Intake Packet for
Early Childhood Mental Health Services

Instructions

1. Read ALL the forms.
2. Please do NOT sign the forms prior to the appointment as many must be witnessed by a staff member. These areas are highlighted for your convenience.
3. Complete as much as possible prior to your appointment, other than signatures.
4. Please bring a copy of your child's insurance card to the appointment.

If you have any questions regarding the paperwork you may contact one of our therapists at 785-842-9679.

If you need to reschedule please call 785-842-9679.

We look forward to working with you and your child.

Positive Bright Start Staff

Client Information

Child's Legal Name_____ Nickname_____

Date of Birth_____ Gender_____ Primary Language_____

Name of School or Child Care Facility _____

Parent or Guardian Name_____ Date of Birth_____

Relationship to Child _____ Employer _____

Address: _____
Street City State Zip

Phone: _____ (cell phone) Ok to leave voice message? Yes / No
Ok to text regarding scheduling only? Yes / No

Phone: _____ (other) Ok to leave voice message? Yes / No

Email _____ Preferred contact method? _____

Would you like to receive the Positive Bright Start newsletter via email? Yes / No

Parent or Guardian Name_____ Date of Birth_____

Relationship to Child_____ Employer _____

Address: _____
Street City State Zip

Phone: _____ (cell phone) Ok to leave message? Yes / No

Phone: _____ (other) Ok to leave message? Yes / No

Email _____ Preferred contact method? _____

Who has legal custody of this child? _____

If separated or divorced, visitation schedule: _____
_____

**If divorced or separated bring a copy of custody agreement to intake appointment.*

Siblings in the home		Siblings not in the home	
Name	DOB	Name	DOB
_____		_____	
_____		_____	
_____		_____	
_____		_____	

People in household, if different from above:

_____

_____

Others who are responsible for care of your child(ren) _____

_____

Primary Care Physician_____ Phone_____ Last seen on_____

Is your child currently under the care of a physician for any medical conditions? If yes, list.

_____

Current medications:

Name	Indication	Dose/Frequency	Start Date	Prescriber

Does your child have any allergies or bad reactions to medications or other substances?

Yes / No If yes, to what?_____

Does your child see any other professionals for services, if so please list: (e.g. OT, PT, Speech Pathologist etc)_____

Is this child a party to any legal action? (e.g. divorce, custody, child in need of care, current adoption, or protection from abuse) If yes, please describe_____

_____

_____

Where did you learn of our services: _____

Emergency Contact Name*_____

Relationship _____ Phone_____

Address:_____

Street City State Zip

*By providing this information you are authorizing Positive Bright Start to contact this person in emergency circumstances.

Insurance Provider_____

Group #_____ Policy Number _____

Name of Insured _____ DOB _____

**Please bring a copy of insurance card to intake appointment.

HIPAA Notice of Privacy Practices

It is the policy of Positive Bright Start (PBS) and Early Childhood Mental Health Consultation (ECMHC) to protect the privacy of client information and to assure that the disclosure of all such information, whether written, verbal, or electronic (including faxes), is conducted in compliance with all federal and state laws governing confidentiality. All staff members, students, interns, volunteers, or other individuals having access to client information have responsibility to protect and preserve confidentiality for all clients. Client information is defined as any written, electronic or verbal information about current or former clients that is personal and private in nature, including his or her existence in PBS and ECMHC services.

PBS and ECMHC personnel will hold confidential all information obtained about clients related to their assessment, care, and services received, and shall not divulge it without the client's authorization unless it is allowed by law (refer to Appendix B for K.S.A., 65-5603 Exceptions to Confidentiality). Authorization to release client information constitutes a signed written consent from the client or legal representative to view the clinical record or to obtain copies of the record; signed court order; or meeting the statutory requirement for protection of persons from harm (see exceptions in K.S.A., 65-5603 attached to Policy on Confidentiality).

Minimum Necessary Rule (HIPAA Privacy Regulation):

- HIPAA and State regulations require the minimum amount of disclosure necessary to meet the purpose of the request.
- Conversations about clients should not take place in public areas.
- Paper documents should not be left out in the clients view.
- The only time we release all records is at the client request or if it is clinically necessary and it must be documented.
- If a client feels their Privacy rights have been violated, they have the right to file a complaint to the Office of Civil Rights. If enough complaints are filed, we will be audited for compliance review.
- Civil or criminal charges can occur (fines of $25,000 for multiple violations within one year; fines of $250,000 and imprisonment up to ten years for intentional misuse of patient information).

