Justice Resource Institute

140 Park Street Attleboro MA 02703 Tel: 508.222.7525 Fax: 508.223.4145

Please fill out & sign. Bring this agreement with you along with you payment. Thank You.

Driver Alcohol Education (DAE) Program
Statewide Client-Agency Agreement contract

Welcome to Justice Resource Institute Driver Alcohol Education (DAE) program. The goal of our program is to provide an educational experience related to alcohol and other drug use, its effect on driving and other life problems. It is the intent of our program to raise your awareness and to influence behavioral changes, thereby lowering your risk for any future DUI and/or other substance use-based problems. Although your enrollment is mandated, we hope your experience will nonetheless be positive. We are here to assist you in whatever way we can.

This document will serve as an agreement between you and our agency. It is intended to inform you of the rules and expectations of our program. Violation(s) of the rules/expectations often have serious consequences, so please read this document carefully before signing it. The intake counselor will clarify any questions you might have and the DAE Program Director is available to help you with any unresolved questions. You may reach the Program Director during regular business hours (9:00 a.m. to 5:00 p.m.) by calling (508) 226-1660 X5006.

If you are refused admission into our program, we must justify your refusal based on a clinical reason and make a recommendation to the court (or referring agency) for a more appropriate level of care. Please be advised that every DAE program in the state must comply with the following rules, expectations and reporting procedures. Upon written request, you have a right to review your records. The time and place for the review will be arranged. The Program Director or Executive Director will be present at the review. You have the right to grieve any specific agency policy or procedure. State regulations require this agency to have a written grievance procedure, which is available for your review upon request. The Clinical Director may make periodic visits to a group in order to ensure the quality.

Program Content

You are expected to attend 40 hours of programming, as follows:

- One individual intake session (not to exceed 90 minutes)
- Thirty-two (32) hours of psycho-educational group sessions (one two-hour session each week for 16 weeks)
- Participate in a mid-point assessment review.
- Two (2) hours of victim impact awareness
- Four (4) hours of attendance at a community-based self-help meeting
- One individual discharge (exit) session (not less than 30 minutes)

It is your responsibility to complete each aspect of the DAE Program. Failure to do so will result in a notification being sent to your referring court and possible suspension/termination. It is your responsibility to stay in contact with the program until you receive a formal certificate/letter of completion.

Attendance and Tardiness Policy

Your attendance at all groups is required. Attendance is taken at each group. In the unlikely event that you must miss a group because of an emergency, you must contact your group facilitator immediately and

documentation will be required. All absences must be made up. If you are absent more than two times during the course of the program your participation will be suspended until the matter can be reviewed. This might result in a court hearing as it is a violation of your probation. If the court allows you to return to the program you may restart the program from week one.

You are expected to schedule and attend your exit interview. If you need to cancel your appointment you must do so a minimum of 24-hours in advance. If you fail to do so, the program may assess a make-up fee. A limited number of cancellations will be permitted before the program suspends you.

You are required to be on time for all groups including the victim-impact sessions. If you are late for a group you may not be allowed in, an absence will be charged that will require a make-up group session. If the tardiness results in your 3rd absence, then you will be suspended pending a court review.

Communication with your Probation Officer/Court

The program participant's rights to confidentiality are protected by Federal Law (42 C.F.R. Part 2). Your Probation Officer will be notified when there is a violation of program non-compliance. In general, the only information that is routinely communicated is 1) did you attend your intake session; 2) your attendance during the group process and further assessments; and 3) did you complete every aspect of the program, including your financial obligation. When necessary, your Probation Officer will be notified if you are deemed a high risk to yourself and others as a result of your current alcohol and/or drug use. The program will not disclose "confidential communications" reported by the client unless it pertains to the following: 1) it is necessary to protect against a threat to life or of serious bodily injury or 2) is necessary to investigate or prosecute an extremely serious crime or 3) in connection with a proceeding in which the client has already presented evidence concerning confidential communication.

Sobriety policy

You are expected to abstain from alcohol and all illicit substances for a period of 24-hours prior to the start of any program activity. If you are suspected of drinking or using illicit substances you will be asked to take a breathalyzer or other form of toxicology test (e.g., urine test) voluntarily. Your failure to submit will result in your immediate suspension. If you are asked (at the client's expense) to take a urine test, the program staff will assist you with information on where one can be conducted. You will be expected to complete the urine test within a specified period of time set by the program. If a test indicates the presence of alcohol or an illicit substance(s), you will immediately be suspended from the program pending a court hearing and your probation officer will be notified. In addition, if during this incident you drove to class you will be asked to secure your car and arraign for alternative transportation (the program staff can assist you with this). If you insist on driving your car, the police will be notified. You will also be subject to a random breathalyzer test at any time as a means to ensure safety of all participants and the integrity of the program.

