

United Community Services, Inc.

Client Information Form

GENERAL

Name: (First) _____ (Last) _____ (MI) _____

Social Security # _____ Gender: MALE or FEMALE

Address _____

Street

City

State

Zip Code

County

Home Phone _____ Work Phone _____

Birth date: _____ Age: _____ Race _____ Ethnicity/Culture: _____

Education: (years) _____ Veteran Status: _____

What is your county of residence _____ Are you pregnant? Y N Date Due _____

Who referred you: _____ Phone Number _____

Have you had IV Drug Use? Y N Are you HIV Positive? Y N Uncertain

What is your sexual orientation? _____

How would you rate your physical health? Good _____ Fair _____ Poor _____

How would you rate your mental health? Good _____ Fair _____ Poor _____

What is the name of your Primary Physician? _____

Address: _____ Phone: _____

Describe any medical conditions we should know about: _____

Are you currently taking medication? _____ If yes, what? _____

Have you ever thought about or attempted suicide? _____ If yes, please explain _____

Have you ever intentionally harmed yourself or anyone else? _____ If yes, please explain _____

Why are you here today? What do you want to get out of treatment?

Marital Status: Married Separated Divorced Widowed Single Cohabiting

With whom do you live? _____

HEALTH

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MISCELLANEOUS

Days you've attended AA/NA/Similar Meetings in the last 30 Days _____

Days of school/work missed in the last 6 months due to Substance Abuse Problems _____

Do you use tobacco? Y N If yes: Cigarettes Cigars/Pipes Smokeless Tobacco Combination

Daily cigarette use? 0 <1/2 <1/2 -1 1-2 >2

Have you been in treatment in the last 10 years? Y N If yes, what kind _____

How long since your discharge _____

Number of arrests in the last 12 months _____

Number of arrests in the past 30 days _____

Number of OWI's in last 6 months _____

Number of Non-drug related arrests while under the influence _____

Number of Non-drug related arrests while **not** under the influence _____

Number of drug/alcohol related arrests _____

List some of your goals in treatment:

1. _____
2. _____
3. _____

List some of your strengths that will help you achieve your goals in treatment:

1. _____
2. _____
3. _____

List some of your weaknesses that could interfere with your achieving your goals

1. _____
2. _____
3. _____

List the persons or agencies that you need to have a release for:

1. _____
2. _____
3. _____
4. _____

United Community Services, Inc.

Consent for the Release of Confidential Information

I, _____, authorize communication between **United Community Services, Inc.**,
(Name of Client)

Magellan Behavioral Care of Iowa (Magellan) and the **Iowa Department of Public Health (IDPH)** for the purposes of auditing, client and program funding and program licensure.

I also authorize **Magellan** to re-disclose to the **IDPH** when necessary to resolve disputes, the following information pertinent to my treatment episode:

1. Assessment and evaluation
2. Proposed treatment plan of care
3. Diagnosis
4. Progress notes related to pre-authorization or concurrent review continuing care plan
5. Other psychosocial information relating to pre-authorization or concurrent review
6. Other (specify) _____

The purpose of the disclosure authorized herein is to aid in the determination of whether to authorize reimbursement for treatment services.

I also authorize **Magellan** to re-disclose the information listed above to the **Department of Human Services** and the **Division of Medical Services** for the purposes of evaluating and auditing **Magellan** and for conducting appeals of reimbursement determinations.

I also authorize **Magellan** to verbally re-disclose case management information to the County Office of the **Department of Human Services** for the purpose of case coordination.

I also authorize **United Community Services, Inc.** to disclose to the **Iowa Consortium for Substance Abuse Research and Evaluation** my name and other information necessary to contact me for a follow-up interview (by phone or by letter) regarding my treatment at United Community Services, Inc. Clients are randomly selected from SARS data that the Department of Public Health provides to the consortium to do follow-up for up to one year after treatment at United Community Services, Inc.

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse Client records (**42 CFR Part 2**), and the Health Insurance Portability and Accountability Act (HIPPA) of 1996 (**45CFR Parts 160 & 164**) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand my signature below acknowledges that I have read, understood, and authorized this consent. This consent becomes effective on the date signed below and will remain in effect for 7 years following date of discharge.

Signature of Client

Date

Signature of Parent/Legal Guardian

Date

Prohibition on Re-disclosure of Information Concerning Client in Alcohol or Drug Abuse Treatment:

This notice accompanies a disclosure of information concerning a Client in alcohol or drug abuse treatment, made to you with the consent of such Client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Client.

United Community Services, Inc.

COLLATERAL CONTACTS

As a part of our program evaluation, the Iowa Consortium for Research conducts post-treatment reviews of services we provide. Please provide the names of three contacts that would be able to give the consortium information about your whereabouts. The researcher will not give any information about why they are trying to locate you or any information about your receiving services from UCS. They will identify themselves as a health research analyst from the University of Iowa. When they contact you for the follow up questionnaire they will offer you a gift certificate for your participation in the study.

Contact #1 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

Contact #2 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

Contact #3 Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: _____
Relationship to you _____

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Substance Abuse Questionnaire

Please answer questions below based on your primary substance of use.

