BEHAVIORAL HEALTH AND RECOVERY

Request for Services

TULALIP TRIBES BEHAVIORAL HEALTH MENTAL WELLNESS INTAKE COVER SHEET FOR FRONT DESK STAFF

TODAY'S DATE

SECTION A PATIENT DEMOGRAPHIC INFORMATION

FULL LEGAL NAME (FIRST)	(LAST)	(MIDDLE INITIAL)	SOCIAL SECURITY #

PREFERRED NAME	PREFERRED PRONOUNS	DATE OF BIRTH	AGE

LEGAL GENDER ☐ Male ☐ Female

GENDER IDENTITY ☐ Male ☐ Female ☐ Transgender Female/ Male-to Female ☐ Transgender Male/ Female-to Male ☐ Other: _____

SEX ASSIGNED AT BIRTH ☐ Male ☐ Female

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ SIGNIFICANT OTHER

ADDRESS

CITY	STATE	ZIP CODE

Is it ok for a therapist to send mail to this address? ☐YES ☐ NO

Is there another address you would like mail sent to from us? ☐YES ☐NO

Preferred Mailing Address:

CITY	STATE	ZIP CODE

HOME PHONE # IS THIS PRIMARY #? ☐ YES ☐ NO	CELL PHONE# IS THIS PRIMARY #? ☐ YES ☐ NO
Is it ok for a therapist to leave a message at this number? ☐ YES ☐ NO	Is it ok for a therapist to leave a message at this number? ☐ YES ☐ NO

SECTION B PATIENT TRIBAL INFORMATION

ARE YOU:
☐ ENROLLED TRIBAL MEMBER
☐ DESCENDENT OF ENROLLED MEMBER
☐ SPOUSE OR PARENT OF ENROLLED MEMBER
☐ NON-NATIVE

NAME OF TRIBE (IF APPLICABLE):_____

ENROLLMENT # (IF APPLICABLE):_____

Please provide Enrollment Card/Tribal Verification to be scanned

SECTION C EMPLOYMENT INFORMATION

NAME OF EMPLOYER

☐Full Time ☐ Part Time ☐ On Call

OCCUPATION:	WORK PHONE#

SECTION D ADDITIONAL PATIENT INFORMATION

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC/LATINO ☐ UNKNOWN BY PATIENT ☐ DECLINED TO ANSWER

RACE: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ AFRICAN AMERICAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ UNKNOWN BY PATIENT

PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

PATIENTS EMAIL ADDRESS:		
SECTION E CONTACT INFORMATION		
PERSON WHO CAN BE CONTACTED IN THE EVENT OF AN EMERGENCY		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

SECTION F ALTERNATE RESOURCE INFORMATION		
DO YOU CURRENTLY HAVE MEDICARE? ☐ YES ☐ NO	MEDICARE NUMBER:	
ARE YOU CURRENTLY ENROLLED IN WA STATE MEDICAID PROGRAM? ☐ YES ☐ NO IF YES, PLEASE GIVE MEDICAID NUMBER:		
DO YOU HAVE AN EMPLOYER SPONSORED INSURANCE PLAN? ☐ YES ☐ NO PLAN NAME:	GROUP #	
POLICY #		
WHO IS THE PRIMARY INSURED (POLICY HOLDER)?	THEIR SOCIAL SECURITY #:	THEIR DATE OF BIRTH:

Please provide insurance card to be scanned

When this cover sheet is completed, return it to the front desk
then continue with the remaining pages.

CONTINUED ON NEXT PAGE ▶

FRONT DESK STAFF USE

☐	DATE RECEIVED	
☐	REGISTERED IN E.P.I.C.	INITIALS

CLINICAL STAFF USE

☐	THERAPIST ASSIGNED:	
☐	APPOINTMENT SCHEDULED:	
☐	REFERRAL ENTERED INTO E.P.I.C.	INITIALS

In order to best meet your needs, please fill out the form below and return to the receptionist. A mental health counselor will contact you for an appointment.

REFERRED BY:

What stressors are you experiencing? (*Please check all that apply*)

- ☐ Family, relationship issues
- ☐ Sad, anxious
- ☐ Grief
- ☐ Housing issues
- ☐ Trauma
- ☐ Anger
- ☐ See medication provider

Notes:

What form of therapeutic service are you seeking? (*Please check all that apply*)

- ☐ Individual Therapy
- ☐ Marriage/Couples or Family Therapy
- ☐ Interested in a Group

Other (Please specify):

What therapeutic technique are you being requesting? (*Please check all that apply*)

- ☐ CBT or DBT
- ☐ CBT-I
- ☐ EMDR or other Somatic Therapy
- ☐ Art Therapy
- ☐ Gender Affirming Care
- ☐ Other (notate below)

Notes:

Preferred Gender Presentation of Provider? (*Please check all that apply*)

- ☐ Male
- ☐ Female
- ☐ Other or Any

Notes:

Are there any scheduling limitations we should be aware of? (*Please check all that apply*)

- ☐ Not able to come in person
- ☐ My availability is outside normal business hours

Notes:

Court Involved (*Please check all that apply*)

Are you seeking a court ordered assessment or evaluation? ☐ Yes ☐ No

Which court is this for? ☐ Tulalip ☐ Snohomish County ☐ King County ☐ Other:

What type of case? ☐ Criminal Court ☐ Civil Court ☐ Family Court ☐ Wellness/Drug Court

Are your charges related to Domestic Violence (DV)? ☐ Yes ☐ No

If an assessment is being requested, please provide documentation of the request.

