TURNING POINT
FAMILY SERVICES
OF SEASIDE HEALTHCARE

Application for Services

Individual completing paperwork: ☐ Individual/Client seeking Services or ☐Guardian of individual

Client Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Phone Number:** _____

Address: _____

City: _____ **State:** _____ **Zip code**: _____

Race : _____ **Gender:** _____

Funding Source

Primary Insurance Carrier: _____ **ID/Policy#**_____

Secondary Insurance Carrier: _____ **ID/Policy#**_____

Who referred to us for services?
Name & Contact Information for Referring Agency (if applicable): _____

_____

Legal Guardian Information

Name(s): _____

Relationship to client: _____

Address (if different from above): _____

Phone Number (if different from above): _____

▫ Not Applicable/I am my own legal guardian

Biological Parents if different from Legal Guardian listed above:

Name of biological parent 1 _____

Name of biological parent 2 _____

☐ Do both biological parents still have contact with client? ☐ Yes or ☐No

☐ Do both biological parents have shared custody? ☐ Yes or ☐No

☐ I can provide documentation of this: ☐ Yes or ☐ No (please note that all custody papers must be provided.

Family member(s) client lives with *(residential please use supplemental page):*

☐ Spouse ☐ Child(ren) ☐ Mother ☐ Father ☐ Siblings ☐ Grandparents

☐ Aunt/Uncle ☐ Cousins ☐ Other: _____

Client Household Monthly Income: * *This is gathered so we can determine possible financial sliding scale eligibility.*

☐ $0-$500 ☐ $500-1500 ☐ $1500-2000 ☐ $2000 +

Other Client/Family Preferences:
Day of the Week/Time of Day Preferences for Sessions: _____

Preference of a Male/Female clinician: _____

Preference of a Translator/translated documentation: _____

Any other needs client/family has that will assist us in getting to know you and provide services: _____

_____

_____

Emergency Contact
(who should we contact in case of an emergency)

Name: _____ _____

Relationship to you: _____

Phone Number:_____

Address: _____

Natural Supports- Please list people that you consider to be a positive support for you in your life:

_____

_____

Do you need assistance building and developing more support systems? ☐ Yes ☐ No
If yes please explain: _____

Client Interests/Skills/Hobbies

☐ Sport/Exercise ☐ Reading ☐ Writing ☐ Cooking/Food ☐ Arts & Crafts ☐ Technology

☐Travel ☐ Animals/Pets ☐ Music ☐ Mechanical/building

☐ Other: _____

Which best describes client's sexual orientation or do you identify as any of the following (select all that apply):

☐ Unknown/client is too young/has not yet identified their sexual orientation

☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Transgender, Male-to-Female

☐ Transgender, Female-to-Male ☐ Transgender, gender non-conforming ☐ Unsure ☐ Deferred

☐ Other: _____

☐ Client needs support/advocacy/referrals from our agency to help them with any stress they may be experiencing due to their gender identity (please explain): _____

_____

Current Legal/DJJ Involvement ☐ Yes ☐ No
If yes, please explain: _____

_____

Current DSS/CPS Involvement ☐ Yes ☐ No
If yes, please explain: _____

_____

Previous Behavioral Health Services/Treatment: (Select all that apply) and list the year last seen:

☐ Medication Management- _____ ☐ Outpatient Therapy_____ ☐ Intensive In-Home_____

☐ MST _____ ☐ Day Treatment_____ ☐ Substance Abuse Therapy _____ ☐ PRTF_____

☐ Residential Services (Therapeutic, IAFT, Group Homes) _____ ☐ Mobile Crisis_____

☐ Hospitalization_____ ☐ Diagnostic History _____

Past or current Diagnosis: _____

If client has had past Residential services/PRTF, list the agencies they have been placed with: _____

_____

_____

This box is for Residential Clients Only:
Reason child was removed from previous home: _____

_____

Date of Placement: _____
Placed in the Home of: _____

Current Primary Care Physician: ☐ check if you do not have a Primary Care Physician.

Name & Practice: _____

Phone Number: _____

Current Dental Provider: ☐ check if you do not have a Dental Provider.

Name & Practice: _____

Phone Number: _____

Medication History

Does client currently take medications to manage symptoms of an emotional or behavioral health need? ☐ Yes ☐ No

If you do take medications, do you feel like they are working? ☐ Yes ☐ No

Allergies or any reaction to medications: _____

_____

Is Client pregnant? ☐ Yes ☐ No **If YES please describe any concerns/needs for prenatal care**:

_____

_____

Any Difficulties with Daily Activities:

☐ Eating ☐ Hygiene ☐ Organizing tasks ☐ Dressing self ☐ Motor skills

☐ Communication difficulties ☐ Inability to maintain work/school ☐ Budgeting & finance

☐ Other: _____

Please describe any difficulties indicated above: _____

_____

Education Level

☐ N/A – I have completed my educational programs and/or am not currently attending any

☐ Traditional K-12 Schooling ☐ Day Treatment ☐ Alternative School setting ☐ Home Schooling

☐ Home-bound program ☐ Trade/Technical school ☐ GED Program ☐ College ☐ Online program

Current School you attend: _____

Client's Literacy Level: (select all that apply)

☐ is expected for their age and development ☐ struggles with reading/writing/comprehension

☐ struggles with English as it is not their primary language ☐ has an identified Learning Disability:

