COMPREHENSIVE
LIFE RESOURCES

Client ID: _____ Admission Date: _____

Comprehensive Life Resources
Admission Form — Outpatient Services

Client Legal Name: _____ **Registered Legal Sex:** ❑ Male ❑ Female

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

Name Client Prefers to Go By: _____

Pronouns: *(check one that applies)*

❑ she/her/hers ❑ he/him/his ❑ they/them/theirs ❑ ze/zir/zem ❑ other _____

Maiden Name: *(if applicable)* _____

Marital Status: *(check one that applies)*

❑ Single or Never Married ❑ Married or in Committed Relationship

❑ Separated ❑ Divorced/Annulled ❑ Widowed

Employment: *(check one that applies)*

❑ Employed Full-Time ❑ Employed Part-Time

❑ Child/Not Applicable ❑ Unemployed but Actively Looking for Work ❑ Not in Labor Force

Gender Identity: *(check one that applies)*

❑ Male ❑ Female ❑ Genderqueer ❑ Transgender (MTF) ❑ Transgender (FTM)

❑ Other ❑ Choose not to answer

Sexual Orientation: *(check one that applies)*

❑ Heterosexual/Straight ❑ Homosexual/Gay/Lesbian ❑ Bisexual ❑ Other ❑ Choose not to answer

Email: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Preferred Method of Contact: *(check one that applies)*

❑ Email ❑ Regular Mail ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Do not contact

Client Mailing Address: _____

City: _____ **Zip Code:** _____ **County:** _____

Ethnicity: *(check any that apply)*

❑ *American Indian/Alaska Native ❑ Asian Indian ❑ Black, African American ❑ Cambodian

❑ Chinese ❑ Filipino ❑ Guamanian/Chamorro ❑ Japanese

❑ Korean ❑ Laotian ❑ Middle Eastern ❑ Native Hawaiian

❑ Other Asian ❑ Other Pacific Islander ❑ Some Other Race

❑ White ❑ Choose not to answer

*If American Indian/Alaskan Native, what tribe are you affiliated with? _____

Hispanic Origin: *(check one that applies)*

❑ Cuban ❑ General Hispanic ❑ Mexican/Mexican-American/Chicano

❑ Not Spanish/Hispanic ❑ Other Spanish/Hispanic ❑ Puerto Rican ❑ Choose not to answer

Primary Language: _____

Education: *(check one that applies)*

❑ Full Time Education ❑ Part Time Education ❑ Not in Educational Program

School Enrolled: _____

Military Service: *(check one that applies)*

❑ Not Applicable ❑ Active Duty ❑ Veteran ❑ Family member/Dependent of Active Duty member

Smoking Tobacco Use:

❑ Never Smoked ❑ Former Smoker

If Smoker, check one that best describes your tobacco use:

❑ Current Every Day Smoker ❑ Currently Smoke Some Days

❑ Heavy Tobacco Smoker ❑ Light Tobacco Smoker

Pregnancy Status:

Are you pregnant? ❑ Yes ❑ No ❑ N/A Are you currently nursing? ❑ Yes ❑ No ❑ N/A

If you checked yes for pregnancy, what is your expected due date? _____

Client Living Arrangements: *(check one that applies)*

❑ Private Residence (House/Apartment/Condo) ❑ Foster Home ❑ Homeless/Sheltered

❑ Homeless/Unsheltered ❑ Residential Care (Park Place/Seeley Lake Lodge/Luckett House) ❑ Other

Consumer Income:

Gross Monthly Income: $ _____ Number of Dependents: _____

Female Head of Household: ❑ Yes ❑ No

Referral Source: *(Please tell us how you heard about CLR)*

❑ Self/Family member ❑ Substance Use Disorder Provider ❑ Other Healthcare Provider

❑ Self Help Group ❑ Employer ❑ Court/Criminal Justice System

❑ Mental Health Provider ❑ School ❑ Other

Referring Organization:

Community Contacts:.

Emergency Contact: _____ Phone: _____ Relationship: _____

❑ Declined Emergency Contact

Primary Care Provider: _____ Phone: _____ Clinic: _____

❑ Does not have a primary care provider (needs referral)

Thank you for taking the time to complete this form. Please return it to the receptionist for processing.

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Consent to Treatment

Client ID # _____ I, _____, hereby apply and give my consent to receive services from Comprehensive Life Resources (CLR).

I understand that individuals providing services directly with clients must be credentialed with the State of Washington Department of Health. The Department of Health and its Health Systems Qualify Assurance Division is responsible for regulating healthcare professionals and facilities in Washington State. This registration or credential does not necessarily imply the effectiveness of treatment.

Client Rights - I have received a copy of the Client Rights Statement, including information about how to file a concern or grievance.

HIPAA Privacy Notice - I have received a copy of the Privacy Notice.

Telehealth Services- I confirm that I have received and read information carefully. I understand my responsibilities as a participant. I have had my questions regarding these services explained.

Treatment Policies - I acknowledge and understand these policies about my treatment at CLR.

- If I do not keep my scheduled appointment or if I cancel the appointment less than 24 hours before the appointment 2 times in a row or for 3 appointments in a calendar year, I may be discharged from services.
- If I am discharged due to no-shows, I will not be eligible to re-enroll in services for a period of 6 months from the date I am discharged.
- If I receive different kinds of services such as counseling, medication management, or peer support, I must meet with my assigned primary counselor or therapist for at least 1 hour each month of I may be discharged from services.
- This policy pertains to all scheduled outpatient services such as counseling, therapy, medication management, and peer support services.
- My treatment team will assess and evaluate my treatment before any decision about my discharge.

