

**BEHAVIORAL HEALTH APPLICATION FOR SERVICES**

<b>San Luis Obispo Behavioral Health Department</b>		<input type="checkbox"/> DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX( 805) 781-1227		<input type="checkbox"/> MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177	
<b>REFERRAL</b> Who referred you?	<input type="checkbox"/> Self	<input type="checkbox"/> Family	<input type="checkbox"/> Friends	<input type="checkbox"/> Doctor	<input type="checkbox"/> Hospital
	<input type="checkbox"/> Court	<input type="checkbox"/> Probation	<input type="checkbox"/> Parole	<input type="checkbox"/> School	<input type="checkbox"/> Employer
	<input type="checkbox"/> Dept. of Social Services	<input type="checkbox"/> Child Welfare Services	<input type="checkbox"/> OTHER		
Social Worker → NAME			Specify →		
Applicant Name (First, Middle, Last, Jr. Sr. I or II)					
Applicant full name as it appears on birth certificate					
Street Address			City	State:	Zip
Home Phone	Cell Phone	Okay to leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address	
Mailing Address (if different than above)			City	State	Zip
Driver's License No.	Driver's License State	Social Security No.		Reason SSN not provided	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		Date of Birth (MM/DD/YYYY)		Date of birth is: <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Age
<b>BIRTHPLACE</b>	<input type="checkbox"/> SLO County	Other CA County → Specify	Other State → Specify	Other Country → Specify	
<b>MARITAL STATUS</b>	<input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner			Biological Mother's <b>FIRST</b> Name	
<b>RACE</b> choose up to 5	<input type="checkbox"/> White	<input type="checkbox"/> Japanese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese
	<input type="checkbox"/> Black	<input type="checkbox"/> Mexican American	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Guamanian
	<input type="checkbox"/> Native American	<input type="checkbox"/> Latin American	<input type="checkbox"/> Laotian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Other Hispanic	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Mixed Race
<b>LANGUAGE</b>	PRIMARY LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (Specify)				<input type="checkbox"/> Services needed in language other than English
	PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (Specify)				
<b>WORK</b>	<input type="checkbox"/> Employed full-time (35 hrs or more per wk) <input type="checkbox"/> Unemployed (looking for work) <input type="checkbox"/> Not in labor force (Not looking for work)				
	<input type="checkbox"/> Part time (less than 35 hrs per wk) <input type="checkbox"/> Unemployed (not looking for work) Why are you not looking for work? →				
<b>LIVING ARRANGEMENTS</b>	<input type="checkbox"/> Alone <input type="checkbox"/> Family or friends <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Group/Foster Home <input type="checkbox"/> Sober living facility <input type="checkbox"/> Homeless <input type="checkbox"/> Other -specify				
<b>APPLICANT'S FAMILY</b>	Is applicant pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date	Number of applicant's children 0-5 years		Number of applicant's children 6-17 years
	Number of children under 18 that applicant cares for at least 50% of the time				
	Has applicant had or currently have an open Child Welfare Services case? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Number of dependent adults 18 years or older that applicant cares for at least 50% of the time				
<b>EDUCATION</b>	Highest Grade completed		Vocational Program <input type="checkbox"/> Yes <input type="checkbox"/> No	Current School Name	
	Specify Degree		Specify Vocational Program	School District	
<b>DISABILITY</b>	Choose all that apply to Applicant <input type="checkbox"/> None <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Mobility <input type="checkbox"/> Mental <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Health <input type="checkbox"/> Other (not drug or alcohol)				
<b>MILITARY</b>	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer		Do you have a military connected disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have VA Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, VA Claim Number:		
<b>OTHER NAMES USED</b>	First	Middle	Last		
<b>EMERGENCY CONTACT INFO</b>	Name		Phone	Work Phone	
	Address			Relationship to Applicant	
<b>LEGAL INFO</b>	Probation Contact Name	Court Case #	CDC #	Parole Contact Name	
	Social Worker Name			Other/Conservatorship/Juvenile Court Status	
<b>FINANCIAL</b>	Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Private Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Medi-Cal/CIN Number (eg. 123456789A)		Medicare Number		
	What is your monthly family income? \$			How many people live on your income including you?	
<b>CLIENT NAME</b>			<b>DATE</b>	<b>CLIENT NUMBER</b>	
AZ 1: Application for Services V14 12-7-10			BH APPLICATION FOR SERVICES		

**BEHAVIORAL HEALTH SIGNATURE SHEET**

San Luis Obispo Behavioral Health Department

 DAS 2180 Johnson Ave, San Luis Obispo, CA 93401  
Phone: (805) 781-4275 FAX( 805) 781-1227 MH 2178 Johnson Ave, San Luis Obispo, CA 93401  
Phone: (800) 838-1381 FAX (805) 781-1177**TREATMENT AUTHORIZATION**

**TREATMENT AUTHORIZATION:** I, the undersigned, am requesting mental health services and/or drug and alcohol services and give my consent to the staff of the San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to administer such treatment as is considered therapeutically necessary and/or desirable. All treatment procedures, including observed urinalysis for drugs of abuse, patching, and breathalyzer, are to be discussed with me and I am free to decline or withdraw from treatment at any time. I expect to receive quality, professional care and understand that there is no guarantee that desired results will be obtained. I understand that San Luis Obispo County Mental Health and/or Drug and Alcohol Services will maintain a medical record of my contacts for services as required by law. This is a shared electronic health record between Mental Health and Drug and Alcohol Services. The confidentiality of these records is protected by law and no information which might identify me will be released without my specific written consent. Exceptions to this confidentiality are: Medical emergencies, the requirements for billing, a judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event that I am of danger to myself or others.