Suspension from the Program for Inappropriate Behavior

The following behaviors may result in suspension from the program:

- Possession of anything considered dangerous to self or others
- Possession of alcohol or any illicit substance
- Verbal abuse, vulgarity, racial, ethnic, sexual or religious slurs
- Disruptive behavior (talking, sleeping, etc.)
- Threats, negative gestures or any acts of violence
- Continued (after being warned to discontinue) rudeness, demeaning or disrespectful speech or other behaviors that lead to the disruption of the group
- Improper dress and/or poor hygiene, as determined by staff
- Failure to adhere to the expectation that participants maintain the confidentiality of each group member's right to privacy

Smoking Policy

Smoking is not allowed anywhere on the property.

Class Cancellation Policy
In case of inclement weather or other emergency that may cause a group session to be cancelled, it is your responsibility to contact the program to obtain information regarding cancellation. If a group is cancelled, the expected timeframe for completion of the program will be extended.

Updated Client Information
You are required to inform the DAE program of any changes to your home and mailing address and phone number(s).

Release of Information Forms and Confidentiality
DAE programs have a dual service relationship between you and the District Court Probation Office from which you were referred. Because of this, you will be requested to sign a Release of Information Form that will allow staff to disclose pertinent information to the court. You may also be asked to sign other release forms to assist staff with communicating and informing other pertinent parties. If you are under the age of 21 and attending this program to satisfy the court and/or the Registry of Motor Vehicles, you will be required to sign a Release of Information Form for the Registry. During the intake session you will have your confidentiality rights thoroughly explained to you, including areas of discussion in group where information can be shared without your consent. You have the right to withdraw your release at any time; however, doing so may impact your continued participation in the program.

Documentation of Enrollment for Hardship License/ Under 21 y/o - 180 day wavier
At this time of this intake you should be aware of your eligibility for either a Hardship license or under 21y/o – 180 days wavier or both. If you need a letter of enrollment for either consideration, a letter will be made available upon the completion of the initial intake session. Our program reserves the right to withhold this letter based on clinical findings in the initial intake.

DAE Program Fees
Your payment options have been explained to you (either by the court or our fiscal department). The fee for this program is $867.76, as established by the Massachusetts Rate Setting Commission. The program fee is inclusive except for additional fees that may be assessed for makeup sessions, missed appointments and costs for toxicology (drug) tests. . If you have been granted a program fee waiver by the court you will be expected to pay for additional fees. These fees will not exceed the established unit cost of the service by the Commission (i.e., $18.71 per15 minutes individual session and $44.88 per 2-hour group session). The program may excuse make-up fees with legitimate and documented proof of the absence. You have agreed to a payment schedule. Failure to adhere to your payment schedule could result in your suspension from the program. Counselors and business staff are available to discuss any difficulties you have with making your payment. Completion certificates will be withheld until all fees are paid in full. If a Judge terminates you from further participation and you have paid for services not yet rendered, then you are entitled to a refund.

I have read the above statements and have had all of my questions answered. By signing this document, I attest that I agree with and will adhere to each aspect of this document.

_____ _____
Participant Name Date

_____ _____
Intake Counselor Date

Justice Resource Institute

140 Park Street Attleboro MA 02703 Tel: 508.222.7525 Fax: 508.223.4145

I, _____, consent to communication between Justice Resource Institute and the Massachusetts Registry of Motor Vehicles for the purpose of informing the registry if I am in compliance with registry requirements to obtain and/or maintain a hardship license. It is my understanding that should I withdraw from the Driver Alcohol Education program prior to completing it, or should the referring court revoke my 24-D status due to probation violation, then the Driver Alcohol Program will inform the Registry that I am no longer meeting the requirements for a hardship license.

_____ _____

Signature of Client Date

_____ _____

Intake Clinician (or Designee) Date

AUTHORIZATION FORM for Exchanging Information
Justice Resource Institute

PERSON SERVED (Name/DOB): _____

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information maintained by:
NAME/ADDRESS: _____

This information may be released under this Authorization to **Justice Resource Institute.**
Written information should be mailed to this address :
ADDRESS Court
ATTENTION: Probation Department

Health information includes information collected from me or created by the agency, or information received by the agency from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

☒ **Check here if you are allowing two way communication between the parties listed**

Health information that may be used or disclosed through this Authorization is as follows: (CHECK ONE):

☐ All health information about me, including my clinical records, created or received by person/organization above. (**including** HIV status, substance abuse/use, mental health records)

OR

☐ All health information about me as described in the preceding checkbox, **excluding** the following:
☐ **HIV status/records**
☐ **Other:** _____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

OR

☐ Specific health information including **only:**
☐ **HIV status/records**
☐ **Other:** _____

OR

☒ **Reports of attendance and fee payments**

******For HIV/AIDS records please note the following******
I also understand that HIV-related information about me is protected by State law and cannot be disclosed unless the disclosure is authorized by State law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This Authorization expires: _____ (Insert date) ☐ 90 Days – one time release ☐ One year
☐ Upon discharge from JRI program - ongoing service provision by contracted/cooperating service provider."

