

INTAKE CHECKLIST

Client Name: _____ Intake Date: _____ Program: _____

All Clients & Residents

- ☐ Client given assessment screeners and Personal Intake information & fee agreement form (2 pages) (Intake Staff)
- ☐ Critical Population Survey Complete in TOM (Intake Staff)
- ☐ Financial Eligibility Form Complete (Intake Staff)
- ☐ The following forms have been signed and complete (Intake Staff)
 - ☐ Consent for Treatment and Admission Information (copy given to client)
 - ☐ Copy of Group Rules, Grievance Form, and Confidentiality Form given to client (copy given to client)
 - ☐ Telemedicine Consent (copy given to client)
 - ☐ Client General Information Checklist (copy given to client)
- ☐ Client Main Demographics: (Intake Staff)
 - ☐ Client information – Part 1 entered in TOM
 - ☐ children information entered in TOM.
- ☐ The following TOM items have been completed (Counselor or Intake Staff)
 - ☐ Register in Group (Registration screen).
 - ☐ Intake Date / Schedule Exit date (Program Enrollment)
 - ☐ Program Status (tab in Program Enrollment)
 - ☐ Other tasks as needed
- ☐ Client photo taken and uploaded to TOM (Main Client Info screen) (Front Desk)
- ☐ Insurance information entered in TOM. & copy of cards uploaded (Front Desk)
 - ☐ Confirm Active Medicaid
 - ☐ In inactive Medicaid appointment with Care Manager has been made
 - ☐ Does the client qualify for Block grant if not on Medicaid? Notify accounting
 - ☐ Other tasks as needed
- ☐ Authorization for the Release of Information filled out for all that apply (Intake Staff)
 - ☐ Treatment Courts (Behavioral, DUI, or Adult Treatment Court)
 - ☐ Child and Family Services
 - ☐ Montana State Probation & Parole
 - ☐ Montana Department of Health & Human Services
 - ☐ Other: _____
- ☐ Schedule Appointment in TOM and give reminder card to client (Front desk)
- ☐ Upload all signed word documents into case file in TOM (Intake Staff)

Boyd Andrew Community Services Staff Signature

Date

Boyd Andrew Community Services Staff Printed Name

Date

PERSONAL INTAKE INFORMATION AND FEE AGREEMENT FORM

PART I – DEMOGRAPHIC INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____ Suffix (if applicable): _____
Alias(es): _____ SSN: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Race: ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other: _____ Tribal Affiliation: _____

PART II – CONTACT INFORMATION

Personal E-Mail Address: _____ @ _____
Driver's License Number: _____ Driver's License Expiration Date: _____
Home Address: _____ City, State, Zip Code: _____
☐ Same as Mailing Address ☐ Homeless
Mailing Address: _____ City, State, Zip Code: _____
Cell Telephone Number: _____ Home Telephone Number: _____
Emergency Contact Name: _____ Relationship: _____
Cell Telephone Number: _____ Home Telephone Number: _____
Address: _____ City, State, Zip Code: _____
Total Number of Minors: _____
Please list names of your kids or minors in the home where you reside below:

Bio	Other	In home	Name of Child:	DOB:	Relationship:
☐	☐	☐	_____	____/____/____	_____
☐	☐	☐	_____	____/____/____	_____
☐	☐	☐	_____	____/____/____	_____
☐	☐	☐	_____	____/____/____	_____

Are you a daycare provider? Y ☐ N ☐ Are you pregnant? Y ☐ N ☐ N/A ☐

PART III – PROGRAM/FEE AGREEMENT

Are you employed? Y ☐ N ☐ If yes, where? _____ Wage: _____
Do you receive SSI/SSDI? Y ☐ N ☐ If yes, amount: _____
Medical Insurance Provider: _____ Insurance Card Number Active Date: _____

I agree to pay for my programming if not covered by subsidy, indigence, or insurance. If eligible, I authorize the release of any medical or other information to process claims through insurance. I authorize payment of my insurance to be paid directly to the provider of service. I understand all fees must be paid in advance of service unless otherwise determined. I understand that if I am unable to keep to my payment schedule, I will contact the BACS office before my payment due date to make arrangements. I agree that any subsidy or indigence payment may be withdrawn due to non-compliance. I further understand that if I fail to abide by the established fee agreement, my file may be terminated and returned to court/referring agency for further action.

Any money paid in advance will be transferred to clear debts in other BACS programs. My fees may be forfeited if I am terminated for non-compliance. I understand that I may not get credit with the Courts/referral source until my fees are paid in full.

I authorize BACS to contact me at the numbers provided on this form. **Text Reminders:** I have been given the option to receive text-message courtesy reminders on my cell phone. I understand that message and data rates may apply, and I may be charged by my wireless carrier. I authorize BACS to send an email, leave a voicemail, send a text message, or leave a message with my emergency contact, if necessary, for me to contact BACS.

Client printed name/signature

Date

Guardian printed name/signature

Date

PART IV - MEDICAL INFORMATION

Do you have any physical or mental disability that needs accommodation? Y ☐ N ☐

If yes, what accommodation? _____

Do you have any known allergies? Y ☐ N ☐ If yes, please list below: _____

Have you ever been in treatment for drug and/or alcohol abuse? Y ☐ N ☐

Have you ever been in treatment? Y ☐ N ☐ If yes, what type? _____

Are you currently using drugs? Y ☐ N ☐ If yes, drug(s) of choice: _____

Have you used drugs in the past? Y ☐ N ☐ If yes, date of last use: _____

Have you ever injected drugs (IV use)? Y ☐ N ☐ If yes, date of last injection: _____

PART V – OTHER INFORMATION *(FOR STATISTICAL PURPOSES ONLY)*

Highest grade level completed: _____

Are you currently under supervision with State P&P? Y ☐ N ☐ If yes, name of Supervising Officer: _____

Are you on any other monitoring with another agency? Y ☐ N ☐

If yes, what type of monitoring? _____ With which agency? _____

Birth City: _____ Birth State: _____

What town/city do you consider to be your home: _____

Boyd Andrew Community Services

MONTHLY FINANCIAL ELIGIBILITY ADULT

Client Name: _____ Date: _____ / _____ / _____

Social Security #: _____ - _____ - _____ DOB: _____ / _____ / _____

(Please make copy of insurance card and give original to Business Manager). Insurance will not be billed until proof is provided.

1. Are you covered by health insurance? _____ If NO please proceed to 4

2. Insurance Company: _____ Name of Insured: _____

Group #: _____ Member ID #: _____

3. Is person covered by Medicaid? _____ If NO please proceed to 5

Proceed by pulling up Medicaid eligibility, and making copy. Must show Eligible Status.

(*) If eligible, but not currently covered by Medicaid, please refer to Medicaid eligibility office.

