Harrisonburg-Rockingham CSB
Adult Services

Thank you for expressing an interest in receiving mental health and/or substance abuse services from the Harrisonburg-Rockingham CSB.

Please complete the following enclosed forms:

1) Intake Initial Information
2) Request for Service
3) Medical History

Clients over the age of 18 may walk-in for an intake appointment, with these completed forms, to 1241 North Main Street, Harrisonburg, VA 22802. Adult intakes are conducted on Mondays, Wednesdays, and Fridays from 8:00am to 2:30pm. The intake appointment typically takes 2-2.5 hours.

After the Intake, many adult clients will be referred to weekly group therapy or case management services. Some clients may be referred to our psychiatrist or nurse practitioner and prescribed medication. Medication management services are only available to clients who are participating in other CSB services. Therapy and case management is also available for children.

Adults receiving therapy services will not usually be able to continue receiving medication through the CSB once they have completed their therapy. Staff will be available to help with the transition to other medication providers in the community. Individuals in case management services may receive long-term medication management.

WELCOME TO THE CSB

We hope your visit to the CSB will be positive and helpful. Here are some things you may want to know about us:

GENERAL HOURS OF OPERATION
8 AM – 5 PM WEEKDAYS

For an appointment or further information call (540) 434-1941

EMERGENCY SERVICES
24-hours a day, 7 days a week, call (540) 434-1766

OUR MISSION:
The Harrisonburg-Rockingham Community Services Board provides services that promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for individuals and their families whose lives are affected by behavioral health or developmental disorders.

OUR CONFIDENTIALITY PLEDGE:
You will have information about you kept confidential. It will not be shared with anyone without your permission, unless required by an emergency, the law, or other applicable regulations.

PARTICIPATION:
You should be included in decisions regarding treatment and discharge planning. You will be asked to sign your individual treatment plan as an indication of your participation.

YOUR RIGHTS:
Client Rights are posted at each CSB location. Your case coordinator will explain your rights to you. If you feel your rights have been, or will be, violated, talk with your case coordinator or the agency's Compliance Manager. Or you may call the Regional Human Rights Advocate at 1-877-600-7437 (toll free) or 1-540-332-8321.

IF YOU ARE UNHAPPY:
You can ask questions and complain at any time. If your issue cannot be solved to your satisfaction by speaking with your case coordinator, ask to speak with the agency's Compliance Manager or any Director, and we will work with you to determine how to best respond to your concerns.

LANGUAGE ASSISTANCE:
You have the right to receive free language assistance if you have limited English skills. Please let any staff member know of your need for help in this area, and we will do what we can to assist you.

SAFETY:
We want your visit to the CSB to be a safe one. Please note that weapons are prohibited in CSB facilities and on CSB property, and anyone with a weapon will be asked to leave and return at a later time.
We have regular fire/emergency evacuation drills. In the event of a fire drill or an actual emergency, staff will assist and direct you. Please let us know of any special needs you may have!

BUILDING LAY-OUT:
For your safety, there are building maps located throughout the building. Also, there are lighted EXIT signs above doors to show you the quickest way out of the building in an emergency. Please ask if you have questions.

PROGRAM GUIDELINES:
These vary from program to program. However, your case coordinator will let you know any requirements for participation.

Intake Initial Information

Identifying Information

Name: _____ Former/Maiden Name_____
First Middle Last

Street Address:_____

City/Town_____ State:_____ Zip:_____

Date of Birth: _____ SSN:_____

Sex : (circle) Male / Female

If you want help with or were referred for substance use concerns:

- **are you currently pregnant? ___Yes ____No ____N/A**
- **are you currently or have you ever used any drugs by injecting? _____Yes _____No**
- **are you using opiates, either prescribed or taking more than prescribed, or street opiates such as heroin? _____Yes _____No**

*(Clerical: If any of the above 3 questions have been answered with a yes- enter **Yes** for SA Priority Population on the client profile).*

Contact Information

E-mail Address: _____ Ok to e-mail (circle) Yes No

Cell Phone: _____ Ok to call (circle) Yes No

Would you like to receive Text Appointment Reminders* (circle) Yes No
***English only/Standard Text Messaging Rates Apply**

