NTBHA
North Texas Behavioral Health Authority

COVID-19 Health Screening Form

The safety of our clients, visitors, their families, and staff is very important to us. To prevent the spread of coronavirus (COVID-19) and reduce the potential risk of exposure to our clients, visitors, and staff, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone at this location. Thank you for your time.

Name:	Date:
Appointment time or walkin? Phone screen	Location: Phone number:

If the answer is "yes" to any of the following questions, we will ask you to reschedule until your symptoms have cleared, have no fever, or once 14 days has passed if you traveled to one of the countries the CDC has flagged as high risk (Level 3 Travel Health Notice for widespread, ongoing transmission). If you are experiencing symptoms or need immediate assistance, we urge you to go to your nearest ER or health department.

Health screening questionnaire	
1	**Have you recently traveled through any of the countries listed by CDC (China, Italy, Iran, South Korea) in the last 14 days? Traveled to Louisiana, NY, NJ, CA, Washington, or any area with high outbreaks of COVID in that last 14 days?** ☐ Yes ☐ No
2	Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? ☐ Yes ☐ No
3	Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)? **Shortness of breath?** ☐ Yes ☐ No

Signature:_____ **Date:**_____

Staff signature:_____ **Date:**_____

Seen today (circle one): Yes No Rescheduled

Outreach, Screening, Assessment, and Referral (OSAR)

OSAR Referral Form

OSAR Referral Form **Client Name:**_____

Client's email: _____ **Date:** _____

Adult: _____ Youth: _____ **Date of Birth**: _____ **County of Residence:** _____

Address: _____ **Phone Number:** _____

Parent/Guardian's name: _____Parent/Guardian's Phone Number_____

Is client currently hospitalized/inpatient? If so, please provide Unit Name or number_____

Referring Agency's Name:_____

Contact's Person Email: _____ **Contact's phone number:**_____

Select What Level of Care You are Seeking ☐ Ambulatory Detox ☐ Residential Detox ☐ Residential ☐ Outpatient

Medication-Assisted Treatment ☐ Methadone ☐ Subutex ☐ Suboxone

Reason for Referral: _____

Type of Insurance: ☐ No Insurance ☐ NTBHA ☐ Unknown ☐ Medicare ☐ Chip Perinate
☐ Private Insurance: _____ ☐ Medicaid: Type of Medicaid:_____

Mental health diagnosis? ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Schizoaffective Disorder
☐ Other:_____ ☐ Unknown **Prior Mental Health Treatment**: Yes ☐ No ☐ Unknown ☐
Current Mental Health Treatment: Yes ☐ No ☐ Unknown ☐
If YES, where? _____

Drug use? Yes ☐ No ☐ Unknown ☐ **Prior Substance Use treatment?** Yes ☐ No ☐ Unknown ☐
Current Substance Use treatment? Yes ☐ No ☐ Unknown ☐ **Current Opioid Use:** Yes ☐ No ☐ Unknown ☐
If YES, where in treatment? _____
Drugs being used:_____
Any IV drug use (current/history): Yes ☐ No ☐ Unknown ☐ **Currently Pregnant**: Yes ☐ No ☐ N/A ☐
Problems at Work/School Due to Use of drugs or mental health: Yes ☐ No ☐ Unknown ☐
Family/Social/Environmental Problems due to use of drugs or mental health: Yes ☐ No ☐ Unknown ☐
Will they need an interpreter? Yes ☐ No ☐ **For what language?** _____

CPS currently? Yes ☐ No ☐ Unknown ☐ **CPS worker name:** _____

Legal history/current charges:

_____
_____
_____

Other pertinent information/needs:

_____
_____
_____

Hospital Name: _____
Projected Discharge Date if in hospital:_____

Please email this form to osar@ntbha.org or fax to 469-420-5396. ***Rev.01/20/20***

North Texas Behavioral Health Authority (NTBHA)
Outreach, Screening, Assessment, and Referral (OSAR)

Client Information Form

Name: _____
(Last) (First) (MI)