Please explain any identified needs: _____

Client Level of Functioning:

Compared to same-age peers in regards to emotional, behavioral and/or cognitive functioning, client is:

☐ At the same developmental level ☐ More advanced than most of their same-age peers

☐ Behind many of their same-age peers ☐ Unknown

Please explain: _____

Does Client Need any Assistive Technology in provision of our services: (select all that apply)

☐ Client does not need any Assistive Technology or other accommodations

☐ Building handicap access ☐ Devices to help client move in their environment

☐ Devices to assist in communication ☐ Devices to help with vision

☐ Devices to assist in learning ☐ Devices to assist with fine motor skills (ex: writing)

Please describe: _____

_____

Employment History & Needs: (select all that apply)

☐ N/A Client is not old enough to have a job ☐ Client is currently employed at one or more jobs

☐ Client is not currently employed and IS seeking work ☐ Client is not currently employed and IS NOT seeking work

☐ Military History

Please describe any identified Employment needs: _____

_____

_____

Client Has an Advance Directive for Mental Health Care? ☐ Yes ☐ No ☐ N/A

** An advance directive is a legal document that outlines your preferences for your medical/mental health care in the event that you become incapacitated or otherwise unable to communicate your preferences.*

If no, would you like assistance in setting up an advance directive? ☐ Yes ☐ No

Traumatic Brain Injury (If client answers yes to any of the below TBI questions please fill out the TBI full screener.)

Have you ever hit your head or been hit on the head, including being told you had a concussion?

☐ Yes ☐ No ☐ Unknown

Did you lose consciousness or experience a period of being dazed and/or confused because of the injury to your head?

☐ Yes ☐ No ☐ Unknown

_____

Client Signature Date

_____

Guardian Signature (if applicable) Date

_____

TPH Staff Date

Consent for Treatment, Medical Treatment (Emergency and Routine), and Transportation

Consumer Name: _____

- I agree for my child to participate in the treatment program provided by Turning Point Family Services.
- I understand that treatment will consist of the following:

☐ Intensive In-Home Services ☐ Outpatient Therapy ☐ Medication Management

☐ Level II, Therapeutic Foster Care, Family foster ☐ IAFT ☐ TCM

☐ Community Support Team ☐ Peer Support ☐ Other: _____

- I have been informed, in advance, of the alleged benefits, potential risks, and possible alternative methods of treatment.
- I understand that this consent for service and treatment is valid for one year.
- I understand that should it be determined that I do not need further treatment or that I will not benefit from these services, these services will be terminated and as appropriate, a referral made to another agency.
- I understand and have been informed that this service is voluntary and that this consent may be withdrawn at any time.
- **Residential Only:** I agree for my child to participate in the treatment program provided by Turning Point Family Services. I understand that this treatment will consist of Level II Therapeutic Foster Care, residential. I also understand that I will be informed of any changes in the service/treatment assignment and have the right to agree/disagree to any referrals to above components prior to my child being placed in the program component, except in an emergency.

Consent to Seek Emergency and Routine Medical Care

I hereby give consent for Turning Point Family Services' clinical staff and/or Therapeutic Foster Parents to obtain routine medical care and wellness visits for my child. In case of an accident or illness, I also give my consent for the clinical staff or the Therapeutic Parent to provide and/or obtain emergency medical treatment by a licensed medical professional/hospital. I understand that as legal guardian, I am responsible for any medical costs that should arise due to such treatment. I also understand that staff are equipped with basic first aid kits and may employ the use of first aid in the event that a minor incident occurs that does not warrant emergency medical treatment by a licensed medical professional/hospital.

Transportation

I authorize the clinical staff and any therapeutic parent to provide transportation with legal guardian's knowledge and as deemed necessary.

I fully understand the above statements that have been read and explained to me by a member of the treatment staff. I also understand that as the Parent/Guardian/Custodian, I may appeal any grievances to the Director and may request a meeting regarding the grievance.

_____ _____

Person Served Date

_____ _____

Parent/Guardian Date

Authorization For The Disclosure And Reciprocal Exchange Of Information

Name: _____ DOB: _____

I hereby authorize Turning Point Homes, Inc. and _____
to share specified information in my client record.

This data shall include the following information:

Psychological Evaluation, Psychiatric Evaluation, Progress Notes from _____ to _____,
Intake Assessment/Comprehensive Clinical/Diagnostic Assessment, Diagnosis, Person Centered Plan, Screening/Contact Assessments, HIV testing, Alcohol and Drug Treatment, STD testing, all Medical Information, IEP/School Information, Social History and Insurance information.

Other Pertinent Information requested: _____

This information will be used for service delivery, continuity of care, referral information and other as listed below.
Other _____

I hereby acknowledge that Turning Point Homes, Inc. has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that the agency has already taken action in reliance on the consent. Request for revocation should be submitted to the Executive Director of Turning Point Homes, Inc... Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. I also understand that I have protection of HIV/AIDS information under G.S. 130A-143 and protection of substance abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2

If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.

I HAVE READ THIS INFORMATION AND INDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF UATORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CONSUMER OR AM AUTHORIZED TO ACT ON BEHALF OF THE CONSUMER, TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

_____ _____ or _____ _____
Consumer Date Legally Responsible Person Date

_____ _____
Witness Date

*Consumer of services must sign whether a child or adult, information protected by Federal Regulations 42 CFR Part 2.