San Luis Obispo Co Drug & Alcohol Services Programs

Triage Sheet

Today's Date: _____

Full Name (First, Middle, & Last): _____

(Spell out middle name)

Date of Birth: _____ **Social Security#:** _____

Address: _____

Phone Number: _____ **DL# or ID#**_____

Referral Source: _____

Substance(s) Used? (please check all that apply) Alcohol Fentanyl Heroin Opiates Methamphetamine THC Benzodiazepines Hallucinogens Other (fill in) _____

Have you experienced an overdose in the last 30 days? ..... Yes No

Are you here for opiate withdrawal management/ suboxone? .... Yes No

Are you here for alcohol detox or for medication to stop drinking? Yes No

Do you have current thoughts about harming yourself? ..... Yes No

Are you pregnant? Yes No Unknown **(If yes, due date _____)**

Have you been released from jail in the past 30 days? ..... Yes No

Do you have transportation to treatment appointments? ..... Yes No

Do you consider yourself homeless? ..... Yes No

Client Name: _____ **Client MR#** _____

County of San Luis Obispo Behavioral Health

Client Information

Social Security Number: _____

Prefix ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Client Name: _____
(First) (Middle) (Last)

Email: _____

Medicaid ID: _____ Medicare Beneficiary ID: _____

Phone Number #1: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Phone Number #2: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Street Address: _____ City/State/Zip Code: _____

Mailing Address: ☐ Yes ☐ No If no, please complete below.

Mailing Address: _____ City/State/Zip Code: _____

Client Aliases

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Demographics

Date of Birth: _____ Sex Assigned at Birth: ☐ Male ☐ Female ☐ Not Listed

Marital Status:
☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Widowed
☐ Never Married ☐ Unknown

Gender Identity:

☐ Male ☐ Female ☐ Non-Binary ☐ Unsure/Questioning ☐ Other ☐ Transgender
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Prefer not to answer
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Unknown/Not Asked
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation:

☐ Heterosexual / Straight ☐ Lesbian (female) ☐ Gay (male) ☐ Bisexual
☐ Prefer not to answer ☐ Unsure / Questioning ☐ Declined to state ☐ Unknown/Not Asked

Pronoun: ☐ He ☐ She ☐ They ☐ Ze

Ethnicity:

☐ Amerasian ☐ American Native ☐ Asian Indian ☐ Black ☐ Cambodian ☐ Chinese
☐ Dominican ☐ Filipino ☐ Guamanian ☐ Hawaiian Native ☐ Hispanic/Latino ☐ Japanese
☐ Korean ☐ Laotian ☐ Mexican/Mexican American ☐ Multiple ☐ Not Hispanic or Latino
☐ Other Asian or Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Unknown

Race:

☐ Alaskan native ☐ American Indian ☐ Asian Indian ☐ Black/African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hmong ☐ Japanese ☐ Korean
☐ Laotian ☐ Mien ☐ Multiracial ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White/Caucasian ☐ Unknown ☐ Prefer not to answer

Language:

Primary/Preferred Language: _____
☐ Client Does not Speak English ☐ Interpreter Services Needed

Hispanic Origin:
☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not of Hispanic Origin
☐ Prefer Not to Answer ☐ Unknown

Providers:

Primary Care Physician: _____ ☐ Does not have PCP

Financial Information

Financially Responsible: ☐ Yes ☐ No

Annual Household Income: $_____ # of Dependents: _____# in Household: _____

Source of Income:
☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension ☐ Disability
☐ Other ☐ None ☐ Unknown ☐ Not collected

Living Arrangements:

☐ Homeless ☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.)
☐ On the streets or in a homeless shelter ☐ Group Home ☐ Foster Family Home
☐ Residential Treatment Center ☐ Jail or Correctional Facility
☐ House or apartment, requiring daily support and supervision (adults only)
☐ Unknown/Not Reported ☐ Other:_____

Education/Employment:

Educational Status:
Currently Enrolled: ☐ Yes ☐ No Grade Level Enrolled: _____
Highest Grade Level Completed: _____
If enrolled in School, Name of School: _____
(Staff Only: School Name is added in Custom Fields)

Military Status: ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No

Employment Status:
☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed Seeking Work
☐ Unemployed Not Seeking Work ☐ Student ☐ Ages 0-5 ☐ Retired
☐ Disabled Not in Workforce ☐ Other: _____

Criminal Justice Involvement:
☐ Probation ☐ Dept of Corrections ☐ Dept of Youth Services Commitment
☐ Jail ☐ Parole ☐ AB109 ☐ Court ☐ Not Involved

Transportation Information

☐ Transportation Services Needed

Special Needs

Note any special needs/accommodations (e.g. wheelchair, service animal)

Preferences

Communication Preference: ☐ Text Message ☐ Email ☐ Voice ☐ Do Not Send Any Notifications

Communication Phone Number: _____

Contacts

Contact #1 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client Street Address: _____

City, State, Zip: _____

Preferred Language: _____ Primary Language: _____

Contact #2 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client Street Address: _____

City, State, Zip: _____

Preferred Language: _____ Primary Language: _____

BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

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

Medical Providers:

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

☐Community Health Center ☐Private Community Physician ☐Hospital Emergency Rooms
☐Urgent Care Center ☐Pain Management Services ☐Specialty Medicine (i.e., Neurology, Cardiology, Endocrinology)
☐Dentists ☐Methadone Clinics

General Health Information

1. Date you last saw a Doctor / Nurse Practitioner / Physician Assistant:	2. What was the purpose of the visit?	3. Date of your last physical exam?

