

Intake Information Checklist

- Telephone number provided
- Emergency Contact Information
- Referral Source
- Physician name
- Completed Life Improvement Form (adult) or Columbia Impairment Scales (child)
- Completed DSM-5 Cross-Cutting Measure
- All current medical and medication information (including allergies)
- Proof of income
- Household income information (including spouse income)
- Insurance information or Medical Card
- Signature on **ALL** required forms

Just a reminder...

- If you feel uncomfortable answering any questions on the Health Risk Assessment, please feel free to leave them blank and we will discuss them at your appointment.
- If you need assistance filling out any of the required paperwork, please let us know and we can make arrangements to assist you.
- Call your insurance provider to determine benefits, copayments, or need for prior approval
- For children age 12 and under, only parents are needed for the first intake session.
- Please give 24-hour notice if you need to cancel, or reschedule. Call us if you are running late.
- **DO NOT DATE** any paperwork, it will be taken care of during the actual intake.
- Fill out **ALL** forms completely; if you are unsure about any form talk with a staff person

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

PERSONAL HEALTH SURVEY

The survey is voluntary and confidential. Your answers will help in understanding any health problems you may have. Please answer every question as best as you can.

CLIENT INFORMATION

First Name: _____ **Last Name:** _____
Date of Birth: _____ **Medicaid ID Number (RIN):** _____
Phone Number: _____ **Alternate Phone Number:** _____
Best Time to Call (day and time): _____
Person Completing Form: _____ **Relationship to Client:** _____

HEALTH SURVEY (Please only answer the survey questions for the person listed above.)

1. Do you have any health problems that need to be taken care of quickly? Yes No
 If YES, what is the health problem? Please explain below.

2. Do you have a primary care doctor? Yes No Don't Know

3. Do you need help making a doctor's appointment? Yes No

4. What health problems or medical conditions do you have or have you ever had in the past?
Check all that apply.

<input type="checkbox"/> Breathing problems, such as asthma, COPD, emphysema	<input type="checkbox"/> Bone or joint problems, such as arthritis, osteoporosis, or back pain
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dementia
<input type="checkbox"/> Developmental Delay/Learning Disability	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Heart problems, such as chest pain, heart attacks, Congestive Heart Failure
<input type="checkbox"/> High Blood Pressure/Hypertension	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Kidney Diseases/Bladder Problems
<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Substance Use Issues	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Other Health Problems (list): _____	

5. Do you need help with any of following activities? Not applicable

<input type="checkbox"/> Bathing/showering	<input type="checkbox"/> Brushing teeth	<input type="checkbox"/> Getting dressed	<input type="checkbox"/> Brushing hair
<input type="checkbox"/> Walking	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Using the bathroom	<input type="checkbox"/> Getting to school/work
<input type="checkbox"/> Getting/making food	<input type="checkbox"/> Eating	<input type="checkbox"/> Managing medications	<input type="checkbox"/> Housework/chores

6. Are you current on your vaccinations? Yes No Don't Know

<input type="checkbox"/> Initial
<input type="checkbox"/> Update
<input type="checkbox"/> Re-assessment