**Client Signature :** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent, Guardian or LPS Conservator Signature \_\_\_\_\_ **Date** \_\_\_\_\_

Legal Status: Minor w/Conservator, Adult w/Conservator, Temp Con, LPS Conservator, Probate, Dependent of Juvenile Court

Print Name of Responsible Person

Address of Responsible Person

Phone

City, State Zip

**INSURANCE AUTHORIZATION**

I authorize San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to receive payment of medical benefits for any and all health insurance plans for which I am covered, including Medi-Cal, MEDICARE and private health insurance. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, for its own or ancillary services, the hospital may disclose portions of the client's record, including his/her medical records which may include information recorded in the diagnosis and treatment of mental health and/or drug and alcohol related conditions, to any person or corporation which is or may be liable, for all or any portion of the hospital's charges, including but not limited to insurance companies, health care service plans, or workers' compensation carriers and government reimbursement entities.

**Client/Responsible Party Signature :** \_\_\_\_\_ **Date** \_\_\_\_\_

**RECEIPT OF CLIENT HANDBOOK**

I have received a copy of the following: (Initial each line as it applies to each client)

1. \_\_\_\_\_ Privacy Practices - I hereby acknowledge that I received a copy of County of San Luis Obispo Health Agency Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the lobby area, and that I will be offered a copy of any amended Notice of Privacy Practices at my appointment.
2. \_\_\_\_\_ Client's Rights and Grievance Procedures. This is also posted in the lobby area.
3. \_\_\_\_\_ HIV/AIDS, Hepatitis C, and TB Information sheet. Phone numbers included for testing and referrals.
4. \_\_\_\_\_ Information on drug testing including:
  - Drug testing guidelines.
  - Medications or substances that may test positive on your drug screen.
  - What over-the-counter medications okay to take while drug testing.
5. \_\_\_\_\_ Follow-Up Consent - I agree to comply with the San Luis Obispo County follow-up procedure. I understand that this entails responding to a questionnaire regarding my status at 90 and 180 days after discharge from the program. I further understand that this information will be strictly confidential, and that I may be offered a follow-up appointment based on the information I give.
6. \_\_\_\_\_ Advance Directive.
7. \_\_\_\_\_ List of Community Service Providers has been given to me.
8. \_\_\_\_\_ Beneficiary Medi-Cal Handbook
9. \_\_\_\_\_ I have read, understand, and agree to abide by the terms and conditions in the Client Handbook.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent, Guardian or LPS Conservator Signature \_\_\_\_\_ **Date** \_\_\_\_\_

Signature of Staff Person Witnessing: \_\_\_\_\_ **Date** \_\_\_\_\_

***If signed by anyone other than the client, please indicate relationship:***

Parent or guardian of minor client  Guardian or conservator of an incompetent client  Beneficiary or personal representative of deceased client

**CLIENT NAME**

**CLIENT NUMBER**

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:  
CRIMINAL JUSTICE REFERRAL**

Name of Client: \_\_\_\_\_ DOB \_\_\_\_\_

I hereby consent to communication between San Luis Obispo County Drug and Alcohol Services and:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Court                  | <input type="checkbox"/> Parole Department                      | <input type="checkbox"/> Probation                      |
| <input type="checkbox"/> DMV                    | <input type="checkbox"/> State Dept Alcohol & Drug              | <input type="checkbox"/> Attorney and District Attorney |
| <input type="checkbox"/> Residential facilities | <input type="checkbox"/> Alternative Treatment Providers Listed |   |

Out of County Court/Probation (specify) \_\_\_\_\_

Other referring Agency (specify) \_\_\_\_\_

The purpose of and need for the disclosure is to inform the applicable criminal justice/treatment agency (ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis/breathalyzer results, payment record, and treatment plan.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into treatment.

**It is okay to leave messages on my machine or service**  Yes  No **Your Phone #** \_\_\_\_\_

Family members listed below for phone messages, payment information and scheduling of appointments.

Name	Relationship to Client	Phone #

I understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties. I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

**Special terms regarding revocability of Criminal Justice Program releases**

Although HIPAA requires that consents be revocable and does not have an exception when a patient is mandated into treatment through the criminal justice system, 42 C.F.R. Part 2 sets forth some special rules when a patient's participation in a treatment program is an official condition of probation or parole, sentence, dismissal of charges, release from imprisonment, or other disposition of any criminal proceeding. While a consent form (or court order) is still required before any disclosure can be made about a criminal justice system ("CJS") referral, the rules concerning duration and revocability of the consent are different.