4. ☐ How many times have you visited an Emergency Room in the past 30 days?

5. ☐ How many days in past 30 have you stayed overnight in a hospital for physical health problems?

6. ☐ How many days in the past 30 have you experienced physical health problems?

7. ☐Yes ☐No Have you ever had surgery? If yes, please list:

8. ☐Yes ☐No Any other illness that requires frequent medical attention? If yes, please give details:

Allergies

9. ☐Yes ☐No Do you have any allergies? If yes, *what type of reaction did you have?* Fill out below-↓

Medication Allergies -

Food Allergies -

Other Allergies -

Medications

10. Please list any prescribed medications and over-the-counter medications you take regularly. (Include dosage and prescribing physician)

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

11. Which Pharmacy do you use?

12. Are you currently experiencing or do you have any of the following?

Yes	No		Yes	No	
☐	☐	Swollen Ankles	☐	☐	Seizures
☐	☐	Jaundice	☐	☐	Headaches
☐	☐	Sinus Problems	☐	☐	Weight Gain or Loss Recently
☐	☐	Bleeding Problems - Bruising Easily	☐	☐	Shortness of Breath
☐	☐	Joint Pain or Stiffness	☐	☐	Blood Transfusions
☐	☐	Difficulty Swallowing	☐	☐	Arthritis
☐	☐	Chest Pain (Angina)	☐	☐	Stroke - If yes, give details: _____
☐	☐	Excessive Heartburn or Abdominal Pains	☐	☐	High Blood Pressure
☐	☐	Excessive Thirst	☐	☐	Low Blood Pressure
☐	☐	Cough, Persistent or Bloody	☐	☐	Artificial Joint
☐	☐	Chronic Back Pain	☐	☐	Head Injury - If yes, give details: details: _____
☐	☐	Tooth or Gum Problems	☐	☐	Cancer
☐	☐	Nausea or Vomiting	☐	☐	Chemotherapy/Radiation
☐	☐	Diarrhea, Constipation, Blood in Stools	☐	☐	Diabetes
☐	☐	Dizziness or fainting	☐	☐	Asthma, Emphysema, or Chronic Bronchitis
☐	☐	Frequent or Bloody Urination	☐	☐	Anemia
☐	☐	Rashes	☐	☐	Heart Attack or Heart Problem - If yes, please give details:
☐	☐	Blurred or Double Vision			
☐	☐	Fever			

CLIENT NAME	CLIENT NUMBER

13. Women Only

Yes No	Yes No
☐ ☐ Are you pregnant? If yes, due date: _____	☐ ☐ Have you experienced any domestic violence?
☐ ☐ Are you breastfeeding? If yes, date of delivery: _____	☐ ☐ Do you have pain with intercourse?
☐ ☐ Have you had any miscarriages or abortions? If yes, please give details: _____	☐ ☐ Have you had an abnormal mammogram or lump? If yes, please give details: _____
☐ ☐ Do you have difficult periods? If yes, please give details: _____	☐ ☐ Have you had an abnormal PAP smear? If yes, please give details: _____
At what age did you start your first period? _____	Date of last GYN exam: _____
Date of last period: _____	

Communicable Diseases

14. ☐Yes ☐No Have you ever been tested for TB? (Tuberculosis)?
15. ☐Yes ☐No Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: _____

16. ☐Yes ☐No Have you been diagnosed with Hepatitis C? Date of last test: _____
17. ☐Yes ☐No Have you been tested for any other liver disease?

18. ☐Yes ☐No Have you been diagnosed with a Sexually Transmitted Disease (STD)? 19. ☐Yes ☐No Did you get treated?	Date of last STD Test?
20. ☐Yes ☐No Have you been tested for HIV? 21. ☐Yes ☐No Did you receive the test result?	Date of last HIV Test?

Mental Health

22. ☐Yes ☐No Have you ever been diagnosed with a mental illness? If yes, what was your diagnosis? _____
23. ☐Yes ☐No Did you receive treatment? If yes, please give details:

24. ☐ How many times in the last 30 days have you received outpatient emergency services for mental health needs?

25. ☐ How many days in the last 30 have you stayed 24 hours or more in a hospital or psychiatric health facility for mental health needs?

26. ☐Yes ☐No In the past 30 days have you taken prescribed medication for mental health needs, including medication for anxiety?

27. ☐Yes ☐No Past suicide attempts?	28. Date of last suicide attempt:	29. How many suicide attempts in your lifetime?

Alcohol and Other Drugs

30. **Do you use the following substances and how frequently:**	**Daily**	**Often**	**Sometimes**	**Date last used**
Alcohol→				
Other substances→				

31. ☐Yes ☐No Have you ever injected drugs?
32. ☐Yes ☐No Have you shared needles?
33. ☐Yes ☐No Have you shared cottons?

34. ☐ How many days in the past 30 have you injected drugs?	Last time injected drugs:

35. ☐Yes ☐No Have you ever used SLO Co. Needle Exchange?

36. ☐Yes ☐No Are you in withdrawal today? If yes, list from what substance(s)?