Client's Name: _____

YES NO

		Have you ever found that you had to drink or use more than you use to, to get the same effect?
		Did you ever find that the same amount of alcohol or drug had less effect on you than ever before?
		People who cut down or stop drinking or using drugs after using for a considerable time often have withdrawal symptoms. Common ones are the "shakes" (hands tremble), being unable to sleep, feeling anxious or depressed, sweating, heart beating fast, seeing or hearing things that aren't there, being nauseated, having diarrhea, runny ears, muscle pain, or having seizures. Have you ever had any of these problems after quitting or cutting down?
		Have you ever used a different substance to help you avoid these symptoms?
		Have you often drunk more or used more than you intended to?
		Have you often drunk more or used for longer periods of time than you intended to?
		Have you ever tried to quit or cut down on drinking or using?
		Have you ever wanted to quit or cut down on your drinking or using?
		Were you ever unable to quit or cut down when you wanted?
		Some people try to control their drinking by making rules like not drinking alone or before 5:00pm. Have you ever made any rules because you were having trouble limiting the amount you used?
		Has there ever been a period when you spent a great deal of time drinking or using, getting alcohol or drugs, or getting over the effects of drinking or using?
		Have you ever given up or greatly reduced important activities in order to drink or use, such as sports, work, or associating with friends or family?
		There are several health problems that can result from drinking or using drugs. Did drinking or using ever cause liver problems, yellow jaundice, stomach problems, cause your feet to tingle or feel numb? Have you ever had memory problems, pancreatitis, accidental overdose, a persistent cough, or a seizure?
		Have you continued to drink or use when you knew you had any (other) serious physical illness that might be made worse by drinking or using?

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Client's Name: _____

YES NO

		Has alcohol or drug use ever caused you emotional or psychological problems, such as feeling uninterested in things, depressed, suspicious of others or paranoid, or caused you to have strange ideas?
		If "Yes" did you continue to use after you knew it caused you those problems?
		Did using or being hung over frequently keep you from household chores or taking care of the children?
		Did using or being hung over frequently cause you to miss work, lose a raise or promotion, or get fired?
		Did using or being hung over cause you to miss school, be suspended from school, or do poorly on schoolwork?
		Have you ever continued to use for several days or longer without sobering up?
		Have you ever accidentally injured yourself when you have been using, for example, had a bad fall or cut yourself badly?
		Have you often been high or drinking in a situation where it increased your chances for being hurt, for instance, when driving a car or a boat, using knives, machinery or guns, crossing against traffic, climbing or swimming?
		Have you ever had a traffic accident because of your drinking or using?
		Have you ever been arrested because of your drinking or drug use?
		Are you now on probation or parole for a drug or alcohol related offense?
		Were there ever objections about your drinking or drug use from your family, spouse, child, relatives, friends, boss, people at school or work?.
		Did your Doctor or Clergyman ever try to persuade you to stop using?

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SUBSTANCE USE HISTORY

Client's Name: _____

Please list your first, second and, third drug* of choice you have used and then complete the following information.

TYPE OF DRUG	AGE OF FIRST USE	METHOD OF USE (CHECK ALL THAT APPLY FOR EACH TYPE OF DRUG)	CURRENT FREQUENCY (PLEASE CHECK THE CORRECT ANSWER FOR EACH DRUG)	DATE OF LAST USE
		ORALLY SMOKING INHALATION INJECTION (IV) OTHER (SPECIFY)	NO USE IN LAST 6 MONTHS NO USE IN PAST MONTH 1-3 TIMES IN PAST MONTH 1-2 TIMES PER WEEK 3-6 TIMES PER WEEK ONCE DAILY 2-3 TIMES DAILY 4 OR MORE TIMES DAILY	
		ORALLY SMOKING INHALATION INJECTION (IV) OTHER (SPECIFY)	NO USE IN LAST 6 MONTHS NO USE IN PAST MONTH 1-3 TIMES IN PAST MONTH 1-2 TIMES PER WEEK 3-6 TIMES PER WEEK ONCE DAILY 2-3 TIMES DAILY 4 OR MORE TIMES DAILY	
		ORALLY SMOKING INHALATION INJECTION (IV) OTHER (SPECIFY)	NO USE IN LAST 6 MONTHS NO USE IN PAST MONTH 1-3 TIMES IN PAST MONTH 1-2 TIMES PER WEEK 3-6 TIMES PER WEEK ONCE DAILY 2-3 TIMES DAILY 4 OR MORE TIMES DAILY	

* Alcohol, Marijuana, Cocaine/ Crack, Methamphetamine, Amphetamines, Heroin/Opiates, Methadone, Prescription Drugs, Hallucinogens, PCP, Club Drugs, Inhalants, Over the Counter, Steroids and other.

United Community Services, Inc.

Financial Information Form

Name: _____

Marital Status _____ Number of Dependants _____

Do you have health insurance? _____ Do you have Medicare or Medicaid? _____

Are you currently employed? Yes _____ No _____

If yes, where? _____ Address _____

Is it full-time _____ or part-time? _____ If you work part-time, how hours per week? _____

How long have you been employed at this job? _____

What is your hourly wage? _____

Months Employed in Last 6 Months? _____

Have you ever received SSI/SSDI? _____

Primary Source of Income None Wages (Please list other sources) _____

Do you have health insurance? _____ Type _____ Does it cover Treatment _____

What amount of monthly income do you receive from the following?

Monthly Salary \$ _____

Unemployment benefits \$ _____

Veterans benefits \$ _____

Social Security Insurance \$ _____

Social Security Disability \$ _____

Family/Friends \$ _____

Savings \$ _____

FIP \$ _____

Child Support/Alimony \$ _____

TOTAL MONTHLY INCOME \$ _____

I confirm that the above information is true and factual to the best of my knowledge:

Signature: _____

United Community Services, Inc.

RELEASE OF INFORMATION

I, _____ do hereby authorize the staff of United Community Services, Inc., to contact the named individual (_____) in the case of a medical emergency. I further authorize United Community Services, Inc. to contact the appropriate medical personnel in such an event, as I am unable to do so.

This release expires automatically 365 days after my discharge.

Signature _____ Date _____