4. Employment

a. Present Employer: _____ Phone #: _____

b. Hourly wage: _____ Monthly Salary: _____

c. Average # of Hours Worked Per Week: _____

d. Length of employment with present employer: _____

e. Pay frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other _____

MONTHLY TOTAL: _____

If unemployed, how long since employed: _____

f. Are you currently seeking work? ☐ Yes ☐ No

g. Are you receiving Unemployment Compensation? ☐ Yes ☐ No

h. Are you or someone in your family unit receiving unemployment income? ☐ Yes ☐ No

If yes, how much per month? _____

MONTHLY TOTAL: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

i. Spouse's Name: _____

j. Place of Employment: _____

k. Hourly wages: _____ Monthly Salary: _____

l. Average # of Hours Worked Per Week: _____

m. Length of employment with present employer: _____

n. Pay frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other _____

MONTHLY TOTAL: _____

5. **ADD UP ALL INCOME PER MONTH:** \$ _____

6. **ALLOWABLE LIABILITIES/DEDUCTIONS PER MONTH:**

Pre-Tax Contributions:

Pre-Tax Health Insurance Cost \$ _____

Pre-Tax 401k/403B Etc. Contribution \$ _____

Pre-Tax HSA/Flex Spending Contribution \$ _____

Moving Expenses \$ _____

Student Loan Interest \$ _____

Tuition & Fees \$ _____

Itemized Medical Expenses (must be 10% of gross annual income or higher)
\$ _____

7. **TOTAL ALLOWABLE LIABILITIES PER MONTH:** \$ _____

8. **Adjusted Monthly Income to determine Eligibility for AMDD funded Services**

(Monthly Income #6 – Allowable Liabilities #8) \$ _____

9. **Adjusted Annual Income** \$ _____

(Adjusted Monthly Income #9 x 12 Months)

10. **Number of family members dependent on taxable income:** _____

(Includes client + spouse (if applicable) + #children (if applicable))

Ages of Children in House: _____, _____, _____, _____, _____

MONTHLY INCOME Sliding FEE Scale (6/2026)								
Discount Fee Group Eligibility	96% A Medicaid	95% B Medicaid	91% C	90% D	89% E Block Grant	80% F	75% G	65% H
Household Size ▼	100%	138%	150%	175%	200%	250%	300%	400%
1	\$1,330.00	\$1,835.00	\$1,995.00	\$2,328.00	\$ 2,660.00	\$3,325.00	\$ 3,990.00	\$ 5,320.00
2	\$1,803.00	\$2,489.00	\$2,705.00	\$3,156.00	\$ 3,606.00	\$4,508.00	\$ 5,409.00	\$ 7,212.00
3	\$2,277.00	\$3,142.00	\$3,415.00	\$3,984.00	\$ 4,554.00	\$5,693.00	\$ 6,831.00	\$ 9,108.00
4	\$2,750.00	\$3,795.00	\$4,125.00	\$4,813.00	\$ 5,500.00	\$6,875.00	\$ 8,250.00	\$11,000.00
5	\$3,223.00	\$4,448.00	\$4,835.00	\$5,641.00	\$ 6,446.00	\$8,058.00	\$ 9,669.00	\$12,892.00
6	\$3,697.00	\$5,101.00	\$5,545.00	\$6,469.00	\$ 7,394.00	\$9,243.00	\$11,091.00	\$14,788.00
Therapy	\$ 10.00	\$ 12.50	\$ 22.50	\$ 25.00	\$ 27.50	\$ 50.00	\$ 62.50	\$ 87.50
Group	\$ 3.00	\$ 3.75	\$ 6.75	\$ 7.50	\$ 8.25	\$ 15.00	\$ 18.75	\$ 26.25
IOP Week	\$ 16.00	\$ 20.00	\$ 36.00	\$ 40.00	\$ 44.00	\$ 80.00	\$ 26.25	\$ 140.00

Rates based on my financial eligibility: Circle Income Eligibility Bracket

* Client Initials Next to Circled Amount

Family Income	Client Liability	Individual Per Hour	Group \$75.00/Per Group	IOP \$400/Week	Client Initials
Group Below 100%	2%	\$5.00	\$1.50	\$8.00	
Group A	4%	\$10.00	\$3.00	\$16.00	
Group B	5%	\$12.50	\$3.75	\$20.00	
Group C	9%	\$22.50	\$6.75	\$36.00	
Group D	10%	\$25.00	\$7.50	\$40.00	
Group E	11%	\$27.50	\$8.25	\$44.00	
Group F	20%	\$50.00	\$15.00	\$80.00	
Group G	25%	\$62.50	\$18.75	\$100.00	
Group H	35%	\$87.50	\$26.25	\$140.00	

I have been requested to provide supporting documentation of my income and will provide it in on my next scheduled appointment.

I WILL PROVIDE THE FOLLOWING DOCUMENTATION:

2 Paystubs SELF _____ Rent or House Payment _____

Last Year Tax Info _____ Utilities _____

Spouse's Last 2 Paystubs _____ Daycare _____

Child Support/Alimony as Income _____ Child Support/Alimony Paid Out _____

Disability/SSI Income _____ Medical Bills (Hardship Adjustment) _____

Other Income: _____ (Unemployment, TANF, Significant Other Income)

By signing this form, I am verifying the above amounts are correct to the best of my knowledge. I understand that a minimum monthly payment is due by the 25th of each month until my account is paid in full. I understand I will only be billed for number of group sessions attended. However, ***INDIVIDUAL SESSIONS WITHOUT 24 HOURS NOTICE WILL BE BILLED A \$25.00 NO-SHOW FEE.*** I am also aware that I need to report significant changes in my household income (ex: pay increase or decrease, new job or loss of job, change of people in household) immediately.

Client Signature

Date

Witness Signature

Date

RIGHTS AND RESPONSIBILITIES

1. I am providing information on this form that is true to the best of my knowledge.
2. I must provide proof of eligibility for benefits. I may receive help in gathering documents or contacting individual or agencies by calling (406) 443-2343
3. I know the information I have given may be reviewed and verified by a representative of the State of Montana or Boyd Andrew Community Services (BACS). I also understand that I must cooperate fully with state, federal and BACS staff if my case is reviewed. By signing this application, I have given my permission for the State of Montana and BACS to obtain verification and information necessary to determine my eligibility or my children's eligibility. I understand that my permission includes the use of my social security number and/or my children's social security number to obtain the information.
4. I know the information I have given is confidential. I agree that medical information about me or my children can be released only if needed to administer, including billing for, the services received. Information will be forwarded to other agencies or organizations only if I have given my permission by signing a release.
5. If my child or I are enrolled in Medicaid, health insurance or other third parties, payments are automatically assigned by law to the State of Montana. Montana law requires that any money received by my household for medical expenses that are previously paid by Medicaid must be reimbursed to the State. Health insurance and third party payments for services received at BACS must be reimbursed to BACS.
6. I understand that I may request a Fair Hearing if I disagree with any action taken as the application for health care is processed, and that the request for Fair Hearing must be in writing.
7. I know this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.
8. If I knowingly give false information on this form I understand that I must reimburse Boyd Andrew Community Services for any cost incurred.

I have read and understand the financial obligations of this agreement.