Cell Carrier (circle): Alltel AT&T/Cingular Boost Mobile Cricket/AIO Wireless Nexttel Sprint

Straight Talk (AT&T) Straight Talk (Verizon) T-Mobile US Cellular Verizon

Virgin Mobile Other: _____

Home Phone: _____ OK to call (circle) Yes No

Other Phone: _____ OK to call (circle) Yes No

Work Phone: _____ OK to call (circle) Yes No

Name and address of person to contact in case of emergency:

_____
Name Address

_____
Phone Relationship

(Continued on back)

Reason/problem for which you are seeking services: _____

Have you ever attempted suicide, harmed yourself or someone else? ___YES ___NO

If so, how long ago?_____

Please describe any other concerns that may need immediate attention:

_____

Demographic Information

***Please check the most appropriate choice for the following*:**

Race

____ Alaskan Native
____ American Indian
____ American Indian or Alaskan Native & White
____ American Indian or Alaskan Native & Black or African American
____ Asian
____ Asian and White
____ Black or African American
____ Black or African American & White
____ White
____ Other / Hispanic
____ Other Multi-Race
____ Native Hawaiian or Pacific Islander

Hispanic Origin

____ Puerto Rican
____ Mexican
____ Cuban
____ Other Hispanic
____ Not of Hispanic Origin
____ Hispanic – Specific origin not identified

Legal Status

____ Voluntary (referred)
____ Treatment Ordered:
____ Condition of probation
____ Condition of parole
____ Condition of diversion
____ Conditional Release (NGRI)
____ Involuntary Civil (MOT, Competency exams)

Referred by

____ Self
____ Family or Friend
____ Developmental Service Provider
____ School
____ Employer/EAP
____ ASAP or DUI Program
____ Police or Sheriff
____ Local Correctional Facility
____ State Correctional Facility
____ Probation ___District 39 ____Court Svcs ___Federal
____ Parole
____ Other Community Referral _____(Name)
____ Private Hospital _____(Name)
____ Private Physician _____(Name)
____ Private MH Outpatient Provider
____ State MH Outpatient Provider
____ State Hospital_____(Name)
____ State Training Center
____ Substance Abuse Provider
____ Court
____ Health Department
____ Other CSB _____(Name)
____ Department of Rehabilitative Services
____ Department of Social Services -TANF
____ Department of Social Services – non TANF
____ Department of Juvenile Justice

Signature:_____ Date:_____

Request for Service

Name_____ **Date of Birth**_____

Insurance Information:

Do you have any type of **Medicaid**? ___YES ___NO **Medicare**? ___YES ___NO

Other health insurance? ___YES ___NO If so, what kind? _____

Name of insured: _____ Relationship: _____

Group #:_____ Policy #: _____

Employer of insured: _____

Information about your Request:

Did someone refer you to the CSB? If YES, who?_____

Are you requesting substance abuse services? ___YES ___NO

Have you had mental health or substance abuse treatment in the past? ___YES ___NO

If so, where and when? _____

Have you come to the CSB before? ___YES ___NO If **YES**, when? _____

Are you now a college student? ___YES ___NO If **YES**, where? _____

Are you currently taking any medication? ___YES ___NO If **YES**, please list:

MEDICATION	DOSAGE	START DATE	PRESCRIBING DOCTOR

Do you have any allergies to medications or foods? __YES __NO If **YES**, please list:

Medication, food, etc.	Severe? YES or NO	Reaction

(continued on back)

Have you ever or are you currently using alcohol or drugs? __YES __NO If **YES** please list:

Type	How often?	How much?	Date of last use	Method of use

Information about You:

Please put a **check** next to the items that are of concern to you.