The purpose(s) of this Authorization is (are): ☐ Eligibility, planning, coordinating and service planning
☐ Treatment planning, legal compliance ☐ Determine legal restriction and court involvement ☐ Aftercare planning
☐ Coordinate/communicate regarding medical concerns and treatment ☐ Eligibility for SSI, Medicare, MassHealth, and other subsidies ☐
OTHER _____

"If you have questions refer to your Privacy Notice. If you would like another copy of the Privacy Notice, ask your Program Director or Clinician and we will provide one for you. If you need additional information, contact the Program Director or JRI Privacy Officer."

Acknowledgement:
"I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that I may withdraw my authorization at any time. I have been provided with a copy of the signed Authorization."

PERSON' SIGNATURE
Person's signature: _____ **Date of signature:** _____
Print Person's full name: _____ Date of Birth: _____

GUARDIAN OR OTHER LEGAL REPRESENTATIVE SIGNATURE
When person is not competent or legally able to give consent, parent, guardian, health care agent signature
Signature of legal representative: _____ **Date of signature:** _____
Print name: _____ Relationship to Person _____

☐ **Oral approval given.** Staff Signature: _____ Date of signature: _____

FOR AGENCY USE ONLY – DOCUMENTATION BY PERSON SENDING THE INFORMATION/FORM
Date information/form sent/released: _____ How it was sent = ☐mail, ☐email, ☐fax

Justice Resource Institute DAE Program

Release of Client/Confidential Information
Authorization to Release Information To
Enterprise Invoice Management/Enterprise Service Management (EIM/ESM)
The Department of Public Health

I understand that in order to provide me with appropriate services and treatment, Justice Resource Institute must collect my enrollment information such as name, address, and date of birth and other records including my medical history, assessment and treatment services received. By signing this release I am authorizing Justice Resource Institute to give identifiable information about me to the Bureau of Substance Abuse Treatment (BSAS) of the Massachusetts Department of Public Health (Department), which licenses and/or funds this program. I understand BSAS takes many steps to protect the privacy and security of information that it receives. I also understand that my treatment records are protected under federal law, 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and by state law, and cannot be disclosed by Justice Resource Institute to BSAS without my approval, unless permitted by law. Access to this information will be limited to authorized staff of BSAS, and may be used by BSAS, for example, to:

- Review my services
- Determine how effective the services are
- Assess the overall program in which I am enrolled
- Plan and support future programs
- Meet federal and/or state reporting requirements to continue funding
- In some cases, pay for services I receive

I understand that when used in analysis across programs, data from my record will be kept anonymous and I will not be identified. No information that identifies me will be connected with any reports that are released outside the Department.

Once I have agreed to this release of my information, I still have the right to cancel this authorization by submitting a written request at any point during my treatment at the Program to
_Justice Resource Institute_____ at __140 Park Street, Attleboro, MA 02703_____.
Name Address
Once my cancellation request has been received, no further information identifying me will be released to BSAS; however I understand that this cancellation will not apply to information already released. This authorization will expire automatically thirty (30) days after I am no longer enrolled in this program or as otherwise specified: _____
Specify a date/event/condition
I also understand in general that I cannot be denied services if I choose not to sign this authorization.

By signing below, I indicate that I understand and agree to the request for the release of my Program information to BSAS.

I, _____ give permission for Justice Resource Institute.
Name (please print)
to release the information described above to the BSAS.

Dated: _____ Signature of Client/Student _____

_____ _____
Signature of Client, Parent or Guardian Signature of Witness (if required)

Justice Resource Institute

140 Park Street Attleboro MA 02780 Tel: 508.222.7525 Fax: 508.223.4145

DAE FEE CONTRACT/TOTAL PROGRAM COST: PAYMENT PLAN OPTIONS

As a condition of acceptance into the DAE program, I agree to pay the $867.76 program fee in full according to the OPTION circled below:

OPTION A:	1 PAYMENT	$ 867.76	Due in full at Intake Interview
OPTION B:	3 PAYMENTS	$ 267.76	Due at Intake Interview
		$ 300.00	Due at First Class
		$ 300.00	Due at Fifth Class
OPTION C	11 PAYMENTS	$267.76	Due at Intake Interview
		$60.00	Due at First Ten Classes

Please be advised that these payments are due at time of service. Intakes cannot be held if payment is not made. Clients will be liable for a $35.00 late cancellation/rescheduling fee for this appointment if client does not show for the appointment or does not provide 24 hour notice of cancellation.