37. ☐Yes ☐No Seizures, delirium tremens? If yes, please give details:

38. ☐Yes ☐No Have you had blackouts? If yes, please give details:

39. ☐Yes ☐No Are you currently smoking / ingesting marijuana? → ☐Yes ☐No Medical Marijuana Card?	Date last smoked/ingested marijuana:
40. ☐Yes ☐No Have you ever overdosed on alcohol or other drugs?	If Yes, please give details:

41. ☐Yes ☐No Do you currently use any tobacco products (cigarettes, electronic cigarettes, chew)?

To the best of my knowledge the above information is accurate and true, and I will inform my provider of changes in my health or medications:

Client Signature: **Date:**

Staff Signature: **Date:**

CLIENT NAME	**CLIENT NUMBER**

Client Name _____Client ID # _____

Consent to Treat

Effective/Start Date _____

Purpose

I would like services for myself or my child from County of San Luis Obispo Health Agency and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

My Rights

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

Privacy Practices

I acknowledge I have been offered a copy of County of San Luis Obispo Health Agency's Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others.
I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

Services

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

Risks and Benefits of Services

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.
I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.
I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary

I understand participation in behavioral health services is voluntary, except for certain situations where County of San Luis Obispo Health Agency is legally required to provide services even if it is involuntary, such as 5150 psychiatric

holds or conservatorships. I understand that even if a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

Eligibility for Services

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure. I understand that County of San Luis Obispo Health Agency may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies

I understand providers are generally available during regular county business hours, which are Monday thru Friday 8am to 5pm, except during county holidays. I understand that some programs have different hours of availability. For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with County of San Luis Obispo Health Agency's after-hours telephone service. For urgent or crisis situations, I or my child can contact: 24-Hour Toll-Free-Telephone Line at: 800-838-1381.
For emergencies, I understand my family or I should call 911.

Change of Clinician/Provider

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance

I understand County of San Luis Obispo Health Agency will ask me to provide my financial information on an annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full. I understand any private insurance will be billed by County of San Luis Obispo Health Agency before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social

worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

Additional Documents for Medi-Cal Clients

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries. I have been offered a copy of all relevant handbooks and understand that they're available in all clinics.

Complaints and Grievances

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from County of San Luis Obispo Health Agency and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

Complaints to the Licensure Board

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Client Name _____Client ID # _____

Informed Consent

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.

Client Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Relationship _____

Staff Signature _____ Date_____

County of San Luis Obispo Behavioral Health
Coordinated Care Consent

Client Name _____Client ID # _____

Coordinated Care Authorization

By signing this form, you authorize certain organizations and individuals to use and share your health and other personal information for purposes related to your treatment and care. They will be able to share your information through an electronic health record system maintained by the California Mental Health Services Authority called SmartCare.

1. **Who will share my information if I sign?**
   By signing, your information may be shared by and with any of the following that provide services to you (your providers) and which are connected to SmartCare:

   - County Health Agency Staff and contracted organizations and individual providers.

   Your providers also include any health insurers that provide you with coverage, including any of your mental health plans.

2. **If I sign, will my providers be able to use and share my information for any reason?**
   No. If you sign, you authorize your providers to use and share your information only for limited purposes. You authorize your providers to use and share your information for purposes of treatment, payment, and health care operations only. For example, your providers can use your information to provide you with medical or behavioral health care, to coordinate your care, to determine how much should be paid for services provided to you, or to improve the quality of care.

3. **What types of information about me may be shared if I sign?**
   Your providers may share the following types of information about you:

   - Behavioral Health information, such as any mental health conditions or alcohol or drug use disorders you may have, which could include information on your substance use history and medications, diagnoses, and drug test results.

- Medical information as it relates to your Behavioral Health record, such as information about illness, injuries, medical treatments, allergies, medications, blood tests, and your HIV status.

4. **Can I obtain a list of providers who saw my information?**
   Yes, we can provide you with a list of those who looked at information about you. Just ask us.

5. **Can the providers who see information about me in SmartCare disclose it to others?**
   Yes, if permitted by state and federal laws. In some cases your information may no longer be subject to federal privacy laws once it is shared. Certain substance use disorder information about you may be redisclosed if permitted under the Health Insurance Portability and Accountability Act, except that you do not authorize the disclosure of such information for uses in civil, criminal, administrative, or legislative proceedings against you.

6. **When does my authorization expire?**
   You authorize your providers to access your information for 1 year after the date you sign, unless you indicate below that you want the authorization to last a different period of time.

7. **Can I change my mind and revoke my authorization later?**
   Yes, you have a right to revoke this form at any time. If you want to revoke, you should contact us at 800-838 -1381. If you revoke, some of your providers will still be legally permitted to see some information about you via SmartCare in certain circumstances, but other information (such as your substance use disorder information) typically will be inaccessible to them.

8. **If I am a parent or guardian, can I sign on behalf of my child who is under 18?**
   Yes, you may do so by including your name as the Legal Representative of your child and by signing below. Your child should also sign if your child is 12 or older since your child has the right to authorize disclosure of certain types of information. If you sign on behalf of a child, the form will expire when your child turns 18.

Client Name _____Client ID # _____

9. **Do I have to sign this?**
   No, signing this form is voluntary, and declining to sign this form will not impact your ability to get medical care, mental health or substance use treatment, health insurance, or any government benefits. If you don't sign, some of your providers still may see some of your information in SmartCare in accordance with the law, but the information accessible to them will be more limited than if you provided authorization.
10. **Can I have a copy of this form?**
    Yes, you have a right to a copy of this form. Just ask us for one.