Mood Problems:

_____Feeling low or down
_____Feeling nervous or anxious often
_____Panic attacks

Relationship Problems:

_____Conflict with important others
_____Feeling lonely often
_____Problems with people at work
_____Relationship loss or death

Substance Abuse Issues:

_____I think I have a problem with alcohol or drugs
_____Someone else thinks I have a problem with alcohol or drugs
_____I need to start an alcohol/drug program

Safety Problems:

_____I am hearing voices or seeing things that others do not
_____I am harming myself or fear I will
_____I am thinking of suicide
_____I am thinking of harming someone else
_____I am in a dangerous or unhealthy life situation

Daily Life Problems:

_____I am having trouble managing finances
_____I am having housing problems
_____I am having a hard time taking care of my daily life and routine needs

Signature:_____ **Date:**_____

Medical History

To be completed by the Client, Guardian or Legal Authorized Representative

Date: _____

Name : _____ **DOB:**_____

Do you have a family doctor? ____ YES ____NO
If Yes, please list name and practice: _____

_____

Do you have any current or recent physical complaints? ____ YES ____NO
If Yes, please describe: _____

_____

Do you have any Chronic Conditions such as Diabetes, Hypertension, Hepatitis C, etc…? ____ YES ____NO
If Yes, please list: _____

_____

Have you had any past serious illnesses; serious injuries; or hospitalizations? ____ YES ____NO
If Yes, please describe:_____

_____

Have you ever been around, or had symptoms of TB such as fever of long duration, unexplained weight loss, a bad cough lasting over two weeks or coughing up blood? ____ YES ____NO

Have you ever had a positive TB skin test ? ____ YES ____NO

Are you under a physician's care? ____ YES ____NO
If Yes , please list Physician(s) name and specialty:_____

_____

(continued on back)

Do you have any communicable diseases? ____ YES ____NO
If Yes, please list: _____

_____

Do you have any handicaps or restrictions on physical activities? ____ YES ____NO
If Yes, explain: _____

_____

Do you have any significant communication problems? ____ YES ____NO
If Yes, please explain:_____

_____

Do any of the following have a serious illness or chronic condition(s)?

Parents? __YES __ NO If yes, describe: _____

_____

Siblings? __YES __ NO If yes, describe: _____

_____

Significant others in the same household? __YES __ NO If yes, describe:_____

_____

Do you have any sexual health or reproductive history related to your request for services? ___ YES ___NO
If Yes, please describe: _____

_____

Items to Bring to Your First Visit:

Insurance Card
If you are covered by insurance, we will need your insurance card to be able to bill your insurance provider. If you have insurance and do not provide us with the information, you will be required to pay full fee. If the services you receive are not covered by your insurance or you do not have any insurance, then you can apply for a reduced fee.

Verification of Household Income
We need income information for all adults in the household to determine your eligibility for a reduced fee. This could include:

- *Wages* – recent check stub
- *Retirement/Pension* – annual report or bank statement showing direct deposit amount
- *Disability* – current disability papers
- *Social Security* – current social security papers
- *Food Stamps* – verification letter
- *Child Support/Alimony* – court order, bank statement showing direct deposit amount, or a copy of the check

Other Information
- *Social Security Number(s)* – for you and each adult members of the household
- *Picture ID* – your driver's license or some other state issued identification, employment badge, student ID card, etc.
- *Weapons Prohibited* – Please be aware <u>that weapons are prohibited in CSB facilities and on CSB property, and anyone with a weapon will be asked to leave and return at a later time</u>

QUESTIONS AND ANSWERS ABOUT FEES AT THE CSB

1. Why do I pay for services offered by the Harrisonburg-Rockingham Community Services Board (CSB)?

CSB services are not free. The CSB is required to collect fees by the Code of Virginia (state law) and regulations of the Virginia Department of Behavioral Health and Developmental Services.

2. How is it decided how much a particular service costs?

We base our fees on how much it costs to provide each service. Some fees are set by the State Medicaid agency.

3. Do I have to pay for the total cost of the services I use?

At the time of your first appointment, you will have a "financial interview" with a member of our financial staff. The purpose is to determine your ability to pay for CSB services.

If you have health insurance, please bring your insurance card/information with you. We will bill your insurance company, and you are responsible for paying the co-pays and deductibles required by your policy.

If you have Medicaid or Medicare, please bring your card(s) with you. We will bill them, and you are responsible for your co-pays.

