



# Jackson Services Facesheet

Today's  
Date: \_\_\_\_\_

<b>Legal Name</b> <i>(Last, First, M.I.):</i>	<b>DOB:</b>	<b>Age:</b>	<b>Birth Sex:</b>	<b>Gender:</b>
<b>Affirmed Name:</b>	<b>Pronouns:</b>			
<b>Preferred Language?</b> <b>Interpreter Needed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SS#:</b>			
<b>Your Name/Relationship to individual seeking Services:</b>	<b>Are you pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
<b>Physical Street Address:</b>  <b>City:</b> <b>State:</b>  <b>Zip:</b>	<b>Mailing Address: (If different then physical)</b>  <b>City:</b> <b>State:</b>  <b>Zip:</b>			
<b>Landline Phone:</b> _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text <b>Youth Cell Phone:</b> _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text <b>Guardian Cell Phone:</b> _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text Checking the boxes above allows Kairos staff to leave detailed voicemails and send detailed text messages.	<b>Phone Number for Reminder Calls:</b>  <b>Voice Reminders:</b> _____  <b>Text Reminders:</b> _____			
<b>Responsible Party(Parent or Legal Guardian):</b> <b>Name:</b> <b>Street Address:</b>  <b>City:</b> <b>State:</b>  <b>Zip:</b> <b>Relationship:</b> <b>Phone #:</b> <b>Email:</b>	<b>Responsible Party(Parent or Legal Guardian):</b> <b>Name:</b> <b>Street Address:</b>  <b>City:</b> <b>State:</b>  <b>Zip:</b> <b>Relationship:</b> <b>Phone #:</b> <input type="checkbox"/> mail:			
<b>Emergency Contact: (outside of household)</b> <b>Name:</b>  <b>Relationship:</b>  <b>Phone #:</b>	<b>Highest Grade Completed:</b> _____ <input type="checkbox"/> <b>Currently a Student</b> <b>School District:</b>  <b>School Name:</b>			

\*Kairos has permission to ID incase of emergency \_\_\_\_\_ (Initial)

<b>Health Insurance (Check all that apply):</b> <input type="checkbox"/> <b>I.D Verified</b> <input type="checkbox"/> <b>No I.D Available</b>		
<input type="checkbox"/> AllCare: 740 SE 7 <sup>th</sup> Street, Grants Pass, OR 97527 Phone (541)471-4106 Fax (541)471-4128 <input type="checkbox"/> Jackson Care Connect: 33 N Central Avenue, Medford, OR 97501 Phone (855)722-8208 Fax(503)416-3723 <input type="checkbox"/> Medicaid Open Card or Other: Card Number: _____ <input type="checkbox"/> Medicare Card Number: _____ <input type="checkbox"/> Private Insurance: Name: _____ ID#: _____ Group Number: _____ Subscriber Name: _____ <input type="checkbox"/> None *We currently only accept those covered by Medicaid with AllCare or Jackson Care Connect as their CCO. There is no copay for Medicaid members and you will not be charged for any services.		
<b>Youth Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other Single Race <input type="checkbox"/> Two or more unspecified races	<b>Youth Ethnicity:</b> <input type="checkbox"/> <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic-Other origin <input type="checkbox"/> Hispanic-No specific origin <input type="checkbox"/> Not Hispanic	<b>Youth Tribal Status:</b> <input type="checkbox"/> None/Not Applicable <input type="checkbox"/> Burns Paiute Tribe <input type="checkbox"/> Confederated Tribes of Coos, Lower Umpqua and Siuslaw <input type="checkbox"/> Confederate Tribes of Grand Ronde <input type="checkbox"/> Confederated Tribes of Siletz <input type="checkbox"/> Confederated Tribes of the Umatilla <input type="checkbox"/> Confederated Tribes of Warm Springs <input type="checkbox"/> Coquille Indian Tribe <input type="checkbox"/> Cow Creek Band of Umpqua Indians <input type="checkbox"/> Klamath Tribe <input type="checkbox"/> Other
	<b>Youth Employment Status:</b> <input type="checkbox"/> Full Time (35 hours or more per week) <input type="checkbox"/> Part Time (Less than 35 hours per week) <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unable to work due to being in a hospital or institution <input type="checkbox"/> Volunteer <input type="checkbox"/> Sheltered/non-competitive <input type="checkbox"/> Not working and not looking for work	
<b>Youth Marital Status:</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>Youth Arrests:</b> Total Arrests in last 30 days: <input type="checkbox"/> None Total Arrests in lifetime: <input type="checkbox"/> None Total D <input type="checkbox"/> II Arrests in last 30 days: <input type="checkbox"/> None Total D <input type="checkbox"/> II Arrests in lifetime: <input type="checkbox"/> None	<b>Youth Legal Status:</b> <input type="checkbox"/> 30 Day Civil Commitment <input type="checkbox"/> 180 Day Civil Commitment <input type="checkbox"/> Incarcerated <input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Psychiatric Security Review Board (PSRB) <input type="checkbox"/> Juvenile Psychiatric Security Review Board (JPSRB) <input type="checkbox"/> Guardianship (Court) <input type="checkbox"/> Guardianship (Child Welfare) <input type="checkbox"/> Aid and Assist <input type="checkbox"/> None <input type="checkbox"/> Involuntary Custody <input type="checkbox"/> Pre-Arrest Jail Diversion <input type="checkbox"/> Post-Arrest Jail Diversion <input type="checkbox"/> Unknown <input type="checkbox"/> Voluntary <input type="checkbox"/> Hold <input type="checkbox"/> 14 Day Diversion <input type="checkbox"/> Mental Health Court <input type="checkbox"/> DUII Diversion <input type="checkbox"/> DUII Conviction
<b>Youth Living Arrangement:</b> <input type="checkbox"/> Other Private Residence <input type="checkbox"/> Private Residence at home alone or with immediate family <input type="checkbox"/> Private Residence with relatives non-parental adults or other relatives <input type="checkbox"/> Private Residence without relatives <input type="checkbox"/> Foster Home <input type="checkbox"/> Transient/Homeless <input type="checkbox"/> Secure Residential Facility <input type="checkbox"/> Residential Facility <input type="checkbox"/> Jail <input type="checkbox"/> Room and board <input type="checkbox"/> Supported Housing <input type="checkbox"/> Supportive Housing Scattered <input type="checkbox"/> Alcohol and Drug Free Housing		
<b>Household Income Information:</b> Annual Gross Household Income: \$ _____ Number of People in Household: _____ Number in each age group dependent on household income: Individuals under 18: _____		