Client Information

First Name _____ Last Name _____

Date of Birth _____ Email _____

Contact _____ Relation of contact to client _____

Phone Numbers

Phone Number _____ ☐ DNC ☐ DNLM

Alternate Number _____ ☐ DNC ☐ DNLM

Addresses

Client Address _____

Mailing Address if different _____

County of San Luis Obispo Behavioral Health
Coordinated Care Consent

Client Name _____Client ID # _____

Consent

I give consent for sharing of information across all services within the County of San Luis Obispo Behavioral Health behavioral health network.

☐ Yes ☐ No

☒ 12 months ☐ 6 months ☐ End of Agency Treatment

Start Date _____ Expiration Date _____

Client Identified Restrictions

Restricted Staff _____

Details on any other restrictions of sharing my data. This will prompt a review by the County of San Luis Obispo Behavioral Health Privacy Officer. This does not guarantee the restriction of this data as specified in the text.

_____

_____

Client Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Relationship _____

Staff Signature _____ Date_____

County of San Luis Obispo Behavioral Health
Consent for Telehealth

Client Name _____Client ID # _____

Consent for Telehealth

Effective/Start Date _____

I hereby agree to receive telehealth services from County of San Luis Obispo Health Agency and its contracted mental health and substance use disorder providers and agree that this is an acceptable mode of delivering health care related services to me in accordance with the terms of this consent form. I understand and agree to the following statements regarding telehealth:

- Telehealth services include the use of video teleconferencing solutions to provide services to a client via electronic interactive audio and video telecommunication from a distant location. Telehealth services are considered face-to-face because the client is visually present. I understand that my provider will not be physically in my presence.
- Telehealth services will be provided to me for purposes of evaluation, diagnosis, management, and treatment.
- The treating provider performing the examination or treatment will keep a record of the consultation in my electronic healthcare record.
- All the information discussed via telehealth is held to the same privacy standards as that of an in-person appointment.
- Should I feel for whatever reason telehealth is not a comfortable means of conducting my treatment sessions, I have the right to withdraw consent for telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with telehealth, 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.

Client Name _____Client ID # _____

- When using my own personal electronic device, County of San Luis Obispo Health Agency does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.
- 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. Audio/visual recording may be allowed with a separate written consent. Such recordings are for staff training purposes only, are not part of the medical record, and are destroyed after intended use.
- Although my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency, I understand that my provider will be unable to render in-person emergency assistance if I experience a crisis during a telehealth session.
- I have a right to access covered services in person. I understand that non-medical transportation benefits are available for in-person visits.

Client Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Relationship _____

Staff Signature _____ Date_____

County of San Luis Obispo Behavioral Health
Consent for Text Communication

Client Name _____Client ID # _____

Consent for Text Communication

Effective/Start Date _____

I hereby agree to receive text messages (SMS) from County of San Luis Obispo Health Agency and its contracted mental health and substance use disorder providers for any purposes related to my treatment, the coordination of my care, or reimbursement for my care, in accordance with terms of this consent form. I acknowledge and understand that:

- If my phone number changes, I should inform County of San Luis Obispo Health Agency as soon as possible. I understand that if I don't inform County of San Luis Obispo Health Agency, providers may continue to text my previous number under this consent, which may result in a breach of confidentiality.
- When using my own personal electronic device, County of San Luis Obispo Health Agency does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.
- Texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular message will be read and responded to within any particular period of time.
- Providers will use reasonable means to maintain security and confidentiality of text information sent and received. Providers and County of San Luis Obispo Health Agency are not liable for any breach of confidentiality caused by the client or any third party.
- I may be charged fees for the sending and receipt of texts by my cell phone carrier.

County of San Luis Obispo Behavioral Health
Consent for Text Communication

Client Name _____Client ID # _____

- I have the right to opt out of the receipt of text messages any time by replying "STOP" to any message I receive from County of San Luis Obispo Health Agency or my provider.
- Depending on the service I use for text messaging, the messages sent may not be encrypted and therefore could potentially be intercepted by other people, and I agree to accept that risk by engaging in text messaging.
- I am under no obligation to communicate with County of San Luis Obispo Health Agency or my providers via text message, and if I have any concerns about communicating via texts I should not do so.

Client Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Relationship _____

Staff Signature _____ Date_____

County of San Luis Obispo Behavioral Health
Consent for Email Communication

Client Name _____Client ID # _____

Consent for Email Communication

Effective/Start Date: _____

I hereby agree to receive emails from County of San Luis Obispo Health Agency and its contracted mental health and substance use disorder providers for any purposes related to my treatment, the coordination of my care, or reimbursement for my care, in accordance with the terms of this consent form. I acknowledge and understand that:

- If my email address changes, I should inform County of San Luis Obispo Health Agency as soon as possible. I understand that if I don't inform County of San Luis Obispo Health Agency, providers may continue to email my previous address under this consent, which may result in a breach of confidentiality.
- When using my own personal electronic device, County of San Luis Obispo Health Agency does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.
- Email is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular message will be read and responded to within any particular period of time.
- Email is not inherently secure and may be intercepted by a third party. Providers will use reasonable means to maintain security and confidentiality of email information sent and received. Providers and County of San Luis Obispo Health Agency are not liable for any breach of confidentiality caused by the client or any third party.
- Email messages from me will be treated as confidential information and may be included in my medical record.

