federal</p> <p><input type="radio"/> Jail / prison - local or state</p> <p><input type="radio"/> Living in own residence with parent/guardian</p> <p><input type="radio"/> Living in own residence</p> <p><input type="radio"/> Living in residence of a family member - other than parent/guardian</p> <p><input type="radio"/> Living with friend or acquaintance</p> <p><input type="radio"/> Mission/shelter</p> <p><input type="radio"/> Personal care home</p> <p><input type="radio"/> SNF/ nursing home</p> <p><input type="radio"/> Staffed residence</p> <p>Primary Language _____</p> <p>English Ability</p> <p><input type="radio"/> Not applicable becasue English is primary language</p> <p><input type="radio"/> Not at all</p> <p><input type="radio"/> Not well/poorly</p> <p><input type="radio"/> Very Well (above average for age)</p> <p><input type="radio"/> Well (average for age)</p> <p>Homeless Indicator</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Race American Indian</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Race Asian</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Race Black</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Primary Income</p> <p><input type="radio"/> Wages/Salary/ Self Employed</p> <p><input type="radio"/> Public Assistance</p> <p><input type="radio"/> Retirement/Pension</p> <p><input type="radio"/> Disability</p> <p><input type="radio"/> Other Sources</p> <p><input type="radio"/> No Income/Support</p> <p>Military History</p> <p><input type="radio"/> No military service</p> <p><input type="radio"/> Active duty without deployment</p> <p><input type="radio"/> Active duty with deployment to a non-combat zone</p> <p><input type="radio"/> Active duty with deployment to a hostile or combatant zone</p> <p><input type="radio"/> Previous duty without deployment(veteran)</p> <p><input type="radio"/> Previous duty with deployment to a non-combat zone (veteran)</p> <p><input type="radio"/> Previous duty with deployment to a hostile / combatant zone (veteran)</p> <hr style="border-top: 1px dashed black;"/> <p>Severe Mental Illness (SMI or CMI)</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Severe Emotional Disability (SED)</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes (SED)</p> <p><input type="radio"/> Impact program client (SED)</p> <p>Developmental Disability (10 and older) / Developmental Delay</p> <p><input type="radio"/> Neither</p> <p><input type="radio"/> Developmental Delay (under age 10)</p> <p><input type="radio"/> Developmental Disabilities (between ages of 10 and 22)</p> <p>Deaf or Hard of Hearing</p> <p><input type="radio"/> No <input type="radio"/> Deaf</p> <p><input type="radio"/> Hard of Hearing <input type="radio"/> Deaf / Blind</p> <p>Head Injury</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Head Injury - Medical</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequency _____</p> <p>Victim of Rape/Sexual Assault/Sexual Abuse</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes, unknown whether seeking treatment</p> <p><input type="radio"/> Yes, not seeking treatment</p> <p><input type="radio"/> Yes, currently seeking treatment</p> <p>Victim of Domestic Abuse</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes, unknown whether seeking treatment</p> <p><input type="radio"/> Yes, not seeking treatment</p> <p><input type="radio"/> Yes, currently seeking treatment</p> <p>Perpertrator of Rape/Sexual Assault/Sexual Abuse</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes, unknown whether seeking treatment</p> <p><input type="radio"/> Yes, not seeking treatment</p> <p><input type="radio"/> Yes, currently seeking treatment</p> <p>Perpertrator of Domestic Abuse</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes, unknown whether seeking treatment</p> <p><input type="radio"/> Yes, not seeking treatment</p> <p><input type="radio"/> Yes, currently seeking treatment</p> <p>Arrests in Past 30 days _____</p>	

SUBSTANCE ABUSE SUMMARY (Complete when client has any SA Diagnosis code.)