Client Signature

Date

Responsible Party Signature (if applicable)

Date

Staff/Witness Signature

Date

SURVEY QUESTIONS

- | | | |
|---|------------------------------|-----------------------------|
| Are you over 65 (sixty-five)? | ☐ Yes | ☐ No |
| Are you pregnant? | ☐ Yes | ☐ No |
| Have you used IV drugs? | ☐ Yes | ☐ No |
| Have you used IV drugs in the last 6 months? | ☐ Yes | ☐ No |
| Have you used IV drugs in the last 7 years? | ☐ Yes | ☐ No |
| Are you a female with dependent children living in your home? | ☐ Yes | ☐ No |
| Are you homeless? | ☐ Yes | ☐ No |
| Do you have SSI/SSDI? | ☐ Yes | ☐ No |
| Do you currently have any STDs? | ☐ Yes | ☐ No |

Do you have any of the following?

- | | | |
|----------|------------------------------|-----------------------------|
| Hep B | ☐ Yes | ☐ No |
| Hep C | ☐ Yes | ☐ No |
| TB | ☐ Yes | ☐ No |
| HIV/AIDS | ☐ Yes | ☐ No |

Boyd Andrew Community Services
60 S. Last Chance Gulch Helena, MT 59601
(406) 443-2343, Fax (406)443-5490

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Yellow sections are for the client to complete. All other sections are for the staff to complete.

Patient Name: _____
LAST FIRST MI MAIDEN
Date of Birth: _____ Social Security #: _____

1. I authorize the use or disclosure of the above patient's health information as follows:
2. The following individual or organization is authorized to receive and disclose information:

Primary Contact/Relationship: _____
Organization Name: _____
Address: _____ City/State/Zip: _____
Phone Number: _____ Alternate Phone Number: _____
Fax #: _____ Alternate Fax Number: _____
Email Address: _____

from and to: **Boyd Andrew Community Services, 60 S. Last Chance Gulch, Helena, MT 59601**

3. The type and amount of information to be used or disclosed is as follows:
--Provide a specific and meaningful description of the information, including dates where appropriate. --

Discharge Summary	Yes No	Bio Psych/Social Assessment	Yes No
Progress and/or Progress Notes	Yes No	Mental Health Evaluation	Yes No
Master Treatment Plan	Yes No	Correspondence/Letter	Yes No

Other (Please be specific): _____ Dates of Treatment Requesting: _____

4. For the purpose of Continuity of Care or: _____

5. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must submit a written request to the Administrative Office Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. This authorization will expire on the following date or event: _____

7. Generally, Boyd Andrew Community Services will not condition treatment on the provision of this authorization, unless services are solely for the purpose of creating information for disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may no longer be protected by federal confidentiality rules.

9. By initialing here _____ I would like a copy of this authorization.

Signature of Patient _____ Date _____	Witness Signature _____ Date _____
--	---------------------------------------

Signature of Parent/Personal Representative _____ Date _____

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: 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 patient.

GENERAL INTAKE INFORMATION CHECKLIST

The following information has been provided as part of the client orientation. A check of the items and the signatures below indicate that each area has been fully explained to the client.

- ☐ Rights and Grievances and appeal procedures
- ☐ Services provided, days and, expected level of participation
- ☐ Hours of operation, Access to emergency services, and After hours: Boyd Andrew Community Services Outpatient program's hours of operation are Monday – Thursday 8:00 a.m. to 5:00 p.m. and Friday 08:00 am to 400 p.m. However, as a program of Boyd Andrew Community Services we have staff available 24 hours a day at our Helena prerelease and through an on-call phone number 406-442-6572. You can reach staff 24 hours a day from following the prompts.
- ☐ Code of ethics/conduct
- ☐ Confidentiality policy, privacy rights, limits of confidentiality
- ☐ Explanation of financial obligations, fees, and financial arrangements
- ☐ Fire, safety, and emergency precautions: All Fire exits are clearly marked in the event of a Fire or other emergency follow staff directions and exit through the nearest exit. Continue to remain with staff or Gather in the designated area at Anchor Park next to the library for a headcount to make sure everyone has exited. **TLF residents:** Please refer to the Emergency Plan you received at Intake
- ☐ Policy on tobacco products: BACS is a tobacco/nicotine free facility. Smoking and chewing of tobacco and/or vaping are only allowed outside of the building 20 (twenty) feet or more away from any entrance per city ordinance restrictions.
- ☐ Policy of illicit of licit drugs brought into the program, Zero tolerance
- ☐ Policy on weapons brought into the program
- ☐ Program rules, including restrictions
- ☐ Infectious Disease Screening, Prevention and Treatment Information (**Intake survey**)

I acknowledge that I have been informed of my client's rights and have received a copy of the Rights and grievances and appeal procedures and a copy of this form.

Client Signature

Date

Client Printed Name

Counselor/Intake Staff Signature

Date

Counselor/Intake Staff Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

NO SHOW/LATE CANCELLATION POLICY

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our clients as efficiently as possible. No-shows and late cancellations cause problems that go beyond a financial impact on our practice when an appointment is made, it takes an available time slot away from another client. No-shows and late cancellations delay the delivery of services to other clients.

A no-show is missing a scheduled appointment. A late-cancellation is canceling an appointment without giving us a 24-hour notice.

We understand that some circumstances are unavoidable, and these situations will be considered on a case-by-case basis.

If you miss 2 appointments without the proper notification, we reserve the right to close you to services.

I have read the above policy and hereby accept the obligation for compliance.

Client Signature

Date

Client Printed Name

Counselor/Intake Staff Signature

Date

Counselor/Intake Staff Printed Name

TELEMEDICINE CONSENT

Client Name: _____ DOB: _____

1. In an effort to limit the possible spread of COVID 19 (the novel coronavirus) that might occur in a treatment facility setting, I understand that my treatment provider wishes me to engage in a telemedicine consultation.
2. My provider will explain to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details that are personally sensitive to me; (2) ask non-treatment personnel to leave the telemedicine examination room: and/or (3) terminate the consultation at any time.
5. I will have the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.
6. In an emergent consultation, I understand that the responsibility of the treatment provider is to notify local emergency personnel or law enforcement.
7. I will have a direct conversation with my provider, during which I had the opportunity to ask questions regarding telemedicine treatment. My questions will be answered and the risks, benefits and any practical alternatives will be discussed with me in a language in which I understand. By signing this form, I certify:
 - That I have read or had this form read and/or had this form explained to me.
 - That I fully understand its contents including the risks and benefits of the procedure(s).
 - That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Signature