Address: _____

City: _____ County of Residence: _____ State: _____ Zip Code: _____

Phone #: _____ Okay to leave message? Select: Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____

City of Birth: _____ Mother's Maiden Name: _____

Marital Status: (Please circle one) Select:

Head of Household: Yes Number of dependents: _____

FEMALES ONLY: Are you pregnant? Select:

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____ Okay to leave message? Select:

Ethnicity: (Please circle one) Select:

Race: (Please circle one) Select:

Other Race: _____

Do you have income? Select: Client income: _____ Spouse income: _____

Do you have Insurance/Medicare/Medicaid: Select: If **yes** please specify: _____

What level of care are you seeking today? Select:

Who referred you to OSAR? Select:

Other _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

NTBHA
North Texas Behavioral Health Authority

North Texas Behavioral Health Authority (NTBHA)
Outreach, Screening, Assessment, and Referral (OSAR)

OSAR ATTESTATION FORM

I, _____, certify that currently all statements noted below are true and accurate.

Please initial by all that apply:

_____Income - I attest to the fact that I do not have the documentation necessary to determine my income for admission to HHSC funded services.

_____Insurance – I attest to the fact that I do not have insurance, or any other assistance, for admission to HHSC funded services.

**If you have insurance coverage please state what coverage you have:*

_____

* Are you currently covered under your ***parent's*** *insurance?* Select:
*If yes, list coverage information*_____

_____Employment – I attest to the fact that I do not have documentation of employment, or any other income, for admission to HHSC funded services.

_____Identification – I do not have proof of identification, and that by signing below, I certify that I am the person named on all required forms.

_____***I refuse to provide documentation.***

I attest that my current address is _____, located in

_____ county in the state of Texas.

Or I am: ☐ Literally homeless ☐ Residing at a shelter (provide location) _____

My signature on this Attestation Form attests to the fact that my financial summary contains an accurate assessment of my income and insurance coverage and shows that I am unable to fully pay for HHSC-funded services.

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of OSAR Staff Date

North Texas Behavioral Health Authority (NTBHA)
Outreach, Screening, Assessment, and Referral (OSAR)

Consent to Services – Adult

I _____ (client), hereby request and consent to services from NTBHA OSAR, which may include, but is not limited to a substance abuse screening, diagnostic assessments, case management, brief interventions, motivational interviewing, and other supportive services as recommended and considered necessary by NTBHA OSAR staff. I understand that upon completion of the screening, I will be given a list of treatment recommendations and community resources as applicable, and I will be referred to the appropriate level of care. I understand that I have the option to accept or reject any recommendations for services.

Rights Acknowledgement

I have received a copy and an explanation of my client rights as a consumer of NTBHA OSAR. I understand that if I have questions about my rights, I may ask NTBHA OSAR staff for clarification.

Please initial to acknowledge:

_____ I have received and signed a copy of the "Client Rights".

_____ I have received a copy of the "Notice of Privacy Practices".

My rights as a consumer were reviewed with me on the date listed below. I understand my rights, have had all questions concerning my rights explained to me and I consent to services from NTBHA OSAR.

_____ _____
Client Signature Date

_____ _____
Legally Authorized Representative Date

_____ _____
OSAR Staff Signature Date

NTBHA
North Texas Behavioral Health Authority

North Texas Behavioral Health Authority (NTBHA)
Outreach, Screening, Assessment, and Referral (OSAR)

Client Rights

Individuals receiving services from OSAR - (NTBHA) have the following rights:

1. The right to give informed consent or to refuse services and to be advised of the consequences of such a decision;
2. The right to actively participate in the development and periodic review of an individual service plan and to know the qualifications of staff providing services;
3. The right to a grievance procedure;
4. The right to a humane and safe environment free from abuse, neglect, and exploitation;
5. The right to dignity and personal privacy;
6. The right to free communication within the constraints of the individualized service plan with justification for any restrictions documented in the client record;
7. The right to know about the cost and third-party coverage of services including limitations on the duration of services;
8. The right to refuse to participate in research without compromising access to services;
9. The right to receive a complete explanation of client rights and grievance procedures in a language the client understands.

