MONTGOMERY COUNTY HEALTH DEPARTMENT

MENTAL HEALTH & SUBSTANCE USE

Thank you so much for allowing Montgomery County Health Department to serve you. Please complete the attached packet entirely. If you have any questions please feel free to call and speak with our clerical staff at 217-532-2001, ext 144.

- ☐ Do not date your paperwork
- ☐ The Health Risk Addendum at the back of the packet must be completed by you
- ☐ You must present your insurance card prior to being seen.
- ☐ You must present a proof of income or notorized letter regarding your income
- ☐ If you do not have Medicaid, ***you must pay your copay or assessed charge each visit.***
- ☐ Please have information regarding the address, phone and fax number of any release.
- ☐ You must arrive 30 minutes prior to your appointment with all paperwork completed.
- ☐ If you have a guardian, you must bring guardianship papers.
- ☐ If you have old debt, you must make payment arrangements prior to being seen.

You MUST FULLY complete the intake paperwork PRIOR to your appointment, or **arrive 1 hour early**, or your session **may be cancelled.**

MCHD MONTGOMERY COUNTY HEALTH DEPARTMENT
11191 Illinois Route 185 Hillsboro, Illinois 62049 217-532-2001

WELCOME
to the
MONTGOMERY COUNTY HEALTH DEPARTMENT

The Montgomery County Health Department – Division of Mental Health is an agency dedicated to serving people experiencing difficulties in their lives. Our commitment is to provide clients with the most appropriate and effective services within our resources. To best serve our clients, we have established the following process to determine your treatment needs and establish the best treatment plan we can offer.

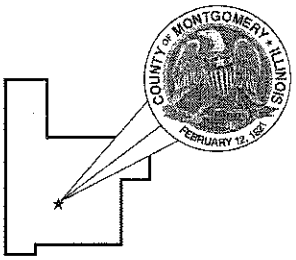
During your first visit with the agency, you will be asked to complete an intake packet to provide us with basic information about you. You will be asked to sign a statement indicating you agree to treatment by MCHD. In addition, you will be given information that explains your rights and responsibilities as a client with MCHD. Information explaining the confidentiality policy as well as the grievance procedure will also be provided. There are fees for services. The Mental Health Billing Specialist will discuss fees and options to make our services more affordable. MCHD offers a sliding fee scale to determine the appropriate income-based fee. Proof of income is required. If you do not bring proof of income, we will not be able to reduce your fee until you bring proof of income. You will also sign an authorization and assignment statement so that we can provide your insurance company with the information needed to cover the services provided. You will then meet with an intake therapist for a mental health or substance use assessment.

Mental Health Clients: The intake therapist will develop an individualized, person-centered, and client-driven treatment plan during the assessment to coordinate your services while you are involved with this agency. After the assessment, you can expect a phone call within seven (7) days with your first appointment date and the name of the therapist or case manager who is best suited to provide the services you need.

Substance Use Clients: Within fourteen (14) days of your admission into treatment, you and your therapist will develop a treatment plan to coordinate your services while you are with this agency.

Initially and periodically, you may be given a questionnaire asking about your satisfaction with the services you have received. These questionnaires help us make changes in our programs so we can provide the best possible services.
Remember, all of our services are provided in a confidential manner. If you have questions about any part of your treatment or agency policy, you may direct those questions to your therapist or case manager.

Hugh Satterlee
Administrator
Montgomery County Health Department
Hillsboro, Illinois 62049
(217) 532-2001



MCHD MONTGOMERY COUNTY HEALTH DEPARTMENT
11191 Illinois Route 185 Hillsboro, Illinois 62049 217-532-2001

Tobacco Use Policy

It is the policy of the Montgomery County Health Department that the use of **any tobacco** products (cigarettes, chewing tobacco, electronic cigarettes, vaping, etc.) is not allowed in its buildings, on its grounds nor in any vehicles parked in its parking lots.

Emergency Information

While receiving services at MCHD, if a fire or tornado should occur, there are maps in each room as to where to go for safety.

If a fire is detected, fire extinguishers are located throughout each building as marked on the emergency building map. Your therapist/case manager will assist you out of the building to a designated location to ensure everyone is accounted for and safe.

If a tornado is detected, the emergency map also indicates where to go for safety. Your therapist/case manager will assist you to this designated location, and everyone will be required to stay in this area until the danger of the tornado has passed.

Montgomery County Health Department
Division of Mental Health

CLIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURE

The client's right shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). All appropriate records kept at the Montgomery County Health Department are subject to the Freedom of Information Act (5U.S.C. 552).