Date

Client Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

CONSENT TO TREATMENT AND ADMISSION INFORMATION

Client Name: _____ Date: _____

1. The minimum length of groups/programs varies. Dependent upon my participation, homework assignments, and presentation of material, it may take longer. I understand that I may be responsible for all/some of the cost of the program.
2. I know I have the right to be free from verbal, mental, or physical abuse, neglect, and financial exploitation by staff and group members. I understand facilitators are required, per policy, to report any confirmed or suspected violation of agency rules by a client. Facilitators, by law, must also report potential child abuse, new crimes, and potential harm to self and/or others.
3. Children cannot attend groups with a parent/guardian. Childcare needs to be arranged in advance of your group.
4. By signing below, I acknowledge that I have been given a copy of HIPAA and confidentiality guidelines and understand them. I understand I must sign a Release of Information for my records to be given to anyone outside of Boyd Andrew Community Services. It shall be my responsibility to maintain the highest level of confidentiality towards my peers. Any violation of the confidentiality of my peers will be a program violation, and I will be immediately terminated from the program and my paperwork returned to my referring agency. I am aware that my counselor has rights and privileges afforded to that profession by law, and therefore my counselor will share with other members of the counseling staff any information pertinent to my participation in the Boyd Andrew Community Services program.
5. If I refuse treatment or I do not choose the recommended treatment, the possible consequences of this decision will be explained by my counselor. I understand I may be terminated from the program and reported to my referring agency for non-compliance. The recommendations for services may include infectious disease screening, prevention, and treatment information, follow up alcohol and drug treatment recommendations or dangerousness and violence assessment recommendations, if appropriate.
6. By signing below, I acknowledge that I agree to the rules and guidelines for receiving treatment with Boyd Andrew Community Services. I understand that if I have a grievance towards staff or the program, I have the right to report it verbally or in writing to my counselor, my program manager, or the compliance officer. If I chose to file a grievance, I understand I may be asked to follow up with a supervisor to investigate my grievance. A grievance form can be requested from any Boyd Andrew Community Services staff member and submitted in a plain envelope to maintain confidentiality. I received a copy of this form at intake and understand I can ask for additional copies at any time while in the program.
7. If you are participating in services through tele-treatment services, we take extra steps to protect your confidentiality by using a secure network and using passcodes to access the links. If we have concerns about your safety or the safety of others, we have a duty to contact emergency services where you are located.
8. You may be asked to submit a random breathalyzer and/or urinalysis drug test at any time while enrolled in treatment. Failure to submit to do so may make me ineligible for group. In that regard, I voluntarily agree to submit to this alcohol and drug testing. If I am found under the influence in group, I will be removed and receive an unexcused absence.
9. I agree to pay for my programming if not covered by subsidy, indigence, or insurance. If eligible, I authorize the release of any medical or other information to process claims through insurance. I authorize payment of my insurance to be paid directly to the provider of service. I understand all fees must be paid in advance of service unless otherwise determined. I understand that if I am unable to keep to my payment schedule, I will contact the BACS office before my payment due date to make arrangements. I agree that any subsidy or indigence payment may be withdrawn due to non-compliance. I further understand that if I fail to abide by the established fee agreement, my file may be terminated and returned to Court/referring agency for further action.

10. Any money paid in advance will be transferred to clear debts in other BACS programs. My fees may be forfeited if I am terminated for non-compliance. I understand that I may not get credit with the Courts/referral source until my fees are paid in full.
11. I authorize BACS to contact me at the numbers provided on this form. Text Reminders: I have been given the option to receive text-message courtesy reminders on my cell phone. I understand that message and data rates may apply, and I may be charged by my wireless carrier. I authorize BACS to send an email, leave a voicemail, send a text message, or leave a message with my emergency contact, if necessary, for me to contact BACS.

I consent to the treatment program I am registering for below: _____

My next appointment is with counselor: _____ @ _____

I am scheduled to start group on _____

Hours of Operation are Monday – Thursday 8:00 am-5:00 pm and Friday 8:00 am to 4:00 pm.

All groups will be held at 60 S. Last Chance Gulch, unless specified differently. Please arrive 10-15 minutes early.

Client Signature

Date

Client Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

TREATMENT RULES AND EXPECTATIONS, RIGHTS, AND CONFIDENTIALITY NOTICE

1. I understand that I will be responsible for the cost of services rendered if not covered by insurance. I am responsible for paying for all groups at time of the session.
2. I must be present, with treatment group book/materials, paid for group, and ready to go to group when the facilitator arrives to escort group to classroom. No late entries will be allowed in group, and I will not be allowed to stay without my book/materials. I will not be wandering the halls.
3. Attendance is mandatory and only verified emergencies are excused. Work is not an excused absence unless authorized by counselor or facilitator. If I am late for group, I will not be allowed late entry. I must call in person to obtain an excuse before missing a class. Unexcused absences may be put into non-compliance status and can result in disciplinary procedures. I understand I must sign the sign-in sheet. The sign-in sheet is used to verify my group attendance.
4. I understand I am expected to show respect towards all Boyd Andrew Community Services staff, group members, and facilitator(s), especially while others are talking. While assignments are being presented in group, I am expected to be respectfully attentive and participate in group discussion and feedback. No sleeping during group. What is said in group stays in group. There is to be no crosstalk while other group members are talking. I am expected to give and to receive feedback in a respectful & helpful manner. There is no rescuing, especially supporting negative thinking and behaviors. Swearing or derogatory comments/statements will not be tolerated. The facilitator reserves the right to remove me for any inappropriate attitude, behavior, or language and may result in disciplinary procedures.
5. No disruptive actions, noises, behaviors, or physical violence will be allowed during group. I will be warned once, and after that will be dismissed from group. Any dismissal from group will count as an unexcused absence.
6. I understand that it is Boyd Andrew Community Services' policy to provide a safe environment for treatment. All fire exits are clearly marked and any questions about safety and emergency precautions have been answered. I understand that there are cameras in each of the group rooms for safety and security procedures.
7. I will not bring electronics, drugs, or weapons to group. Cell phones must be turned off and placed on the table in front of me. All clothing must be appropriate and free of scented products. No tight or revealing clothing, hats, or bandanas. Nothing that glamorizes or promotes alcohol, drugs, or gang affiliations. No food, gum, or tobacco products. I understand if I am wearing scented products or caught with electronics, drugs, or weapons I will be asked to leave, and will receive an unexcused absence.
8. I understand that I cannot use mood altering substances, including alcohol, during the time I am enrolled in this program. You may be asked to submit a random breathalyzer and/or urinalysis drug test at any time while enrolled in treatment. Failure to do so may make me ineligible for group. In that regard, I voluntarily agree to submit to this alcohol and drug testing. If I am found under the influence in group, I will be removed and receive an unexcused absence. Use violations may result in a referral to a higher level of care.

9. I understand that it is the policy of Boyd Andrew Community Services which prohibits discrimination in accepting referrals on the basis of sexual preference, gender, disability, race, creed, religion, political views, or national origin. If I need an accomodation for a disability, I know it is my responsibility to notify my program manager or counselor.
10. I understand that I am required to attend all required appointments with my Counselor which may include additional evaluations or meetings (i.e., Dangerousness and Violence Risk Assessment or Chemical Dependency Assessment, exit interviews, and/or treatment plan meetings) and may include a discharge/transition plan.