County of San Luis Obispo Behavioral Health
Consent for Email Communication

Client Name _____Client ID # _____

- Depending on the service I use for emails, the messages sent may not be encrypted and therefore could potentially be intercepted by other people, and I agree to accept that risk by sending emails.
- I am under no obligation to communicate with County of San Luis Obispo Health Agency or my providers via email, and if I have any concerns about communicating via email I should not do so.

Client Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____

Client Name _____ Date of Birth _____ Client ID _____

DRUG & ALCOHOL SERVICES OUTPATIENT TREATMENT
Admission Agreement

☒ San Luis Obispo Clinic
2180 Johnson Ave
San Luis Obispo CA, 93401
(805) 781-4275

☐ Grover Beach Clinic
1523 Longbranch Ave
Grover Beach, CA 93433
(805) 473-7080

☐ Atascadero Clinic
5575 Hospital Drive
Atascadero, CA 93422
(805) 461-6060

☐ Paso Robles Clinic
805 E. 4th Street
Paso Robles, CA 93446
(805) 226-3200

☐ South Street Youth Clinic
277 South St Suite T
San Luis Obispo, CA 93401
(805) 781-4754

By signing this Admission Agreement, I confirm voluntary participation in outpatient Substance Use Disorder (SUD) services through Drug & Alcohol Services Outpatient Treatment. By enrolling in the Drug & Alcohol Outpatient Treatment program, I agree to participate by attending appointments as scheduled and following the program expectations listed below.

Services to be Provided:
The length and frequency of Drug & Alcohol Outpatient Treatment services are based on client needs, typically including weekly appointments. Regular appointments shall include one or more of the services listed below:

- Assessment
- Individual Counseling
- Group Counseling
- Education
- Family Sessions
- Care Coordination
- Urine Drug Screens
- Withdrawal Management (WM)
- Medications for Addiction Treatment (MAT)
- Discharge Planning

Program Schedule:
Clients enrolled in the Drug & Alcohol Services Outpatient Treatment program will work with their Specialist/Clinician to schedule individual counseling and to identify group counseling meeting times. Group times are pre-determined, and a schedule will be provided to individuals to determine which times they can attend. Any missed appointment times without advance

notice will be considered a "No-Show" and will be documented in the client's record. Treatment services may be face-to-face in the clinic, by telephone, or by telehealth. Some services, like care coordination, may be provided in the community.

Payment for Services:
There is a charge for every service you receive from Drug & Alcohol Services Outpatient Treatment. This includes your first visit with a Specialist/Clinician, services provided by telephone, and all other scheduled appointments. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

Any change in your financial/insurance status should be reported to Drug & Alcohol Services Outpatient Treatment staff as soon as possible**.** To ensure successful payment for your services please do the following:

- Bring your Medi-Cal Insurance ID card to first appointment;
- Provide a Proof of Eligibility as requested by Drug & Alcohol Services Outpatient Treatment staff for any month in which you receive treatment services;
- If you do not have Medi-Cal for any month, please notify Drug & Alcohol Services Outpatient Treatment staff immediately; and
- Please submit share-of-cost paperwork to Drug & Alcohol Services Outpatient Treatment staff if applicable;
- Notify staff of any other health insurance you may have.

Individuals with Private Insurance coverage will be referred to another SUD provider. The program can assist individuals that need help with applying for Medi-Cal coverage.

Refunds:
Services are billed to Medi-Cal. Because the program does not accept payment from individuals, refunds to clients are not applicable.

Recurrence of Use:
All quality substance use treatment programs will employ some form of testing as part of an outpatient protocol. The reason for testing is to assist in recovery by giving personal accountability to a client. If there were to be a relapse, we know it is best to address it as soon as possible to learn from the relapse and make necessary adjustments. By requiring testing, a client will know there is no point in trying to hide what has happened and encourages honesty. In addition, there can be a motivation for a person to see the tangible results of their success as demonstrated by consistent negative test results. Some clients have told us that the knowledge that they will be randomly tested has made the difference when they were contemplating a relapse.

For individuals receiving MAT, all drug screening results will be shared with the prescriber. Non-compliance with prescribed medications will be addressed on an individual basis with the prescriber as agreed upon in the Medication Consent agreement.

Client Name _____ Client ID_____

If you are at risk of relapse because you are experiencing triggers and/or a strong desire to use drugs or alcohol, we recommend that you utilize your relapse prevention plan that you have developed while in treatment. Contact those people in your life that are of support to you and get in touch with your Specialist/Clinician as soon as possible. If it is after business hours or on the weekend, contact the County's Behavioral Health toll-free crisis phone number at: (800) 838-1381.

Should an individual experience a relapse during treatment, it is important that they contact their Specialist/Clinician right away. Your Specialist can provide assistance during an individual counseling session to help with understanding the circumstances that led to relapse. This is called a Relapse Analysis. Based upon individualized needs, the program may discuss a Behavioral Intervention Agreement – a contract that asks the client to complete specific actions to help them comply with their Treatment Plan and to provide the safest care possible. We can also help you walk through other steps that might be necessary on your part should there be other agencies involved in your treatment such as Probation, Parole, or Child Welfare Services. Being honest about the relapse is the best approach so that the various people involved in your care can adequately support you.

