HEALTH AND HUMAN SERVICES

CLIENT DEMOGRAPHICS AND INFORMATION

You can get this form in different ways, like large print or other languages.
If you need help with this form, just ask us.

To help us prepare for your visit, we ask that you bring the following items (if applicable):

- Identification of Client o Parent/Guardian
- Insurance card
- Pay Stubs

Please provide the information for the individual seeking services below

Name: First | MI | Last | Date of Birth:

Name you go by: | Last Name at Birth:

Marital Status *(Select)*: ☐Never Married ☐Married/Living as Married ☐Divorced ☐Widowed ☐Separated ☐Unknown

Sex at Birth *(Select)*: ☐Male ☐Female ☐Other

Physical address: | City | State | Zip | County

☐ Mailing address is Same as Above ☐ Unable to receive Mail

Mailing address *(If different from physical address)*: | City | State | Zip | County

Contact information: *Please be sure to inform the staff of any changes to keep your information current.*

☐ No phone	Comments: *(belongs to/preferred language)*	Call OK?	Msg OK?	Text OK?	Reminder OK?
Primary:		☐	☐	☐	☐
Secondary:		☐	☐	☐	☐
Alternative:		☐	☐	☐	☐

Email Address:

Race *(Select)*: ☐Alaska Native ☐American Indian ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Unknown ☐Prefer not to respond

Ethnicity *(Select)*: ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Specific Hispanic ☐Hispanic *(Specific origin not specified)* ☐Not of Hispanic origin ☐Unknown ☐Prefer not to respond

Tribal Affiliations:

Military Status *(Select)*: ☐ None ☐ Current/Active ☐ Veteran

Preferred language: _____ ☐ Interpreter needed

CLIENT PURPOSE AND REFERRAL INFORMATION

What type of treatment services are you interested in? *(select all that apply)*

☐Mental Health ☐Substance Use ☐Family & Youth ☐Public Health ☐Developmental Disabilities ☐Veterans Services

Were you referred to treatment services? ☐Yes ☐No

If yes, how or by whom?

Client Name: _____ DOB: _____

CLIENT REPRESENTATIVE

If someone other than the client is completing this form, please provide the information below.

Relationship to Client: ☐Spouse ☐Biological Parent
☐Legal Guardian **only select if you are able to provide documentation**
☐Other: _____

Name: _____ Phone#: _____

Email Address:

CLIENT INSURANCE INFORMATION

☐ Oregon Health Plan (OHP) OHP ID# _____

☐ Private Insurance *(please provide a copy of the insurance card)*

Insurance Company: _____ ID#: _____

Policy Holder Name: _____ DOB: _____

☐ No Insurance **I would like information on how to apply for*
☐ Oregon Health Plan ☐ Reduction in fees for services

CLIENT EDUCATION AND EMPLOYMENT

What is the highest grade or level completed: _____ ☐ Currently enrolled

Name of School: _____

Please complete the section that best describes your employment status.

Employed*(select)* ☐Full Time ☐Part Time
Name of Employer: _____
Occupation/Job Title: _____ *Hire Date:* _____

Unemployed *(select)* ☐Seeking Employment ☐Not seeking employment ☐Student
☐Disabled (Unable to work) ☐Retired ☐Homemaker
☐Other:

CLIENT HOUSEHOLD INCOME AND DEPENDENTS

The information on this form is used to determine eligibility for a reduced fee schedule.

Primary Source of Household Income *(Check one)*

☐ Wages/Salary ☐ Social Security Disability Insurance *(SSDI)* ☐ None
☐ Public Assistance ☐ Supplemental Security Income *(SSI)* ☐ Unknown
☐ Retirement/Pension ☐ SSDI and SSI ☐ Other

Gross Monthly Household Income: ☐ Unknown ☐ No Income

Current Living Situation *(Check one)*

☐ Alone/ Spouse/ Significant other/ Parent ☐ Friend ☐ Relative ☐ Foster Home
☐ Institution *(Hospital/ Corrections)* ☐ Residential Facility ☐ Room & Board ☐ Houseless

List the number of household members living with you in each category ☐ Unknown

Self		Adult Dependents:		Child Dependents (0-17):		Total Dependents:
	+		+		=	

HEALTH AND HUMAN SERVICES

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

This form is available in alternative formats including large print, Spanish and oral presentation.

Legal last name of client/applicant:	**First:**	**MI:**	**Date of Birth:**

Other names used by client/applicant:	**EHR ID Number:**

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

RELEASE FORM

Release from one record holder: *(Individual, school, employer, agency, medical or other provider)*	**Release To:** *(Address required if mailed. If releasing to a team, list members)*
Yamhill County Behavioral Health	**My treating providers, health plans, third-party payers, and people helping to operate this program**

I authorize a mutual exchange of the information listed below between parties: ◉ **YES** ○ **NO**

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

Mental Health ____ Alcohol/drug ____ Gambling ____ HIV/ AIDS ____ Genetic Testing ____

SPECIFIC INFORMATION TO BE DISCLOSED

All behavioral health and medical records.

Records dated From: To:

Purpose: Treatment, payment, and health care operations

This authorization is valid for one year from the date of signing unless otherwise specified below.

Expiration date or event: _____ **or** ☑ **365 days after client closes to services** ☐

Adapted from MSC 2099; 2/26/24

SIGNATURE & COPIES:

I was given the opportunity to ask questions about this form and what it does. I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will. I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, drug/alcohol, and gambling diagnosis and treatment records without specific authorization.

Signature of Individual/legal guardian:	**Date:**	**Relationship to client:**
		☐ Legal Guardian Documentation on File
Name of staff person (print):	**Date:**	**Initiating agency**

REQUIRED INFORMATION FOR THE CLIENT:

To provide or pay for health services: If Yamhill County Health and Human Services (YCHHS) is acting as a **provide**r of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services unless the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests, or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This is a voluntary form. YCHHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Redisclosure: 42 CFR part 2 prohibits unauthorized use or disclosure of these records.

USING THIS FORM

1. Assistance: Whenever possible, a YCHHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.

2. Terms used: Mutual exchange: A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization.

3. Special attention: For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse or gambling,** the authorization must clearly identify the specific information that may be disclosed and the purpose.

4. Records dated: For clarifying dates for record requests to be released, or if an individual wants to limit shared information. This section only needs to be filled out if applicable.

5. Guardianship/custody: If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody and their representative signs, their custody authority must be attached to this form.

6. Minors: If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.

7. Cancel: If you later want to cancel this authorization, contact your YCHHS staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing. No more information can be disclosed or requested after authorization is cancelled. YCHHS can continue to use information obtained prior to cancellation.