If you do not have insurance and cannot afford the full fee, you may apply for a reduced fee. If you are eligible, we will give you a discount on services you receive. If you do not qualify for a reduced fee, you are responsible for the full charge.

4. If I qualify, how is my reduced fee determined?

We use an "ability to pay scale" based on your total household income and the number of people in your household. You will need to provide documentation of your total household income (for example – pay stubs, child support payments, Social Security benefits, etc.) and the Social Security number and employment information for each adult in your household. If we do not receive this information, we must charge you the full fee. In order to continue your eligibility for a reduced fee, we expect you to provide us with complete and verifiable information, and promptly inform us any time there is a change.

5. When do I pay?

Payment is due when you come to each appointment at our offices. We will also send you a monthly statement showing all charges, payments, and unpaid balances due. You can mail payments to the CSB or bring the money to your next appointment. We accept cash, checks, money orders, and Visa or Mastercard payments.

OVER…..

6. What if I cannot afford the reduced fees?

We will work with you to determine an affordable payment plan. Talk with us. No one will be refused services because of an inability to pay. We do expect you to pay what you can.

7. What if my financial situation changes?

We realize situations change. Simply contact the CSB's financial staff at 434-1941 to discuss the matter. If your income goes up or down (for example – if you lose your job or get a new one) it is your responsibility to promptly notify us. To continue your eligibility for a reduced fee, you must always provide us with current, accurate information on your total household income.

8. What if I disagree with my bill?

Please contact the CSB's financial staff at 434-1941 to discuss the problem.

9. If I have a crisis situation, will I be charged?

Yes, you will be charged a fee for services you receive in an emergency or crisis situation. If you have not had a financial interview and cannot afford the cost of this service, please contact us. A staff person will work with you to determine your eligibility for financial assistance, and arrange a suitable payment. If you are currently using CSB services, and have already completed a financial interview, the existing terms of your Fee Agreement will apply.

10. Do you accept Visa and Mastercard payments?

Yes, we do. Visa and Mastercard payments may be made over the telephone (434-1941) or in person.

11. Are there any special payment agreements for the CSB to send a report to my Probation Officer, ASAP Case Manager, or to the Court?

When you have completed treatment and your account is paid in full, we will send a Final Compliance Report to the appropriate officials.

Harrisonburg-Rockingham Community Services Board
Privacy Notice

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.

We are required by law to maintain the privacy of your protected health information (PHI), to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. You have a right to a copy of this notice.

This Notice was revised in September 2013 to meet requirements of the HIPAA Omnibus Final Rule.

Your Privacy is Important to Us

The Harrisonburg-Rockingham Community Services Board (HRCSB) understands your privacy is important. All information we receive about you will be handled only as allowed by federal/state law and agency policy, adhering to the most stringent law that protects your health information.

Each time you receive services from us, we document those services. The medical record contains your assessment, service plan, progress notes, diagnoses, treatment, and transition or discharge plan for continuity of care.

Your Individual HIPAA Rights

There are several rights concerning your health information in the medical record that we want you to be aware of:

- You have the right to request access to your paper and/or medical record in order to inspect, amend, or correct it. This process is kept confidential. This right is not absolute. In certain situations, we can deny access to your medical record if it is determined that access would cause you harm. You may make this request to your Care Coordinator or the agency's Compliance Supervisor.
- You have the right to ask us to communicate with you using a certain method or location. For example, you may ask us to send your mail to a different address. We will agree to all reasonable requests.
- You have the right to ask and receive a paper and/or electronic copy of your medical record.
- You have the right to receive an accounting of the agency's disclosure of your medical record.
- You have the right to receive notification whenever a breach of your unsecured Protected Health Information (PHI) occurs.
- You have the right to ask for a restriction of your PHI to your health plan if you pay for medical services entirely out-of-pocket.
- You have the right to ask for other restrictions with regard to the use or disclosure of your PHI. Your request will be given serious consideration. You will be informed promptly whether we will be able to use the restriction and still offer effective services, receive payment and maintain health care operations. However, we are not required to agree to a requested restriction.