Attending Services Under the Influence:
All Drug & Alcohol Services Outpatient Treatment sites are drug and alcohol-free environments. Clients agree not to attend services while under the influence of alcohol or other drugs. If staff determine that a client is under the influence, the following actions apply:

- Client will be asked to leave group sessions to meet individually with a counselor;
- Safety will be assessed and the Emergency Contact and / or legal guardian may be notified;
- Client may be asked to leave the premises;
- If applicable, car keys will be confiscated, and individual will be supported in arranging for safe transportation;
- If driving away under the influence, law enforcement will be called; and
- Client may be required to agree to follow a Behavioral Intervention Agreement prior to returning to the program.

Termination:
Drug & Alcohol Services Outpatient Treatment program has the right to terminate services for any individual not complying with program requirements. Reasons for termination may include the following but are not limited to:

- Any form of violence, threats of violence, property destruction or breaking the law while on premises.
- The possession of any type of weapon.
- Verbally abusive language.

Client Name _____ Client ID_____

- Possession of drug/alcohol/illegally obtained prescription drugs while on the premises.
- Persistent failure to appear at program sessions.
- Alteration of a drug test or use of a cheating device.
- Theft of any program property or the property of another client.
- Not adhering to program rules, your treatment plan, or any other condition.

Prior to termination, or for behavior resulting in immediate termination, individuals will be given a Notice of Adverse Benefit Determination (NOABD).

Client Rights:
All clients receiving Drug & Alcohol Services Outpatient Treatment services have the following rights to receive quality services without discrimination:

- Receive medically needed services.
- Be treated for the life-threatening, chronic disease of substance use disorder with honesty, respect, and dignity, including privacy in treatment and in care of personal needs.
- Confidentiality and privacy as provided for in HIPAA and Title 42, Chapter I, Subchapter A, Part 2 Sections 2.1 through 2.67, Code of Federal Regulations.
- Be treated with respect and with due consideration for your privacy, and to be accorded dignity in personal relationships with staff and other persons.
- A safe, healthy, ethical, and comfortable treatment environment.
- Be free from intellectual, emotional, verbal and/or physical abuse, exploitation, prejudice, or inappropriate sexual behavior.
- Be afforded access to emergency medical or dental care.
- Be free from discrimination due to race, ethnicity, color, ancestry, national origin, religion, creed, age, disability, sex, sexual orientation, gender identity or expression, marital status, medical condition, or military or veteran status.
- Be informed of all the aspects of treatment recommended to you, including the option of no treatment, risks of treatment, and expected results, presented in a manner appropriate to your condition and ability to understand.
- Free oral interpreter when needed.
- Be treated by qualified staff and receive evidence-based treatment.
- Be treated simultaneously for co-occurring behavioral health conditions, when medically appropriate and when we are authorized to treat co-occurring conditions.
- Receive an individualized, outcome-driven treatment plan or progress notes.
- Remain in treatment for as long as we are authorized to treat you.
- Receive support, education, and treatment for families and loved ones, if needed.
- Participate in decisions about your health care, including the right to refuse treatment.
- Be afforded access to your client records and medical records, and the ability to request that they be amended or corrected.

Client Name _____ Client ID_____

- Receive a copy of the Beneficiary Handbook, which describes our services and your rights.
- Be informed of these rights once enrolled to receive treatment, as evidenced by written acknowledgment or by documentation by staff in the clinical record that a written copy of these rights was given.
- Receive materials in other formats (large print, audio, or other language) upon request within 5 working days.
- Receive ethical care that covers and ensures full compliance with the requirements set forth in Chapter 5 (commencing with Section 10500) of Division 4 of Title 9 of the California Code of Regulations and the alcohol and other drug program certification standards adopted in accordance with Section11832, as applicable.
- Receive services from us that meet the requirements of our contract with the State and the law.
- File a Grievance, either verbally or in writing, about us or the care you receive.
- File an Appeal, either verbally or in writing, when we give you a Notice of Adverse Benefit Determination.
- Request a State Fair Hearing or expedited State Fair Hearing if we don't agree with your Appeal.
- Request a second opinion from us at no cost to you.
- Be free from any form of restraint, exploitation, or seclusion used as a means to coerce, discipline, or retaliate against you in any way.
- Access Minor Consent Services, if you are a minor.
- Freely exercise your rights without fear that it will adversely affect the way we treat you.
- Take medications prescribed by a licensed medical professional for medical, mental health, or substance use disorders.

We are required to:

- Make sure we provide you with information about our services.
- Have enough staff or providers to make sure that you get services as quickly as you need them.
- Arrange or pay for medically necessary services for you if we don't have a provider within our network to treat you. Out-of-network services are free to you.
- Make sure our providers are qualified to treat you.
- Mark sure that we provide enough kinds and amounts of service for enough time to meet your needs.
- Make sure that we fully assess your needs.
- Coordinate the services we provide with your other providers (your Doctor or other community services).
- Have emergency/crisis services available 24 hours a day, 7 days a week, when you need them.
- Provide services that respect the cultural and language differences and needs of all San Luis Obispo County residents.

Client Name _____ Client ID_____

- Make sure that we never retaliate or charge your services because you stood up for your rights.

