

Intake/annual Checklist

Please complete the following to see what forms need to be completed:

All highlighted fields must be completed for list to generate below.

Format:

Paper

Age Group	Please Select
Substance Use Diagnosis	Please Select
HIV Diagnosis	Please Select
Insurance	Please Select
Has a Guardian	Please Select
Services Needed	Please Select
Visit Type	Please Select
Rendering SB&H Staff is Licensed	Please Select
Recommended Steps Completed	0

<u>Intake Consents & Steps</u>	<u>Required (If Applicable)</u>	<u>Location</u>	<u>Completed</u>
Consent Packet Acknowledgement		Axiom/Excel	
SUD Release		Axiom/Excel	
Advance Directives		Axiom/Excel	
PCP ROI		Axiom/Excel	
School ROI		Axiom/Excel	
JPO ROI		Axiom/Excel	
External BH provider ROI		Axiom/Excel	
Family/Friends ROI		Axiom/Excel	
Dual Enrollment- OTP specific		Axiom/Excel	
Transport Authorization- youth specific		Axiom/Excel	
Copy of Insurance Card		Axiom - Scanned documents	
Private Pay Agreement		Confluence	
Copy of Birth Certificate, Notice to Provider (DCS Only), or Proof of Guardianship		Axiom - Scanned documents	
Copy of Member ID or Birth Certificate		Axiom - Scanned documents	
Create Chart in Axiom		Axiom - Scanned documents	

<u>Screening Forms</u>	<u>Required?</u>	<u>Location</u>	<u>Completed</u>
Cover Sheet		Axiom/Excel	
Demographic [834]		Axiom	
Adult Health Risk Assessment [HRA]		Axiom/Excel	
Youth Health Risk Assessment [HRA]		Axiom/Excel	
PCP Medical History Form		Axiom/Paper	
Depression Screener [PHQ-9]		Axiom/Paper	
Anxiety Screener [GAD-7]		Axiom/Paper	
ADHD Screener		Axiom/Paper	

Assessment Forms	Required?	Location	Completed
Engagement Session Note [Assessment]		Axiom	
Substance Use Screener [ASAM]		Axiom	
Service Plan		Axiom	
Support & Safety Plan		Axiom	
ART/CFT/Staffing Plan		Axiom	
Developmental History Assessment		Axiom	
Columbia-Suicide Severity Rating Scale		Axiom	
CALOCUS		CALOCUS Portal	
Strength Needs Culture Discovery [SNCD]		Axiom	
PCP Note 3.0		Axiom	

Wrap Up	Required?	Location	Completed
Overview of next steps		Confluence	
PCP Communication		Axiom	
Birth to 5 Observations Scheduled		Axiom - scheduling	
Nursing Assessment Scheduled		Axiom - scheduling	
Therapy Appointment Scheduled		Axiom - scheduling	
Psych Eval Scheduled		Axiom - scheduling	
PCP Visit Scheduled		Axiom - scheduling	
Copies of Service Plan and Support & Safety Plan given to member		Axiom	
Pend Engagement Session Note and Service Plan to BHP		Axiom	
Document Closed		Axiom	



Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name	SSN	DOB
Address, City, State Zip	Phone	

I have received a copy of the Southwest Behavioral and Health Services Consent Packet, summarized below. I understand each form as they have been presented to me and agree to expectations and guidelines. I have been offered the opportunity to review the below consent forms and understand that I have the ability to ask questions to my satisfaction as part of the SB&H intake process. I understand that a copy of this page will be placed in my clinical record to show that I received the contents of this document.

Consent for Evaluation and/or Treatment (SB&H Handbook)
I hereby attest and acknowledge that I have read this entire consent for evaluation and/or treatment agreement and expressly declare, confirm and certify that I have the authority to execute this agreement on behalf of myself or applicable minor pursuant to any and all of the terms and conditions identified as expressed within this Agreement. I have had ample opportunity to review the contents of this Agreement and hereby authorize SBH to proceed based upon my authority to grant SBH the ability to evaluate and/or treat myself or applicable minor. I unequivocally expressed and represented my ability and authority to grant SBH the right to so proceed.

Informed Consent to Participate in Telepractice Services (SB&H Handbook)

I agree I do not agree to participate in telepractice services

Consent for Communication Email Voicemail Text Messages

Attendance Guidelines Agreement (SB&H Handbook)

Health Plan Member Handbook Acknowledgement (links in SB&H handbook)

Payment Agreement: *I give my consent for SBH to bill my insurance carrier for services provided per the Notice of Privacy Practices referenced below. I elect to receive services with the understanding that I may be personally responsible to pay for the service being rendered to me. (SB&H Handbook)*