Acceptable forms of payment for the DAE program are personal check, money order, VISA or MasterCard. **We are no longer accepting cash.** Checks are to made payable to JRI.

Clients are asked to report for the Intake appointment 30 minutes earlier than your scheduled time to fill out paperwork prior to meeting with the Intake Clinician. If you are more than 15 minutes later than your scheduled Intake time, you may have to reschedule, so plan on being on time.

CLIENT AGREEMENT

My signature below indicates that I understand that failure to comply with the 24D program requirements or the payment agreement will result in notification of my probation officer, which may affect my 24D disposition. This could include additional court hearings. Therefore I agree to abide by the conditions of my probation and all program requirements of the Attleboro Driver Alcohol Program.

_____ _____

Client Signature Date

_____ _____

Intake Counselor (or designee) Date

Substance Abuse Redisclosure Notice

Justice Resource Institute
140 Park Street, Attleboro, MA 02703

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning an individual in an alcohol or drug abuse treatment program, made to you with the consent of such individual.

This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., 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 C.F.R., 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 individual being treated for alcohol or drug abuse.

_____ _____

Client Signature Date

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary
MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

KNOW YOUR RIGHTS

You have many rights under 105 CMR164.079 related to your care. There are also 'rules' describing how treatment should be provided. You are encouraged to contact the Department of Public Health, Bureau of Substance Addiction Services (BSAS) to report any potential violations of these rights or rules.

- If a provider completes an assessment and determines that this is not the right level of care for you, the provider must make a referral to the appropriate level of care and support you through the referral process.

- You ***cannot*** be denied admission based only on the results of a drug screen.

- You ***cannot*** be denied admission only because of a medication prescribed to you by a physician. This includes medications such as methadone, buprenorphine, naltrexone, and other medications prescribed for substance use disorder, mental health, or other medical conditions.

- You ***cannot*** be denied re-admission to a program based solely on one of the following happening when you were in the program:

(1) you left treatment against medical advice;
(2) you relapsed while in treatment; or
(3) you filed a grievance or complaint either to the program or to the Bureau of Substance Addiction Services regarding any aspect of your treatment.

IF YOU THINK YOUR RIGHTS OR THE ABOVE RULES AROUND TREATMENT HAVE BEEN VIOLATED, PLEASE CALL:

The Massachusetts Substance Use HELPLINE
HelplineMA.org – (800) 327-5050
BSAS CONFIDENTIAL COMPLAINT LINE – (617) 624-5171

I acknowledge that I have read and understand my Rights as a participant in a BSAS licensed program. I have been provided with a copy of the Client Rights Statement.

Client Name:_____ **Date:**_____

Staff Signature:_____ **Date:**_____

Justice Resource Institute

Southern New England Behavioral Health & Trauma Center

COMPLAINT/GRIEVANCE PROCEDURE

Justice Resource Institute's Behavioral Health Centers/Community Based Service Programs believe in providing supports and listening to feedback and concerns in all areas of services provided. Maximizing these services includes offering an opportunity to communicate grievances.

You may submit any complaint to the Human Rights Officer or Program Director. Complaint forms are available upon request or at the reception desk of any JRI site. There is no time limit for you to file a complaint. JRI will respond to your complaint within 3 business days.

JRI Human Rights Officer: Cecelia Murphy 508-222-7525 X2577, pmurphy@jri.org
Program Director: Sarah Gallow 508-272-4310

In addition you may contact:

The Massachusetts Division of Public Health
Division of Health Care Quality
10 West Street
Boston, MA 02111
617-727-5860

The Massachusetts Substance Use HELPLINE
HELPLINEMA.ORG
1-800-327-5050
BSAS CONFIDENTIAL COMPLAINT LINE AT
617-624-5171

Joint Commission
To report the details about your complaint to The Joint Commission, use one of the following options:
E-mail: complaint@jointcommission.org
Fax: 630-792-5636
Mail: The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
For more information, call The Joint Commission's toll free number, (800) 994-6610, available weekdays, 8:30 a.m. to 5 p.m., Central Time.