Methadone

Yes No

IV Drug User

Yes No

DUI Conviction

Yes No

Attendance at Self Help Programs

Pregnant Women

Yes No

Pregnant Women - Due Date

Women with Dependant Children

Yes No

Drug Type Code, Primary at Admission

Frequency of Use - Primary (Admission)

- No use in past month
- 1-2 times in past month
- Daily
- 1-3 times in past month
- 3-6 times in past week

Route of Administration - Primary

- Oral
- Smoking
- Inhalation
- Injection

Age of First Use or Alcohol Intoxication - Primary

Drug Type Code, Secondary at Admission

Frequency of Use - Secondary (Admission)

- No use in past month
- 1-2 times in past month
- Daily
- 1-3 times in past month
- 3-6 times in past week

Route of Administration - Secondary

- Oral
- Smoking
- Inhalation
- Injection

Age of First Use or Alcohol Intoxication - Secondary

Drug Type Code, Tertiary at Admission

Frequency of Use - Tertiary (Admission)

- No use in past month
- 1-2 times in past month
- Daily
- 1-3 times in past month
- 3-6 times in past week

Route of Administration - Tertiary

- Oral
- Smoking
- Inhalation
- Injection

Age of First Use or Alcohol Intoxication - Tertiary

0201 - Alcohol
0301 - Crack
0302 - Other Cocaine
0401 - Marijuana/Hashish
0501 - Heroin/Morphine
0601 - Methadone (Dolophine)
0701 - Codeine
0702 - d-Propoxyphene (Darvon)
0703 - Oxycodone (Roxicodone; Supevdol, Percocet, Percodan, OxyContin)
0704 - Meperidine (Demerol, Peihadol)
0705 - Hydromorphone (Dilaudid)
0706 - Other Narcotic Analgesics (opium)
0707 - Pentazocine (Talwin)
0708 - Hydrocodone (Vicodin, Lertab, Lorcet)
0709 - Tramadol (Ultram)
0752 - Fentanyl (Duragesic)
0801 - PCP / PCP Combinations
0901 - LSD
0902 - Other Hallucinogens (DMT, STP)
1001 - Methamphetamine/Speed (Desoxyn)
1050 - Non-prescription Methamphetamine
1101 - Amphetamine (Dexedrine, Benzadrine)
1103 - Methylenedioxymethamphetamine (MDMA, Ecstasy)
1109 - Other Amphetamines

1201 - Other Stimulants
1202 - Methylphenidate (Ritalin)
1301 - Alprazolam/Bromazepam (Xanax, Lectopam)
1302 - Chlordiazepoxide (Librium, Libritabs, A-Poxide)
1303 - Clorazepate (Tranxene, Gen-xene)
1304 - Diazepam (Valium, T-Quil, Valdelease)
1305 - Flurazepam (Dalmane, Derapam)
1306 - Lorazepam (Ativan, Alzapam)
1307 - Triazolam (Halcion)
1308 - Other Benzodiazepine (Centrax, Doral)
1309 - Flunitrazepam (Rohypnol)
1310 - Clonazepam (Klonopin, Rivotril)
1401 - Meprobamate (Miltown; Equanil)
1403 - Other Tranquillizers
1450 - Soma
1501 - Phenobarbital (Solfoton, Barbita, Luminal)
1502 - Secobarbital/Amobarbital (Tuinal)
1503 - Secobarbital (Seconal)
1509 - Other Barbiturate Sedatives
1550 - Fiorinal
1601 - Ethelorsynol (Placidyl)
1602 - Glutethimide (Doriden)
1603 - Methaqualone (Quaalude)
1604 - Other Non-barbiturate Sedatives
1605 - Other Sedatives (Numbatal, Gemonil, Mebaral, Busodiam, Butalan, Butisol, Sarisol No. 2)

1651 - Ambien
1652 - Lunesta
1701 - Aerosols (Lysol, Pam, hair sprays)
1702 - Nitrates (Amyl Nitrate)
1703 - Other Inhalants (glue, paint, spray paint, plastic cement, shoe polish)
1704 - Solvents (acetone, ethers, toluene, gasoline, lighter fluid, paint thinner)
1705 - Anesthetics
1801 - Diphenhydramine (Benadryl)
1809 - Other Over-The-Counter
1850 - Steroids
1851 - Phenylephedrine (Pseudoephedrine)
2001 - Diphenylhydantoin Sodium
2002 - Other drugs
2003 - GHB/GBL (gamma-hydroxybutyrate, gamma-butyrolactone)
2004 - Ketamine (Special K)
2050 - Smoked Tobacco
2051 - Oral Tobacco
9997 - Unknown

Signature _____



Seven Counties Services

3717 Taylorsville Road
Louisville, KY 40220
Office: (502) 459-5292
Fax: (502) 287.0647

Therapy Services Physician Information Form

Patient Name: _____ Patient Date of Birth: _____

Physician Name: _____ License #: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____



3717 Taylorsville Road
Louisville, KY 40220
Office: (502) 459-5292 Ext. 7190
Fax: (502) 287.0647

State Required Annual Information Update

Client Name: _____

Client ID: _____

Total Gross Annual Household Income.: \$ _____

Number of persons living in home?: _____

Parent/Guardian Signature: _____

Date: _____

AGENCY VOTER REGISTRATION RIGHTS AND DECLINATION

(Applicant's Name)

(Applicant's Social Security No.)