Acknowledgement of Receipt of Notice of Privacy Practices

Positive Bright Start
Early Childhood Mental Health Services

Notice to Client:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this notice, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this client but it could not be obtained because:

☐ The client refused to sign.
☐ Due to an emergency situation, it was not possible to obtain acknowledgement.
☐ We weren't able to communicate with the client.
☐ Other (please provide specific details).

_____ _____
Employee Signature Date

Consent for Data Collection for Early Childhood Block Grant

Early Childhood Mental Health Services at PBS *are funded in part by the Early Childhood Block Grant (ECBG). That grant requires that* PBS *collect data on the children and families that we serve in an effort to ensure that children are being screened, appropriately referred and treated for developmental and social emotional services. This release allows us to collect that information and provide it to our funders.*

WICHITA STATE UNIVERSITY
CENTER FOR COMMUNITY SUPPORT AND RESEARCH

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PHONE | 316.978.3843
TOLL FREE IN KS | 800.445.0116
FAX | 316.978.3593
WEBSITE |ccsr.wichita.edu
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Purpose of the Evaluation: Wichita State University's Center for Community Support and Research (CCSR) is working with the Kansas Children's Cabinet and Trust Fund (KCCTF) and the University of Kansas (KU). The goal is to find out how children and families are doing in programs being paid for by the Early Childhood Block Grant (ECBG) in the 22 ECBG sites. The research will look at children ages 0-5 years old and their development. The research will help funders decide what helps to make children ready for school.

Participant Selection: You have been asked to help with this research because you are a parent who has a child in a program paid for by the ECBG.

Explanation of Procedures: Your child or your family may be asked information. These tools include (although all may not be used):

Tools program/agency staff will fill out:
Keys to Interactive Parenting Scale (KIPS)

Tools we will ask you to fill out:
Ages & Stages Questionnaire (ASQ-3)
Ages & Stages Questionnaire – Social-Emotional (ASQ-SE)
Devereux Early Childhood Assessment (DECA)

Discomfort/Risks: The tools ask questions about you or your child. Completing these tools and/or the information you learn from them may make you feel uncomfortable. You can skip over questions you don't want to answer or quit at any time.

Benefits: You will be helping with the research on the 22 ECBG sites. The reason for this project is to show how well programs are helping children and their families all over Kansas. It is important to show that the programs improve children's readiness for school over time. This can only be done by getting information from children and families in these programs across different points in time.

Confidentiality: Information from your forms will be entered into an electronic database. The electronic database is safe, secure and password protected. You will be asked to put your name and your child's name on the forms. This information will allow for the assignment of a unique study number to you and your child by your child's program. This is to protect your confidentiality. If you chose to participate and do not wish for full names to be used, first name, last initial and birthdates can be substituted to further protect the confidentiality of you and your child. The names or birthdates and study numbers assigned will not be shared with anyone other than the ECBG site or program you are participating with and it will be stored in the secure data system created for the Kansas Children's Cabinet and Trust Fund. You and your child's anonymous data will be combined with data from other families for reporting purposes by the Kansas Children's Cabinet and their contractors. Your name or your child's name will never be shared with anyone outside of the secure data system.

Refusal/Withdrawal: You do not have to do any of the forms if you don't want to. Your decision whether or not to help with this research will NOT affect your future relations with Wichita State University, Wichita State University's Center for Community Support and Research, the program(s) your child is in, or the Kansas Children's Cabinet and Trust Fund or their agents. You are free to skip any question or quit at any time. You have the same rights with all the forms.

Contact: If you have any questions about the research, you can contact Dr. Lynn Schrepferman of CCSR by phone at 316-978-6772 or by email: lynn.schrepferman@wichita.edu. If you have questions pertaining to your rights as a research participant, you can contact the Office of Research and Technology Transfer at Wichita State University, Wichita, KS 67260-0007, telephone 316-978-3285.

Being a part of the Kansas ECBG Evaluation depends on you signing this consent form for you and your child.

☐ I consent to my child participating in these evaluations and the collecting of demographic information including my name and that of my child.

☐ I consent too my child participating in these evaluations but do NOT consent to our full names being used.

☐ I do not consent to my child participating in these evaluations.

You will be given a copy of this consent form to keep at your request.

_____
Name of Participant (Parent/Caregiver) (Please print)

_____ _____
Signature of Participant (Parent/Caregiver) Date

_____
Name of Child (Please print)

_____ _____
Witness Signature Date

Referrals and Supportive Services

Please indicate below resources or supportive services you are interested in obtaining.