We are required to follow other State and Federal laws, including, but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- 42 C.F.R. section 438.10, 438.206-210
- Age Discrimination Act of 1975; 45 CFR part 91
- Rehabilitation Act of 1973
- Americans with Disabilities Act (ADA)

To file a complaint or grievance, contact the County of San Luis Obispo Patients' Rights Advocate:

Patients' Rights Advocate
Behavioral Health Services
2180 Johnson Avenue
San Luis Obispo, CA 93401
Telephone: (805) 781-4738
Fax: (805) 781-1232

To file a complaint directly with the Department of Health Care Services:

Department of Health Care Services
Licensing and Certification Division
P.O. Box 997413, MS 2601
Sacramento, CA 95899-7413
Telephone: (877) 685-8333
Fax: (916) 440-5094

You can also file a Civil Rights Complaint with the U.S. Department of Health and Human Services, office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

- https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- By mail or phone at:
  U.S. Department of Health and Human Services
  200 Independence Avenue
  SW Room 509F
  HHH Building
  Washington, D.C. 20201
  1 (800) 368-1019, 1 (800) 537-7697 (TDD)
- Complaint forms are available at:
  https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Client Name _____ Client ID_____

To request a State Fair Hearing conducted by the California Department of Social Services:

- Write to:
  State Hearings Division
  California Department of Social Services
  P.O. Box 944243, Mail Sation 19-3
  Sacramento, CA 94244-2430
- Call:
  1 (800) 952-5253 or 1 (800) 952-8349 (TDD)

Conditions Under Which the Agreement May be Terminated:

- This agreement will be terminated should the certification by the Department of Health Care Services (DHCS) be suspended or revoked for Drug & Alcohol Services Outpatient Treatment program.
- This agreement will be automatically terminated should a client receiving services pass away.

By signing below, I agree to the terms outlined in this Admission Agreement.

Client Signature: _____ Date: _____

Staff Name: _____

Staff Signature: _____ Date: _____

Client Name _____ Client ID_____

County of San Luis Obispo Behavioral Health
Release of Information

Client Name_____**Date of Birth** _____**Client ID** _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

Authorization for the Disclosure of Protected Health Information

By signing this form below, I am authorizing the disclosure of my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

☐ Organization/Provider ☐ Contact ☐ Release To ☐ Obtain From

Release To/Obtain From: ALL TREATMENT PROVIDERS

Purpose of Disclosure

☐ Process insurance/third part claims ☑ Treatment/Care Coordination

☐ Quality Improvement ☐ Other _____

Preferred Method of Delivery

☐ Paper ☐ Encrypted Email ☐ Unencrypted Email

☐ Fax ☐ Encrypted USB ☐ In-Person Drop-Off/Pick-Up

☐ Other: _____

Client Name_____ **Date of Birth** _____ **Client ID** _____

Expiration

If nothing is marked, the authorization will expire one (1) year from date signed. If you would like to specify a different expiration date, then do so by selecting one of the alternative options below or using the "end date" box below.

☐ 1 time disclosure ☐ 6 months

Start Date _____ **End Date** _____

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available

Type: ☐ MH ☑ SUD

☑ All Records ☐ Acknowledgement of Treatment ☐ Medications Prescribed

☐ Billing &/OR Insurance Information ☐ Intake/Admission Information

☐ Psychological Evaluation(s) Reports ☐ Discharge Summary/Plan

☐ Progress Review /Summary ☐ Screening Assessment(s)

☐ School Records/Reports/IEPs ☐ Treatment Plan(s) ☐ Progress Notes

☐ Medical History, Lab Results, Immunization Records

☐ Other _____

Records Start Date _____ Records End Date _____

Client Name_____ **Date of Birth** _____ **Client ID** _____

Restrictions

_____

_____

_____

Terms

I understand:

- Under state and federal confidentiality provisions only the information specified can be released.
- The recipient(s) of my information may disclose it to others. I understand that in some cases my information may no longer be subject to privacy laws once it is disclosed.
- I may revoke this authorization at any time, but a revocation will not apply to information that has previously been released.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature.
- This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get medical care, health insurance, or any government benefits. I have been given the chance to ask questions and receive answers pertaining to this document.
- I have a right to a copy of this form.

Signing for a Child

- I understand that if I am signing this form on behalf of a minor, I should include my name as the “Legal Representative” of my child, and that I should sign this form. If my child is 12 or older, my child should also sign.

By signing, I authorize the disclosure as described above.

County of San Luis Obispo Behavioral Health
Release of Information

Client Name_____**Date of Birth** _____**Client ID** _____

Agency Contact Information

Program _____ Attention _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Copy Given to Client ☐ Yes ■ Declined a copy

Agency Staff _____

ID verified by: ☐ Driver's license ☐ Other picture ID ■ Known to Agency

Information about HIV/AIDs and Substance Abuse Treatment –

Information about HIV/AIDs status and treatment for Substance Abuse will not be released without your specific permission. Do you authorize these releases of information to the person/organization listed above?