**Household Source and Amount of Income:**

- ☐ Wages/Salary \$\_\_\_\_\_
- ☐ Retirement/Pension/Social Security  
Income:\$\_\_\_\_\_
- ☐ Other (Alimony/Child Support, Care of foster  
child: \$\_\_\_\_\_
- ☐ Unknown:\$\_\_\_\_\_
- ☐ Public Assistance: \$\_\_\_\_\_
- ☐ Disability/Social Security Disability:  
\$\_\_\_\_\_
- ☐ None(no source of income for household)

**Youth Veterans Status:**

- ☐ Veteran with current or former  
active duty military
- ☐ Current or former guard/reserve  
with active duty
- ☐ Current or former guard/reserve  
with no active duty
- ☐ No Military service

Religious Preference:\_\_\_\_\_

**Referred By:**

**Briefly describe what brought you here today:**

\_\_\_\_\_  
Youth Signature (14 and over)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Kairos Staff Only**

Input Received By :

Date :







Jackson Services  
10 Crater Lake Ave  
Medford, Oregon 97504  
Office (541) 772-0127  
Fax (541) 772-0966

### Walk-in Hours

Tuesday and Wednesday – 12:00pm to 3:00pm

Thursday and Friday – 8:00am to 3:00pm

Crisis- Please call Jackson County  
Mental Health at 541-774-8201

Emergency – 911



**Admission Consent and Release Form**  
**Jackson Services**

Youth's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Youth's Preferred Language: \_\_\_\_\_

**Consent to Treatment**

I/we, the undersigned, as responsible party(ies), hereby request services for the above named youth with Kairos, and consent to their care and treatment as recommended and provided by the their Care Team.

\_\_\_\_\_  
Youth if 14 or over

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kairos Representative

\_\_\_\_\_  
Date

**Agreement to Participate in Treatment and Aftercare**

I/we, the undersigned, as responsible party(ies) hereby agree to participate in the treatment of the above named youth while s/he is in the care of Kairos.

\_\_\_\_\_  
Youth if 14 or over

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

I have an Advanced Health Directive.

It is located at: \_\_\_\_\_

I do not have an Advanced Directive but would like information and assistance in creating one.

I do not have an Advanced Directive and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

I have a Declaration for Mental Health Treatment.

It is located at: \_\_\_\_\_

I do not have a Declaration for Mental Health Treatment but would like information and assistance in creating one.

