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

Seven Counties Services

CLIENT INFORMATION SHEET

Developmental Services Division
3717 Taylorsville Rd., Louisville, Ky 40220

Date _____

Client Information

Last Name _____ First Name _____ Middle Name _____

Social Security Number _____ Date of Birth ____/____/____ Sex M / F

Street Address _____ Bldg #: _____ Apt #: _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____ May we leave voice mail? Please circle: Home Cell

Client Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating ☐ 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

☐ Wages/Salary $ _____ ☐ Retirement/Pension $ _____

☐ Disability $ _____ ☐ Other Sources $ _____

☐ Public Assistance $ _____ ☐ 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: M / F

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

All individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. 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 receive individualized treatment, be involved in planning your treatment, to include family members or surrogate decision-makers in the planning 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 give or withhold your informed consent for services and participation in research.
9. To be informed verbally and/or in writing about the benefits, risks and side effects of medication prescribed for you.
10. To refuse treatment to the extent permitted by the law and to be informed about the possible consequences of your action.
11. To expect continuity of care from one service to another, should you need another service.
12. To examine and receive an explanation about the bill for your services.
13. To review your record with your counselor or case manager, to request an amendment to your record, to obtain information on disclosures of the information and to receive a copy of your record to the extent permitted by law.
14. To receive information about the staff responsible for your care, treatment or services and to request a different person to provide your services.
15. To request the opinion of a consultant at your own expense.
16. To bring an advocate to a grievance meeting.
17. You have the right to file a complaint about the care you have received. To file a grievance, you may contact:

Seven Counties Services, Inc/Bellewoood & Brooklawn (SCS/B&B) Ombudsman
10401 Linn Station Road, Ste. 100
Louisville, KY 40223
Phone: 502-587-8240
Email: ombudsmanSCS@sevencounties.org

Cabinet for Health and Family Services
Office of the Ombudsman and Administrative Review
275 East Main Street
Frankfort, KY 40621
Phone: 1-800-372-2973
Email: CHFS.Listens@ky.gov

Seven Counties Services Inc. is accredited by The Joint Commission. If you have an unresolved complaint about safety or the quality of care you have received, you may contact The Joint Commission by sending an email to complaint@jointcommission.org or by calling 1-800-994-6610.

If your services are in a residential facility:

- Clients are allowed to have personal clothing and possessions and to freely use common areas in the facility with due regard for privacy, personal possession, and the rights of others.
- Clients have the right to be accorded privacy and freedom for use of bathrooms at all hours
- Clients have the right to associate and communicate privately with persons of their choice. If the organization restricts visitors, mail, telephone calls or other forms of communication beyond the established program rules, those restrictions are determined with the participation of the individual served and with their legal guardian or representative, documented in the clinical/case record, and reduced or eliminated as soon as those restrictions are no longer therapeutically indicated.
- Clients rights to pastoral and other spiritual services are accommodated.
- Clients have the right to vote in a political election.

Client Signature: _____ Witness: _____ Date: _____

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All individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. 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 receive individualized treatment, be involved in planning your treatment, to include family members or surrogate decision-makers in the planning 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 give or withhold your informed consent for services and participation in research.
9. To be informed verbally and/or in writing about the benefits, risks and side effects of medication prescribed for you.
10. To refuse treatment to the extent permitted by the law and to be informed about the possible consequences of your action.
11. To expect continuity of care from one service to another, should you need another service.
12. To examine and receive an explanation about the bill for your services.
13. To review your record with your counselor or case manager, to request an amendment to your record, to obtain information on disclosures of the information and to receive a copy of your record to the extent permitted by law.
14. To receive information about the staff responsible for your care, treatment or services and to request a different person to provide your services.
15. To request the opinion of a consultant at your own expense.
16. To bring an advocate to a grievance meeting.
17. You have the right to file a complaint about the care you have received. To file a grievance, you may contact:

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Louisville, KY 40223
Phone: 502-587-8240
Email: ombudsmanSCS@sevencounties.org

Cabinet for Health and Family Services
Office of the Ombudsman and Administrative Review
275 East Main Street
Frankfort, KY 40621
Phone: 1-800-372-2973
Email: CHFS.Listens@ky.gov

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- Clients are allowed to have personal clothing and possessions and to freely use common areas in the facility with due regard for privacy, personal possession, and the rights of others.
- Clients have the right to be accorded privacy and freedom for use of bathrooms at all hours
- Clients have the right to associate and communicate privately with persons of their choice. If the organization restricts visitors, mail, telephone calls or other forms of communication beyond the established program rules, those restrictions are determined with the participation of the individual served and with their legal guardian or representative, documented in the clinical/case record, and reduced or eliminated as soon as those restrictions are no longer therapeutically indicated.
- Clients rights to pastoral and other spiritual services are accommodated.
- Clients have the right to vote in a political election.

Client Signature: _____ Witness: _____ Date: _____

Seven Counties Services

10101 Linn Station Rd.
Louisville, KY 40223
502-589-8600

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.	• 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.	• 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	• 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	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  ◦ 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.
	  ◦ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• 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	• 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 you 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

	who are treating you. • We can use and disclose your health information about you to provide, coordinate or manage your care and related services.	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.
Run our Organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Examples:* 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.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Examples:* We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share you 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	We can share health information about you for certain situations such as: • 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	We can use or share your information for health research.
Comply with the law	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.
Respond to lawsuits and legal actions	We can share health information about you in response to a court order.
Work with a medical examiner or funeral director	We may share health information with a coroner, medical examiner, or funeral director when an individual dies.
Respond to organ and tissue donation requests	We may share health information about you with organ procurement organizations.
Address workers' compensation, law enforcement and other government requests	We may use or share health information about you: • 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 changes 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

CLIENT COPY

RE: _____
Individual Receiving Waiver Services

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- 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**

CENTERSTONE
FORMERLY SEVEN COUNTIES SERVICES

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 812 South 2nd Street, 40203 (Downtown between Breckinridge & Kentucky)	502.992.2448	✓	✓	✓
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	1st Choice:	_____
	2nd Choice:	_____
	3rd Choice:	_____
Physical Therapy	1st Choice:	_____
	2nd Choice:	_____
	3rd Choice:	_____
Speech Therapy	1st Choice:	_____
	2nd Choice:	_____
	3rd Choice:	_____

_____ _____

Parent/Guardian Signature Date

STATE REPORTING FORM

Client Name _____ ID Number _____ Client Review Date _____

SSI or SSDI
- ○ No Receives None
- ○ Yes, SSI Only
- ○ Yes, SSDI Only
- ○ Yes, Both SSI and SSDI
- ○ Yes, TANF Only
- ○ Yes, TANF and SSDI

Primary Income
- ○ Wages/Salary/ Self Employed
- ○ Public Assistance
- ○ Retirement/Pension
- ○ Disability
- ○ Other Sources
- ○ No Income/Support

DCBS Involvement
○ Yes ○ No

State Guardianship
○ Yes ○ No

School Attendance Status
- ○ No
- ○ No, School/College on Break
- ○ Yes, Public/Private/Home/College
- ○ Yes, Special Education

Living Arrangements
- ○ Alcohol/Drug treatment facility
- ○ Boarding home
- ○ Family care home
- ○ Foster care
- ○ Homeless /uninhabitable dwelling
- ○ Hotel/motel
- ○ ICF/MR Private facility
- ○ ICF/MR State facility
- ○ Jail /prison - federal
- ○ Jail / prison - local or state
- ○ Living in own residence with parent/guardian
- ○ Living in own residence
- ○ Living in residence of a family member - other than parent/guardian
- ○ Living with friend or acquaintance
- ○ Mission/shelter
- ○ Personal care home
- ○ SNF/ nursing home
- ○ Staffed residence