**Client will receive an explanation of these rights at any time throughout the span of services.*

Grievance Procedure

You have the right to file a complaint with any staff member or submit a complaint to the Texas Human Services Commission (HHSC) for violation of client rights or Commission standards. The grievance shall be written and you may receive assistance in writing the grievance if you have difficulty with reading and writing. You will have access to paper, pen, envelope, postage, and telephone for the purpose of filing the complaint. HHSC will respond in writing to a client within 24 hours on weekdays and 72 hours on weekends. HHSC will evaluate the grievance thoroughly and objectively, obtaining additional information as needed. The client shall be informed of the investigation's findings and recommendations within 7 calendar days. The governing body shall take action to resolve the grievance promptly and fairly. Written unresolved grievances shall be forwarded by the governing body of the HHSC. Under no circumstances will you, the client, who should exercise your rights or file a grievance be discouraged, intimidated, harassed, or sought retribution against. NTBHA will not interfere with your right to communicate with an attorney or the Commission regarding a complaint.

**Texas Health and Human Services Commission (HHSC) can be contacted at P.O. Box 13247 Austin, TX 78711-3247 or 1-800-735-2989.*

Limits of Confidentiality

Federal law and regulations protect the confidentiality of client records maintained by NTBHA. Representatives of NTBHA may not disclose to anyone outside the program whether a client participates in or has had contact with the program. The ONLY exceptions are:

1. The client or the client's legally authorized representative consents in writing.
2. The disclosure is made to medical personnel in a medical emergency or to a qualified person for research, audit or program evaluation.
3. The disclosure is required by court order. The right to privileged communication for physicians, psychologists, and other mental health professionals is not recognized by the courts of the State of Texas. If certain information regarding a participant if formally requested by a court order, our agency has no choice but to provide that information.
4. The staff at NTBHA is ethically bound to report any information that suggests:
   a. An elderly or disabled person has been or may be abused, neglected, or subject to financial exploitation, NTBHA is required to make a report to the appropriate state agency.
   b. Information disclosed about a person from whom you sought counseling in the State of Texas behaving toward you in a sexually inappropriate manner must be reported (your identity may remain anonymous at your request).
   c. If your records are requested by a valid subpoena or court order, we must respond.
   d. If you are a minor (under the age of 18) and express suicidal/homicidal thoughts.

As a Health and Human Services Commission (HHSC) provider, North Texas Behavioral Health Authority (NTBHA) utilizes Clinical Management for Behavioral Health Services (CMBHS), a web-based client referral and information system. Information concerning your history, care, and treatment may be communicated using CMBHS in several ways, one of which may include communication through a computer-based system that uses telephone lines and wireless lines to send and receive information. The highest levels of security measures will be used to protect the confidentiality of all information sent and received by NTBHA staff.

My signature below serves as acknowledgement that the Client Rights, Grievance Procedure, and Limits of Confidentiality within NTBHA has been explained to me and that I have received a copy of the Notice of Privacy Practices.

Client Printed Name	Client Signature	Date
Parent/Guardian Printed Name	Parent/Guardian Signature	Date
OSAR Staff Printed Name	OSAR Staff Signature	Date

NTBHA
North Texas Behavioral Health Authority

Substance Use History

Instructions: Fill out the section for each of the drugs that you are CURRENTLY USING or HAVE EVER USED. If you don't remember specifics, please give your best estimate. Complete the requested information on each type of drug that applies to you.