I do not have a Declaration for Mental Health Treatment and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

## Risks and Benefits of Treatment

Mental Health treatment can have many benefits, but also some risks. Kairos staff work diligently with youth and families to develop and utilize skills using the agency's treatment philosophy of Collaborative Problem Solving. Through the course of individual, group, family therapy, and/or skills training and peer support the discussion of unpleasant topics such as previous trauma may result in uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. However, treatment has been shown to have many benefits for those who go through it. Treatment often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Additionally, please know that we do not keep secrets. During the course of family therapy your Individual and Family Therapist may disclose information obtained during the course of individual work when working with other members of the family. Please ask to speak with your therapist or the program manager should you have any questions or concerns about the risks and benefits of treatment.

\_\_\_\_\_  
Youth if 14 or over

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kairos Representative

\_\_\_\_\_  
Date

### Youth Age 14 and Over

If you are a minor 14 years of age or older, you have the right to consent for outpatient mental health treatment without the knowledge or consent of a parent or guardian. However, unless you are emancipated or the involvement of your parent/guardian is believed to be clinically harmful to you, attempts will be made to involve your parent/guardian prior to the end of treatment. Additionally, we may disclose information to your parent/guardian or primary caregiver at any point if you disclose a plan to cause serious harm or death to yourself, you plan to cause serious harm or death to someone else who can be identified, or you tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past and disclosure is deemed clinically necessary to maintain your safety or the safety of others.

\_\_\_\_\_  
Youth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kairos Representative

\_\_\_\_\_  
Date

We schedule appointments reserving that time just for you and/or your family. If you need to miss an appointment or will not be home during your scheduled appointment time, please provide Kairos with 24 hours' notice so that we may reschedule your time to benefit others.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632- 9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377- 8642 (relay voice users). USDA is an equal opportunity provider and employer.

KAIROS Health History—Jackson Services

In order to obtain a complete picture of you, we need some information about your health history and current health status. Please complete as much information as you know about the following.

Name of PCP:_____	Clinic Name:_____
Date of last visit:_____	Phone Number:_____
Dentist Name:_____	Clinic Name:_____
Date of last visit:_____	Phone Number:_____
Date of last hearing exam:_____	
Date of last eye exam:_____	
Mental Health Provider:_____	Clinic Name:_____
Date of last visit:_____	Phone Number:_____

Do you have a history of self-harm or attempted suicide?    ☐ no   ☐ yes  
Please list the date(s) and describe:

\_\_\_\_\_

\_\_\_\_\_

Do you have a history of harming other people or animals?    ☐ no   ☐ yes  
Please list the date(s) and describe:

\_\_\_\_\_

\_\_\_\_\_

Do you have any environmental allergies?    ☐ no   ☐ yes  
Please list and note what type of reaction occurs:\_\_\_\_\_

Are you allergic to any medications?    ☐ no   ☐ yes  
Please list and note what type of reaction occurs:\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medications?    ☐ no   ☐ yes

Name of Medication	Dosage and Instructions	Prescribing Provider

Pharmacy Name:_____	Location:_____
Phone Number:_____	

Do you have any other health concerns that you feel we should know about? Please explain:

\_\_\_\_\_

\_\_\_\_\_

Please select any of the following that you have experienced in the last 30 days: ☐None