MISSION STATEMENT

The Montgomery County Health Department Division of Mental Health operates to provide professional, confidential services to persons experiencing symptoms of a mental health or substance use disorder and educate the community to promote a better understanding of such symptoms. These services are available to all persons regardless of race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation, or ability to pay.

Our services are funded in part by the Department of Human Services, the Office of Mental Health, the Office of Developmental Disability, and the Office of Alcoholism and Substance Use. The Federal Government also provides funding dollars.

CLIENT RIGHTS

Montgomery County Health Department staff wants you to know that your rights are important to us. Our goal is to provide quality services that respect the rights and dignity of the recipients. Receiving services here does not affect your legal rights in any way. As service providers, we will work to protect your rights, which include the following:

- Access to services that will not be denied based on race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation, or ability to pay.
- To have services provided in the least restrictive environment available.
- To confidentiality regarding HIV/AIDS status and testing as governed by the AIDS Confidentiality Act [410 ILCS 305] and the AIDS Confidentiality and Testing Code (77 Ill Adm Code 697).
- To nondiscriminatory access to services as specified in the Americans With Disabilities Act of 1990 (42 USC 12101).
- To have disabilities accommodated as required by the Americans With Disabilities Act, Section 504 of the Rehabilitation Act, and the Human Rights Act (775 ILCS 5).
- To receive confidential services as governed by the Confidentiality Act of Alcohol and Drug Use Patient Records regulations (42 CFR 2(1987)), of the Alcohol, Drug Use and Mental Health Administration of the Public Health Service of the United States Department of Health and Human Services and the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110] and the Health Insurance Portability and Accountability Act of 1996 [42 U.S.C. & 1320dd2]. Only in cases of suspected child abuse/neglect, in cases of imminent harm to yourself or someone else, or in the case of necessary communication with parents of minor children can information be released without consent. Please note that the only individuals with access to our files are professional staff members, support staff, and any entity with direct administrative control over the services provided.
- To receive appropriate, humane services, the staff will strive to provide the best treatment within our resources. You have a right to be free of physical, verbal, emotional, sexual, and/or financial abuse as well as neglect, humiliation, or exploitation as per the Mental Health and Developmental Disabilities Code [405 ILCD 5].
- To receive any intrusive procedures such as injections, etc., in a safe manner, with consideration to the physical, developmental, and abuse history of the persons served.
- To choose whether or not to participate in research projects.
- To receive concurrent services, i.e., seeing the doctor and/or a therapist, case manager, etc.
- To participate in developing your treatment plan and to be informed of the composition of your Treatment Team.
- To have your bill and specific charges explained to you and to question any charges you believe may be in error.
- To contact the Network Manager for the Department of Human Services.
- To know what medication is prescribed for you, why it is prescribed, and possible side effects it may cause.
- Review your record with the assistance of program staff per agency policy.
- To give or withhold informed consent regarding treatment and confidential information.
- To request alternative channels of communication.
- To refuse treatment or any specific treatment procedure and be informed of the consequences resulting from such refusal in a timely manner to allow you to make an informed decision regarding your treatment.
- To present grievances up to and including the Executive Director or comparable position. The Grievance Procedure is detailed on the back of this notice.
- To contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
- The right to contact HFS or its designee and to be informed by HFS or its designee of the client's healthcare benefit and the process for reviewing grievances.
- To be free from retaliation for expressing concerns, problems, grievances, etc.
- To terminate services - our services are voluntary and require your cooperation.
- You will not be denied, suspended, or terminated from services or have services reduced for exercising any of the rights named above.
- To be free from seclusion and/or restraint.

- To contact the Illinois Guardianship and Advocacy Commission and Equip for Equality, Inc. We will assist any client in contacting these groups. Contact information for each is included in this notice.