MBHP Members:
The Massachusetts Behavioral Health Partnership (MBHP) is committed to ensuring that all Members are educated about privacy issues and understand that they have the right to file complaints, grievances, and appeals. As a member, you have the right to file a complaint with MBHP at 1-800-495-0086. A staff member will document and review the problem. If the staff member is unable to resolve your complaint on the same day, you can file a grievance with MBHP.
To make a written complaint, write MBHP at:
Quality Management Department
Massachusetts Behavioral Health Partnership
150 Federal Street, 3rd Floor
Boston, MA 02111

Behavioral Health Care Complaint and Grievance Process For Members of Neighborhood Health Plan of MA and Boston Medical Center Health Net Plan
Any member or provider has a right to file a complaint or grievance with Beacon Health Strategies regarding behavioral health care services or provider. Members or their representatives, who wish to initiate an inquiry, or file a complaint or grievance, should contact Beacon Health Strategies:
Fax: 781-994-7642
Phone: Neighborhood Health: 800-414-2820
BMC HealthNet Plan: 888-217-3501
Mail: Beacon Health Strategies
500 Unicorn Park Drive
Suite 401
Woburn, MA 01801
Attn: Ombudsperson

Justice Resource Institute

140 Park Street Attleboro MA 02780 Tel: 508.222.7525 Fax: 508.223.4145

Hello,

Welcome to Justice Resource Institute Driver Alcohol Education/Intervention Program. Today's initial intake session has been scheduled for an hour and a half (1 ½) hours. Our goal for all our clients in this program is to make the program a positive experience for you and to help you get the most out of your time here.

This program also meets the requirements for Registry referrals to the Youth Alcohol Program and other RMV requirements.

To help you to achieve this goal, please take a few moments to:

- Read all the attached forms
- Answer all questions on the following pages

If you have any questions, your intake counselor will be happy to answer them when you go in to see her/him.

Please answer all questions on these pages as openly as you can. All information you disclose at this interview is confidential. The only person we can share information with is your Probation Officer. The information he/she is generally interested in is: Did you come in for your intake, are you coming to your groups, and did you complete the program?

Your answers to all the questions today will help us to best serve whatever needs you have while in the program.

Your intake counselor will be with you shortly.

Thank You

NAME: _____ DATE OF BIRTH: _____

Educational History

Highest grade completed in school:
(Circle one)

School	Technical	College	Masters	Doctorate
6 7 8 9 10 11 12	1 2 3 4	1 2 3 4		

Demographics-Cultural Characteristics

What is your primary Ethnicity/Ancestry?

___ African American
___ Asian Indian
___ Brazilian
___ Cape Verdean
___ Chinese
___ Eastern European
___ European
___ Filipino
___ Haitian
___ Japanese
___ Korean
___ Latin American Indian
___ Middle Eastern
___ Native American
___ Portuguese
___ Russian
___ Southeast Asian
___ Unknown
___ Other, Specify_____

What is your Race?

___ American Indian/Alaskan Indian
___ Asian
___ Black, African American
___ Native Hawaiian/Pacific Islander
____White
____Other, specify: _____
____Refused
____Unknown

Employment History

Are you Currently Employed? Yes_____ No_____ Full time_____ Part Time_____
If not employed, how long unemployed: Years_____ Months_____

What kind of work do you do? _____
Name of Employer: _____
How long with this Employer: Years_____ Months_____

How many different employers have you worked with in the past 5 years? _____
Have you had any work problems? Yes_____ No _____ if yes, please explain: _____
_____

Military History

Have you been in the Military? Yes_____ No _____
Branch of Service: _____ Type of Discharge: _____
Combat Experience: Yes _____ No _____ if yes, where: _____

Were there any problems in the Military? Yes ____ No ____ if yes, please explain: _____
_____

Do you suffer from PTSD due to Military Service? Yes _____ No _____

Personal Information

1. Do you need any special services that the program should be aware of? Yes _____ No _____
2. Religious Preference: _____ Do you attend services? Yes _____ No _____
3. What do you like to do in your leisure time? Hobbies? _____
4. Do you have any learning disabilities or difficulties in reading and/or writing? Yes _____ No _____

5. Emergency Contact Person: _____
6. Phone Number: _____

Family History

1. Have any of your family members had a significant alcohol, drug or psychiatric problem that did or should have led to treatment? Yes _____ No _____
2. Did you experience any major stress or trauma when you were growing up? (e.g., death of a close family or friend, divorce, physical/sexual/verbal abuse, family substance use or emotional illness?) If yes, explain: _____
   _____
3. Do you live with anyone who has a current drug/alcohol problem? If yes, describe: _____
   _____
4. How important to you now is treatment for family/social support problems? _____

