COLLABORATIVE HELPING MAP

FAMILY VISION

Where would you like your family to be headed in your lives?

1. Describe vividly the kind of family you want to live in – what does it look like / sound like / feel like?
2. Think of a happy time in your life and describe it to me.
3. Ask the miracle question: "If you woke up one morning and overnight everything would have miraculously turned perfect, what would life in your family be like?"
4. Prompts to address family functioning: "What would you like to be able to do as a family that you don't or can't do now?"
5. Prompts to address individual functioning: "What would you like to be able to do (or your child to be able to do) that you don't do now?"
6. How would you like your children to behave?
7. How would you like your partnership to be (co-parenting)?
8. Prompt for clinician to reframe an individual focus to a family systems perspective – clinician should observe interactional patterns in a family systems context, describing actions and reactions, while avoiding blame and recognizing that all family members are doing the best they can in the moment.

OBSTACLES/CHALLENGES

What gets in the way?

- MH issues
- Limiting beliefs
- Finances
- Family systems issues / stuck interactional patterns
- Dilemmas / catch 22s
- Issues of race, culture, socioeconomic status, etc.
- Long working days
- Ambivalence

SUPPORTS

What helps you get there?

- Formal education / support groups
- Identify natural support network – family, friends, religious institution, neighbors …
- Individual qualities and family strengths
- Personal attitude/attitude of taking responsibility, determination
- Sustaining beliefs and habits
- Dreams, hopes, values

PLAN

How can IHT help you get to where you want to go?
What needs to happen next?

- Referrals needed – plan for wait list time
- Information or resources needed
- Differentiate clearly what IHT can/cannot do and what the family can/cannot do.
- "How will you know that IHT is ready to close?"

COLLABORATIVE HELPING MAP

FAMILY VISION

Where would you like your family to be headed in your lives?

OBSTACLES/CHALLENGES

What gets in the way?

SUPPORTS

What helps you get there?

PLAN

How can IHT help you get to where you want to go?
What needs to happen next?

South Shore Behavioral Health Clinic

DIAGNOSTIC INTAKE

Client Name:_____ DOB:_____

Clinician:_____ Date Completed: _____

1. Place of Service: ❑Clinic ❑Client Home ❑Nursing Home
❑School ❑ Day Program _____❑Other: *(specify)*

2. Reason Client is Seeking Mental Health Services (presenting problem): _____

_____

_____

3. Agencies With Whom Client is Involved: **(Check all that apply)**

❑ DMH ❑ DCF ❑ DYS ❑ DMR ❑ Other *(including probation /court ordered)*_____

❑ None ❑ Other Agencies _____

4. History

A. Symptom History *(current symptoms / age of onset/ effect on functioning)*

_____

_____

_____

B. Client's Current Life Situation or Marital Status:

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Partner

Current Residence (describe):_____

Members of Current Household: _____

Current Daily Activity Pattern:

Employed ❑ Student ❑ Unemployed ❑ Retired ❑ Day Program Describe:_____

Financial Status: ❑ Comfortable ❑ Stable ❑ No Steady Income

❑Receives Assistance:_____

C. Recent Life Stressors of Life Changes: _____

_____

D. Developmental / Educational History:

Early Developmental Milestones: _____

Highest Grade Completed: _____

Describe Client's School Functioning:_____

E. Significant Family Relationships *(include family of origin):* _____

_____

_____

South Shore Behavioral Health Clinic

DIAGNOSTIC TREATMENT PLAN

Client Name:_____DOB:_____:

Clinician:_____Date Completed:_____

F. Childhood Losses /Trauma

❑ Parental Divorce ❑Death of Parent ❑Death of Sibling

❑ Parental Substance Abuse ❑Abuse /Neglect ❑Foster Care/Adoption

❑Domestic Violence Victim ❑Domestic Violence Witness ❑ Other

Describe the impact of the above

_____

G. Legal Status (history or current involvement in the legal system):

_____

H. Military Status: ❑None ❑Active ❑Veteran

5. History of Mental Health Care:

❑Outpatient ❑ Inpatient

Describe:

_____

Medication History: _____

*Prescribing Physician:*_____

Family History of Mental Illness: _____

_____

6. Relevant Medical History:

Primary Care Physician: _____

Current Conditions/Allergies: _____

Current Medications: _____

7. Alcohol / Substance Use History ❑ **Yes** / ❑ **No** / ❑ **None Reported (Please Specify Below)**

Substance	**First use**	**Peak usage Amt**	**Current Use**	**Last Use**

8. Mental Status:

A. Communication Barriers:

❑ *No* ❑*Yes*

B. Behavior, Attitudes, and Activities:

General Behavior	❑ Unremarkable	❑ Other _____
Dress / Appearance	❑ Unremarkable	❑ Other _____
Voice	❑ Unremarkable	❑ Other _____
Motor Activity	❑Unremarkable	❑Other _____
Orientation	❑ Unremarkable	❑ Other _____

C. Physiological Functioning and Initiative:

Disturbance of Sleep	❑Absent	❑ Present_____
Eating Disturbance	❑Absent	❑ Present_____
Sexual Disturbance	❑ Absent	❑ Present_____
Muscle Tension	❑Absent	❑Present _____
Sweating	❑ Absent	❑Present _____
Quick to Startle	❑ Absent	❑ Present_____