CLIENT RESPONSIBILITIES

As a service recipient, you have the following responsibilities:

- To actively participate in the treatment process and development of a treatment plan. It is expected that you will work on tasks aimed toward helping you attain your stated goals in and outside treatment sessions.
- To honestly discuss any changes you want to make in your treatment plan, usage of medication, or desire to continue in treatment sessions.
- To be on time for scheduled sessions. If you must cancel, we ask that you notify us 24 hours before your appointment. It is our policy to bill for failed appointments. This fee is not covered by insurance.
- Pay your bill in full for services provided, or make arrangements with the business office to make payments. We will do our best to accommodate you, but you must ask.
- To protect the confidentiality of other members of any group or program you participate in.
- To refrain from any tobacco use on any MCHD property, including personal vehicles on MCHD property.
- To neither bring or be in possession of any illicit drugs and/or weapons of any type on MCHD property.
- To avoid behaviors that can result in the termination from or restrictions of services, including:
    - Inappropriate gestures or comments of a sexual nature toward other persons served or staff.
    - To be in the possession of dangerous or hazardous materials or weapons.
    - Possession of illegal or illicit drugs on MCHD property, an exception will be made for those voluntarily relinquishing custody to staff.
    - Any remarks or speech that intentionally reduce the self-esteem of staff or persons served includes, but is not limited to, remarks of race, religious affiliation and/or spirituality, age, national origin, gender, sexual orientation, and physical or mental handicaps.
    - Intentional misuse of prescribed medications.
    - To verbally or physically threaten or assault other persons served or staff.

GRIEVANCE PROCEDURE

If you feel a decision made regarding your treatment or the treatment of the individual you are the guardian of was unfair, or there has been an infringement of your rights, you have the right to file a grievance.

The grievance process is as follows:

Grievances must be presented in writing to your therapist/case manager and include the nature of the grievance. If your grievance is with your therapist/case manager, you may present your written grievance to their supervisor. The supervisor will then contact you to set a meeting time with you to discuss your concerns within 72 hours of your request.

If you are not satisfied with the results of this conference, you may appeal in writing to the following people:

1. Behavioral Health Coordinator
2. Administrator of the Health Department

The appeal process must start with the first step, and you may go through each step until you are satisfied. At each step, you will receive a written response to your grievance within ten (10) working days of your meeting.

The Administrator's decision on the grievance shall constitute a final administrative decision. MCHD shall maintain a record of and the response to all grievances.

Any staff member dealing directly with clients will advise all individuals of their rights in accordance with the documents cited above. If you need assistance with writing your grievance, please let us know, and an impartial staff member will be assigned to assist you.

If you have a grievance which you believe was not satisfactorily resolved after completion of the agency grievance procedure, you may contact:

Illinois Department of Human Services, Office of Alcoholism and Substance Use
222 South College, Second Floor
Springfield, Illinois 62704
(217) 782-0685

Illinois Department of Human Services, Office of Mental Health
100 S. Grand Ave. East
Springfield, Illinois 62704
(800) 843-6154

Illinois Department of Human Services, Office of Division of Developmental Disabilities
600 E. Ash, Building 400, Mail Stop 1 South
Springfield, Illinois 62703
(217) 782-3075 Fax: (217) 558-1509

Guardianship and Advocacy Commission (GAC)
Metro East Regional Office
4500 College Ave, Suite 100
Alton, IL 62002-5051
(618) 474-5503 Fax: (618) 474-5517

Equip for Equality, Inc.
1 W. Old State Capitol Plaza #816
Springfield, Illinois 62701
(217) 544-0464

Land of Lincoln Legal Assistance
111 E. Fourth Street, Suite 330
Alton, IL 62002
(618) 462-0029 (800) 642-5570

NAMI – Southwestern IL Office
Gateway Regional Medical Center
2100 Madison Ave., 4th Floor
Granite City, IL 62040
(618) 798-9788 Fax: (866) 332-5338

Rev. 5/07; 6/07; 8/10; 7/19; 08/23

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

☐ New/Returning ☐ Annual Update

Date	Client Name (First, MI, Last)		Home Phone ( )
Social Security Number	Date of Birth	Age	Cell Phone ( )
Primary Method of Communication: ☐ Verbal: ○ English ○ Spanish ○ Other: _____ ☐ Written ☐ Sign			Mother's Maiden Name
Physical Address	City	State	Zip
Mailing Address ☐ Same as Physical	City	State	Zip
County of Legal Residence	Do you require any assistive technology in the provision of your services? If yes, explain. ☐ No ☐ Yes		
Race ☐ White ☐ Black ☐ Asian ☐ Amer Indian ☐ Pacific Island ☐ Alaskan Native ☐ Other:	Ethnicity ☐ Not of hispanic origin ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other		
Born Gender ☐ Male ☐ Female	Identified Gender ☐ Male ☐ Other ☐ Female	Sexual Orientation ☐ Bisexual ☐ Unknown ☐ Heterosexual ☐ Queer ☐ Homosexual ☐ Other	
Have you or a loved one ever served in the US Armed Forces If not you, then who?	☐ Yes ☐ No Branch ☐ Honorable ☐ Dishonorable ☐ Retired ☐ Less than Honorable		

EMERGENCY CONTACT

Name	Home Phone	Cell Phone	
Address	City	State	Zip
Email	Relationship		

Can we speak with your emergency contact regarding appointments? ☐ Yes ☐ No

Would you like to receive text reminders for future appointments? ☐ Yes ☐ No

Can we contact you by email? ☐ Yes ☐ No Email:

REFERRAL SOURCE

Who referred you to Montgomery County Health Department?