Client Signature

Date

Client Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

SUD TREATMENT RULES AND EXPECTATIONS, RIGHTS, AND CONFIDENTIALITY NOTICE

1. I understand that I will be responsible for the cost of services rendered in not covered by insurance.
2. I must be present, with treatment group book/materials, and ready to go to group when the facilitator arrives to escort group to the classroom. No late entries will be allowed in group unless approved beforehand, and I will not be allowed to stay without my book/materials. I will not wander the halls.
3. Attendance is mandatory and only verified emergencies are excused. Work is not an excused absence unless authorized by the counselor or Clinical Supervisor. I must call in person to obtain an excuse before missing a class. If terminated unsuccessfully, all my paperwork may be returned to the referring agency as non-compliant. I understand I must sign the sign-in sheet. The sign-in sheet is used to verify my group attendance.
4. I understand I am expected to show respect towards all Boyd Andrew Community Service staff, group members, and facilitator(s), especially while others are talking. While assignments are being presented, I am expected to be respectfully attentive and participate in group discussion and feedback. No sleeping during group. What is said in group stays in group. There is to be no crosstalk while other group members are talking. I am expected to give and to receive feedback in a respectful manner. There is no rescuing, especially supporting negative thinking and behaviors. Swearing or derogatory comments/statements will not be tolerated. The facilitator reserves the right to remove me for any inappropriate attitude, behavior, or language.
5. No disruptive actions, noises, behaviors, or physical violence will be allowed during group. I will be warned once, and after that will be dismissed from group. Any dismissal from group will count as an unexcused absence.
6. I understand that it is Boyd Andrew Community Services policy to provide a safe environment for treatment. All fire exits are clearly marked and any questions about safety and emergency precautions have been answered. I understand that there are cameras in each of the group rooms for safety and security procedures.
7. I will not bring electronics, drugs, or weapons to group. Cell phones must be turned off and placed on the table in front of me. All clothing must be appropriate and free of scented products. No tight or revealing clothing, hats, or bandanas. Nothing that glamorizes or promotes alcohol, drugs, or gang affiliations. No food, gum, or tobacco products. I understand if I am wearing scented products or caught with electronics, drugs, or weapons I will be asked to leave, and will receive an unexcused absence.
8. I understand that I cannot use mood altering substances, including alcohol, during the time I am enrolled in this program. Any prescribed mood-altering substances must be pre-approved by the Clinical Supervisor or Director. You may be asked to submit a random breathalyzer and/or urinalysis drug test at any time while enrolled in treatment. Failure to submit to do so may make me ineligible for group. In that regard, I voluntarily agree to submit to this alcohol and drug testing. If I am found under the influence in group, I will be removed and receive an unexcused absence.

9. I understand that it is the policy of Boyd Andrew Community Services which prohibits discrimination in accepting referrals on the basis of sexual preference, gender, disability, race, creed, religion, political views, or national origin. If I need an accomodation for a disability, I know it is my responsibility to notify my program manager or counselor.
10. I understand that I am required to attend all required appointments with my counselor which may include additional evaluations, meetings, and individual sessions. In addition, self-help attendance and obtaining a sponsor/mentor is expected while enrolled in group. Unless otherwise directed by your counselor, two self-help meetings per week is standard.

Client Signature

Date

Client Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

NON-SUD GROUP TREATMENT RULES AND EXPECTATIONS, RIGHTS, AND CONFIDENTIALITY NOTICE

1. I understand that I may be responsible for all/some of the cost of the program including materials. If payment is not made in advance, I will not be allowed to stay for the group session. I understand if I am terminated for non-compliance, any fees paid are non-refundable and may be forfeited.
2. I must be present, with treatment group book/materials, paid for group, and ready to go to group when the facilitator arrives to escort group to classroom. No late entries will be allowed in group, and I will not be allowed to stay without my book/materials. I will not be wandering the halls.
3. Attendance is mandatory and only verified emergencies are excused. Work is not an excused absence unless authorized by the referring Judge/agency/case manager. If I am late for group I will not be allowed late entry. I must call in person to obtain an excuse before missing a class. Unexcused absences may be put into non-compliance status and can result in disciplinary procedures. If terminated unsuccessfully, all my paperwork will be returned to the referring agency as non-compliant. I understand I must sign the sign-in sheet. The sign-in sheet is used to verify my group attendance.
4. I understand I am expected to show respect towards all Boyd Andrew Community Services staff, group members, and facilitator(s), especially while others are talking. While assignments are being presented in group, I am expected to be respectfully attentive and participate in group discussion and feedback. No sleeping during group. What is said in group stays in group. There is to be no crosstalk while other group members are talking. I am expected to give and to receive feedback in a respectful & helpful manner. There is no rescuing, especially supporting negative thinking and behaviors. Swearing or derogatory comments/statements will not be tolerated. The facilitator reserves the right to remove me for any inappropriate attitude, behavior, or language and may result in disciplinary procedures.
5. No disruptive actions, noises, behaviors, or physical violence will be allowed during group. I will be warned once, and after that will be dismissed from group. Any dismissal from group will count as an unexcused absence. If I am dismissed a second time from group, I may not be readmitted to group, I may be terminated from the program, and/or the referring agency notified of my non-compliance.
6. I understand that it is Boyd Andrew Community Services' policy to provide a safe environment for treatment. All fire exits are clearly marked and any questions about safety and emergency precautions have been answered. I understand that there are cameras in each of the group rooms for safety and security procedures.
7. I will not bring electronics, drugs, or weapons to group. Cell phones must be turned off and placed on the table in front of me. All clothing must be appropriate and free of scented products. No tight or revealing clothing, hats, or bandanas. Nothing that glamorizes or promotes alcohol, drugs, or gang affiliations. No food, gum, or tobacco products. I understand if I am wearing scented products or caught with electronics, drugs, or weapons I will be asked to leave, and will receive an unexcused absence which may result in non-compliance or disciplinary procedures.

8. I understand that I cannot use mood altering substances, including alcohol, during the time I am enrolled in this program. Any prescribed mood-altering substances must be pre-approved by the Clinical Supervisor or Director. You may be asked to submit a random breathalyzer and/or urinalysis drug test at any time while enrolled in treatment. Failure to do so may make me ineligible for group. In that regard, I voluntarily agree to submit to this alcohol and drug testing. If I am found under the influence in group, I will be removed and receive an unexcused absence. Use violations may result in a referral to a higher level of care.
9. I understand that it is the policy of Boyd Andrew Community Services which prohibits discrimination in accepting referrals on the basis of sexual preference, gender, disability, race, creed, religion, political views, or national origin. If I need an accomodation for a disability, I know it is my responsibility to notify my program manager or counselor.
10. I understand that I am required to attend all required appointments with my Counselor which may include additional evaluations or meetings (i.e., Dangerousness and Violence Risk Assessment or Chemical Dependency Assessment, Exit Interviews, and/or Treatment Plan meetings) and may include a Discharge/Transition Plan.

Client Signature

Date

Client Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

Client Orientation Information

Services Provided at Boyd Andrew Community Services (BACS)

Therapeutic methods, philosophies, and orientations shall be determined by management. BACS offers the following required services:

Crisis Intervention: The process of intervening in a crisis to encourage appropriate treatment of substance use disorders.

Screening and Evaluation: The process of collecting information, which will indicate diagnosis and appropriate treatment.

Individual Counseling: Face-to-face interaction between a licensed or eligible Licensed Addiction Counselor (LAC) and an individual client. Unless otherwise specified in the job description, counselors are expected to carry a client caseload of 1-20 at a minimum.

Group Counseling: Face-to-face interaction between two or more clients and a licensed or eligible Addiction Counselor(s) for a specific therapeutic purpose.

Family Counseling: Face-to-face interaction between a licensed or eligible Addiction Counselor and family member(s) with or without the client for a specific therapeutic purpose.

Intervention Services: The process of intervention to assist a person in acknowledging the existence of SUD problems in his/her life and to facilitate appropriate treatment.