D. Mental Activity, Speech and Thought:

Form of Speech	❑ Absent	❑ Present_____
General Content	❑ Absent	❑ Present_____
Hypochondriasis	❑ Absent	❑ Present_____
Phobias	❑ Absent	❑ Present_____
Delusions	❑ Absent	❑ Present_____
Loose Associations	❑ Absent	❑ Present_____
Thought Insertion	❑ Absent	❑ Present_____
Intrusive Thoughts	❑ Absent	❑ Present_____
Obsessions	❑ Absent	❑ Present_____
Flight of Ideas	❑ Absent	❑ Present_____

E. Disorders of Perception:

Depersonalization	❑ Absent	❑ Present_____
Derealization	❑Absent	❑ Present_____
Illusions	❑ Absent	❑ Present_____
Visual Hallucinations	❑ Absent	❑ Present_____
Auditory Hallucinations	❑Absent	❑ Present_____

F. Mood /Affect:

Predominant Mood: _____

Predominant Affect: _____

G. Cognitive functioning (estimate):

❑ Below average ❑ Average ❑ Above Average

9. . Mood and Emotional Symptoms:

❑Depressed	❑Diminished Energy	❑ Diminished Concentration
❑Anxious	❑Guilt / Self-blame	❑ Diminished Interest / Pleasure
❑Hopelessness	❑Helplessness	❑ Persistent / Unrealistic Worries
❑Suicidal Ideation	❑Homicidal Ideation	

10. Risk Assessment:

Suicidality:

❑None present ❑ Ideation ❑Plan ❑ Intent to Act ❑Available Means to Act ❑Previous Attempts

Level of Risk: ❑Low ❑ Moderate ❑ High ❑ ECP attached

NOTE: Moderate to High risk requires attached Emergency / Crisis Plan (ECP)

Describe in Detail:

Homicidality:

❑ None Present ❑ History of Assaultive Behavior ❑ Access to Weapons

❑ Plan to Use Weapons ❑ Intended Victim Identified *(Please not duty to warn victim and police)*

Level of Risk: ❑ Low ❑ Moderate ❑ High ❑ ECP attached

NOTE: Moderate to High risk requires attached Emergency / Crisis Plan (ECP)

Describe in Detail:

South Shore Behavioral Health Clinic

DIAGNOSTIC TREATMENT PLAN

Client Name:_____ DOB:_____

Clinician:_____ Date Completed:_____

9. Client Strengths/Protective Factors: ❑Academic ❑Behavioral ❑Cognitive ❑Communicative ❑Community ❑Family ❑Financial ❑Hopeful for Recovery ❑Motivated for Treatment ❑Physical ❑Relationships ❑Social ❑Spiritual ❑Other: _____

10. Client Leisure/Meaningful Activities:

_____

_____

11. Client Social Supports:

_____

_____

12. Client Religious/Spiritual Beliefs and Cultural Identification:

_____

_____

13. Client's Identified Goals:

_____

_____

14. Language Ability

_____

_____

South Shore Behavioral Health Clinic

New Intake Instructions

1. New clients are required to fill out new client intake packet in it's entirety, and return it to the office within 10 days
    a. Packets can be mailed out from our office
    b. Packets can be downloaded from our website - https://southshorecounselingandassociates.com or South Shore Behavioral Health Clinic.com
2. Completed packets must be:
    a. Filled out by the client's Parent or guardian for clients under 18 years old. *(note: for clients in DCF custody, Foster Care or Guardianship, proof of permission to sign must be included with submitted paperwork)*
    b. Must Signed by a witness (any adult other than the person signing the consents)
    c. A copy of the photo ID of the person filling out the paperwork must be submitted with the paperwork and a copy of the insurance card of the patient to be treated.
3. Packets can be returned in the following manner, and must be received within 10 days in order to continue services. For clients with packets not returned within 10 days, services will be paused until packet is received.
    a. Mailed to:
    South Shore Behavioral Health Clinic
    C/O Intake
    200 Cordwainer Drive
    Suite 200
    Norwell, MA 02061
    b. Faxed to:
    Attn: Intake
    (339)788-9904
    c. Securely Emailed to intake@ssbhc.com
    Most email servers are not HIPPA compliant, meaning that information sent via email may be susceptible to data breach and or data loss. This method is not recommended, and may be used at client's own liability.
    For those choosing to email documents, they must be password protected.

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

Intake Checklist and Signature Page

Please Check all boxes when each form is signed, and to verify all forms are in packet

Please Check off and initial the Rights and Policies below. Initial

- ☐ I have read the SSBHC Agency Policy..... ☐
- ☐ I have read the Client Rights..... ☐
- ☐ I have read the Summary of Privacy Practices ..... ☐
- ☐ I have read the deductible agreement..... ☐
- ☐ I have read and consent to treatment at SSBHC..... ☐
- ☐ I have read and consent to SSBHC no show policy..... ☐
- ☐ I have read the informed consent for treatment at SSBHC..... ☐

Client: _____ Date: _____
(print name)

Client/Parent/Guardian: _____ Date: _____
(Signature)

Therapist: _____ Date: _____
(Signature)

I have read all the policies above, and by signing below I acknowledge receipt of copies of the above policies.