☐ Self ☐ Court ☐ Physician ☐ Parole ☐ Other
☐ Employer ☐ DCFS ☐ Probation ☐ School _____

What services are you seeking at this time and what do you hope to accomplish?

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

FINANCIAL RESOURCES

Monthly household income (before taxes): $ _____ Household size: _____

Please check ALL that apply and list monthly amounts (check even if no money is involved)

☐	Employment	$	☐	Spouse's	$	☐	Unemployment	$
☐	Retirement	$	☐	Workman Comp	$	☐	Veteran's Payment	$
☐	Child Support	$	☐	Alimony	$	☐	Trust beneficiary	$
☐	SSI	$	☐	SSDI	$	☐	DORS	$
☐	Link Card	$	☐	CEFS	$	☐	Savings / Checking	$
☐	TANF (DHS)	$	☐	Township	$	☐	Family / Friends	$

DOCUMENTATION OF CONSUMER CHOICE

The Department of Human Services (DHS) may pay for some or all of the costs of your community mental health services. If DHS is to pay for these services, the provider must report certain personal information to the Department. If you do not want the provider to report this information, you may decline to be a recipient of DHS funding. If you do not decline, the provider will report all of the following information to the Department of Human Services.

* Your full name (first, last and middle initial)
* Your social security number
* Your date of birth
* All mental health services for which the provider expects payment
* Your gender
* Your county of residence
* Your household income and size

☐ I **DO** choose to have MCHD bill DHS for my services, and I understand MCHD will report the information above to the Illinois Department of Human Services.

_____ _____

Signature of Consumer or Parent / Guardian Date

☐ I **DO NOT** choose to have MCHD bill DHS for my services as I have private insurance or am uninsured. MCHD will not report the information above to Illinois Dept of Human Services.

_____ _____

Signature of Consumer or Parent / Guardian Date

INSURANCE INFORMATION

Primary ☐ Private Insurance ☐ Medicare ☐ IDPA ☐ MCO ☐ Self ☐ Other

Name of Insurance	Policy ID#	Group ID# (if applicable)
Insurance Carrier's Name	Ins Carrier's Relationship	Ins Carrier's DOB

Secondary ☐ Private Insurance ☐ Medicare ☐ IDPA ☐ MCO ☐ Self ☐ Other

Name of Insurance	Policy ID#	Group ID# (if applicable)
Insurance Carrier's Name	Ins Carrier's Relationship	Ins Carrier's DOB

MCHD accepts payment from a variety of payers. However it is the client's responsibility to ensure their insurance is accepted by our agency. Client monthly income and household size are required regardless of whether or not you allow MCHD to bill the Department of Human Services in order to provide the client with a reduced fee. Regardless of a client's insurance status, MCHD will work with each client to meet their financial expectations. More specific information regarding insurance coverage and the client's financial obligations are listed on the Authorization and Assignment. Upon completion of this intake paperwork, you will be asked to complete a Fee Schedule which will assign the client's fee based upon income and household size. Proof of income and valid insurance must be presented to qualify for reduced fee.