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

1. GENERAL INFORMATION						
Client First and Last Name:		Date of Birth:	RIN:	Gender:	Referral Source:	Date First Contact:
Phone Number:	Primary Language:	Interpreter Services:	<input type="checkbox"/> None required	<input type="checkbox"/> TDD/TYY	<input type="checkbox"/> Spoken Language: _____	<input type="checkbox"/> Other: _____
Address:	City:		State:	Zip Code:	County:	
US Citizen:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic	<input type="checkbox"/> White	Ethnicity:		<input type="checkbox"/> Hispanic
<input type="checkbox"/> Yes	<input type="checkbox"/> Asian	<input type="checkbox"/> Hawaiian Native/Other Pacific Islander	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> No	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-Race				
Insurance Coverage and Company: <input type="checkbox"/> N/A		Household Size:	Household Income:	Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Married	<input type="checkbox"/> Domestic Partnership	<input type="checkbox"/> Widowed
Guardianship Status:	<input type="checkbox"/> Own guardian	<input type="checkbox"/> Youth in Care	Employment Status:	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Military	<input type="checkbox"/> Employed full-time
	<input type="checkbox"/> Biological Parent	<input type="checkbox"/> Other court appointed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed part-time
	<input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Unemployed	
Living Arrangement:	<input type="checkbox"/> Lives alone	<input type="checkbox"/> Residential/Institutional Setting (residential, nursing home, shelter)	<input type="checkbox"/> Independent Living	<input type="checkbox"/> Community integrated living arrangement (CILA)	<input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s)	<input type="checkbox"/> Foster Care
	<input type="checkbox"/> State operated facility (mental health/dev. disability)	<input type="checkbox"/> Homeless	<input type="checkbox"/> Jail or correctional facility	<input type="checkbox"/> Other: _____		
Education Level:	<input type="checkbox"/> Never attended	<input type="checkbox"/> Grade 4 – 5	<input type="checkbox"/> H.S. diploma/GED	<input type="checkbox"/> Trade/technical training	<input type="checkbox"/> Master's/Doctoral degree	
(last completed)	<input type="checkbox"/> Pre-K/Kindergarten	<input type="checkbox"/> Grade 6 – 8	<input type="checkbox"/> Some college	<input type="checkbox"/> Professional certificate		
	<input type="checkbox"/> Grade 1 – 3	<input type="checkbox"/> Grade 9 – 12	<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Bachelor's degree		
Parent, Guardian, or Significant Other Info.	First and Last Name:	Relationship to Client:	Phone Number:	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Significant Other
	_____	_____	_____	_____	_____	_____
	Address:	City:	State:	Zip Code:	County:	
	_____	_____	_____	_____	_____	
Emergency Contact Information	First and Last Name:	Relationship to Client:	Phone Number:	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Significant Other
	_____	_____	_____	_____	_____	_____
	Address:	City:	State:	Zip Code:		
	_____	_____	_____	_____		
Members of Family Constellation	Name	Age	Relation to Client	Living in Home	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	_____	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Established Supports	Agency	Contact Name	Phone	Email		
Physician						
School/Daycare						
Counselor/Therapist						
Child Welfare Worker						
ISC/PAS Agent						
Probation Officer						
Other: _____						
Other: _____						
Other: _____						

Health Risk Assessment

Date: _____ Client # _____

18. General Information					
First Name:		Last Name:		Date of Birth:	
Gender:		Primary Care Doctor's Name:		Date of last Physical:	
Height: ____ Ft. ____ In.	Weight: ____ lbs			Date of last flu shot:	

19 Medication(s)					
Are you currently taking any psychotropic medications (antidepressants, anti-anxiety, mood stabilizer, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> no					
If Yes, do you regularly receive lab work <input type="checkbox"/> Yes <input type="checkbox"/> no <input type="checkbox"/> not required <input type="checkbox"/> Unknown					
List current and previous medications below, including over the counter medications.					
Medication	Prescriber	Dosage	Date Started	Date Ended	Medication Issues
What pharmacy do you use?			Pharmacy phone#		

20. Health Status	
<p>a. How would you rate your physical health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>b. How many snack foods or drinks (e.g. chips, cookies, candy, soda) do you usually consume in a day? <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> more than 4</p> <p>c. How many servings of fruits and vegetables do you eat in a day? <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> more than 4</p> <p>d. Do you engage in physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, how often? _____</p> <p>e. Do you use any form of tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>Health Concerns: Do you have any current health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, describe below _____ _____ _____</p> <p>Breathing issues: Do you have any trouble breathing? <input type="checkbox"/> Yes <input type="checkbox"/> no (if NO, skip to the next section)</p> <p>a. What are the breathing issues related to? Check all that apply. <input type="checkbox"/> Physical activity <input type="checkbox"/> Weather extremes <input type="checkbox"/> Other: _____</p> <p>b. Do you take medication for breathing issues? <input type="checkbox"/> Yes <input type="checkbox"/> no</p>	<p>f. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, how often and how much?: _____</p> <p>g. Have you ever fainted or passed out? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES describe: _____ _____</p> <p>h. Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, list: _____ _____</p> <p>i. Have you fallen in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>j. Do you want help to quit smoking? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>General Illness: Do you have the tendency to any illnesses <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, describe below _____ _____ _____</p> <p>Cognitive (skip if you are under age 50)</p> <p>a. Have you ever had a significant head injury? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, when? _____</p> <p>b. Do you have difficulty remembering or recalling events? <input type="checkbox"/> Yes <input type="checkbox"/> no</p>