Give to Clients

- ☐ SSBHC Agency Policy
- ☐ Summary of Privacy Practices
- ☐ Clients Rights

Place in Client Folder

- ☐ Credit Card Auth (if applicable)
- ☐ Couples Release (if applicable)
- ☐ Consent for Treatment in School setting (if applicable)
- ☐ Deductible Agreement
- ☐ Emergency Contact / Phone List Form
- ☐ Authorization to Obtain/Release PHI (2 sided) MBHP Med Communication Form

South Shore Behavioral Health Clinic

Clients Rights, Responsibilities and Consent

Clients Rights

1. **South Shore Behavioral Health Clinic** provides evaluations and counseling by medical health professionals including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and masters level clinicians. As a client you have the right to services which are provided in a professional manner.
2. If you feel that an evaluation was not explained fully, or that psychotherapy is not being provided as agreed upon, please first discuss it with your therapist. If you are not satisfied, you may write or call the Site Director at the site your services are provided.

Clients Responsibilities,

1. Payment of the clinical fee is the responsibility of the client, and is due at the time the service is rendered. Clinical policy prohibits scheduling further appointment when there is an overdue balance.
2. When partial or full payment is available through medical insurance plans, the client may defer payment of part or all of the fee. Any portion of the fee not covered must be paid in *full by* the client at the time the service is rendered.
3. When third party payment is uncertain, as with certain commercial insurance plans, the fee must be paid in full by the client until *the third* party payment is received. Any resulting overpayment will be reimbursed or credited to client's account.
4. Repeated cancellations or no-shows may result in termination of service.

Client Consent and Authorization

- I authorize **South Shore Behavioral Health Clinic** to release information necessary to process insurance claims.
- I authorize **South Shore Behavioral Health Clinic** to provide information to the managed care company (when relevant) for purposes of outpatient services authorization.
- ❑ **I hereby give consent for outpatient treatment and understand that I may rescind this authorization and terminate care at any time, with or without prior notice.**
- *I hereby authorize my* insurance carrier to pay **South Shore Behavioral Health Clinic** directly for services rendered.
- I have received and understand my Clients Rights as contained in Massachusetts General Law, Section 70E of Chapter 111.
- I understand that information about me will be kept confidential and will not be released without my consent except in specific circumstances which have been explained to me. I understand that the primary clinician assigned to my care by **South Shore Behavioral Health Clinic** may discuss that care with other persons employed by or consulting to **South Shore Behavioral Health Clinic** for purposes of supervision, guidance and consultation regarding my care.

South Shore Behavioral Health Clinic
CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with South Shore Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety under the "Duty to Warn, Duty to Care Law" MGL Chap 123, sec 36B..

- Massachusetts state law requires that staff of the **South Shore Behavioral Health Clinic** who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.

- A court order, issued by a judge, may require the **South Shore Behavioral Health Clinic** staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us, or your therapist if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the South Shore Behavioral Health Clinic

.

_____ _____

Signature of Client *Signature of Therapist*

_____

Date

South Shore Behavioral Health Clinic
200 Cordwainer Drive, Suite 200 Norwell, MA. 02061
109 Rhode Island Road, Lakeville MA 02347
Tel: 781-878-8340

SSBHC Agency Policy

- If you are seeing another therapist or professional, or another agency that results in non-payment of services you will be responsible for the charges incurred.
- Paperwork requested that is not to another mental health agency, physician, or mental health professional will be at a charge of $1.00 per page, for copies. Letters will be at $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist. Correspondence to attorneys or certain agencies are not covered by insurance and are subject to the above fees.
- Any paperwork for services not covered by insurance will be subject to $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist letters, and evaluations.
- Any client that is under the influence of Alcohol or Illegal Drugs that impair their therapy session will result in termination of the session. The session may be rescheduled at the discretion of the therapist and supervisor.
- Dissemination of Mental Health Records are at the discretion of the Supervisor or Medical Director, unless the records are for another Hippa Compliant Mental Health Agency, Licensed therapist, Medical Professional, Psychological Evaluation, or By Subpoena signed by a Judge.
- Cancellation policy requires that a client call with at least 24 hour notice to avoid cancellation fee if without appropriate notice. A fee of $75.00 dollars for a therapist, and $250.00 dollars for the Psychiatrist or Psychologist will be incurred without appropriate notice. Multiple cancellations without notice may result in discontinuation of services with the therapist. Psychiatric Appointments that are repeatedly cancelled or no showed may result in termination of psychiatric services.
- The Client is responsible to notify the Agency Immediately of any changes in insurance, such as new insurance provider, cancellation of policy, Any charges incurred due to cancellation of insurance, changing of policy without notice will be the responsibility of the client or responsible party.

South Shore Center for Wellness LTD

200 Cordwainer Dr, Ste 200 Norwell MA 02061
Tel: 781-878-8340 Fax: 339-788-9904

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is posted in our waiting room. A copy of this document is also available from our front office staff. Please contact our Privacy Officer about any questions or problems you may have.

We will use information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

For Treatment
We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, they can share some of your PHI with us so that the services you receive will be able to work together. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For Payment
We may use your information to bill you, your insurance, or others so we can be paid for the treatments we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changed we expect in your conditions. We will need to tell them about when we have met, your progress, and other similar things.

Your Health Care Operations
There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

Other Uses in Healthcare
Appointment Reminders. We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatment or alternatives that may be of help to you.

Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

South Shore Behavioral Health Clinic

Clients Rights, Responsibilities and Consent

Clients Rights

1. **South Shore Behavioral Health Clinic** provides evaluations and counseling by medical health professionals including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and masters level clinicians. As a client you have the right to services which are provided in a professional manner.
2. If you feel that an evaluation was not explained fully, or that psychotherapy is not being provided as agreed upon, please first discuss it with your therapist. If you are not satisfied, you may write or call the Site Director at the site your services are provided.