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

PRESENTING MENTAL HEALTH CONCERNS				
Please check any of the following apply	Mild	Moderate	Severe	Describe how this impacts your daily life
☐ Angry outburst/loss of temper	○	○	○	
☐ Anxious mood	○	○	○	
☐ Appetite increase/decrease	○	○	○	
☐ Confusion/disorganized thinking	○	○	○	
☐ Criminal behaviors/thinking	○	○	○	
☐ Cutting/self-injurious behaviors	○	○	○	
☐ Delusions	○	○	○	
☐ Depressed mood	○	○	○	
☐ Diminished interest in activities	○	○	○	
☐ Distrust/suspicious of others	○	○	○	
☐ Elevated mood on a persistent basis	○	○	○	
☐ Excessive worry	○	○	○	
☐ Fatigue/lack of energy	○	○	○	
☐ Fears/Phobias	○	○	○	
☐ Feelings of hopelessness	○	○	○	
☐ Food binging/purging	○	○	○	
☐ Forgetful/loses things	○	○	○	
☐ Hallucinations (auditory/visual)	○	○	○	
☐ Hyperactivity	○	○	○	
☐ Impulsivity	○	○	○	
☐ Inappropriate guilt	○	○	○	
☐ Increase in goal-directed activity	○	○	○	
☐ Increased sexual behaviors/thoughts	○	○	○	
☐ Inflated self-esteem	○	○	○	
☐ Irritability	○	○	○	
☐ Lack of motivation	○	○	○	
☐ Legal issues (describe)	○	○	○	
☐ Neglect of critical roles/self care	○	○	○	
☐ Odd sexual behaviors	○	○	○	
☐ Overspending	○	○	○	
☐ Panic/shortness of breath/palpitations	○	○	○	
☐ Paranoia	○	○	○	
☐ Persistently elevated mood	○	○	○	
☐ Physical aggression/assault	○	○	○	
☐ Poor concentration/easily distracted	○	○	○	
☐ Racing thoughts	○	○	○	
☐ Recurrent suicidal thoughts	○	○	○	
☐ Risk taking/endangering self or others	○	○	○	
☐ Shoplifting/theft	○	○	○	
☐ Sleep change increase/decrease	○	○	○	
☐ Social withdrawal/isolation	○	○	○	
☐ Substance use/abuse	○	○	○	
☐ Suicidal thoughts/attempts/gestures	○	○	○	
☐ Talkative more than usual	○	○	○	
☐ Tearfulness/crying	○	○	○	
☐ Other	○	○	○	

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

LEGAL STATUS

ADVANCED DIRECTIVE

☐ Yes, I have an advanced directive (please provide a copy) ☐ No, I do not have an advanced directive	Do you need assistance with advanced directive? ☐ Yes ☐ No

☐ Own Guardian/Payee

☐ Legal Guardian(s) Name	Relationship	Phone
☐ Guardian Representative Name	Relationship	Phone
☐ Protective Payee	Relationship	Phone
☐ Power of Attorney ○ Medical ○ Financial	Relationship	Phone

COMPLIMENTARY HEALTH APPROACHES

Has the client ever used any complementary health approaches?

☐ No ☐ Massage therapy ☐ Acupuncture ☐ Meditation

☐ Naturopathy ☐ Healers ☐ Other (describe)

SPIRITUAL BELIEFS

What are your current spiritual beliefs?

LIVING SITUATIONS

Mark your current living arrangement (check all that apply)

☐ Own home ☐ Rent ☐ Homeless ☐ Group / Nursing Home ☐ Treatment facility

☐ Living alone ☐ with parents ☐ with spouse ☐ with other relatives ☐ with other non-relatives

PERSONAL FAMILY HISTORY

Please list everyone who **LIVES WITH YOUR CHILD** and describe their relationship with each.

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please complete below.

Household Member Names	Relationship	Age	Describe Quality of Relationship

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

PERSONAL FAMILY HISTORY

Blended Family ☐ No ☐ Yes (please explain)

Are you adopted ☐ No ☐ Yes (please explain)

Please check the appropriate box for any family member who has experienced any of the following

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please complete below.

	Self	Father	Mother	Grandparent	Spouse	Sibling	Child
Drug Abuse							
Alcohol Abuse							
Sexually abused							
Physical health							
Physical disability							
Mental health							
Mental disability							

FAMILY HEALTH HISTORY

Please mark any family members who have had significant health issues and describe those issues

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please complete below.

☐ Self	
☐ Father	
☐ Mother	
☐ Grandparent(s)	
☐ Sibling	
☐ Sibling	
☐ Child	
☐ Other	

PERSONAL HEALTH HISTORY

Please check all immunizations your child has had:

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please update below.

Please check all immunizations your child has had:

☐ Chicken Pox ☐ Diptheria ☐ German Measles ☐ Hepatitus B ☐ Measles

☐ Mumps ☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

Have any of these immunizations been received in the last year? ☐ No ☐ Yes (If yes, which?)

Has your child ever had a vision test?	Has your child ever had a hearing test?
☐ No ☐ Yes, when?	☐ No ☐ Yes, when?

MONTGOMERY COUNTY HEALTH DEPARTMENT

CHILD MENTAL HEALTH DIAGNOSTIC ASSESSMENT

LEGAL HISTORY

Please complete the following section about your child's legal history.

