Human Services, Inc.
50 James Buchanan Dr.
Thorndale, PA 19372
P: 610-200-6222 F: 484-784-5660

Intake Contact:
intake@humanservicesinc.org
610-200-6222 ext. 252

Client Registration Packet

Date ______________ Referral Source/Name of Organization (IF APPLICABLE) ______________

Phone # ______________ Contact Information ______________

Client Information

First Name (Mr. Ms. Mrs. Mx.) ______________ Last Name ______________ Phone Number (REQUIRED) ______________

Address ______________

City ______________ State/Zip Code ______________ DOB ______________

Email Address ______________ Race/Ethnicity ______________ Gender – Alias/Other Preference/Pronouns ______________

Social Security Number (REQUIRED) ______________ Emergency Contact Name & Phone Number (REQUIRED) ______________

Insurance Provider (PRIMARY) ______________ Insurance Member ID ((REQUIRED) ______________

Insurance Provider (SECONDARY) ______________ Insurance Member ID ______________

If you are currently uninsured or under insured, are you interested in applying for County Funding, if eligible? (This is NOT a Medicaid Program)

Yes ______ No ______ I Prefer to Self-Pay ______

PLEASE BE ADVISED: FORM MUST BE COMPLETED IN ITS ENTIRETY. INCOMPLETE FORMS WILL BE RETURNED.

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Please complete all of the following questions.

Are you currently experiencing Suicidal (Thought/Plans) Ideation? ☐ Yes ☐ No
If yes, do you have a plan: ____________________

Are you currently experiencing Homicidal (Thought/Plans) Ideation? ☐ Yes ☐ No
If yes, do you have a plan: ____________________

Do you hear/see things that other people do not see/hear (Psychotic Episode)? ☐ Yes ☐ No

Do you Self Harm (Cut, Burn, Skin Pick)? ☐ Yes ☐ No

Are you experiencing/recently experienced Domestic Violence? ☐ Yes ☐ No

If you are currently experience a crisis or in an emergent situation please contact the Police Department at 911 or Valley Creek Crisis Center at (610) 280-3270

Do you/have you used Illegal Substances? ☐ Yes ☐ No
Drug of Choice? ____________ Last Used? ____________
How Often? ____________ How Much? ____________

Do you drink/have you drunk Alcohol? ☐ Yes ☐ No
Last Used? ____________ How Often? ____________
How Much? ____________
Date of Last Drug & Alcohol Evaluation: ____________

Are you currently receiving any of the following services?
☐ Drug & Alcohol Treatment Where: ____________
☐ Medication Management Where: ____________
☐ Mental Health Services Where: ____________
☐ Case Management Services Where: ____________

Have you previously received services from Human Services, Inc.? ☐ Yes ☐ No

Have you recently discharged from a hospital for Mental/Behavioral Health? ☐ Yes ☐ No
Name of Facility: ____________ Date of Discharge: ____________

Per Human Services, Inc. policy, individuals MUST receive medication management in conjunction with Outpatient Therapy Services. Failure to attend regularly scheduled therapy appointments will result in the cancellation of medication review appointments. Individuals MUST provide accurate financial and insurance information, Failure to comply may result in a $300 Charge.
Client Initials: ________

Are there other services that you are interested in receiving from Human Services, Inc.?
☐ Blended Case Management (BCM) ☐ Critical Time Intervention (CTI/Housing)
☐ Psych Rehab (Transitions/Clubhouse) ☐ Dialectical Behavioral Therapy (DBT) Group

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Are you currently on Probation/Parole? ☐ Yes ☐ No

Officer Name: ______________________

Contact Phone Number ______________________

Type of Probation/Parole: ☐ County ☐ State ☐ Federal

Are Court Ordered for Treatment Services/Involuntary Outpatient Commitment (IOC)? ☐ Yes ☐ No

Next Court Date: ______________________

If yes, please check: ☐ Mental Health Evaluation ☐ Anger Management ☐ Retail Theft ☐ Domestic Violence ☐ Sex Offender ☐ IOC

Sentencing Sheet Showing Court Order **Must Be** Provided Prior To Scheduling Initial Intake.

Please note that Human Services Inc. does not participate/testify in court proceedings

Are you involved with Children and Youth Services? ☐ Yes ☐ No

County/State: ______________________

Caseworker Name & Phone Number: ______________________

Are you involved with Family Based Services, Wraparound Services or a Partial Hospital Program (PHP) with another agency? ☐ Yes ☐ No

Please Specify: ______________________

Any MEDICAL concerns or diagnosis, unrelated to Mental Health? ☐ Yes ☐ No

Please Specify: ______________________

____

What concerns do you want to address while at Human Services, Inc.? RESPONSE REQUIRED

____

____

Please know that we take many factors into scheduling our clients to best fit their needs.
We cannot guarantee that all requests can be met.

Please check your preferences: ☐No Preference

Office:	☐ Thorndale	☐ Oxford	☐ Brandywine
Time of Day:	☐ Morning/Afternoon	☐ Evening (After 5pm)	
Therapist:	☐ Male	☐ Female	
Language:	☐ English	☐ Spanish	☐ Other

If Other, Please Specify: ______________________

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IF NOT BEING REFERRED BY HOSPITAL/INPATIENT FACILITY, PLEASE CONTINUE TO PAGE 5

Referral Information:
Transfer of Care from Hospital/Inpatient Facility

Client Name: ____DOB: ____________________

Name of Facility: ____

Address:____

Phone: _____________________ Fax: ____________________ Email: __________________

Date admitted: _____________________ Discharge Date:________________________

BH/MH Diagnosis(s): ____

Medical Diagnosis(s): ____

Medications being discharged on: ____

Name	Dosing Instructions	Qty given

Please Email/Fax Copy of any Psych Evaluations performed while in your care

This form MUST be fully completed and submitted with completed referral form. Intake appointments will not be scheduled without this information.