Substance	Age of FIRST Use	Date of LAST Use	Amount last used	# of days used in the last 30 days	Frequency of Use in the past 12 months	Route of Ingestion (Indicate use through IV, Smoke, Snort, Oral)
Alcohol						
Benzodiazepines						
Xanax						
Valium						
Klonopin						
Other Benzodiazepines						
Opiates						
Heroin						
Morphine						
Codeine						
Synthetics (*i.e., Demerol, Fentanyl, Dilaudid, Norco, etc.*)						
Vicodin/Hydrocodone						
Non-prescribed Methadone						
Marijuana						
K2/Spice						
Stimulants						
Amphetamine						
Methamphetamine						
Cocaine						
Crack Cocaine						
Non-prescribed Ritalin/Adderall						
PCP						
LSD						
Mushrooms						
Mescaline						
Peyote						
Ecstasy/MDMA						
Inhalants						
Tobacco						
Other (not listed above)						

Client Name: _____ Date: _____

NTBHA
North Texas Behavioral Health Authority

OSAR: Tobacco Use Questionnaire

Have you used any form of tobacco products in the last six months? Select:
Have you ever used any form of tobacco products in your life? Select:
Note: If you answered NO to either question then you do not have to complete the rest of this form.)

Anyone in your household a tobacco user? Select:

Which tobacco products have you used? Select all that apply:
☐ Cigarettes ☐ Cigars ☐ Dip/chew/smokeless tobacco ☐ Pipe ☐ Cigarillos ☐ Other

Amount (example: 2 packs a week): _____
Describe your pattern of Tobacco Use:
☐ Current User, DAILY ☐ Past User, Daily ☐ Never Used, non-smoker
☐ Current User, Less Than Daily ☐ Past User, Less than Daily

Have you ever tried to stop using tobacco? Select
If yes, how many times have you tried to stop? _____
How many times have you tried to stop in the past 12 months? _____
Longest period of time without using tobacco products? _____

What method did you use to stop tobacco use?
☐ On my own ☐ Medications: Bupropion or Varenicline
☐ Nicotine Replacement Therapy
☐ Patch ☐ Nasal Spray
☐ Gum ☐ Lozenge
☐ Inhaler
☐ Counseling ☐ Other

Please indicate your current level of motivation to quit using tobacco:
☐ Ready to Quit ☐ Thinking about Quitting in the next 30 days
☐ Thinking about quitting but not in the next 30 days ☐ Not ready to quit using tobacco

Name: _____ **Date** _____

Community Resources
For telephone counseling: American Cancer Society, 1-877-YES-QUIT
For referrals to community resources: 1-800-ACS-2345
For Web information: www.cancer.org

NTBHA
North Texas Behavioral Health Authority

North Texas Behavioral Health Authority (NTBHA)
Outreach, Screening, Assessment, and Referral (OSAR)

Tuberculosis / HIV/AIDS / STD/Hepatitis C – Risk Assessment

Tuberculosis (TB) Risk

YES	NO	Please check Yes or No to ALL symptoms, which apply to you.
☐	☐	1. Productive cough (3 weeks or more)
☐	☐	2. Been tested (screened for TB) within the past year

HIV/AIDS, Sexually Transmitted Disease (STD) and/or Hepatitis C Risk

YES	NO	Please check Yes or No to ALL symptoms, which apply to you.
☐	☐	1. Used needles to inject drugs (within the past two (2) years)
☐	☐	2. Used needles to inject drugs (at any time within the past 20 years)
☐	☐	3. Shared injecting equipment (within the past two (2) years)
☐	☐	4. Shared injecting equipment (at any time within the past 20 years)
☐	☐	5. Have had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier) with person(s) whose HIV status is unknown (more than 10 times within the past two years)
☐	☐	6. Have had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier) with person(s) whose HIV status is unknown (at any time within the past 20 years)
☐	☐	7. Have had unprotected sex with someone known to inject drugs (within the past two (2) years)
☐	☐	8. Have had unprotected sex with someone known to inject drugs (at any time within the past 20 years)
☐	☐	9. Have had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier) with person(s) whose sexual history is unknown (within the past one (1) month)
☐	☐	10. Have had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier) with person(s) whose sexual history is unknown (within the past six (6) months)

✓I further verify that I have been informed of the address and telephone number of the County Health Department.
✓I have discussed any questions or concerns with my Counselor.

Client/Guardian/Legally Authorized Representative Signature Date

OSAR Staff Signature Date