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please complete below.

Has your child ever been arrested? ☐ No ☐ Yes (If yes, please describe the circumstances surrounding the arrest)

Do they have a court order pending? ☐ No ☐ Yes (if yes, describe the reason)

Please select all that apply ☐ Court Supervision ☐ Parole Begin Date: _____
☐ Probation ☐ TASC End Date: _____

Name of Probation/Parole/TASC Officer	Address	Phone

EDUCATIONAL HISTORY

Highest grade level completed: _____

☐ Preschool ☐ HS graduate ☐ GED
☐ Vocational training ☐ 1 year college ☐ 2 years college ☐ 3 years college
☐ Associate's Degree ☐ Bachelor's Degree ☐ Post Sec College Degree ☐ Unknown

Attendance ☐ Above average ☐ Normal ☐ Tardiness ☐ Absenteeism

Performance ☐ Exemplary ☐ Good ☐ Average ☐ Below average

History of learning difficulty (including performance/behavioral problems due to alcohol and/or drug use)

☐ No known impairments ☐ Special school placement
☐ Learning Disability/Type : _____
☐ Other:

Was school a positive or negative experience ? Explain why.

Can you read? ☐ No ☐ Yes ☐ Good ☐ Poor ☐ Average
Can you write? ☐ No ☐ Yes ☐ Good ☐ Poor ☐ Average

EMPLOYMENT HISTORY

☐ Currently Employed (check all that apply) ☐ Not in the labor force (skip to next section)

Please complete the following section about your employment history.

For annual updates ONLY: ☐ no changes (skip to next section) ☐ if changes, please complete below.

☐ Full Time (35+ hrs) ☐ Part Time (>35 hrs) ☐ FT unsubsidized ☐ PT unsubsidized
☐ Vocational/Day Prog ☐ Odd Jobs

Name of employer	Position	Length of Employment

Attendance	Explain
☐ Above average ☐ Normal ☐ Tardiness ☐ Absenteeism	

Performance	Explain
☐ Exemplary ☐ Good ☐ Average ☐ Below average	

NOT IN THE LABOR FORCE

☐ Student ☐ Institutionalized ☐ Homemaker ☐ Unemployed ☐ Retired
☐ Disabled (please list the date disabled and nature of disability)

PERSONAL / SOCIAL INVOLVEMENT HISTORY	
Describe your involvement in the following: ☐ None	
☐ Personal Friendships	
☐ Recreation/Sports	
☐ Peer Groups	
☐ Community Affiliations	
☐ Church	
☐ Other (specify)	
What are your interests and hobbies?	
What are your personal strengths?	

SIGNATURES	
Client Signature (12 & older)	Date
Parent/Guardian Signature	Date
MCHD Witness Signature	Date
MCHD Counselor/Case Manager Signature	Date

PLEASE CONTINUE TO PAGE 9

MONTGOMERY COUNTY HEALTH DEPARTMENT

ADULT MENTAL HEALTH DIAGNOSTIC ASSESSMENT

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REQUIRED DOCUMENTATION RECEIVED

Proof of Identification

☐ Social Security Card	☐ Driver's License	☐ Prim Insurance Card	☐ Medicare Card
☐ Birth Certificate	☐ Photo ID	☐ Sec Insurance Card	☐ Public Aid Card

Proof of Income		Proof of HH size	Gross Annual $	HH size	Client's Fee
☐ Tax returns	☐ Pay stubs	☐ Tax returns			☐ Assessed
☐ Bank Stmt	☐ Temp POI	☐ IDPA card			☐ FR
☐ Soc Sec	☐ Notarized POI	☐ Temp POI			☐ Copay

Please mark the following additional forms that must be completed at time of intake check-in.

☐ Authorization and Assignment ☐ Fee Schedule ☐ Informed Consent

Please mark the following releases that were completed

☐ Appt Contact	☐ Employer	☐ Primary Care	☐ Social Security
☐ Attorney	☐ Family	☐ Probation	☐ Other _____
☐ DCFS	☐ Parole	☐ School/Midstate	☐ Other _____

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ASSESSOR'S OBSERVATIONS OF SOCIAL DETRIMENTS TO CARE

The assessor observed the following social detriments to inhibit health care.

☐ No detriments at this time	☐ Social and community context
☐ Healthcare access and quality	☐ Economic stability
☐ Education access and quality	☐ Neighborhood and built environment

Healthcare access and quality

This includes lack of access to quality doctors, lack of insurance to pay for consistenet healthcare, and lack of transportation to access healthcare.