SB&H Member Handbook Acknowledgement (*Program Responsibilities, List of Available Services at SB&H, Service Planning, Transition/Discharge Planning, Fees, Safety, SB&H Code of Ethics, SB&H Notice of Privacy Practices, AHCCCS Notice of Privacy Practices, Confidentiality of Substance Abuse Records, Rights of Persons Served, Additional Rights for Inpatient or Residential Treatment Facilities, Legal Rights for Persons with Serious Mental Illness, Notice to Persons with Serious Mental Illness, Notice to Individuals Receiving Substance Abuse Services, Grievance, Appeal and Complaint Policy and Procedure*). **Bureau of Medical Facilities Licensing: 602-364-3030; Bureau of Behavioral Health Facilities Licensing: 602-542-3422.**

Signature of Member

Date



[Signature line for Parent, Guardian, or authorized representative]

Signature of Parent, Guardian, or authorized representative (when required)

[Date line]

Date

[Signature line for Witness (Staff)]

Witness (Staff) Signature

[Date line]

Date

Member's Name:

DOB:



Southwest Behavioral & Health Services
Release of Information and Records Request Form

Please check only ONE of the following options:

- Check here if you would like to Release/Send your records
Check here if you would like to Request your record
Check here if you would like to both Release AND Request your records

How would you like to receive your records? Please select:
Mail
Digital format via Mail (50 page minimum required)
Email:

Dates of Service (for records to be sent):
past 60 days
past 90 days
past year
Other (list date range):

I, Member's Name
SSN
DOB
Address, City, State, Zip
Phone Number

Authorize releases, and/or record requests as selected herein between:

Southwest Behavioral & Health Services
Name of Healthcare Organization with Treatment Relationship
3450 N. 3rd Street, Phoenix, AZ 85012
Address, City, State, Zip
602-265-8338
Phone Number
602-323-2351
Fax Number

AND

Name of Person and Agency (Recipient)
Address, City, State, Zip
Phone Number
Fax Number

Notice to Recipient: This information has been disclosed to you from records that Federal law protects. These records are not subject to redisclosure. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains...

Note: Federal and state government rules require a separate authorization be completed for each of the following categories: Information on HIV/AIDS and other communicable diseases, and Alcohol/Substance Abuse Records.

What kind information would you like released and/or requested as selected herein? Check all that apply:

- Clinical Assessment
Clinical Services Notes
Discharge Summary
Psychological Assessment
Other (Please specify i.e. billing records, treatment summary, etc):
Psychiatric Evaluation
Treatment/Service Plans
Substance Use Information
Verbal disclosure of treatment information
Medications
Test Results/Labs
AIDS/HIV Information
School Records

Purpose for Release/Request:

A purpose for the request/disclosure is required for all 3rd party releases only. This section identifies to the authorized party and signer why the records are being requested and/or what the records will be used for. The purpose is not required when members are requesting their own records. I understand that at anytime, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures...

Authorization will expire:

- 1 Year From this Date
Other: (Enter Date, no greater than 1 year)

Signature of Member/Guardian/Authorized representative
Date
Other Required Signature (If Applicable)
Witness (if Member is unable to sign)

If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required



Southwest Behavioral & Health Services Cover Sheet

Member's Name _____			Member SS# _____			DOB _____		
Address, City, State Zip _____				Phone _____		Email _____		
Gender:	<input type="checkbox"/> Gender Variant	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Intersex	<input type="checkbox"/> Questioning	<input type="checkbox"/> Transgender	<input type="checkbox"/> Decline to answer	
Race:	<input type="checkbox"/> American Indian/Alaskan Native			<input type="checkbox"/> Asian or Pacific Islander		<input type="checkbox"/> Black	<input type="checkbox"/> Caucasian	
	<input type="checkbox"/> Native Hawaiian		<input type="checkbox"/> Decline to answer					
Ethnicity:	<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Non-Hispanic/Latino			<input type="checkbox"/> Decline to answer		
Primary Language _____			Preferred Language _____					
Insurance Coverage: <i>Attach a copy of medicaid, medicare, commercial and other insurance cards</i>								
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Private (Self-pay)	<input type="checkbox"/> TriCare	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> HMO	<input type="checkbox"/> Other		
Insurance Co. _____			Insurance ID# _____			Policy# _____		
Special Needs:								
Interpreter (spoken)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify language _____						
Translator (written)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify language _____						
Mobility Assistance	<input type="checkbox"/> No	<input type="checkbox"/> Yes, identify assistance needed _____						
Visual Impairment Assistance	<input type="checkbox"/> No	<input type="checkbox"/> Yes, identify assistance needed _____						
Hearing Impairment Assistance	<input type="checkbox"/> No	<input type="checkbox"/> Yes, identify assistance needed _____						
Need Childcare Arrangements	<input type="checkbox"/> No	<input type="checkbox"/> Yes, identify need _____						
Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. ↓								
Key Contacts:							<input type="checkbox"/> No	<input type="checkbox"/> Yes
If applicable, select custody arrangement <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Ward of Court (DCS) or Legal Guardian								
Parent/Legal Guardian(s):			Phone _____			Phone _____		
<i>Must provide current legal document</i>			Phone _____			Phone _____		
Emergency Contact:			Phone _____			Phone _____		
<i>Complete ROI</i> Address _____			Phone _____			Fax _____		
PCP/Physician:			Phone _____			Fax _____		
<i>Complete PCP ROI</i> Address _____			Phone _____			Fax _____		
Dentist:			Phone _____			Fax _____		
Other Healthcare Specialist(s):			Phone _____			Fax _____		
<i>(e.g. Mental health, substance use, OBGYN, neuro, pain, naturopath, etc)</i> Address _____			Phone _____			Fax _____		
Address _____			Phone _____			Fax _____		
Pharmacy:			Address _____					
Other Key Contacts: <i>(e.g. school, probation/parole officer, other involved agencies [DDD/DCS], significant other, neighbors, family)</i>								
Name: _____			Relationship: _____					
Phone: _____			Fax: _____					
Name: _____			Relationship: _____					
Phone: _____			Fax: _____					