Structured Sessions in Education/Prevention: A group of assignments designed to give individual clients information and understanding concerning the recovery process.

ADDITIONAL SERVICES

Intensive Outpatient Program: (ASAM 2.1), (IOP), treatment of substance uses to families and individuals through a structured series of lectures and group therapy. The lecture portion of the treatment series is designed to educate individuals and families about substance use, abuse or dependency, and life skills necessary to live a chemically free lifestyle. The therapy groups for individuals and families offer a therapeutic environment necessary for behavior alteration, exploration of feelings, confrontation of defenses and self-destructive behavior, self-assessment, and insight. The family portion of the treatment series brings together members of families in treatment and focuses both on understanding how families become dysfunctional with substance use and alternatives available to restore family functioning.

Outpatient Program: (ASAM 1.0) (OP) Individual sessions every other week and group therapy once a week.

Co-Occurring Disorder Program: (COD) Individual sessions, weekly, bimonthly, or monthly and group therapy once a week.

Prime for Life (PFL) – is the evaluation component utilized to identify substance use patterns of the offenders and to make appropriate recommendations for education and/or treatment. A complete biopsychosocial assessment is required in all cases in which treatment is recommended. Misdemeanor dangerous drug offenders may complete the assessment with the PFL program or a state approved treatment program which offers a Major Depressive Disorder (MDD) education program. Education group is component based on curriculum contained and explained in the PFL course curriculum manual. The course will be based on the PFL curriculum but must contain specific information on misdemeanor drug laws.

Group Only Program: Weekly groups – Anger Management, Parenting, Co-Dependency, Seeking Safety, MRT, Batterers Intervention,

The specific content and duration of all treatment services is determined by the presence and nature of the most current version of ASAM placement continued stay criteria. Criteria are identified at admission and during periodic continued stay reviews.

Disaster Policy and Plan

It is the policy of the BACS TLF to establish and maintain fire prevention procedures to ensure the safety of staff, offenders, and visitors. These regulations will include, but are not limited to:

- Provision for an adequate fire protection service
- A system of fire inspections and testing of equipment at least quarterly or at intervals approved by the authority having jurisdiction, following the procedures stated for variances, exceptions, or equivalencies
- An annual inspection by local or state fire officials or other qualified person(s)
- Availability of fire protection equipment at appropriate locations throughout the facility

The Fire/Emergency Evacuation Plan will contain, at a minimum:

- Location of building/room floor plan
- Use of exit signs and directional arrows for traffic flow
- Location of publicly posted plan
- Specific evacuation routes

INFECTION CONTROL POLICY

It is the policy of BACS that an organization-wide plan for the control of infection shall be in effect and reviewed annually. Consultants shall be used to augment staff training when necessary to ensure current infection control practices. The infection control program is designed to provide effective, organization-wide surveillance activities that prevent and/or control infections.

Client Signature

Date

Client Printed Name

Counselor/Intake Staff Signature

Date

Counselor/Intake Staff Printed Name

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Printed Name

CONFIDENTIALITY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) * and the Confidentiality Law**. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g., Clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g., State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program’s premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

* 42 U.S.C. § 130d et. seq., 45 C.F.R. Parts 160 & 164 *

* 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g., another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program’s records, and to request and receive an accounting of disclosures of your health-related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.

- To make any of the above requests, you must fill out the appropriate form that will be provided by the program.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information at the program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

- Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.
- Communication with Business Associates such as clinical laboratories (drug patch, urinalysis), agencies that provide on-site services (lectures, group therapy), and long-term record storage.

The Program's Duties

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current clients with an updated notice and will provide affected former clients with new notices when substantive changes are made in the notice.

Complaints and Reporting Violations

Clients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The client may complete a Statement of Grievance form and submit the grievance. The Grievance will be reviewed by the grievance coordinator who may be the.

The complaint will be reviewed by an appropriate individual, based on the nature of the complaint. That individual will complete the Statement of Grievance form.

Violation of the Confidentiality law by a program is a crime. The client may also register a complaint with the:

Montana Department of Public Health and Human Services
PO Box 202960
Helena, MT 5920-2690

<https://dphhs.mt.gov/Portals/85/qad/documents/programCompliance/HIPPS/complaintform.pdf>

You will not be retaliated against for filing such a complaint.

Effective Date 4/9/18

GRIEVANCE PROCEDURE

The purpose of a grievance procedure policy is to set forth clearly the rights of a client to file a grievance and the procedure for doing so. Any client of Boyd Andrew Community Services has a right to file a grievance for any reason without alteration, interference, or delay, and without fear of any adverse action occurring as a result. Staff and clients are asked to keep in mind that the grievance procedure is to be used when informal procedures do not work or are felt to be inadequate.

If a client has a complaint or grievance the following steps should be taken. These steps should be taken in order unless there is an over-riding reason to skip a step.

1. The grievance or complaint should be orally presented to the client's assigned counselor. This will often resolve the problem. If the client is not satisfied, he/she should proceed to step 2 within five working days.
2. The client should next make an appointment with the Director of SUD services. The client will be asked to fill out a "Grievance Form" (see FORMS MANUAL) and give a detailed explanation of the grievance. The Director of SUD services will investigate the grievance and give a written response as to findings and actions taken within five working days.
3. If a client is not satisfied, he/she should request in writing that the Director of HR/Ops investigate. A letter should be submitted to the Director of HR/Ops within five working days. The letter should be submitted to the CEO who will pass it on to the Board of Directors.
4. If the client is still not satisfied, he/she should request in writing that the Board of Directors investigate. A letter should be submitted to the Board President within five working days of receipt of the report issued above by the Director of HR/OP to the Board President via the CEO.

The Board President will then select a committee, consisting of the President and two other board members, who will investigate the grievance. The committee selection, investigation, and subsequent report to the client will be completed in an expeditious manner.

NOTE: If at any time the client wishes to drop the grievance, they must inform the Grievance Coordinator in writing.

STATEMENT OF GRIEVANCE

Name of Individual filing grievance: _____

Program: _____

Please state grievance precisely. Attach additional sheets if necessary and include details such as who, what, when, where, and why in regard to the grievance. The Grievance Procedure can be found on the reverse of this form.

Grievances are not group activities; each grievance must be submitted by an individual client.

What do you feel should be done to remediate this grievance?

Signature of Complainant

Date

(_____) I have reviewed this grievance with the Investigator and accept the following resolution. I do not wish to pursue a committee hearing.

() I wish to pursue a hearing before a Grievance Committee.