Education access and quality

This includes issues like graduating from high school, enrolling in higher education, language and literacy, and early childhood education and development.

Social and community context

This includes the cohesion within a community, your social support network of friends, family, and neighbors, civic participation, discrimination, workplace conditions, and incarceration.

Economic stability

This includes income, cost of living, and socioeconomic statu. Major influences in this areas include poverty, employment, food security, and housing stability.

Neighborhood and built environment

It includes things like housing quality, access to transportation, neighborhood crime rates, and air and water quality.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

	SUICIDE IDEATION DEFINITIONS AND PROMPTS Ask questions that are **Bold** and Underlined	In Last 30 Days YES	 NO
	Ask questions 1 and 2		
1)	**Wish to be Dead:** Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished your were dead or wished you could go to sleep and not wake up?***		
2)	**Suicidal Thoughts:** General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
	If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3)	**Suicidal Thoughts with Method (without Specific Plan or Intent to Act):** Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different thatn a specific time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when or where or how I would actually do it.... and I would never go through with it." ***Have you been thinking about how you might kill yourself?***		
4)	**Suicidal Intent (without Specific Plan):** Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5)	**Suicide Intent with Specific Plan:** Thoughts of killling oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6)	**Suicide Behavior** ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuable, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: kelly Posner, Ph.D.

New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10332; posnerk@nyspi.columbia.edu

MONTGOMERY COUNTY HEALTH DEPARTMENT

Montgomery County Health Department protects client information. A release of information form allows a patient access to their own nedical records and allows them control over to whom those records are released. A simple release form will identify the following basic elements and will be valid for one year unless the client chooses to rescind the release in writing.

Who will disclose the information and who will receive the information

What information will be disclosed

Where information may be disclosed and re-disclosed by the recipient

When the authorization will expire

Why the information is being disclosed

How a patient may authorize and revoke disclosure of information

Please check the box of each release that you may need during your services with MCHD. You will receive releases to complete at the time of your initial assessment. Please be sure to have all contact information for your releases at that time.

- ☐ Contact person regarding appointments and medications
- ☐ Attorney
- ☐ DCFS
- ☐ Employer
- ☐ Family
- ☐ Parole
- ☐ Probation
- ☐ Primary Care Physician
- ☐ School / Midstate
- ☐ Social Security
- ☐ Other: _____
- ☐ Other: _____

Montgomery County Health Department requires payment for the release of records as follows:

Pages 1 - 25	=	$1.00 per page + postage
Pages 26-50	=	$0.66 per page + postage
Pages 50 +	=	$0.33 per page + postage

ILLINOIS DEPARTMENT OF Healthcare and Family Services

☐ Initial
☐ 12 month re-assessment
☐ Discharge

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

Addendum 1 – Health Risk Assessment (HRA)

Please note: This assessment must be completed for all individuals once every 12 months.

18. GENERAL INFORMATION (HRA)

Staff Name:	Individual First and Last Name:	RIN:	Date of Birth:	Gender:

Height: _____ ft. _____ in.	Weight: _____ lbs.	Primary Care Doctor's Name:	Date of Last Physical Exam: _____ ☐ Visit due	Date of Last Flu Shot: _____

19. MEDICATION(S) List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.

Is the individual currently taking any psychotropic medications? ☐ Yes ☐ No **CANS Rating – Medication Compliance:** _____

If **yes**, does the individual regularly receive lab work? ☐ Yes ☐ No ☐ Not required ☐ Unknown

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Issues

20. HEALTH STATUS

CANS Rating – Medical/Physical: _____

a. Individual's self-report on general physical health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day?
☐ 0-1 ☐ 2-3 ☐ More than 4

c. How many servings of fruits and vegetables does the individual usually eat in a day?
☐ 0-1 ☐ 2-3 ☐ More than 4

d. Does the individual engage in physical activity? ☐ Yes ☐ No
If **yes**, how often? _____

e. Does the individual use any form of tobacco? ☐ Yes ☐ No

f. Does the individual drink alcohol?
If **yes**, how often and how much? _____

g. Has the individual ever fainted or passed out? ☐ Yes ☐ No
If **yes**, describe: _____

h. Does the individual have any allergies? ☐ Yes ☐ No
If **yes**, list: _____

i. Has the individual fallen in the past 12 months? ☐ Yes ☐ No
If **yes**, describe: _____

j. Does the individual want help to quit smoking? ☐ Yes ☐ No ☐ N/A

HEALTH CONCERNS: Does the individual have any current health concerns? ☐ Yes ☐ No If **yes**, describe below.