Current Marital Status:

Never Married ____ Married ____ Significant Partnership Rel. ____ Divorced ____ Separated ____ Widowed ____

If married, how long? Years _____ Months _____

If divorced/separated, for how long? Years ____ Months ____
If divorced, how many times? _____

If with a significant other, are you living with this person? Yes ____ No ____
How long have you been together with your significant other? Years _____ Months _____

Do your spouse/significant other drink? Yes ____ No _____
How often and how much/occasion? _____
What kind of a drinker do you feel your spouse/significant other is? Social ____ Problem ____ Alcoholic ____

How many children/stepchildren do you have? _____ Ages: ____ ____ ____ ____ ____ ____ ____ ____

Who do they live with? _____

If you don't live with your children, how often do you see them? _____

Treatment History

Substance use and mental health (list 1 or 2 of most recent treatments (year, place & reason)

Impatient: 1. _____

2. _____

Outpatient: 1. _____

2. _____

- Currently in addiction treatment program? Yes ____ No _____
- Currently in mental health treatment program? Yes _____ No_____

Your Health is: Excellent ____ Good ____ Fair ____ Poor ____
Do you have a Primary Care Physician? _____
Do you have any physical health problems that we need to know about (e.g. high blood pressure, seizures, allergies, etc.)? _____

Please list all current medications:

Medication Name	Dosage	Condition	Prescriber
1.			
2.			
3.			
4.			
5.			
6.			

Do you understand how your medications interact with alcohol? Yes ____ No ____

When was your last physical exam? _____
Do you have a Dentist? Yes ____ No____ When was your last visit? _____

Have you ever been hospitalized or had a major operation or illness? Yes ____ No ____
If yes, explain: _____

Have you ever had a head injury? Yes ____ No ____ if yes, explain: _____

Do you have any medical conditions which may require intervention (i.e. seizures) Yes ____ No ____
If yes, explain: _____

Do you have a heart condition? Yes ____ No ____ if yes, explain: _____

Have you ever been treated for an alcohol overdose? Yes ____ No ____ if yes, how many times? _____

Have you ever been treated for an overdose of opiates? Yes ____ No ____ if yes, how many times? _____
If yes, when were you last treated? Within last 6 months _____ past 6-12 months ____ over a year ago _____

Bureau of Substance Addiction Services
Massachusetts Department of Public Health

ESM Client ID:

Provider ID:

Intake Form Standard

▶ **ESM Release of Information:** ☐ Yes ☐ No

▶ Enrollment Date: / / (mm dd yyyy)

ALL QUESTIONS MARKED WITH A ▶ MUST BE COMPLETED.

1. First Name: **Middle Initial:** **Last Name:** **Suffix:**

▶ **2. Highest Grade Completed:**

☐ Not of school age ☐ High school diploma/GED ☐ College degree or higher ☐ No formal education
☐ Some schooling, no high school ☐ Some college ☐ Other credential (degree, certificate) ☐ Unknown
☐ Some high school ☐ Associates degree

▶ **3. Gender:** Male ☐ Female ☐ Transgender ☐ ▶ **4. Birth Date:** / / (mm dd yyyy)

▶ **5. SSN:** *If client refuses to give SSN or it is unknown, enter 999-99-9999*

PERSONAL INFORMATION>ADDRESS

▶ **6a. Address Type:** Home ☐ Near Homeless ☐ Homeless ☐ *See Job Aid in the Intake Manual to determine Homeless vs. non-Homeless!*

If Address Type is "Homeless", only enter the city/town and zip code where client is usually homeless. ***Do not use the Program's city/town/zip.***

Street Address: Unit:

▶ City/Town: ▶ State: ▶ Zip code:

▶ **6b. Is this your Primary Address?** Yes ☒

ALTERNATE NAME Section

If client has an alternate name, complete the following:

7a. First Name: **Middle Initial:** **Last Name:**

7b. Name Type: Alias ☐ Nickname ☐ Known by ☐ Married Name ☐ Maiden Name ☐ Name at Birth ☐ Prior Marriage Name ☐

DEMOGRAPHICS>CULTURAL CHARACTERISTICS

▶ **8a. Are you Spanish/ Hispanic/Latino?** Yes ☐ No ☐

If 'yes' to Question 8a, complete Question 8b. ***If 'no' to Question 8a, go to Question 9***

8b. Which of the following ethnicities best describes you?