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INFORMED CONSENT FOR SERVICES (Telehealth or In-Person)

I,____, the undersigned, hereby attest that I have voluntarily given my consent for treatment/services or the treatment/services for myself, a minor and/or person under my legal guardianship mentioned above, to receive services at Human Services, Inc. Further, I consent to have treatment provided using telephonic/video/telephone equipment or in person services. For my psychiatric appointment there may be a support staff from Human Services, Inc. in the appointment to assist me and I can decline this in writing at any time. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the services may be discontinued at any time by either party, however Human Services, Inc. encourages that this decision be discussed with the treating clinician/prescriber in order to facilitate a more appropriate plan for discharge. I understand that with the use of technology there may be communication and technological challenges in being able to complete my appointment and that <u>two failed attempts may result in my need to attend an in-office, face to face appointment</u>.

<u>I understand that I am required to be seen in person for psychiatry appointments AND therapy appointments at least once a year to remain in compliance with federal telehealth mandates.</u>

I further understand that I may request to change the type/mode of delivery of services (telephone, telehealth, in- person) at any time and will discuss with my provider my preferences. I acknowledge that my provider may also change the type/mode of delivery of services of communication at any time per their policy on telehealth as discussed/reviewedwith me.

I understand that there will be an evaluation process in order to recommend the most appropriate mental health services for the recovery of self, the minor in my care or person under my legal guardianship. I understand that I am an active member of my treatment team and therefore have a partnership in the development of my recovery treatment plan concerning the services that will be obtained.

I agree that if I am choosing Telehealth services that I have a private location that prevents interruptions and distractions such as children, family or visitors during my appointment and that I have the necessary connection capabilities to effectively engage in my appointment with my provider. I have been informed of the use of Telehealth aspart of my treatment/services at Human Services, Inc. I understand that I have the option to decline the use of Telehealth to receive my services and can accept any available appointment at another location or be referred to another provider if the appointments offered do not meet my needs.

<u>I agree that consenting to telehealth visits require an electronic signature or handwritten signature that will be provided at the time of visit.</u> Where I cannot provide my electronic signature, I am consenting to my provider obtaining my verbal consent and documenting my consent in my visit that I understand that the following statement applies to my fiscal responsibility:

"I certify that the information shown on the invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws". MAID# 1007278830050

Signature: ____ Date: ________________________

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Fiscal Forms Consent Acknowledgement for
Receiving Mental Health Services at Human Services, Inc.

By signing this form, I (print name) ____________________________________, acknowledge that I am requesting mental health services for myself or for _________________________________ (as his/her legal guardian) at Human Services, Inc.

By checking and signing below, you as the consumer are agreeing that you have read/understand and been given copies of the following documents:

☐ I have read and understand the agency's Complaint/Information Form.
☐ I have read and understood the agency's Individual Responsibility for Outpatient Services Form.
☐ I have read and understand the agency's notice of Individual Financial Responsibility Form.
☐ I have read and understand the agency's Civil Rights Compliance Form.
☐ I have read and understand agency's Freedom of Choice Notification. I agree that I have entered into treatment voluntarily and have the choice to obtain mental health services from any provider that I choose. I understand that I have input into the development of my treatment plan.
☐ I have read and understood the agency's Notice of Privacy Practices.
☐ I have been provided copies of Mental Health Emergency Numbers.
☐ I have read and understood the agency's Limited English Proficiency Policy.
☐ I have read and understood the agency's Bill of Rights.
☐ I have read and understood the agency's Nondiscrimination of Services.
☐ I have been provided copies of the Behavioral/Physical Health Resources-Chester County.
☐ I have been provided copies of the Substance Use and Benzodiazepine Policy.

I understand that there will be an evaluation process to determine what mental health services will be recommended for me (or for my ward). I understand that I have input into the development of the services plan concerning what services I will receive.

Signature: ________________________ DOB: _____________________ Today's Date: ______________

☐ Please check if signing as parent/legal guardian/Power of Attorney.
Proper documentation must be submitted

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Human Services, Inc.
Voter's Registration Questionnaire

Last Name: ______________________________ First Name: ____________________________________

Address:____

City: _______________________ State: _____________________ ZIP: ______________________________

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

- ☐ Yes
- ☐ Yes, but I would like to take the form with me and apply later.
- ☐ No, I am already registered to vote where I live.
- ☐ No
- ☐ I do not wish to check a box. IF YOU DECIDE NOT TO CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you apply to register to vote, the office at which you submit this registration application form will remain confidential. No information relating to preference to register to vote will be used for any purpose other than for voter registration. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day of the next election, you must have be a citizen of the United States for at least one (1) month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election, and you must not have been confined to a penal institute for a conviction of a felony within the last five (5) years.

If you believe that someone has interfered with your right to register or your application to register to vote, or your right to right to choose your own party preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, Pennsylvania 17120 or call the Department of State, toll-free at 1-877-VOTESPA (1-877-868-3772).

Signature: _________________________ DOB: ______________________ Today's Date: ______________

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Human Services, Inc.

PLEASE INCLUDE A COPY OF THE FOLLOWING:

ID/DRIVER'S LICENSE

ALL INSURANCE CARDS (FRONT & BACK)

IN-PERSON OR VIA EMAIL AT:

INTAKE@HUMANSERVICESINC.ORG