GENERAL ILLNESS: Does the individual have a tendency to any illnesses ☐ Yes ☐ No If **yes**, describe below.

BREATHING ISSUES: Does the individual have any trouble breathing? ☐ Yes ☐ No *(if **NO**, skip to next section)*

a. What are the breathing issues related to? Check all that apply.
☐ Physical activity ☐ Weather extremes ☐ Other: _____

b. Does the individual take medication for breathing issues?
☐ Yes ☐ No

COGNITIVE ASSESSMENT: *(skip if the individual is **under age 50**)*

a. Has the individual ever had a significant head injury? ☐ Yes ☐ No
If **yes**, when? _____

b. Does the individual have any difficulty remembering or recalling events?
☐ Yes ☐ No

c. Can the individual correctly tell you what year, month, and day it is?
☐ Yes ☐ No

BLOOD SUGAR/DIABETES:

a. Does the individual urinate more frequently than appears normal? ☐ Yes ☐ No

b. Does the individual seem to have an increased thirst, compared to others in the same age range? ☐ Yes ☐ No

c. Does the individual have any special dietary instructions related to his/her blood sugar? ☐ Yes ☐ No
If **yes**, describe: _____

d. Does the individual take any medication to control his/her blood sugar? ☐ Yes ☐ No

CHRONIC PAIN: Does the individual experience chronic pain, or complain of pain frequently? ☐ Yes ☐ No *(if **NO**, skip to next section)*

a. Has the individual ever taken or been prescribed medication for pain?
☐ Yes ☐ No
If **yes**, indicate the type: ☐ Cannabis ☐ Opioids
☐ Other (list): _____

b. Describe the location and intensity of the pain. _____

SEXUAL RISK BEHAVIORS: Is the individual sexually active?
☐ Yes ☐ No (*if **NO**, skip to next section*)

a. Does the individual use any protection against sexually transmitted diseases/infections (STDs/STIs) when engaged in sexual activity?
☐ Yes ☐ Sometimes ☐ No

c. When was the individual last tested for STDs/STIs? _____

d. Has the individual ever been diagnosed with an STD/STI or HIV?
☐ Yes ☐ No
If **yes**, list the diagnosis and the age of occurrence. _____

FEMALE REPRODUCTIVE HEALTH: *(if the individual is a **male**, or if the **female has not had her first period**, skip to next section)*

a. Does the individual see a women's health provider?
☐ Yes - date of last visit: _____ ☐ No – referral needed

b. Is the individual experiencing any issues related to her menstrual cycle or menopause? ☐ Yes ☐ No
If **yes**, describe. _____

c. Is the individual currently or has the individual ever been pregnant?
☐ Yes – currently ☐ Yes – previously ☐ No
If **yes**, describe the status or the outcome of the pregnancy.

21. DEVELOPMENTAL HISTORY

Complete this section based on the individual's early childhood experiences.

a. Did the individual's mother receive the appropriate prenatal care?
☐ Yes ☐ No ☐ Unknown

b. Were there any complications during the mother's pregnancy?
☐ Yes (describe below) ☐ No ☐ Unknown

c. Was the individual's birth normal or premature?
☐ Normal ☐ Premature ☐ Unknown

d. Was the individual exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?
☐ Yes (describe below) ☐ No ☐ Unknown

e. Were there any unusual issues related to the mother's labor and delivery? ☐ Yes (describe below) ☐ No ☐ Unknown

f. What was the individual's birth weight? _____

g. When did the individual first crawl? _____ Walk? _____ Talk? _____

h. When did the individual begin toilet training? _____

i. Does the individual have a biological parent or sibling that has developmental or behavioral problems?
☐ Yes ☐ No ☐ Unknown

Supporting Information: Provide additional information on the individual's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.

22. MEDICAL HISTORY

How many times has the individual been to the Emergency Room in the past 12 months? ☐ 0 ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4+ times

What was the reason for the ER visit(s)?

Has the individual ever been psychiatrically hospitalized? ☐ No ☐ Yes (*If **YES**, please list below. Attach additional pages as needed.*)

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List all additional hospitalizations the individual has experienced. Attach additional pages as needed. ☐ N/A

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List the names and specialties of the providers currently providing medical treatment to the individual. Attach additional pages as needed.

Provider Name	Specialty	Service(s) Provided

Supporting Information: Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above.