REGISTERING TO VOTE:

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

YES	NO	NO, I AM ALREADY REGISTERED
<input type="checkbox"/>	<input type="checkbox"/>	

IF YOU DO NOT CHECK ONE OF THE BOXES ABOVE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applicant's Signature

Date

.....
VOTER REGISTRATION RIGHTS

If you register to vote or decline to register to vote, this decision and any information regarding the office to which the application was submitted remains confidential and is used only for voter registration purposes.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may complete the application form in private, if you desire.

If you complete a voter registration application form, it will be forwarded to your local county clerk, who will assign you a voting precinct. A confirmation notice with your precinct and voting location will be mailed to you by the county clerk. **IF YOU DO NOT RECEIVE SUCH NOTICE WITHIN FOUR (4) WEEKS, PLEASE CALL YOUR COUNTY CLERK.**

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 or other preference, you may file a complaint by writing or calling the State Board of Elections, 140 Walnut Street, Frankfort, KY 40601, phone 1-800-246-1399.

Please note that KRS 116.045(2) requires the clerk to close all registration 28 days prior to any election. If your application is received during this period, you will not be eligible to vote until the next election.

AUTHORIZATION TO DISCLOSE INFORMATION

1. I, Client Name: _____ Social Security Number: _____

Date Of Birth: _____ Health Record ID#: _____

authorize the use and disclosure of the listed individual's health information as described below. I understand that I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.

2. **a. Disclosures by Seven Counties Services**

PRIMARY CARE PHYSICIAN INFORMATION

FROM (List address of office)

 Developmental Services

 3717 Taylorsville Rd.

 Louisville, KY 40220-13668

 FAX: 502-452-9079 Phone: 502-459-5292

TO (Full name and address of individual or agency)

b. Disclosures to Seven Counties Services

TO (List address of office)

 Developmental Services

 3717 Taylorsville Rd.

 Louisville, KY 40220-13668

 FAX: 502-452-9079 Phone: 502-459-5292

FROM (Full name and address of individual or agency)

3. I understand that the purpose of this disclosure is for:

Use in future treatment

Other (specify) _____ Ongoing service provision

Please Call 502-459-5295 if there will be a charge for this information.

4. The type of information to be used or disclosed is as follows: (include dates where appropriate)

- | | | |
|---|---|---|
| <input type="checkbox"/> Comprehensive Assessment | <input type="checkbox"/> Medication History | <input type="checkbox"/> Alcohol and Other Drug Use, Abuse, and/or Treatment Information |
| <input type="checkbox"/> Risk/Crisis Assessment | <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV. |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress Notes | |
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Discharge Summary | |
| <input type="checkbox"/> Treatment Plan | <input checked="" type="checkbox"/> Other : _____ | Requested documentation, as specified – _____ |

5. Any person, insurer or third party who receives mental health or chemical dependency client information is prohibited by KRS 304.17A.555 from redisclosing that information without specific written consent of the patient. However, Seven Counties Services cannot prevent the redisclosure by the recipient, and the potential exists that information disclosed pursuant to this authorization will be redisclosed and no longer protected by HIPAA.

6. If the information being requested is from an alcohol or drug treatment case **42 C.F.R. Part 2, Confidentiality of Substance Use Disorder Patient Records** applies: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

7. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present my written revocation to the health information management personnel. I understand that the revocation will not apply to information that has already been released in response to this authorization or information disclosed for the purpose of receiving reimbursement from a third party payer.

8. Unless otherwise revoked, this authorization will be valid for the Duration of Treatment or upon the following event _____

 Client / Personal Representative Signature Date

Personal Rep's Authority Parent Spouse Adult Child
 Other _____

 Staff Witness / Verification Date

mail fax processed by _____ date _____

REVOCAION OF AUTHORIZATION My signature in this space indicates that I have revoked this authorization to disclose form, and from this date information may not be release to the entity listed above without my resigned authorization. **Signature** _____ **Date** _____