_____ Central American
_____ Cuban
_____ Dominican
_____ Mexican, Mexican American, Chicano
_____ Puerto Rican
_____ Salvadoran
_____ South American
_____ Unknown
_____ Other, specify _____

If 'no' to Question 8a, Select one from below

9. What is your primary Ethnicity/Ancestry? *(select one only)*

_____ African
_____ African American
_____ American
_____ Asian Indian
_____ Brazilian
_____ Cambodian
_____ Cape Verdean
_____ Caribbean Islander
_____ Chinese
_____ Eastern European
_____ European
_____ Filipino
_____ Haitian
_____ Japanese
_____ Korean
_____ Laotian
_____ Latin American Indian
_____ Middle Eastern
_____ Portuguese
_____ Russian
_____ Thai
_____ Vietnamese
_____ Unknown
_____ Other ,specify _____

10. What is your race? *(check all that apply)*

_____ American Indian/Alaskan Indian	_____ Native Hawaiian or Pacific Islander	_____ Unknown
_____ Asian	_____ White	_____ Refused
_____ Black, African American	_____ Other, specify: _____	

11. In what language do you prefer to read or discuss health related materials?

_____ American Sign Language	_____ Haitian Creole	_____ Russian
_____ Cambodian (Khmer)	_____ Hmong	_____ Spanish
_____ Cape Verdean Creole	_____ Korean	_____ Vietnamese
_____ Chinese	_____ Laotian	_____ Other, specify _____
_____ English	_____ Portuguese	

HOUSEHOLD CHARACTERISTICS Section

12. Number of Adults in Household: *(if client is Homeless, enter 1)*

13. Number of Children Living in Household *(children under 19)*: *(children currently living with the client whether or not related)*

14a. Client Income: $

14b. Income Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

15. Source of Income: *(Check all that apply)*

_____ Wages/Salary	_____ Veterans Disability Payment	_____ Retirement - Social Security
_____ Child Support	_____ Private Disability Payment	_____ Retirement/Pension - Private
_____ Alimony	_____ Public Assistance - TANF	_____ Veterans Pension
_____ Disability	_____ Public Assistance - General	_____ Non-employment Cash Income
_____ Disability - SSI	_____ Unemployment Compensation	_____ None
_____ Disability - SSIDI	_____ Workers Compensation	_____ Other

16. Received Income Verification: ☐

17. Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Partnership Rlat.

INSURANCE Section *(Data Entry: To get to Insurance section, return to Face Sheet and select Insurance link on left side of screen.)*

18. Insurance Type:

☐ **Uninsured** ☐ **MC** (Medicaid / MassHealth / MBHP ☐ **MP** (Medicare –Over 65-some disabled) ☐ **VA** Veterans Administration

☐ **HM** Private HMO – through employment or client pay ☐ **CI** Private Insurance – through employment or client pay with no subsidy ☐ **OT** Other - Includes State subsidy – ConnectCare / Health Safety Net

Insurance Company Name
Not required if uninsured:

Policy Number:
*If Insurance Type is **MC**, the MassHealth Number, which begins with "100", must be entered.*

Data Entry: *If entering a New insurance record, enter the Enrollment Date as the Insurance Effective Date.*
If existing client with new insurance, end date previous insurance record with day before this Enrollment Date
If existing client and the insurance has Not Changed since the client's last enrollment (whether or not at your program), simply hit SAVE!!!

19. Is this your Primary Insurance? Yes ☐ No ☐

If the client has additional insurance coverage, complete the following. If not, intake is complete.

20. Additional Insurance Type: *Note: Uninsured is not an option under additional insurance.*

☐ **MC** Medicaid / MassHealth / MBHP ☐ **MP** Medicare –Over 65-some disabled ☐ **VA** Veterans Administration

☐ **HM** –Private HMO – through employment or client pay ☐ **CI** Private Insurance – through employment or client pay with no subsidy) ☐ **OT** Other - Includes State subsidy – ConnectCare / Health Safety Net)

Insurance Company Name:

Policy Number:
*If Insurance Type is **MC**, the MassHealth Number, which begins with "100", must be entered.*

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

(Check all that apply below)

1. What drugs do you usually use? ☐ N/A
☐ Heroin ☐ Other Opiates ☐ Cocaine ☐ Alcohol ☐ Methadone ☐ Benzodiazepines
☐ Inhalants ☐ Marijuana ☐ Amphetamines ☐ Other: _____

2. How do you use your drugs? ☐ N/A
☐ Inject ☐ Oral ☐ Smoke ☐ Snort ☐ Other: _____

3. If you inject drugs, how often do you use new needles? ☐ N/A
☐ Sometimes ☐ Always ☐ Never

4. If you use new needles, where do you get them? ☐ N/A
☐ Pharmacy ☐ Friends ☐ Needle Exchange ☐ Other _____

5. If you use needles, how do you dispose of them? ☐ N/A
☐ Throw Away ☐ Needle Exchange ☐ Bring to Pharmacy ☐ Disposal Site ☐ Other _____