How We Are Allowed to Use and Disclose Your PHI

In order to provide effective services, there will be times that the agency uses and discloses necessary information about you within the agency and with business associates in order to provide:

- **Treatment** - In order to effectively provide treatment/service, HRCSB staff may consult and share PHI about you with other service providers within the agency.
- **Payment** - In order to receive payment of services provided, your health information may be sent to those companies or groups responsible for payment coverage, and a monthly bill is sent to the Responsible Party identified by you and noted on the financial form. You can request that certain PHI is not disclosed to your health plan(s), if you choose to pay the full fee out of pocket.
- **Healthcare Operations**- In day-to-day business practices, trained staff may access your paper and/or electronic medical record for service delivery, filing documentation, providing appointment reminders by call or letter, as well as conducting quality assessment and improvement activities. Certain data elements are collected for statistical reporting to the Department of Behavioral Health and Developmental Services (DBHDS).
- **Marketing** – HRCSB will not sell or use your PHI for marketing purposes.
- **Fund Raising –** HRCSB does not conduct fundraising activities.

Uses and Disclosures without Authorization

HRCSB is allowed by federal and state law in certain circumstances to disclose specific health information about you without your consent, authorization, or opportunity to agree or object. There is documentation available to you upon your request listing what information was disclosed, to whom and for what reason.

These specific circumstances are:

- **Required by law** (ex: Court-ordered warrant or subpoena)
- **Public health authorities** for authorized activities (ex: Communicable diseases)
- **Legal proceedings** (ex: Order from a court or administrative tribunal)
- **Law enforcement purposes** (ex: reporting of gun shot wounds; limited information requested about suspects, fugitives, material witnesses, missing persons; witnesses criminal conduct on premises)
- **Avert a serious threat to health and safety** (ex: in response to a statement/action made by person served to harm self or another)
- Children or incapacitated adults who are **victims of Abuse, Neglect or Exploitation**
- **Specialized government functions**
  - Military services (ex: in response to appropriate military command)
  - National security and Intelligence activities (ex: in relation to protective services to the President of the United States)
  - State Department (ex: medical suitability for the purpose of security clearance)
- **Correctional facilities** (ex: to correctional facility about an inmate)
- **Research** (ex: for research approved by institutional review board)
- **Health oversight activities** (ex: DBHDS)
- **Workers compensation** (ex: facilitate processing, treatment and payment)

- **Coroners and medical examiners** (ex: for identification of a deceased person or to determine cause of death)
- **Secretary of Health and Human Services** (ex: HHS Secretary may monitor for HIPAA compliance)
- **Emergencies** (ex: serious health condition for treatment)

Uses and Disclosures by Authorization Only

We are required to obtain your authorization prior to use or disclosure of your PHI for any reason other than treatment/services, payment, or health care operations, and those specific circumstances outlined previously. For example, medical records pertaining to drug/alcohol treatment are further protected by federal confidentiality rules (42 C.F.R., Part 2) and are only used and disclosed with your written authorization. We use an *Authorization to Release/Receive Medical Records and/or Exchange Information* form that is signed by you or your legal representative and specifically states what information can be given to whom, and for what purpose. In most circumstance, only the minimum necessary information is used/disclosed. You have the right to revoke the signed authorization at any time by a written statement given to us for that purpose, except to the extent that we have acted on the authorization.

Changes to This Notice

HRCSB may change the terms of this Notice and privacy policies and practices as allowed by federal and state law. The new notice will be available upon request, in our office, and on our web site.

Additional Information

If you want more information about your privacy rights, are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your PHI, you can make a complaint verbally or in writing. We will not take any action against you for filing a complaint.

If you would like additional information concerning our Privacy Policy, or the federal and state laws pertaining to privacy, or to make a complaint, please contact:

- ***HRCSB Compliance Supervisor**, Phone # 434-1941*
- ***HRCSB Privacy Officer**, Phone # 434-1941*
- ***HRCSB Medical Records Supervisor, Phone** # 434-1941*
- ***Secretary of U.S. Department of Health and Human Services**, Phone # (202) 619-0257*