<p>Blood Sugar and Diabetes:</p> <p>a. Do you urinate more frequently than appears normal? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>b. Do you seem to have an increased thirst, compared to other in your same age range? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>c. Do you have any special dietary instructions related to your blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>d. Do you take any medication to control your blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> no</p>	<p>Chronic Pain: Do you experience chronic pain or complain of pain frequently? <input type="checkbox"/> Yes <input type="checkbox"/> no (If NO, skip to the next section)</p> <p>a. Have you ever taken or been prescribe medication for pain? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>b. Describe the location and intensity of your pain below.</p>
<p>Sexual Risk Behaviors: Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> no (if NO, skip to the next section)</p> <p>a. Do you use any protection against sexually transmitted diseases/infections (STD's, STI's)? <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> no</p> <p>b. When were you last tested for STD's/STI's? _____</p> <p>c. Have you ever been diagnosed with an STD/STI or HIV? <input type="checkbox"/> Yes <input type="checkbox"/> no If YES, list the diagnosis and the age it occurred. _____ _____ _____</p>	<p>Female Reproductive Health: (If MALE, or if female and not had first period, skip to next section)</p> <p>a. Do you see a women's health provider? <input type="checkbox"/> Yes-date of last visit: _____ <input type="checkbox"/> No-Referral needed</p> <p>b. Are you experiencing any issues related to your menstrual cycle or menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, describe. _____</p> <p>c. Are you currently or have you ever been pregnant? <input type="checkbox"/> Yes-currently <input type="checkbox"/> Yes-previously <input type="checkbox"/> No If YES, describe the status or the outcome of the pregnancy. _____</p>

21. Developmental History--- Complete based on your early childhood experiences

<p>a. Did your mother receive the appropriate prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> no <input type="checkbox"/> Unknown</p> <p>b. Were there any complications during your mother's pregnancy with you? <input type="checkbox"/> Yes <input type="checkbox"/> no <input type="checkbox"/> Unknown</p> <p>c. Was your birth normal or premature? <input type="checkbox"/> Normal <input type="checkbox"/> Premature <input type="checkbox"/> Unknown</p> <p>d. Were you exposed to your mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy with you? <input type="checkbox"/> Yes—Describe. _____ _____ _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>e. Were there any unusual issues related to your mother's labor and delivery of you? <input type="checkbox"/> Yes—Describe. _____ _____ _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>f. What was your birth weight? ____ lbs. ____ oz.</p> <p>g. When did you first crawl? ____ Walk? ____ Talk? ____</p> <p>h. When did you begin to toilet train? _____</p> <p>i. Do you have a biological parent or sibling that has developmental or behavioral problems? <input type="checkbox"/> Yes <input type="checkbox"/> no <input type="checkbox"/> Unknown</p>
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22. Medical History

How many times have you been to the Emergency Room in the past 12 months?
 0 1time 2 times 3 times 4+times

What was the reason for the ER visit(s)? _____

Client# _____

Have you ever been psychiatrically hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, please list below.			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List all medical/other hospitalizations you have experienced. <input type="checkbox"/> N/A			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List the names and specialties of the providers that are currently providing you treatment.		
Provider Name	Specialty	Service(s) Provided

<p>Do you have any vision problems?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If YES, explain. _____</p> <p>_____</p>	<p>Do you have any hearing problems?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If YES, explain. _____</p> <p>_____</p>
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<p>Do you want MCCC to be in contact with your Physician(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, explain. _____</p> <p>_____</p>