Under the special rules of 42 C.F.R. Part 2, consent can be made irrevocable until a certain specified date or condition occurs, and the duration of the consent can be linked to the final disposition of the criminal proceeding. 42 C.F.R. § 2.35. This allows programs to provide information even after the client leaves treatment. If the client does not comply with treatment, the program can report the problem to the judge or prosecuting attorney or testify in a probation revocation hearing because there has been no final disposition of the criminal matter. A CJS consent allows programs to use the expiration condition provided in 42 C.F.R. Part 2: "when there is a substantial change in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a client were on parole or probation, there would be a change in criminal justice system status when the parole or probation ends, either by successful completion or revocation. Thus the program could provide periodic reports to the parole or probation officer monitoring the client, and could even testify at a parole or probation revocation hearing, since no change in criminal justice status would occur until after the hearing.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of parent, guardian or authorized representative  
(if required)

**CLIENT NAME:** \_\_\_\_\_

**CLIENT NUMBER:** \_\_\_\_\_

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION  
DEBT COLLECTION**

Name of client: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize San Luis Obispo County Drug and Alcohol Services to disclose to:  
The San Luis Obispo County Probation Department or other collection agency

And I authorize the Probation Department or other collection agency to redisclose to:  
The courts, attorneys, the State Franchise Tax Board and any other person or entity as necessary to collect or facilitate collection of any fees owed for services provided to me by the San Luis Obispo County Department of Drug and Alcohol Services and associated collection charges.

The following information: any information that will facilitate collection of fees owed

The purpose of the disclosure authorized in this is to:  
Facilitate collection of fees owed and associated collection charges, which includes, without limitation, pursuing collection through the State Franchise Tax Board or a court of law.

Family members listed below for phone messages, payment information, and collections status.

Name	Relationship to Client	Phone

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: Upon payment in full of all fees owed and associated collection charges.

I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

**Revocability of Release**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 you have the right to revoke any release of information that you have previously signed giving San Luis Obispo Drug and Alcohol Services permission to release information to another agency, business, person, or organization. However, both HIPAA and 42 C.F.R. Part 2 provide that if a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed. 45 C.F.R. § 164.508(b)(5); 42 C.F.R. § 2.31(a)(8).

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of parent, guardian or authorized representative where required

**CLIENT NAME:** \_\_\_\_\_

**CLIENT NUMBER:** \_\_\_\_\_



## Participant's Certification of DUI Program Enrollment or Completion

(Instructions for completing this form are on the reverse side.)

PROGRAM PROVIDER NAME: SAN LUIS OBISPO COUNTY DRUG & ALCOHOL SERVICES		PROVIDER'S ADP LICENSE NUMBER 40-001-01-120
PARTICIPANT NAME: (LAST FIRST MIDDLE)		DRIVER LICENSE NUMBER OR "X" NUMBER
PROGRAM TYPE		
<input type="checkbox"/> Education Only (23140 CVC Conviction) <input type="checkbox"/> First Offender Program ____ months <input type="checkbox"/> Multiple Offender Program    ____ 18 months    ____ 30 months    ____ 18 of 30 months (IID Restriction only)		
ENROLLMENT DATE	DL 107 CERTIFICATE NUMBER	OR
<i>I certify under penalty of perjury under the laws of the State of California that I have enrolled in, or completed the program as indicated above.</i>		
DATE	PARTICIPANT'S SIGNATURE 	TELEPHONE NUMBER (    )

DL 804 (REV. 1/2003) WWW

### Instructions for Completing the Participant's Certification of DUI Program Enrollment or Completion (DL-804)

This form is to be used under the following circumstances:

- When a program participant has completed all the required DUI Program components, but you are unable to immediately issue a Notice of Completion Certificate (DL 101) and capture the participant's signature on the (paper) completion certificate.
- When a program participant has completed all the required DUI program components and you are submitting an electronic Notice of Completion Certificate (DL 101) via an authorized Internet access link with the Department of Motor Vehicles (DMV).
- When a program participant has enrolled in a DUI program and you are submitting an electronic Proof of Enrollment Certificate (DL 107) via an authorized Internet access link with the DMV.

This form captures the participant's signature, which certifies under penalty of perjury that the participant has either enrolled in a DUI program, or completed the required DUI program. This signature would normally be on the DL 101 or DL 107, but in the above circumstances you may not be able to capture the participant's signature on the certificate.

Please, ensure that the information on this form is consistent with the information on the Proof of Enrollment Certificate (DL 107) or the Notice of Completion Certificate (DL 101) you submit for the identified participant.

You must retain this form in your office in a manner that will allow you to retrieve it by searching for the serial number of the corresponding Certificate (DL 107 or DL 101) and for the period required by Section 9866 of Title 9, California Code of Regulations.

On the printed Notice of Completion Certificate (DL 101) you submit without a participant's signature, type or print the words "Signed DL 804 in file" in the space provided for participant's signature.

**Do not submit a DL 804 to DMV unless you are requested to do so.**

DL 804 (REV. 1/2003) WWW