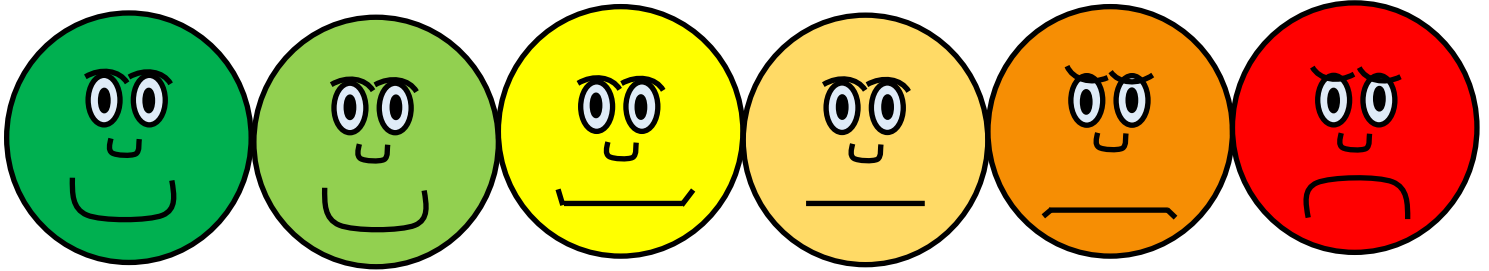
Eyes	<input type="checkbox"/>	Blurred Vision?
	<input type="checkbox"/>	Seeing Double?
	<input type="checkbox"/>	Seeing Halos?
	<input type="checkbox"/>	Eye Pain?
	<input type="checkbox"/>	Watering?
	<input type="checkbox"/>	Itching?
	<input type="checkbox"/>	Wear Glasses/Contacts?
	Ears	<input type="checkbox"/>
<input type="checkbox"/>		Buzzing or Ringing?
<input type="checkbox"/>		Frequent Earaches/Infections?
<input type="checkbox"/>		Motion Sickness?
<input type="checkbox"/>		Drainage?
<input type="checkbox"/>		Use Hearing Aid(s)?
Nervous Systems	<input type="checkbox"/>	Numbness/Tingling?
	<input type="checkbox"/>	Trembling/Shaking?
	<input type="checkbox"/>	Fainting Spells?
	<input type="checkbox"/>	Changes in Handwriting?
	<input type="checkbox"/>	Speech Difficulty?
	<input type="checkbox"/>	Loss of Muscle Strength?
	<input type="checkbox"/>	History of Seizures?
	<input type="checkbox"/>	Date of last Seizure?
Digestive	<input type="checkbox"/>	Frequent Indigestion
	<input type="checkbox"/>	Heartburn
	<input type="checkbox"/>	Frequent Bloating
	<input type="checkbox"/>	Bloated Stomach
	<input type="checkbox"/>	Loss of Appetite
	<input type="checkbox"/>	Nausea or Vomiting
	<input type="checkbox"/>	Spit up Blood
	<input type="checkbox"/>	Constipation
	<input type="checkbox"/>	Diarrhea
	<input type="checkbox"/>	Black/Grey/Blood Stools
	<input type="checkbox"/>	Rectal Pain
	<input type="checkbox"/>	Rectal Bleeding
	<input type="checkbox"/>	Change in Stools
	General	<input type="checkbox"/>
<input type="checkbox"/>		Trouble Sleeping
<input type="checkbox"/>		Often Crying
<input type="checkbox"/>		Depressed
<input type="checkbox"/>		Hopeless Outlook
<input type="checkbox"/>		Considered Suicide
<input type="checkbox"/>		Loss Temper Often
<input type="checkbox"/>		Trouble Relaxing
<input type="checkbox"/>		Anxiety
<input type="checkbox"/>		Work/Family Problems
<input type="checkbox"/>		Change in Memory/Concentration
<input type="checkbox"/>		Sexual Difficulty/Problems
Head & Neck		<input type="checkbox"/>
	<input type="checkbox"/>	Migaines?
	<input type="checkbox"/>	Neck Pains?
	<input type="checkbox"/>	Lumps or Swelling?
	<input type="checkbox"/>	Difficulty Swallowing?
Other?	<input type="checkbox"/>	

Youth Name: \_\_\_\_\_

**Pain Screening:**

What is **your current physical pain level?**

Please mark the one most accurate number (0-10) on the scale below.



No Hurt

Hurt a Little

Hurts Little More

Hurts Even More

Hurts Whole Lot

Hurts Worst



**Where** is this pain located? ☐ Head ☐ Arms ☐ Legs ☐ Back ☐ Hands  
☐ Feet ☐ Ankles ☐ Knees ☐ Other: \_\_\_\_\_

**What** caused the pain? \_\_\_\_\_  
\_\_\_\_\_

**Form completed by:**

Print Name

Sign Name

Relationship to Youth

Date

**Kairos Representative Reviewing Form:**

Print Name

Sign Name

Title

Date

Recommended follow-up with Primary Care Provider: ☐ Yes ☐ No



## Youth and Family Information Attestation Jackson Services

\_\_\_\_\_  
Youth Name

\_\_\_\_\_  
DOB

I/we the undersigned have been informed and received the following information regarding services provided by Kairos. Please initial in the lines provided:

- \_\_\_\_\_ After-Hours Crisis Support Information
- \_\_\_\_\_ Notice of Privacy Practices
- \_\_\_\_\_ Abuse Reporting Guideline
- \_\_\_\_\_ Custody Disclosure
- \_\_\_\_\_ Client and Family Rights
- \_\_\_\_\_ Voter Registration Information
- \_\_\_\_\_ Grievance Procedure "Have A Problem Or A Complaint?"
- \_\_\_\_\_ Behavior Support Philosophy
- \_\_\_\_\_ Feedback Informed Treatment (FIT) and OpenFIT Use Disclaimer
- \_\_\_\_\_ Home Safety Service Delivery Agreement
- \_\_\_\_\_ Video Surveillance Acknowledgement
- \_\_\_\_\_ Attendance Policy

\_\_\_\_\_  
Youth if 14 or over (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent and/or Legal Guardian (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KAIROS Representative (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Youth refused to sign for the receipt of the above documents, however copies of all the above guidelines were given to the youth and/or parent/legal guardian \_\_\_\_\_ (Kairos Representative)