Southwest Behavioral & Health Services Youth Health Risk Assessment

Member's Name	Member SS#	DOB
Address, City, State Zip	Phone	Email

Substance Related Disorders Screening Adult (18+) Youth (0-17) *As appropriate, ask the youth these questions*

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? No Yes

Do you ever use alcohol or drugs while you are by yourself alone? No Yes

Do you ever forget things you did while using alcohol or drugs? No Yes

Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs? No Yes

Do your family or friends ever tell you that you should cut down on your drinking or drug use? No Yes

Have you ever gotten into trouble while you were using alcohol or drugs? No Yes

Who in your family uses alcohol or other substances? _____

Please list any history and treatment of behavioral health or substance use issues that your family members have had: _____

Youth Health Risk Screening Questionnaire

Have you been diagnosed with diabetes or asthma? No Yes

If yes, what medications are you taking for this? _____

Check the symptoms the youth experiences regularly:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Persistent cough or wheezing
<input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Over/Under Weight	<input type="checkbox"/> Other: _____

Does the youth eat a poor diet? No Yes

Is the youth sedentary or minimally active? No Yes

Is the youth up to date on immunizations? No Yes

Does the youth use tobacco or are they exposed to second hand smoke? No Yes

If yes, what and how often?

<input type="checkbox"/> Vape	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Chew	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Other: _____

Health History (Please include all medical, dental, and behavioral health history)

<input type="checkbox"/> PCP on file	Date of last Physical Visit _____	Current health issues _____
	Any Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please Specify _____
<input type="checkbox"/> Dentist on file	Date of last Dental Visit _____	Current oral issues _____
<input type="checkbox"/> Other:	Date of last Visit _____	Other health issues _____
<input type="checkbox"/> Other:	Date of last Visit _____	Other health issues _____

Untreated physical and/or behavioral needs can impact overall health and negatively impact progress toward Goals.

A PCP appointment is recommended for further evaluation.

Would you like help with the above or other physical health needs? No Yes

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Transportation Authorization and Release of Liability

I, _____ (name of parent or legal guardian). Herein referred to as Legal Guardian, residing at _____ (address) hereby affirm that I am the parent or legal guardian of _____ (full name of minor), whose AHCCCS ID is _____ and date of birth is _____, herein referred to as Minor.

Minor is _____ (age) years old. Upon completion and signing of this form, I hereby provide my limited consent for Minor to be transported for the purpose of _____ (include purpose of transportation), herein referred to as Purpose. The Minor may be transported for this Purpose from _____ (start date of authorization) to _____ (end date of authorization; cannot be more than 3 months after the start date of the authorization).

Minor will be transported without the presence of their Legal Guardian.

By providing this authorization and release of liability, I represent that Minor is capable of being transported without the presence of their Legal Guardian and will comply with all safety rules and regulations communicated by the driver. I understand if Minor does not follow the rules, the Minor may no longer be transported without a Legal Guardian. I agree to ensure that Minor will be ready for their pickup for their trip and will be able to get themselves to the specific pickup location at the scheduled time.

I agree to inform the AHCCCS enrolled provider within 48 hours if for any reason I cease being the Legal Guardian of Minor and agree to provide the name and contact information for the newly designated Legal Guardian. I agree to inform the AHCCCS enrolled provider immediately in the event that I no longer consent to Minor receiving non-emergency transportation for medical necessary services. I agree to provide an updated signed Transportation Authorization and Release of Liability form 3 months after the date of signature below to continue the authorization for the Purpose outlined above. I may ask at any time, in writing, that this authorization be canceled.

Upon execution of this authorization and release for transportation of a Minor, I hereby release AHCCCS and the AHCCCS contracted health plan, its employees, officers, agents, and subcontractors from any and all liability, causes of action, or claims in connection with the transportation.

If any of the above information should change, the Legal Guardian is responsible for providing an updated Authorization and Release of Liability Form.

Signature of Legal Guardian

Date

Printed Name of Legal Guardian

Date