Alcohol/Drug Abuse:

☑ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☑ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Client Name_____ **Date of Birth** _____ **Client ID** _____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____

County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name_____ Date of Birth _____ Client ID _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

Authorization for the Disclosure of Protected Health Information

By signing this form below, I am authorizing the disclosure of my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

☒ Release To ☒ Obtain From

Initial whom we can release to or obtain from:			
	SLO County Counsel		Parole
	SLO County District Attorney's Office		Pharmacy
	SLO County Jail Custody Staff		Probation
	SLO County Sheriff (Bailiff)		School
	SLO County Superior Court		SLO City Attorney's Office
	SLO County Social Services		SLO Police Department
	Attorney(s):		Sober Living Environments
	5-Cities Homeless Coalition		Transitional Mental Health Association
	CAPSLO Direct SVCS/Parent Education		Tri-Counties Regional Center
	Court Appointed Special Advocates (CASA)		Veterans' Service Officer
	Family Members (Specify):		Other:
	Foster Parent		Other:

County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name_____ **Date of Birth** _____ **Client ID** _____

Purpose of Disclosure

☒ Treatment/Care Coordination ☐ Other _____

Preferred Method of Delivery

☒ Paper ☐ Encrypted Email ☐ Unencrypted Email

☐ Fax ☐ Encrypted USB ☐ In-Person Drop-Off/Pick-Up

☐ Other: _____

Expiration

☐ 1 time disclosure ☐ 6 months ☒ One (1) Year

Start Date _____ **End Date** _____

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available

Type: ☐ MH ☒ SUD **OR** ☐ MH and SUD

☒ All Records ☐ Acknowledgement of Treatment

☐ School Records/Reports/IEPs ☐ Intake/Admission Information

☐ Psychological Evaluation(s) Reports ☐ Medications Prescribed

☐ Discharge Summary/Plan ☐ Progress Review /Summary

☐ Screening Assessment(s) ☐ Treatment Plan(s) ☐ Progress Notes

☐ Medical History, Lab results, Immunization Records

☐ Other _____

Client Name_____ Date of Birth _____ Client ID _____

Records Start Date _____ Records End Date _____

Restrictions:

_____

_____

_____

Terms

I understand:

- Under state and federal confidentiality provisions only the information specified can be released.
- The recipient(s) of my information may disclose it to others. I understand that in some cases my information may no longer be subject to privacy laws once it is disclosed.
- I may revoke this authorization at any time, but a revocation will not apply to information that has previously been released.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature.
- This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get medical care, health insurance, or any government benefits. I have been given the chance to ask questions and receive answers pertaining to this document.
- I have a right to a copy of this form.

Signing for a Child

- I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form. If my child is 12 or older, my child should also sign.

By signing, I authorize the disclosure as described above.

Agency Contact Information

County of San Luis Obispo Central Health Information at **805-781-4724**

Program _____ Attention _____

Address _____

City _____ State _____ Zip Code _____

Copy Given to Client ☐ Yes ☐ Declined a copy

Agency Staff _____

ID verified by ☒ Driver's License ☐ Other Picture ID ☐ Known to Agency

Information about HIV/AIDs and Substance Abuse Treatment –

Information about HIV/AIDs status and treatment for Substance Abuse will not be released without your specific permission. Do you authorize these releases of information to the person/organization listed above?

Alcohol/Drug Abuse:

☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☒ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name_____ Date of Birth _____ Client ID _____

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☒ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Client Signature _____ Date _____

Parent / Guardian /
Legal Representative Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT

CLIENT COST EXPLANATION AND AGREEMENT

Your provider will explain the cost of services to you. In some cases, you must pay a reasonable fee for the services you receive. Contact your provider or the Billing office at (805) 781-4702 right away if:

- You are unable to pay your fee
- Your income/the number of people dependent on your income change
- You get (or lose) private insurance
- **You get (or lose) Medi-Cal**

☐ **Full Scope Medi-Cal (May include Medi-Medi)**
We accept Full Scope Medi-Cal as payment in full if **you remain eligible**. If you lose your Medi-Cal, you must pay for your services. Please let your provider know as soon as possible so we can help you regain your Medi-Cal or set fees.

☐ **Other Funding Sources (8500)**
County Referrals: AB109, Probation, Superior Court, Department of Social Services (DSS), Child Welfare Services, Family Treatment Court, Youth Treatment Services, School Referrals and Driving Under the Influence (DUI) Program Referrals. Drug and Alcohol Services receives grant money or is contracted by other agencies to provide services at no cost to you while you are enrolled in specific programs. If you also have Medi-Cal in San Luis Obispo, your Medi-Cal will be billed first.

☐ **Share of Cost (SOC) Medi-Cal (May include Medi-Medi)**
Some types of Medi-Cal have a monthly Share of Cost that you must pay before Medi-Cal covers the cost of treatment. The services you receive from every provider apply toward your Share of Cost. Call the Billing Office at 781-4702 to learn about how we help with your Share of Cost or talk to your Eligibility Technician at Department of Social Services to see if you qualify for full scope Medi-Cal, which has no Share of Cost.

Your monthly Share of Cost is: $_____

Client Name:_____ Client Number: _____

Please note, transportation costs are not covered by your UMDAP, it is your responsibility to pay for any uncovered or non-medical transportation costs.

Restricted/Emergency Only Medi-Cal
Emergency or Restricted Medi-Cal only pays for certain emergency services. Your provider will complete an UMDAP with you to determine your responsibility for the cost of the other services you receive.

Medicare only or Private Insurance
Medicare or private insurance may pay for a portion of the cost of your treatment. Your provider will complete an UMDAP with you to determine your responsibility for the cost of the other services you receive. Please be sure we get a copy of both sides of your Medicare or Insurance card.

No known funding source/self-pay
Your provider will complete an UMDAP with you to determine your responsibility for the cost of the other services you receive.

Annual period begins _____and ends: _____

My signature below confirms my understanding of the cost of services.

Client or Responsible Person's Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____