Clients Responsibilities

1. Payment of the clinical fee is the responsibility of the client, and is due at the time the service is rendered. Clinical policy prohibits scheduling further appointment when there is an overdue balance.
2. When partial or full payment is available through medical insurance plans, the client may defer payment of part or all of the fee. Any portion of the fee not covered must be paid in *full by* the client at the time the service is rendered.
3. When third party payment is uncertain, as with certain commercial insurance plans, the fee must be paid in full by the client until *the third* party payment is received. Any resulting overpayment will be reimbursed or credited to client's account.
4. Repeated cancellations or no-shows may result in termination of service.

Client Consent and Authorization

- I authorize **South Shore Behavioral Health Clinic** to release information necessary to process insurance claims.
- I authorize **South Shore Behavioral Health Clinic** to provide information to the managed care company (when relevant) for purposes of outpatient services authorization.
- ❑ **I hereby give consent for outpatient treatment and understand that I may rescind this authorization and terminate care at any time, with or without prior notice.**
- *I hereby authorize my* insurance carrier to pay **South Shore Behavioral Health Clinic** directly for services rendered.
- I have received and understand my Clients Rights as contained in Massachusetts General Law, Section 70E of Chapter 111.
- I understand that information about me will be kept confidential and will not be released without my consent except in specific circumstances which have been explained to me. I understand that the primary clinician assigned to my care by **South Shore Behavioral Health Clinic** may discuss that care with other persons employed by or consulting to **South Shore Behavioral Health Clinic** for purposes of supervision, guidance and consultation regarding my care.

Print Name of Client: _____

Client /or Legal Guardian Signature Date

Witness Date

South Shore Center for Wellness LTD
DBA South Shore Behavioral Health Clinic
200 Cordwainer Drive Suite 200 Norwell MA 02061
Tel: 781-878-8340

Authorized Phone Numbers to Contact Clients

Home: _____ is it ok to leave message _____ yes _____ No

Work: _____ is it ok to leave message _____ yes _____ No

Cell: _____ is it ok to leave message _____ yes _____ No

Spouse: _____ is it ok to leave message _____ yes _____ No

Texting Number : _____ it is ok to text _____ yes _____ No

Email _____ is it ok to leave message _____ yes _____ No

I _____ hereby authorize you to call the above numbers checked yes to contact me, leave me a voice message, Email, or contact be by Text.

Client: _____ Date : _____

Witness: _____ Date: _____

In Home Therapy/ Therapeutic Mentor Safety Policies

During a session the following policies must be adhered to for the safety for the team. If these policies fail to be complied with during any session, the clinician reserves the right to end the session and re-schedule for a time when all policies can be complied with.

- No illegal or illicit activity in the home
- All weapons must be locked up and put away
- All pets must be locked up or kept away from clinicians
- Only family members are allowed to be present during scheduled sessions, unless agreed upon before hand with the team
- No use of cell phones or other electronics (including the television) during session unless it is an emergency
    - Attendance Policy Agreement and commitment for the first 5 visits is expected at intake
    - Attendance policy must be adhered to or the case could be reviewed and closed
- We require at least 24 hours notice for a cancelled appointment.
- If you cancel 3 sessions the case can also be reviewed to close
- If a client or family member becomes aggressive toward the clinician it is their right to leave the situation. Under no circumstance should family members or clinicians use hands or other body parts to restrain or defend themselves.
- Imminent Risk Assessment: If a child is at imminent risk of harm as determined by clinician, it is our ethical and legal responsibility to call the mobile crisis team in your area, or 911. 911 May be called with or without the permission of the caregiver if necessary.

By signing this form you agree that you discussed and understand these policies.

Parent/ Guardian X_____

Witness/Clinician X_____

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name: South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Transgender

Safety and Protective Factors: Indicate below if the person is currently engaged with any Safety and Protective Activities. Comment on each "Yes" answer.

These factors often support individuals with self-management of risk issues. Many of these factors are found elsewhere in the assessment but repeated here for ease of formulating concerns about risk.	Yes	No	Not Known	Comments and/or Context
Stable Housing	☐	☐	☐	
Stable Employment	☐	☐	☐	
Has Income/ Insurance/ Benefits	☐	☐	☐	
Has Positive Alliance with Service Providers	☐	☐	☐	
Experience Positive Benefits from Treatment	☐	☐	☐	
Seeks Assistance When at Risk/ In Danger	☐	☐	☐	
Had Developed a Crisis/Safety Plan/ WRAP Plan/ Self Care Plan	☐	☐	☐	
Medication Adherence	☐	☐	☐	
Able to Plan and Follow Through	☐	☐	☐	
Capacity for Empathy / Perspective Taking	☐	☐	☐	
Religious / Spiritual Beliefs or Involvement	☐	☐	☐	
Stable / Positive Personal Relationships	☐	☐	☐	
Positive Family Supports / Has Children or Pets	☐	☐	☐	
Has Insight About Her/His Symptoms	☐	☐	☐	
Sobriety / No Active Substance Use	☐	☐	☐	
Low Psychosocial Stressors	☐	☐	☐	
Capacity to Weigh Risks and Benefits of Decisions	☐	☐	☐	
Capacity for Emotional Self-Regulation	☐	☐	☐	
Capacity for Self-Management of Behaviors	☐	☐	☐	
Future Orientation / Goals	☐	☐	☐	
Recovery Orientation	☐	☐	☐	

Risk Factors: Indicate below if the person has any past or current risk factors relating to the category. For each item marked "past" or "current," please note the context of the risk factor and any other relevant information regarding its occurrence. If there is current presentation of an acute risk, such as suicidal ideation, homicidal ideation, etc., please refer to agency specific protocols.