- ☐ Housing
- ☐ Food assistance/food pantries
- ☐ Clothing or diapers
- ☐ Medical card
- ☐ Food stamps, child care subsidy, etc.
- ☐ Transportation
- ☐ Locating childcare services and/or scholarships
- ☐ Parenting support (discipline, potty training, rules/expectations, etc.)
- ☐ Parent education (child development, appropriate responses to children, interacting with children, etc.)
- ☐ Individual Therapy/support for child and or Family Therapy
- ☐ Referral for adult mental health services
- ☐ Safety Plan
- ☐ Other _____

Protective Factors Survey

Please indicate below those areas that you feel are strengths in your family life.
You may also indicate if you would like help in any of these areas.

S= Strength
H= Help

___ I believe that I have a close relationship with my child and that I am able to understand, communicate, and respond to his/her needs.

___ I am comfortable with my knowledge about child development, and know what to expect as my child grows and goes through different stages of development.

___ Even though parenting is often stressful, I have the ability to recognize signs of stress and to use problem-solving skills to help me cope or get the help that I need.

___ I have a network of family and friends that I can call on when I need help and support when times are tough.

___ I have access to the services that I need in terms of housing, finances, child care and other services necessary to meet the needs of my family.

Statement of Intent to Bill

PBS is a non-profit organization. As such, there are never any charges to our clients for services provided. However, as of January 2013 we will be billing KanCare for reimbursable services in an effort to help subsidize the grants that we receive. You will not be asked to pay for services, but we will need to make a copy of your KanCare card so that we can bill them for our services.

Billing & Confidentiality
It is important for you to understand that when we bill for services, clinicians are required to diagnose clients. As clinicians, we do not provide a diagnosis without careful consideration and evaluation. Additionally, once our clinicians submit a diagnosis and continue to bill for services, we no longer have control over the confidential information released to the insurance company. Although the insurance company is required by law to be HIPPA compliant, this does put you at additional risk regarding your confidential information.

_____
Child's Name (please print)

_____
Parent/Guardian Name (please print)

_____ _____
Signature Date

Additional Contacts

We believe it is imperative that open communication with relevant parties helps to facilitate treatment. To that end we ask that we discuss what Releases of Information are relevant to ensure the best care possible for your child. Please fill out the information below (as applicable) and provide any additional contacts you find relevant to facilitate a discussion regarding releases. Providing information here does not equal consent, and is merely meant as a starting point for determining if Releases of Information are needed.

- **Primary Care Physician**_____ Phone_____
- **Teacher** _____ School _____

  Phone_____
- **DCF Worker** _____ Phone_____
- **Child's Previous Therapist**_____

  Organization_____ Phone_____
- **Parent Therapist**_____Organization_____

  Phone_____

Has your child received services from other community providers? (e.g. Tiny-K, Occupational Therapy, Physical Therapy, Speech Therapy, KVC, The Willow, Parents as Teachers, Lawrence Community Shelter)

- **Organization** _____

  Worker name_____ Phone_____
- **Organization** _____

  Worker name_____ Phone_____
- **Organization** _____

  Worker name_____ Phone_____

Other contacts we should be aware of? (Step-parent, grandparents, person who will be transporting your child to or from therapy etc)

- **Name**_____ Phone_____

  Relationship to child _____
- **Name**_____ Phone_____

  Relationship to child _____

Treatment Goals

Reason that you are seeking services at this time:_____

_____

_____

_____

Please list a few goals that you have for your child in therapy

1. _____

   _____

2. _____

   _____

3. _____

   _____

Attendance Policy

PBS Mental Health staff is committed to providing the highest quality care for our clients. To that end we feel it is essential that services are consistent. Consistency allows us to build a rapport with a child and do the most efficient work possible to move a child through treatment. Due to this, and out of consideration for families waiting for service, we have adopted the following policy effective January 15, 2016.

____ **If during a 90 day period a client misses 3 appointments without calling in advance the client will be terminated from services.**

We understand that situations arise that cannot be avoided and special circumstances will be taken into consideration, if this occurs please talk to your clinician as soon as possible.

Please let us know as far in advance as possible if you know you will have to miss or need to reschedule an appointment.

Additionally please note:

____ If an appointment is missed and was not cancelled in advance we ask that you make contact with us as soon as possible.

____ If a second **CONSECUTIVE** regularly scheduled appointment is missed without cancelling in advance the therapist will not hold that regularly scheduled appointment time for you unless you call to reschedule and the time will be subject to availability.

____ When 2 non-cancelled appointments are missed (consecutive or non-consecutive), within 90 days, your child's therapist will notify you that one more no-show will remove your child from services.

I understand the Attendance policy.

_____
Child's Name (please print)

_____
Parent/Guardian Name (please print)

_____ _____
Signature Date