Additional information:

Questions

Are you having thoughts of hurting yourself or suicide at this time? ☐ Yes ☐ No

Do you have a history of hurting yourself or attempted suicide in the past? ☐ Yes ☐ No

Are you having thoughts of hurting anyone else? ☐ Yes ☐ No

Have you ever assaulted anyone? ☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No If so, what? Last use:

Do you use alcohol? ☐ Yes ☐ No If so, what? Last use:

Relationships

SIGNIFICANT OTHER	WHO DO YOU LIVE WITH?
MOTHER	FATHER
EMERGENCY CONTACT	PHONE
SIBLINGS	
CHILDREN	

TULALIP BEHAVIORAL HEALTH PRESCRIPTION CONTRACT

To receive a prescription for the appropriate medication to treat persistent mental health conditions, you must:

- Be referred to the Tulalip Behavioral Health medication provider by one of our therapists.
- Commit to and participate in an ongoing treatment plan with your therapist.
- Make appointments to receive prescription refills through your therapist.
- Plan ahead for prescription refills.
- Tulalip Behavioral Health will not provide replacements or reauthorization for lost or stolen prescriptions.

Two ways to plan ahead for your medication refills:

- Call the pharmacy and ask for a refill at least one week before your medication runs out. Tell the pharmacy that our fax number is: 360-716-0758.
- If you have not seen your therapist or the medication provider for some time, call your therapist and make an appointment as soon as possible. It may be several days before you can be seen. All appointments with the medication provider are made through your therapist.

IMPORTANT: Some medications require a urinalysis because the possibility of adverse drug interactions. If you are prescribed one of these medications, you must also be willing to submit to random urinalysis tests at the discretion of the Tulalip Behavioral Health medication provider.

Please list the name and phone number of the pharmacy you wish to use below. Prescriptions and subsequent refills will only be sent to the pharmacy listed below:

NAME OF PHARMACY	PHONE

Statement

I, (*my printed name*):

☐ Am <u>not</u> currently taking Suboxone, methadone, benzodiazepine, gabapentin, or any other prescription narcotics for pain management.

☐ <u>Am</u> currently taking Suboxone, methadone, benzodiazepine, gabapentin or any other prescription narcotics for pain management. The narcotic medication that I am currently taking includes (please list and bring bottle to your appointment with our medication provider):

I also agree to act in accordance with the conditions stated above in order to receive psychiatric services from Tulalip Behavioral Health.

DATE OF BIRTH	DATE

YOUR SIGNATURE

Washington Administrative Code defines Consumer as "A person who has applied for, is eligible for, or who has received mental health services." For a child, (thirteen to eighteen) whose parents or legal guardians are involved in a treatment plan, the definition includes "parents or legal guardians."

WAC CONSUMER RIGHTS
(WAC 388-865-0410)

(1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WAC 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division:

You have the right to:

(a) Be treated with respect, dignity and privacy;
(b) Develop a plan of care and services which meets your unique needs;
(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
(d) Refuse any proposed treatment, consistent with the requirements in chapters 71.05 and 71.34 RCW;
(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
(f) Be free of any sexual exploitation or harassment;
(g) Review your clinical record and be given an opportunity to make amendments or corrections;
(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;
(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;
(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;
(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;
(m) If you are Medicaid eligible, receive all services which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from:
    (i) A provider within the regional support network about what services are medically necessary; or
    (ii) For consumers not enrolled in a prepaid health plan, a provider under contract with the mental health division.
(n) Lodge a complaint with the ombudsman, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombudsman may, at your request, assist you in filing a grievance. The ombudsman' phone number is 1-888-336-6164 (Ext. 0)
(o) Ask for an administrative hearing if you believe that any rule in this chapter was incorrectly applied in your case."

Client Grievance Procedure

Policy: The Tulalip Tribes Mental Health Program recognizes the importance of settling client problems and grievances promptly and fairly. The agency also recognizes the desirability of settling problems in the most informal, appropriate way possible. It is the policy of The Tulalip Tribes Mental Health Program to inform clients of the following process for: 1) problem resolution (informal) and 2) grievance resolution (formal). Clients shall be free from agency interference, coercion or reprisal should they choose to file a grievance.