Have you used any complementary and integrative health approaches? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, which ones?		
<input type="checkbox"/> Natural products (dietary supplements)	<input type="checkbox"/> Meditation	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Deep breathing strategies	<input type="checkbox"/> Massage	<input type="checkbox"/> Hypnotherapy
<input type="checkbox"/> Yoga, Tai Chi, or Qi Gong	<input type="checkbox"/> Special Diets	<input type="checkbox"/> Movement therapy
<input type="checkbox"/> Chiropractic or Osteopathic Manipulation	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Progressive Relaxation	
	<input type="checkbox"/> Guided Imagery	

CLIENT EMERGENCY CARE CONSENT FORM

Clients Name: _____

Address: _____

Telephone: (H) _____ (C) _____

Can we leave a message saying "Counseling Center" Yes or No

Emergency Contact: _____ **Relationship:** _____

Telephone: (H) _____ (C) _____

Can we leave a message saying "Counseling Center" Yes or No

Hospital Preference: _____

Physicians Name: _____ **Phone #** _____

Allergies: _____

Medications: _____

Pharmacy: _____

Primary Insurance: _____

ID # _____ Group # _____

Secondary Insurance: _____

ID# _____ Group# _____

In case of sickness, accident, or other emergency situations. I hereby give consent to Moultrie County Counseling Center to communicate the above information to the appropriate medical care providers as necessary. I understand that I may revoke this consent at any time. It has been explained to me that if I refuse to sign this consent, emergency care cannot be given.

Client/Parent/Guardian Signature: _____

Date

Signature of Person Gathering Information: _____

Date

CONSENT WITHHELD: _____ Date _____

Client Generated Treatment Plan Goals

Client # _____

Describe the problem(s) that led to you entering therapy.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Imagine that while you're sleeping, all of your problems are solved. When you wake up, how will you know that things are better? What specific changes do you notice?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

What are three broad goals you would like to work on during therapy sessions?

Example: "Improve my relationship with my spouse."

- 1. _____
- 2. _____
- 3. _____

For each of the goals you listed above, describe specifically how your life will be different once you've completed therapy.

Example: "My spouse and I would communicate about our problems. When we get angry at one another, we would know how to get through it without big fights."

- 1. _____
- 2. _____
- 3. _____

Client: _____

Date: _____

Parent /Guardian: _____

Date: _____

Life Improvement Form

Do you have problems in any of these areas of life? Please explain each problem area you would like to improve:

HEALTH: _____

SELF-ESTEEM: _____

MONEY: _____

WORK: _____

HELPING: _____

RELATIONSHIPS: _____

CHILDREN: _____

HOME: _____

PLEASE LIST ADDITIONAL CONCERNS: _____

VOTER REGISTRATION INFORMATION

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

(Public assistance agencies include the following:
"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 DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

YES NO

Signature

month day year

Date

IMPORTANT!

If you would like help 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 in private.

All information will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Please Print Full Name

(tear here)

COMPLAINT INFORMATION

If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to chose your own political party or other political preference, you may file a complaint with Daniel W. White, Executive Director, State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704-2999 (217)782-4141 or TDD (217) 782-1518.

(Half 8 ½" x 11" sheet)

Consent for Mental Health Screening & Assessment, Treatment, and Follow-up

Consent for Mental Health Screening & Assessment: During your first visit(s) to Moultrie County Counseling Center, you will be assessed for the need for behavioral health services. This screening and assessment may include a detailed intake interview to explore the reasons why you are seeking services. At the conclusion of the assessment phase you may be: Assigned to a counselor or therapist to begin treatment, Referred to another individual or agency that can better meet your needs, or Receive a recommendation that mental health services are not required at this time. If you begin treatment at Moultrie County Counseling Center, you will be assigned to one or more of the available treatment services as outlined in the enclosed Agency Brochure. You will be informed of our policies on billing and procedures for determining your fee.