Primary Language _____

English Ability
- ○ Not applicable becasue English is primary language
- ○ Not at all
- ○ Not well/poorly
- ○ Very Well (above average for age)
- ○ Well (average for age)

Homeless Indicator
○ Yes ○ No

Race American Indian
○ Yes ○ No

Race Asian
○ Yes ○ No

Race Black
○ Yes ○ No

Race Pacific
○ Yes ○ No

Race White
○ Yes ○ No

Military History
- ○ No military service
- ○ Active duty without deployment
- ○ Active duty with deployment to a non-combat zone
- ○ Active duty with deployment to a hostile or combatant zone
- ○ Previous duty without deployment(veteran)
- ○ Previous duty with deployment to a non-combat zone (veteran)
- ○ Previous duty with deployment to a hostile / combatant zone (veteran)

Severe Mental Illness (SMI or CMI)
○ Yes ○ No

Severe Emotional Disability (SED)
- ○ No
- ○ Yes (SED)
- ○ Impact program client (SED)

Developmental Disability (10 and older) / Developmental Delay
- ○ Neither
- ○ Developmental Delay (under age 10)
- ○ Developmental Disabilities (between ages of 10 and 22)

Deaf or Hard of Hearing
- ○ No
- ○ Hard of Hearing
- ○ Deaf
- ○ Deaf / Blind

Head Injury
○ Yes ○ No

Head Injury - Medical
○ Yes ○ No

Frequency _____

Victim of Rape/Sexual Assault/Sexual Abuse
- ○ No
- ○ Yes, unknown whether seeking treatment
- ○ Yes, not seeking treatment
- ○ Yes, currently seeking treatment

Victim of Domestic Abuse
- ○ No
- ○ Yes, unknown whether seeking treatment
- ○ Yes, not seeking treatment
- ○ Yes, currently seeking treatment

Perpertrator of Rape/Sexual Assault/Sexual Abuse
- ○ No
- ○ Yes, unknown whether seeking treatment
- ○ Yes, not seeking treatment
- ○ Yes, currently seeking treatment

Perpertrator of Domestic Abuse
- ○ No
- ○ Yes, unknown whether seeking treatment
- ○ Yes, not seeking treatment
- ○ Yes, currently seeking treatment

Arrests in Past 30 days _____

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 Womem - 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, Pethadol)
0705 - Hydromorphone (Dilaudid)
0706 - Other Narcotic Analgesics (opium)
0707 - Pentazocine (Talwin)
0708 - Hydrocodone (Vicodin, Lortab, 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, Valrelease)
1305 - Flurazepam (Dalmane, Dorapam)
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 Tranquilizers
1450 - Soma
1501 - Phenobarbital (Solfoton, Barbita, Luminal)
1502 - Secobarbital/Amobarbital (Tuinal)
1503 - Secobarbital (Seconal)
1509 - Other Barbiturate Sedatives
1550 - Fiorinal
1601 - Ethclorvynol (Placidyl)
1602 - Glutethimide (Doriden)
1603 - Methaqualone (Quaalude)
1604 - Other Non-barbiturate Sedatives
1605 - Other Sedatives (Numbutal, Gemonil, Mebaral, Busodium, 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 - Steriods
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

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Therapy Services
Physician Information Form

Patient Name: _____ Patient Date of Birth: _____

Physician Name: _____ License #: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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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
☐	☐	

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)

☐ Comprehensive Assessment
☐ Risk/Crisis Assessment
☐ Psychiatric Evaluation
☐ Laboratory Tests
☐ Treatment Plan
☐ Medication History
☐ Treatment Progress
☐ Progress Notes
☐ Discharge Summary
☑ Other : Requested documentation, as specified –
☐ Alcohol and Other Drug Use, Abuse, and/or Treatment Information
☐ Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV.

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* _____

REVOCATION 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** _____