6. Do you ever share needles/injection equipment? ☐ N/A
☐ Yes ☐ No

7. In the last five years, about how many people have you had sex with?
☐ 20 or more ☐ 10-19 ☐ 3-9 ☐ 0-2

8. How often do you use protection against infections? ☐ N/A
☐ Sometimes ☐ Never ☐ Always

9. Have you had sex for money, drugs or something you needed?
☐ Yes ☐ No

10. When was the last time you were tested for HIV?
☐ _____ ☐ Never

11. Did you receive your results? ☐ N/A
☐ Yes ☐ No

12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

Please check what was provided to Person Served below:
☐ HIV Fact Sheet ☐ Discussion Only ☐ Referral ☐ Viral Hepatitis Information
☐ Other STI Information ☐ Other: _____

Other Notes / Recommendations:

Person's Name (First MI Last):	Record #:

Person's Signature (Optional, if clinically appropriate)	Date:	Parent/Guardian Signature (if appropriate):	Date:
Clinician/Provider - Print Name/Credential:	Date:	Supervisor - Print Name/Credential (if needed):	Date:
Clinician/Provider Signature:	Date:	Supervisor Signature (if needed):	Date:
Psychiatrist/MD/DO (if required):	Date:		

JRI TB History, Risk Assessment, Screening Tool

Name: _____ Date _____

NOTE – IF YOU HAVE HIV OR CERTAIN ILLNESSES SUCH AS DIABETES, CANCER, KIDNEY DISEASE, RHEUMATOID ARTHRITIS, OR HAVE HAD STOMACH OR INTESTINAL SURGERY, YOU SHOULD BE AWARE THAT TB CAN MAKE THESE CONDITIONS WORSE.

PART ONE INSTRUCTIONS: Complete BOTH the TB History and TB Risk Assessment Sections

TB HISTORY

1-Have you ever had a positive skin test for TB? • Do you have written results? Yes No Date: Result: (mm):	YES	NO
2-Have you ever had a positive blood test for TB? • Do you have written results? Yes No Date: Result:	YES	NO
IF THE ANSWER IS "NO" TO ALL OF THE ABOVE = STOP and complete TB Risk Assessment		
3-Do you have a chest x-ray result written down? Date: • Result: Normal Abnormal	YES	NO
4-Did you take medication for your positive skin test?	YES	NO
5-Have you ever been sick with TB disease?	YES	NO
*** If yes, did you take medication for your illness?	YES	NO

TB RISK ASSESSMENT

1-Have you lived with or spent time with anyone who has been sick with TB in the last 2 years?	YES	NO
2-Have you ever lived or traveled for more than a month in Asia, Africa, Eastern Europe, Middle East, Russia, Central or South America or the Caribbean?	YES	NO

PART TWO:

- **If the answer is NO to all questions on the TB HISTORY and TB RISK ASSESSMENT, STOP HERE**
- **If the answer is YES to any question on the TB HISTORY or TB RISK ASSESSMENT, complete TB SYMPTOM SCREEN**

TB SYMPTOM SCREENING

1 – Have you had a prolonged, unexplained cough lasting more than 3 weeks or a recent change in a chronic cough?	YES	NO
IF THE ANSWER TO QUESTION #1 IS "NO", THEN STOP HERE		
2 – Have you recently lost weight of 10 pounds or more for no apparent reason?	YES	NO
3 – Have you had a fever of more than 100 degrees F for over 2 weeks?	YES	NO
4 – Do you sweat at night?	YES	NO
5 – Have you felt unusually tired recently?	YES	NO

ACTIONS TO BE TAKEN IF TB HISTORY or TB RISK IDENTIFIED:

- **If Two Or More TB Symptoms (Including #1) Are Answered "Yes", Referral To PCP For Medical Evaluation prior to working with persons in program**
- **If No Symptoms Present, AND No History Of Having Had A TB Skin Test, Or If Test More Than Three Months Ago, Refer To PCP For Evaluation of need for TB skin testing**
- **If No Symptoms Present, AND History Of Negative TB Test Within 3 Months, No Further Testing Is Indicated**
- **If No Symptoms Present AND History Of Positive TB Test, AND Symptoms Develop, Refer To PCP For Evaluation**
- **If There Is A Change In History OR If Symptoms Develop, Refer To PCP For Evaluation**
- **FILE THIS DOCUMENT AS A SEPARATE PART OF PERSONNEL FILE**