Problem Resolution: From time to time, clients of The Tulalip Tribes Tribal Mental Health Program have questions, concerns, complaints or problems that relate to their therapy, the handling of their case, appointment scheduling, policies and procedures, etc. Should such a problem arise, clients are encouraged to request an opportunity to discuss and resolve the concerns informally with the relevant staff or department.

Grievance Resolution: On some occasions, a client may feel the above process is inadequate, or they may have a concern or complaint of a more serious nature. Should a client wish to file formal grievance, the formal procedure should be followed.

1. When the client tells any staff member of their desire to file a grievance, the grievance form will be given to the client to fill out, and the client will be instructed to give it to the grieved person's supervisor.
2. The grieved staff person will not participate in accepting, investigating or deciding any grievance of which they are the object. Clients stating that they want to make a grievance will be told how to reach the grieved person's supervisor and that the form should be turned in to the supervisor. The supervisor will assist the client in filling out the form if necessary.
3. The supervisor will notify and send copies of the form to the Manager of The Tulalip Tribes Mental Health Program and the Executive Director of Health Services.
4. The supervisor will make the client aware that he/she may choose a staff member, family member, friend or other advocate to represent him in a grievance procedure.
5. Staff who are not involved in the case will investigate. The supervisor will coordinate the investigative process.
6. A written report from the supervisor shall be made to the client in 15 days when possible or in any event within 30 days.
7. The client may appeal the decisions of the grievance staff to the Executive Director. A written report of the Director's decision shall be made to the consumer with 15 days when possible but, in all cases, within 30 days.
8. Grievances may also be filed with the state office of Human Rights and/or the DSHS office of Equal Opportunity.
9. There will be no retaliation.

Mental Health Fee Agreement Disclosure Statement

Each client shall be informed about the fees to be charged, the method of a payment agreed upon, and the collection consequences, with sensitivity toward the client's ability to pay.

Fee Policy: Each patient is billed for services rendered; either to private insurance companies or to the state, if the patient is on Medical Coupons. If there is no insurance or medical coupon the policy is that you must apply for a medical coupon. Ultimately you are responsible for your portion of the cost of being seen at Tulalip Behavioral Health Family Services. Co-pays are due at time of service.

Tribal Affiliation (*provide tribal enrollment card*): • Tulalip • Other enrolled Native • Family of Tulalip • Family of other Native

Enrolled Natives: If you have no insurance all enrolled natives will be asked to apply for insurance. In the event that you are denied you will still be seen.

Family Members of Natives: Nonnative family members who have insurance other than HMA, will not be seen until we know what your insurance will cover and what you will need to pay at time of service. A sliding fee scale is provided for those who have no insurance.

Sliding Fee Scale: The only clients who are eligible for our sliding fee scale are family members of tribal members who are living in the tribal home, such as a spouse or a child. The sliding fee scale is based on family income. Our TFS Office Administrator will work up a fee agreement with you based on the sliding fee scale which must be set up before you can be seen.

HMA Insurance: (Current policy effective November 1, 2014) Make a copy of insurance card, both sides.
Bronze Plan: Your responsibility is a $25 co pay **Gold/Platinum Plan**: Your responsibility is a $15 co-pay *Tulalip Tribal Members & other Natives: HMA Co-pay is waived. All others will be responsible for Co-pay. Visits are unlimited, but after 8 sessions your therapist must request more sessions from Reliant Behavioral Health. Please see your HMA Employee Health Care Plan booklet for more information.*

Other Insurance: We are not currently on any other insurance boards, meaning that you will have to contact your insurance to see what your coverage is for 'out of network'. Once you have that information our Finance Coordinator can work up a fee agreement with you.

NAME OF INSURANCE

Make copy of insurance card, both sides

CO-PAY	NUMBER OF SESSIONS PER YEAR
IDENTIFICATION NUMBER	GROUP NUMBER

Washington Apple Health (Medicaid) • Yes, get copy of current Insurance Card
Medicare: Unfortunately at this time we do not bill Medicare

Fee Schedule for Mental Health Services

Assessment	$185.00	Group Sessions (1 1/2 to 2 hours)	$80.00 per group
Individual (45 to 50 minutes)	$85.00	Family or Couples Sessions	$85.00 per session
Brief Individual (20 to 30 min.)	$40.00 per session		

ARNP Varies by the amount of time you are seeing our provider. Please see our Finance Coordinator.

Your counselor or case manager is required to be registered or licensed with the Washington State Department of Licensing unless otherwise exempt. The Law requires counselors to provide a written disclosure statement for your signature.

TULALIP TRIBES FAMILY SERVICES THERAPIST DISCLOSURE STATEMENT

WELCOME!

We appreciate the courage it takes to reach out for professional help when you are experiencing personal challenges in your life. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies.

AIMS AND GOALS:

Our major goal together is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals
3. Identifying personal treatment goals
4. Promoting wholeness through psychological/emotional healing and growth

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress.

Clear Form | Print Form