For Staff use only:

☐ Informal
☐ Formal

☐ Standard
☐ Emergency

☐ Staff Conduct
☐ Procedural
☐ Other:

Signature of Complainant

Date

Signature of Investigator

Date

Number _____ Assigned To:
Date: _____

Alcohol and Drug Use History

[illegible]

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No
2. Did a parent or other adult in the household **often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No
3. Did an adult or person at least 5 years older than you **ever** ...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No
4. Did you **often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No
5. Did you **often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No
6. Were your parents **ever** separated or divorced?
Yes No
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No
10. Did a household member go to prison?
Yes No

Now add up your "Yes" answers: _____ This is your ACE Score

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you use more than one drug at a time?	Yes	No
3	Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use? (If never use drugs, answer "No")	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

General Anxiety Disorder (GAD-7)

NAME _____

DATE _____

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
<i>Add the score for each column</i>				
TOTAL SCORE <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐ 0	☐ 1	☐ 2	☐ 3

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –“Have you ever”

- | | | |
|---|-----|----|
| 1) Have you <u>ever</u> talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? | YES | NO |
| 2) Have you <u>ever</u> felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? | YES | NO |
| 3) Have you <u>ever</u> been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? | YES | NO |
| 4) Have you <u>ever</u> been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? | YES | NO |
| 5) Have you <u>ever</u> heard voices no one else could hear or seen objects or things which others could not see? | YES | NO |
| 6) Have you <u>ever</u> been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? | YES | NO |
| Did you <u>ever</u> attempt to kill yourself? | YES | NO |
| 7) Have you <u>ever</u> had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? | YES | NO |
| 8) Have you <u>ever</u> experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? | YES | NO |
| 9) Have you <u>ever</u> given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? | YES | NO |
| 10) Have you <u>ever</u> felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? | YES | NO |

11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES NO

16) Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17) Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES NO

Program to which client will be assigned: _____

Name of Admissions Counselor: _____ Date: _____

Reviewer's Comments: _____

Total Score: _____ (each yes = 1 pt.)

Patient Health Questionnaire (PHQ-9)

Patient Name: _____

Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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
	☐	☐	☐	☐

**Boyd Andrew Community Services
SHORT MAST**

Client Name: _____

Date _____

Directions:

Carefully read each question and decide whether your answer is YES or NO and check the appropriate answer. Please be sure to answer every question.

Yes	No	Score	
_____	_____	_____	1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)
_____	_____	_____	2. Does your spouse or children or relatives and friends ever worry or complain about your drinking?
_____	_____	_____	3. Do you ever feel guilty about your drinking?
_____	_____	_____	4. Do friends or relatives think you are a normal drinker?
_____	_____	_____	5. Are you able to stop drinking when you want to?
_____	_____	_____	6. Have you ever attended a meeting of alcoholics anonymous?
_____	_____	_____	7. Has drinking ever created problems between you and your spouse, children or other near relative?
_____	_____	_____	8. Have you ever gotten into trouble at work because of your drinking?
_____	_____	_____	9. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?
_____	_____	_____	10. Have you ever gone to anyone for help about your drinking?
_____	_____	_____	11. Have you ever been in a hospital because of drinking?
_____	_____	_____	12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcohol?
_____	_____	_____	13. Have you ever been arrested, even for a few hours because of drunken behavior?

Total Score: / 13

LAC Signature

Date

SOUTH OAKS GAMBLING SCREEN
[SOGS]

Name: _____ Date: _____

1. Please indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "Not at All," "Less than Once a Week," or "Once a Week or More."

PLEASE "✓" ONE ANSWER FOR EACH STATEMENT:	NOT AT ALL	LESS THAN ONCE A WEEK	ONCE A WEEK OR MORE
a. Played cards for money			
b. Bet on horses, dogs, or other animals (at OTB, the track or with a bookie)			
c. Bet on sport (parlay cards, with bookie at Jai Alai)			
d. Played dice games, including craps, over and under or other dice games			
e. Went to casinos (legal or otherwise)			
f. Played the numbers or bet on lotteries			
g. Played bingo			
h. Played the stock and/or commodities market			
i. Played slot machines, poker machines, or other gambling machines			
j. Bowled, shot pool, played golf, or some other game of skill for money			
k. Played pull tabs or "paper" games other than lotteries			
l. Some form of gambling not listed above (please specify: _____)			

2. What is the largest amount of money you have ever gambled with on any one-day?

_____ Never gambled	_____ More than \$100.00 up to \$1,000.00
_____ \$1.00 or less	_____ More than \$1,000.00 up to \$10,000.00
_____ More than \$1.00 up to \$10.00	_____ More than \$10,000.00
_____ More than \$10.00 up to \$100.00	

3. Check which of the following people in your life has (or had) a gambling problem.
- | | |
|---|--|
| ☐ Father | ☐ Mother |
| ☐ Brother/Sister | ☐ My Spouse/Partner |
| ☐ My Child(ren) | ☐ Another Relative |
| ☐ A Friend or Someone Important in My Life | |
4. When you gamble, how often do you go back another day to win back money you have lost?
- | | |
|---|---|
| ☐ Never | ☐ Most of the Times I Lose |
| ☐ Some of the Time
(less than half the time I lose) | ☐ Every Time I Lose |
5. Have you ever claimed to be winning money gambling, but weren't really? In fact, you lost?
- | |
|--|
| ☐ Never |
| ☐ Yes, less than half the time I lost |
| ☐ Yes, most of the time |
6. Do you feel you have ever had a problem with betting or money gambling?
- | | | |
|-----------------------------|------------------------------|--|
| ☐ No | ☐ Yes | ☐ Yes, in the past, but not now |
|-----------------------------|------------------------------|--|
7. Did you ever gamble more than you intended to? ☐ Yes ☐ No
8. Have people criticized your betting or told you that you had a problem, regardless of whether or not you thought it was true? ☐ Yes ☐ No
9. Have you ever felt guilty about the way you gamble, or what happens when you gamble? ☐ Yes ☐ No
10. Have you ever felt like you would like to stop betting money on gambling, but didn't think you could? ☐ Yes ☐ No
11. Have you ever hidden betting slips, lottery tickets, gambling money, IOUs, or other signs of betting or gambling from your spouse, children or other important people in your life? ☐ Yes ☐ No
12. Have you ever argued with people you live with over how you handle money? ☐ Yes ☐ No

13. (If you answered "Yes" to question 12) Have money arguments ever centered on your gambling? _____ Yes _____ No
14. Have you ever borrowed from someone and not paid them back as a result of your gambling? _____ Yes _____ No
15. Have you ever lost time from work (or school) due to betting money or gambling? _____ Yes _____ No
16. If you borrowed money to gamble or to pay gambling debts, who or where did you borrow from (check "Yes" or "No" for each):
- a. From household money _____ Yes _____ No
 - b. From your spouse _____ Yes _____ No
 - c. From other relatives or in-laws _____ Yes _____ No
 - d. From banks, loan companies, or credit unions _____ Yes _____ No
 - e. From credit cards _____ Yes _____ No
 - f. From loan sharks _____ Yes _____ No
 - g. You cashed in stocks, bonds or other securities _____ Yes _____ No
 - h. You sold personal or family property _____ Yes _____ No
 - i. You borrowed on your checking accounts (passed bad checks) _____ Yes _____ No
 - j. You have (had) a credit line with a bookie _____ Yes _____ No
 - k. You have (had) a credit line with a casino _____ Yes _____ No

The SOGS may be reproduced as long as the language is used as printed and the scored items are not revised without permission of the author.

University of Rhode Island Change Assessment (URICA) Scale

Name: _____ Date: _____

This questionnaire is to help us improve our services. Each statement describes how a person might feel when starting therapy. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem", answer in terms of the problem you have written at the top. And "here" refers to the place of treatment.