Responsibility to Provide CLR with Demographic and Financial Information

I acknowledge and understand that I will provide CLR with information about the persons in my household, my family income, any insurance coverage and/or other financial and family related information. I agree to provide this information even if I am not currently paying for my treatment or I am not currently eligible for Medicaid or Medicare. I also understand that CLR may send my identifying information to third parties such as Medicare, Health Care Authority, Managed Care Organizations, Community Service Offices and insurance companies allowed by law. All client information sent pursuant to these types of disclosures is confidential and used solely for billing purposes.

Financial Responsibility - I understand and accept my financial responsibility to CLR for any costs by me and or family members receiving services at CLR.

- If I or a family member has both Medicaid/Medicare and private insurance, I understand that my private insurance will always be billed first.
- If I have private insurance coverage, I will pay any applicable co-pays or deductibles.
- Any private fees assessed for services will be based on several factors including size of my household and family income.
- If I am receiving services through Life Connections or New Beginnings and become eligible for Medicaid while I am receiving services in Life Connections or New Beginnings, I will notify CLR immediately.
- Any unpaid balances on client accounts older than 6 months or 180 days may be assigned to collections unless an effort is made to arrange payment.

Security Cameras- I acknowledge and understand that, to improve security for clients and staff, CLR public areas are monitored by security cameras with audio and video capabilities.

Data Collection - I have been advised and understand that I may continue to receive services even if I choose not to participate in or complete the confidential data collection of the service I receive.

EHR Photograph Consent: I understand that my photograph may be taken and securely stored in my electronic health record (EHR) for identification purposes, in accordance with HIPAA privacy and security standards.

Client Name_____Client ID#_____

Client Signature_____Date_____

Representative Name_____Relationship to consumer_____

Representative Signature_____Date_____

Washington State Department of Social & Health Services

Transforming lives

MENTAL HEALTH DIVISION
GAIN-SS

Section Completed by Clinician
Location of screen:
❑ Intake/Admission
❑ Tx Plan Session
❑ Crisis Episode
Consumer:
❑ Declined
❑ Unable to complete

Demographic Information and GAIN-SS (Self-Report) Completed by Consumer			
DATE	LAST NAME	FIRST NAME	MIDDLE NAME
5. DATE OF BIRTH	7. GENDER ❑ Male ❑ Female		

By answering the questions in this checklist, you w ll help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.

Completing the checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for <u>two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.</u>
Please answer the questions Yes or No.

During the past 12 months, have you had significant problems		
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	❑ Yes	❑ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling sleep during the day?	❑ Yes	❑ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	❑ Yes	❑ No
d. when something reminded you of the past, you became very distressed and upset?	❑ Yes	❑ No
e. with thinking about ending your life or committing suicide?	❑ Yes	❑ No
IDS Sub-scale Score (0 to 5)		
During the past 12 months, did you do the following things two or more times?	❑ Yes	❑ No
a. Lie or con to get things you wanted or to avoid having to do something?	❑ Yes	❑ No
b. Have a hard time paying attention at school, work or home?	❑ Yes	❑ No
c. Have a hard time listening to instructions at school, work or home?	❑ Yes	❑ No
d. Been a bully or threatened other people?	❑ Yes	❑ No
e. Start fights with other people?	❑ Yes	❑ No
EDS Sub-scale Score (0 to 5)		
During the past 12 months, did....	❑ Yes	❑ No
a. you use alcohol or drugs weekly?	❑ Yes	❑ No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	❑ Yes	❑ No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	❑ Yes	❑ No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	❑ Yes	❑ No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or void withdrawal problems?	❑ Yes	❑ No
SOS Sub-scale Score (0 to 5)		
SIGNATURE	DATE	

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Patient Health Questionnaire- 9 (PHQ-9)

For ages 18+

Client Name: _____ Client ID: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by the following problems?

(Please check corresponding option)

	Not at all (0)	**Several Days** (1)	**More than Half the days** (2)	**Nearly Every Day** (3)
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling asleep or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself — or that you are a failure or have let yourself or family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or in hurting yourself in some way	☐	☐	☐	☐
(For Office Use — Scoring)				
Total Score:				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult

❑ Very difficult ❑ Extremely difficult

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Courtesy Agreement

As part of our commitment to maintaining a safe and inclusive environment for all clients and staff at Comprehensive Life Resources, we have a zero-tolerance approach to hate speech as we strive to maintain a culture of belonging for all.

Hate speech refers to any form of communication or expression that promotes discrimination, hostility, or prejudice against individuals or groups based on attributes such as race, ethnicity, religion, gender, sexual orientation, disability, economic status or appearance. We believe in fostering an atmosphere of respect, empathy, and support, where everyone feels valued, safe and included.

It is imperative that each client understands the severity of engaging in hate speech and its detrimental impact on the wellbeing of our community.

If any client is found participating in hate speech of any kind, we will address this behavior immediately as a reminder of our expectations for respectful and inclusive conduct. We encourage clients to use the opportunity to seek support and resources for reflection, education, and continued growth. Engaging in hate speech after a warning could result in discharge from services.

By signing this agreement, I acknowledge I have read and understood this agreement and commit to being a part of building a culture of belonging at CLR.

Client Name:_____Client ID:_____

Client Signature:_____Date: _____

If the client is under 13 years of age:

Guardian Signature:_____Date: _____