Harm to Others Factors	Past	Current	None	Comments and/or Context
Thoughts / Plans for Harming / Killing Others	☐	☐	☐	
Direct Violent Thoughts	☐	☐	☐	
Indirect Threats Implying Violence	☐	☐	☐	
Verbal Aggression that Precedes Violence	☐	☐	☐	
Serious Property Damage	☐	☐	☐	
Physical Assault / Violence to Others	☐	☐	☐	
Sexual Assault Against Others	☐	☐	☐	
Illegal or Antisocial Behaviors / Arrest / Conviction / NGRI / Incarceration	☐	☐	☐	
Neglect or Abuse of Dependents	☐	☐	☐	
Stalking / Restraining Order / Obsession Targeted at a Particular Person	☐	☐	☐	
Arson / Fire Setting / Fire Safety Issues	☐	☐	☐	
Extreme Paranoia / Perception of Threats / Command Hallucinations to Harm Others	☐	☐	☐	
Failure of Prior External Supervision to Control or Reduce Harm to Others	☐	☐	☐	
Other Harm or Danger to Others Issues:	☐	☐	☐	
Other Harm or Danger to Others Issues:	☐	☐	☐	

Person's Name (First MI Last):	Record #:

Self-Harm Factors	Past	Current	None	Comments and/or Context
Suicidal Thoughts / Plans / Rehearsal Behaviors	☐	☐	☐	
Suicide Attempts	☐	☐	☐	
Self-Harm Behaviors	☐	☐	☐	
Family History of Suicidal / Self-Harm	☐	☐	☐	
Life Threatening Eating Disorder	☐	☐	☐	
Victimized by Others / Places Self in Danger	☐	☐	☐	
Command Hallucinations for Self-Harm	☐	☐	☐	
Elopement Without Ability to Self-Preserve	☐	☐	☐	
Other Self-Harm:	☐	☐	☐	
Other Self-Harm:	☐	☐	☐	
Other Self-Harm:	☐	☐	☐	

Other Risk Factors *These factors may increase the level of concern a clinician has regarding potential risk*	Past	Current	None	Comments and/or Context
Recent Significant Loss	☐	☐	☐	
Memory Impairment / Dementia / Disorientation	☐	☐	☐	
Developmental Disability / PDD Spectrum	☐	☐	☐	
Young Age at Time of First Violent Behavior	☐	☐	☐	
Early Attachment Issues	☐	☐	☐	
Traumatic Brain Injury	☐	☐	☐	
Cognitive Impairment / Learning Disability	☐	☐	☐	
Extreme Impulsivity	☐	☐	☐	
Presents with Trauma Related Symptoms	☐	☐	☐	
Lack of Empathy / Remorse When Aggressive	☐	☐	☐	
Injury to Animals	☐	☐	☐	
Positive Views of Criminal Behavior	☐	☐	☐	
Requires Substitute Decision Making	☐	☐	☐	
Access to / Keeping / Carrying / Using Weapons	☐	☐	☐	
Non-Violent Problematic Sexual Behavior	☐	☐	☐	
Person is Actively Abusing Substances	☐	☐	☐	
Increased Risk Associated with Presence of Psychiatric Symptoms	☐	☐	☐	
Unwilling / Unable to Engage in Shared Risk Decisions / Risk Reduction Efforts	☐	☐	☐	
Chronic Medical Illness or Chronic Pain	☐	☐	☐	
Unable / Unwilling to Manage Risks	☐	☐	☐	
Experiencing Acute High Stress Situation	☐	☐	☐	

Summarize the Risk and Protective Factors and Indicate if Further Planning is Needed per Agency Protocols:

Person's Signature (Optional, if clinically appropriate):	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID (MASSHEALTH)

PERMISSION TO GET AND SHARE INFORMATION IN THE MASSHEALTH CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) SYSTEM

Name of MassHealth member (Member) _____

Name of behavioral-health assessor (Assessor) _____

Name of provider organization (Provider) _____

Provider address _____

_____ (Member) is under the age of 21 and is receiving a behavioral health assessment.

What is the CANS?

Behavioral-health providers (providers) use a tool called the Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about members under 21. For members who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.

The information collected using the CANS tool (CANS Information) helps providers to do a number of things, such as:

- decide what behavioral health services a member may need
- check over time that behavioral health services are helping the member

Why MassHealth Wants to Obtain and Share CANS Information

MassHealth has a computer system that a provider can use to enter CANS Information each time a behavioral health assessment is done or updated. MassHealth wants to use the system to access CANS Information and share it with providers and MassHealth managed care entities (organizations that manage and pay for a member's care) so that such parties can work together to make sure that the behavioral health services offered to the member meet the member's needs. Sharing CANS Information through the system will also help better inform the member's providers of the member's medical history and reduce the overall amount of information that such providers must collect from the member, as further described below.

If you give your permission, the Provider noted above will enter any CANS Information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the

system to give the Provider access to any CANS Information entered by the Member's other providers. This will allow the Provider to update the Member's CANS Information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other providers with permission access to the CANS Information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS Information collected by the Provider.