There are **FIVE** possible responses to each of the items in the questionnaire: Strongly disagree, disagree, undecided, agree, and strongly agree. Circle the number that best describes how much you agree or disagree with each statement.

There are FIVE possible responses:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to be here.	1	2	3	4	5
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	1	2	3	4	5
7. I am finally doing some work on my problem.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5

There are FIVE possible responses:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
9. I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11. Being here is pretty much of a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12. I'm hoping this place will help me to better understand myself.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have a problem and I really think I should work on it.	1	2	3	4	5
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19. I wish I had more ideas on how to solve my problem.	1	2	3	4	5
20. I have started working on my problems but I would like help.	1	2	3	4	5

There are FIVE possible responses:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
21. Maybe this place will be able to help me.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone here will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
31. I would rather cope with my faults then try to change them.	1	2	3	4	5
32. After all I had done to try and change my problem, every now and again it comes back to haunt me.	1	2	3	4	5



DLA-20 Self Report

During the last 30 days did your symptoms interrupt any of the following everyday activities?

Please use scale below to score each daily living activity

No, not at all
Rarely
Sometimes
Usually
Yes, always

Physical Health and Mental Wellness During the last 30 days...	1	2	3	4	5	
I managed my mental health symptoms such as anxiety, racing or disturbing thoughts, depression, memory lapses or stressful repetitive behaviors. Other symptoms/comment:						Total
I managed my moods such as anger, sadness or happiness.						
I managed my physical health such as problems with pain, high blood pressure, weight or diet restrictions. Other symptoms/comment:						
I took all my medications as prescribed. ___ N/A (not on medication)						

Stable Housing During the last 30 days...	1	2	3	4	5	
I lived in the same place.						Total
I managed to keep up with my household duties such as cleaning.						

Communication During the last 30 days...	1	2	3	4	5	
I listened to others and understood what they were saying.						Total
I was able to focus, express my needs and wants in a positive manner.						

Safety During the last 30 days...	1	2	3	4	5	
I have been free from thoughts of harming myself.						Total
I have been free from thoughts to harm others.						
I made safe decisions at home and while out in the community.						

DLA-20 Self Report

No, not at all
Rarely
Sometimes
Usually
Yes, always



Time Management During the last 30 days...

1 2 3 4 5

I slept between 5-9 hours most nights.

Total

I felt rested most days when I woke up.

I followed a regular routine most days.



Money Management During the last 30 days...

1 2 3 4 5

I had a monthly source of income.

Total

I independently managed my money.

I paid my bills and expenses on my own.



Nutrition During the last 30 days...

1 2 3 4 5

I ate 2 nutritious meals most days.

Total

I limited my caffeine and sugar intake.

I prepared most of my meals.



Problem Solving During the last 30 days...

1 2 3 4 5

I solved day to day problems.

Total

I managed stressful situations.



Relationships with Family/Significant Others During the last 30 days...

1 2 3 4 5

I felt supported by my family or significant other.

Total

I was satisfied with my relationships with family/significant other.

DLA-20 Self Report

No, not at all
Rarely
Sometimes
Usually
Yes, always

 Alcohol & Drugs During the last 30 days...	1	2	3	4	5	
I avoided drinking more than 2 beers or 2 drinks of alcohol daily.						Total
I avoided cigarettes, vaping and tobacco.						
I avoided all drugs such as marijuana, opiates and heroin.						

 Leisure & Physical Activities During the last 30 days...	1	2	3	4	5	
I enjoyed time with others in my community, doing a healthy activity.						Total
I enjoyed personal hobbies such as exercising, reading, writing, painting or other activities.						

 Community Resources During the last 30 days...	1	2	3	4	5	
I used community resources that I needed such as churches, my doctor's office, mental health clinic or the grocery store.						Total
I used sources of transportation such as a car, bus or a family/friend to help me get around in the community.						

 Friendships with Support Systems During the last 30 days...	1	2	3	4	5	
I enjoyed time with a friend, neighbor or co-worker.						Total
Friends, neighbors or co-workers were kind and supportive of me.						

 Sexual Health During the last 30 days...	1	2	3	4	5	
I am satisfied with my current relationship status such as single or in relationship with a partner.						Total
I am satisfied that I am choosing safe sexual practices.						
I have questions and want to talk to my provider about sexual health concerns.						☐ Yes ☐ No

DLA-20 Self Report

No, not at all
Rarely
Sometimes
Usually
Yes, always



Productivity During the last 30 days...

1 2 3 4 5

I am satisfied with my role of working at a job, homemaking, volunteering or attending school.

Total

I feel productive while working at a job, homemaking, volunteering or at school.



Coping During the last 30 days...

1 2 3 4 5

I recognized my triggers such as symptoms or events that may lead to relapse.

Total

I used coping skills when I noticed symptoms such as being nervous, irritated, angry, sad or depressed.



Community Norms During the last 30 days...

1 2 3 4 5

I enjoyed everyday freedoms in my community without conflict.

Total

I abided by all laws and my interactions with law enforcement or courts were positive.



Oral & Personal Hygiene During the last 30 days...

1 2 3 4 5

I independently managed my personal hygiene such as baths and showers.

Total

I brushed my teeth each day, with no pain or discomfort.

I was able to eat, chew, drink hot or cold liquids without pain or discomfort.



Grooming During the last 30 days...

1 2 3 4 5

My overall appearance was neat such as hair brushed, hands and nails clean.

Total



Dress During the last 30 days...

1 2 3 4 5

My clothes are generally comfortable and clean.

Total

I am satisfied that my clothing is in good repair.

Overall Score

Boyd Andrew Community Services
60 S. Last Chance Gulch Helena, MT 59601
(406) 443-2343, Fax (406)443-5490

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Yellow sections are for the client to complete. All other sections are for the staff to complete.

Patient Name: _____
LAST FIRST MI MAIDEN

Date of Birth: _____ Social Security #: _____

1. I authorize the use or disclosure of the above patient's health information as follows:
2. The following individual or organization is authorized to receive and disclose information:

Primary Contact/Relationship: _____
Organization Name: _____
Address: _____ City/State/Zip: _____
Phone Number: _____ Alternate Phone Number: _____
Fax #: _____ Alternate Fax Number: _____
Email Address: _____

from and to: **Boyd Andrew Community Services, 60 S. Last Chance Gulch, Helena, MT 59601**

3. The type and amount of information to be used or disclosed is as follows:
--Provide a specific and meaningful description of the information, including dates where appropriate.--

Discharge Summary	Yes No	BioPsych/Social Assessment	Yes No
Progress and/or Progress Notes	Yes No	Mental Health Evaluation	Yes No
Master Treatment Plan	Yes No	Correspondence/Letter	Yes No

Other (Please be specific): _____ Dates of Treatment Requesting: _____

4. For the purpose of Continuity of Care or: _____

5. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must submit a written request to the Administrative Office Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. This authorization will expire on the following date or event: _____

7. Generally, Boyd Andrew Community Services will not condition treatment on the provision of this authorization, unless services are solely for the purpose of creating information for disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may no longer be protected by federal confidentiality rules.

9. By initialing here _____ I would like a copy of this authorization.

Signature of Patient Date

Witness Signature Date

Signature of Parent/Personal Representative Date

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: 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 patient.

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