Consent for Treatment: You are requesting treatment and you are attesting to the following:

The nature and purpose of treatment, the possible complications and/or the possible consequences have been fully explained to you. There is no guarantee or assurance given to you by anyone regarding the results of treatment. You have been informed that your records are privileged and will be kept absolutely confidential. You have also been informed in the Client's Rights and Responsibilities statement of the exceptions to this privilege. You understand your case may be discussed in clinical staff meetings attended by Agency personnel and that the secretarial and billing staff may be required to access your client record.

Consent for Follow-up: Throughout your treatment, your primary counselor/therapist will be measuring your progress. Our goal at Moultrie County Counseling Center is to assist you in reducing your symptoms and in increasing your level of functioning. It is important to measure your progress not only while in treatment, but also after you have left the program.

You have read, or had explained to you, all of the above information. You are authorizing Moultrie County Counseling Center to contact you or your emergency contact as outlined on the Emergency Care Contact Form following your discharge from Moultrie County Counseling Center Services.

Your signature below gives Moultrie County Counseling Center permission to contact you or your emergency contact regarding treatment outcomes. Your signature also gives your consent to treatment for you, your minor child, or a person who is under your guardianship. Your signature authorizes consent to a mental health screening/assessment.

_____	_____
Client (age 12 or older)	Date
_____	_____
Parent/Guardian (if applicable)	Date
_____	_____
Witness Signature	Date

****Please keep this document for your convenience****

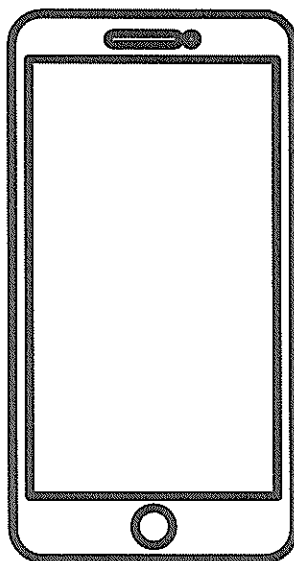
PROCEDURES FOR THE MOULTRIE COUNSELING CRISIS LINE

All calls made to the crisis line after 5:00 p.m. weekdays, all day Saturday, Sunday, and on official holidays will be forwarded to Moultrie County Counseling Center Staff member who is on call. Callers will hear a recorded message directing him/her to leave a message and a telephone number where he/she can be called. A person can expect to get a call back within 5 (five) minutes. There is also a backup number provided on the message if a call back is not received within that 5 (five) minutes. Blocked or Restricted numbers will not be answered unless there is a message left with the information needed. When leaving a message, please leave your name and complete telephone number. To aid us in returning your call, please keep your telephone line open so we can reach you.

MCCC CRISIS line number: 217-728-7611

We offer this service to assist you in contacting a staff member during a mental health emergency. We welcome you to use this service.

If you have any questions about the use of the crisis line or if any problems in the use of the crisis line occur, please let us know as soon as possible by calling our office at 217-728-4358 during regular business hours.



The Warm Line: Peer and Family Support by Telephone

The Illinois Mental Health Collaborative for Access and Choice is pleased to announce the Warm Line!

*Sometimes what is needed most in difficult times is someone to talk to:
Someone who listens and understands.*

The Warm Line is an opportunity in Illinois for persons with mental health and/or substance use challenges and their families to receive support by phone. Peer and Family Support Specialists are professionals who have experienced mental health and/or substance use recovery in their own lives. They have been trained in recovery support, mentoring, and advocacy and are ready to listen and support you. The warm line is not a crisis hotline, but is a source of support as you recover or help a family member to recover.

- **Call: 1 (866) 359-7953**
- **TTY: 1 (866) 880-4459**
- Hours of Operation: Monday through Saturday, 8am-8pm except holidays
- From the main menu, select option #2 for Consumers and Families Next, select option #5 for the Warm Line: Peer and Family Support by Phone.

Crisis Text Line

is a free, 24/7 emotional support for those in crisis.

Anyone can use this service by texting the number

741741

Texters remain anonymous.

For Ages 13 & up

Learn more: <http://www.crisistextline.org/>