Your Permission

By signing below, you give permission for the Provider listed above to:

- enter all of the CANS Information about the Member that it collects into the MassHealth system
- view and copy any CANS Information about the Member that other providers have entered into the MassHealth CANS system

By signing below, you also give permission for MassHealth to use the system to share CANS Information collected by the Provider with:

- the Provider noted on the first page of this form
- the MassHealth managed-care entity in which the Member is enrolled at the time that the CANS is entered into the MassHealth CANS system
- other providers for whom you have given permission

Things You Should Know

Neither MassHealth nor the Provider may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this form or whether you decide to take back the permission in the future.

If you give your permission to the activities noted above, the Provider will enter CANS Information about the Member into the MassHealth system, and MassHealth will access such information and share it with the Provider, other providers for whom permission is given and the Member's managed-care entity. Your permission will also allow MassHealth to give the Provider access to CANS Information entered into the system by the Member's other providers. **Note that even if you do not provide your permission, MassHealth and the Provider may still use or disclose CANS Information about the Member as required or permitted by law.**

After CANS Information is shared through the MassHealth system, the organization that shared the information will no longer be able to control how it is used or disclosed. The privacy laws covering CANS Information may be different when MassHealth, providers, or managed care entities hold the information, but each such organization must follow the privacy laws that apply to it when using or disclosing the information.

You may put a permission end date on this form below. If you do not, the permission ends one year from when you sign this form.

You may cancel this permission at any time in writing. The cancellation will prevent the Provider and MassHealth from using the MassHealth system to share CANS Information that is collected after you cancel your permission. Information that has already been made available to MassHealth, managed care entities, the Provider or other authorized providers through the MassHealth system prior to receipt of your cancellation cannot be taken back.

The written cancellation must:

- say who the Member is
- give the Member's birth date
- say who you are
- say if you are the Member, the Member's custodial parent, or explain why you can act for the Member
- say that you are cancelling your permission to enter and share CANS Information online

You must give the written cancellation to the Provider at the address noted on the first page of this form. The Provider must then notify MassHealth by emailing a scanned copy of the written cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Your Signature

By signing this permission form, you are giving permission for the uses and disclosures of CANS Information about the Member as noted above. You are also saying: that you have read the whole form and signed it willingly; and that you have the right to get a signed copy of the form.

_____
Printed name of person signing permission

_____
Signature of person signing permission

_____
Date of signing (date permission starts)

_____
Date permission ends (If no date is written on this line, permission will end one year from the date of signing.)

Please check the line below saying why you can sign this permission under law.

_____ I am the Member. I am 18 years old or older. If I am not 18 years old or older, I can give my permission for other reasons under law.

_____ I am the Member's custodial parent.

_____ I am able to act for the member to give permission to give out medical information. I have attached a legal document showing why I can do this.

Reminder to Provider: A signed copy of this form must be given to the Member or caregiver. If the Member or caregiver later cancels this consent, you must e-mail a scanned copy of the cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Guidelines for Individuals/Families in Creating a Safety Plan

You can choose to write a Safety Plan on either side of this document. The formatted side of the Safety Plan has three sections. You can complete any or all of the sections as you find them useful. The Safety Plan can be updated at any time as you gain experience with what is working, change the goal of the plan, or think of new/different actions to take. Below is a description of each of the sections and some questions to think about as you complete the plan.

1. **CONTACTS AND RESOURCES:** This is a section for listing in one place all of the names, roles, and numbers of individuals who you think will be most helpful to you or your family in a crisis.

   Questions to Consider:

   - *Is there anyone you feel you MUST notify if there is a crisis situation? (employer, school, other parent)*
   - *Are there any people that you think can help calm the situation? (family, friends, teachers, neighbors, clergy)*
   - *Are there any support persons or professionals you might want to contact? (current treatment provider, CSA team member, MCI team, helpline, PPAL, mentor, urgent treatment center, hospital emergency department, poison control, 911)*
   - *Is there anyone you might want to call who might be able to help with managing other priorities while you are focusing on the crisis (child care, pets, closing up the house, transportation, covering a shift, etc.)?*
   - *If you could call/talk to anyone to calm you/your child down when (insert name of crisis/risk), who would it be?*

2. **GOAL OF PLAN:** It isn't always possible to prevent a crisis, so sometimes the goal of a crisis plan is to manage the situation well or to keep people from getting hurt. The goal might be focused on the person in crisis or it might be focused on how other members of the family act during/respond to the crisis.

   Questions to Consider:

   - *What do you want the plan to accomplish for you/your family in a crisis situation?*
   - *What would be a measure of success in managing a crisis episode?*
   - *If you don't feel you can realistically prevent a crisis, what could you do? How could you take a step towards your long-term goal?*
   - *What would you like to accomplish as a parent/guardian in managing the crisis?*
   - *What could be done to reduce the chance of harm or injury?*

3. **ACTIONS:** Knowing the goal makes it easier to think about actions that can be taken. Only list actions that people are really willing to take and that you think have a chance of working.

   Questions to Consider:

   - *What things can you see yourself doing that will help you achieve your goal?*
   - *What has worked in the past that you could try again?*
   - *What actions could (parent/guardian) take to achieve the crisis goal?*
   - *What actions could (others) take to help achieve the goal?*
   - *What are the ways you think you could calm down the situation?*
   - *If you think about trying the actions, does it feel like they would work?*

Contacts and Resources

Name/role	Phone	Name/role	Phone
_____	# _____	_____	# _____
_____	# _____	_____	# _____
_____	# _____	_____	# _____

Notes:

Goal of Plan

Actions

Developed by:

_____

Date Completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared With:

☐ _____
☐ _____
☐ _____
☐ _____

This plan is for:

___/___/_____ _____ _____
Date of birth **First name** **Last name**

_____
(other information, needs, requests)

_____**ph:**_____**ph:**_____
Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____
Printed name of the Parent/Guardian, if applicable

Developed by: _____ **Date Completed** ____/____/____ ☐ **Initial** ☐ **Revision** **Shared with:** ☐ _____ ☐ _____ ☐ _____ ☐ _____	**This plan is for:** ____/____/____ _____ _____ **Date of birth** **First name** **Last name** _____ **(other information, needs, requests)** _____**ph:**_____**ph:**_____ **Printed name of the Parent/Guardian, if applicable** _____**ph:**_____**ph:**_____ **Printed name of the Parent/Guardian, if applicable**

Contacts and Resources

Name/role	Phone	Name/role	Phone
_____	# _____	_____	# _____
_____	# _____	_____	# _____
_____	# _____	_____	# _____

Notes:

Goal of Plan

Actions

Developed by:

_____

Date Completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared With:

☐ _____
☐ _____
☐ _____
☐ _____

This plan is for:

___/___/_____ _____ _____
Date of birth **First name** **Last name**

_____
(other information, needs, requests)

_____**ph:**_____**ph:**_____
Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____
Printed name of the Parent/Guardian, if applicable

Developed by: _____ **Date Completed** ____/____/____ ☐ **Initial** ☐ **Revision** **Shared with:** ☐ _____ ☐ _____ ☐ _____ ☐ _____	**This plan is for:** ____/____/____ _____ _____ **Date of birth** **First name** **Last name** _____ **(other information, needs, requests)** _____**ph:**_____**ph:**_____ **Printed name of the Parent/Guardian, if applicable** _____**ph:**_____**ph:**_____ **Printed name of the Parent/Guardian, if applicable**

Guidelines for Individuals/Families for Completing an "Advance Communication to Treatment Provider"

The Advance Communication to Treatment Provider (Advance Communication) allows you to communicate in writing to providers who in the future might provide crisis support or intervention for you or your child. In the Advance Communication, you can describe what is important to you or your family. You may have a good idea of what is useful to you/your child in a crisis situation and might have learned through experience what interventions make things better and what makes things worse. You might have choices for types of treatment based on the location, program style, or the kind of care you have received in the past.

The Advance Communication is NOT a legal document, and the provider does not have to do everything that you ask. For example, the type of treatment that you prefer may not be available. Or, you/your child may be hospitalized against your wishes if the provider finds that the criteria are met for involuntary treatment and alternatives are not acceptable or available.

However, many times it is possible to develop a plan for crisis support/intervention and further treatment that is in line with what you want for yourself or for your child. The Advance Communication promotes consideration of your personal choices and gives you a voice in decisions that are made.

One side of the Advance Communication is for completion by the person who will be RECEIVING the crisis service. The other side is for completion by the PARENT or GUARDIAN. Only one side of the paper or the other needs to be completed. Use the side that makes the most sense to you.

<u>Completing the form</u>
There are not any "wrong" answers. This is about the health and well-being of you/your family. Your beliefs about what works are important. There are often a number of ways to resolve a crisis situation, and your opinions and choices matter.

You do not need to complete every section—just the ones that are important to you. You can update the plan any time there is a change that you want to make.

Copies of the Advance Communication can be sent to a Mobile Crisis Intervention (MCI) team so that they have it on file if there is a crisis.

You can attach additional pages to this document if there is more information to share than there is room for on the form.

<u>Additional information, accommodations, or requests</u>
If you have specific needs, requests, or other information that would be useful for a treatment provider to know, they can be listed here. Examples include:

- Communication needs *("Both parents need a Spanish language interpreter."*)
- Physical limitations *("I cannot climb stairs."*)
- Information about people *("My husband is working out of state, but he will want to be included in this intervention by telephone.")*
- Logistical considerations *("I am a single parent of three children, and childcare is very hard to arrange. I prefer that an MCI team come to the home*.")
- Cultural, ethnic, and/or religious preferences

Advance Communication to Treatment Provider

What I experience when I am in crisis:

My priorities in a crisis:

What helps me in a crisis:

Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family):

Treatment I prefer NOT to receive:

If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc.).

Additional information, needs, or requests:

Developed by:

_____

Date completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared with:

☐ _____

☐ _____

☐ _____

☐ _____

This Advance Communication is for (person who will be receiving the crisis service):

___/___/_____ _____ _____

Date of birth **First name** **Last name**

_____

(other information, needs, requests, accommodations)

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

Advance Communication to Treatment Provider

How my/our child looks and acts when in crisis:

My/our priorities when my/our child is in crisis:

What helps my/our child during crisis support/intervention:

What helps my/our family during crisis support/intervention:

Treatment I/we prefer for my/our child:

Treatment I/we prefer my/our child NOT receive:

If I/we cannot be immediately reached if child is in crisis, please contact:

Additional information, needs, or requests:

Developed by:

_____

Date completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared with:

☐ _____

☐ _____

☐ _____

☐ _____

This Advance Communication is for (person who will be receiving the crisis service):

___/___/_____ _____ _____

Date of birth **First name** **Last name**

_____

(other information, needs, requests, accommodations)

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

Advance Communication to Treatment Provider

What I experience when I am in crisis:

My priorities in a crisis:

What helps me in a crisis:

Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family):

Treatment I prefer NOT to receive:

If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc.).

Additional information, needs, or requests:

Developed by:

_____

Date completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared with:

☐ _____

☐ _____

☐ _____

☐ _____

This Advance Communication is for (person who will be receiving the crisis service):

___/___/_____ _____ _____

Date of birth **First name** **Last name**

_____

(other information, needs, requests, accommodations)

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

Advance Communication to Treatment Provider

How my/our child looks and acts when in crisis:

My/our priorities when my/our child is in crisis:

What helps my/our child during crisis support/intervention:

What helps my/our family during crisis support/intervention:

Treatment I/we prefer for my/our child:

Treatment I/we prefer my/our child NOT receive:

If I/we cannot be immediately reached if child is in crisis, please contact:

Additional information, needs, or requests:

Developed by:

_____

Date completed ___/___/___ ☐ **Initial** ☐ **Revision**

Shared with:

☐ _____

☐ _____

☐ _____

☐ _____

This Advance Communication is for (person who will be receiving the crisis service):

___/___/_____ _____ _____

Date of birth **First name** **Last name**

_____

(other information, needs, requests, accommodations)

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

_____**ph:**_____**ph:**_____

Printed name of the Parent/Guardian, if applicable

South Shore Behavioral Health Clinic
CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with South Shore Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety under the "Duty to Warn, Duty to Care Law" MGL Chap 123, sec 36B..

- Massachusetts state law requires that staff of the **South Shore Behavioral Health Clinic** who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.

- A court order, issued by a judge, may require the **South Shore Behavioral Health Clinic** staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us, or your therapist if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the South Shore Behavioral Health Clinic

.

_____ _____

Signature of Client *Signature of Therapist*

_____

Date

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:_____ - _____Date of Birth:_____
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____
Print Name of Provider You are asking for records or speak to

Address: _____
Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: South Shore Center for Wellness LTD _____
Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information
Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

My health information may be disclosed under this Authorization to:

To the Recipient: _____
Organization to receive the information Print Name of Individual to receive information

Address: _____
Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (I) this test is ordered, performed, or reported and ([I) the test results are positive or negative.
- Information regarding the results of a genetic test.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:_____ Date of Birth: _____
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

_____

❑ Specific health information including only:

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)_____

_____

; or _____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: _____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1._____ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2._____ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3._____ 1 understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. 1 further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_____ Date: _____

Print Full Name of Person Served:_____

Relationship of Representative to Person Served:_____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan Network Health Fallon Community Health Plan Neighborhood Health Plan PCC Plan

The member below is currently receiving services and has consented to share the following information between their PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member Name: _____ DOB: _____ Member ID#: _____

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: _____

Section A: *(completed by BH Provider)*

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

_____ _____

_____ _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. The patient has the following Substance Abuse problem(s) (if applicable):

_____

_____

_____

4. Please describe any special concerns:

_____

_____

_____

_____

Behavioral Health Clinician: _____

Behavioral Health Clinician Signature: _____

Provider Name/Site Name: _____

Address: _____

South Shore Behavioral Health Clinic

200 Cordwainer Drive, Suite 200

Norwell MA 02061

Phone: 781-878-8340

Fax: 339-788-9904

Date this form completed:

Section B: *(completed by Primary Care Provider)*

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

_____ _____

_____ _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

_____

_____

4. Please describe any special concerns (i.e., include abnormal lab results):

_____

_____

_____

_____

_____

Primary Care Provider: _____

Primary Care Provider Signature: _____

Provider Name/Site Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Date this form completed:

To make a referral to Care Management, please call the members' plan at:

Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (781) 994-7500

Neighborhood Health Plan: (781) 994-7500 • Primary Care Clinician Plan: (617) 790-5633

(Updated 11/07/2009)

IHT PROGRESS INDICATORS FOR TRANSITION

MassHealth
CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)

Instructions for Families: Throughout your involvement with IHT, we want to have regular conversations with you to gather your feedback on progress, experience with IHT, and when would be an appropriate time to start the process of transitioning/closing IHT services, as well as create a plan with you for a smooth and successful ending with IHT.

1. **I feel my youth/family has made progress in the last three months.**

1	2	3	4	5	6	7	8	9	10
Disagree									Strongly Agree

2. **I am ready to continue working on my current treatment plan.**

1	2	3	4	5	6	7	8	9	10
Not ready		Little		Moderate			Significant		Fully ready

3. **I feel the treatment plan is helpful in addressing our youth/family's need areas/concerns.**

1	2	3	4	5	6	7	8	9	10
Unhelpful		Little		Moderate			Significant		Fully helpful

4. **I/My family is ready to start the closing phase of treatment.**

1	2	3	4	5	6	7	8	9	10
Not ready		Little		Moderate			Significant		Fully ready

5. **I and my youth/family can manage and express big feelings appropriately.**

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

6. **As a caregiver, I can manage challenging behaviors with my youth in the home.**

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

7. **I/My family can manage safety concerns with my youth.**

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

8. **I/My youth can follow through on plans/routines/tasks.**

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

9. I am confident that my youth/family can continue to make progress towards our goals.

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

10. I am confident that my family can maintain progress made without IHT involvement.

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

11. I am confident in my abilities to access supports and resources without IHT.

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

12. I am confident in being able to maintain my family's support system.

1	2	3	4	5	6	7	8	9	10
Not		Little		Moderate			Significant		Completely

Additional Comments for Transition Planning (current needs/concerns, supports/resources needed, etc):