Josephine Services Facesheet

Today's Date:_____

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

Health Insurance (Check all that apply): ☐ **I.D Verified** ☐ **No I.D Available**

☐ AllCare: 740 SE 7th Street, Grants Pass, OR 97527 Phone (541)471-4106 Fax (541)471-4128
☐ Jackson Care Connect: 33 N Central Avenue, Medford, OR 97501 Phone (855)722-8208 Fax(503)416-3723
☐ Medicaid Open Card or Other: Card Number:_____
☐ Medicare Card Number: _____
☐ Private Insurance: Name: _____ ID#:_____
Group Number:_____ Subscriber Name:_____
☐ 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.

Youth Race:
☐ White
☐ Alaska Native
☐ American Indian
☐ Black/African American
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ Other Single Race
☐ Two or more unspecified races

Youth Marital Status:
☐ Never Married
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Youth Living Arrangement:
☐ Other Private Residence
☐ Private Residence at home alone or with immediate family
☐ Private Residence with relatives non-parental adults or other relatives
☐ Private Residence without relatives
☐ Foster Home
☐ Transient/Homeless
☐ Secure Residential Facility
☐ Residential Facility
☐ Jail
☐ Room and board
☐ Supported Housing
☐ Supportive Housing Scattered
☐ Alcohol and Drug Free Housing

Youth Ethnicity:☐
☐ Puerto Rican
☐ Mexican
☐ Cuban
☐ Hispanic-Other origin
☐ Hispanic-No specific origin
☐ Not Hispanic

Youth Employment Status:
☐ Full Time (35 hours or more per week)
☐ Part Time (Less than 35 hours per week)
☐ Unemployed
☐ Homemaker
☐ Student
☐ Retired
☐ Disabled
☐ Unable to work due to being in a hospital or institution
☐ Volunteer
☐ Sheltered/non-competitive
☐ Not working and not looking for work

Youth Arrests:
Total Arrests in last 30 days:
☐ None
Total Arrests in lifetime:
☐ None
Total D□II Arrests in last 30 days:
☐ None
Total D□II Arrests in lifetime:
☐ None

Household Income Information:
Annual Gross Household Income:$_____
Number of People in Household: _____
Number in each age group dependent on household income:
Individuals under 18:

Youth Tribal Status:
☐ None/Not Applicable
☐ Burns Paiute Tribe
☐ Confederated Tribes of Coos, Lower Umpqua and Siuslaw
☐ Confederate Tribes of Grand Ronde
☐ Confederated Tribes of Siletz
☐ Confederated Tribes of the Umatilla
☐ Confederated Tribes of Warm Springs
☐ Coquille Indian Tribe
☐ Cow Creek Band of Umpqua Indians
☐ Klamath Tribe
☐ Other

Youth Legal Status:
☐ 30 Day Civil Commitment
☐ 180 Day Civil Commitment
☐ Incarcerated
☐ Parole
☐ Probation
☐ Psychiatric Security Review Board (PSRB)
☐ Juvenile Psychiatric Security Review Board (JPSRB)
☐ Guardianship (Court)
☐ Guardianship (Child Welfare)
☐ Aid and Assist
☐ None
☐ Involuntary Custody
☐ Pre-Arrest Jail Diversion
☐ Post-Arrest Jail Diversion
☐ Unknown
☐ Voluntary
☐ Hold
☐ 14 Day Diversion
☐ Mental Health Court
☐ DUII Diversion
☐ DUII Conviction

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 Recieved By :
Date :

Josephine Services

1750 Nebraska Ave, Suite B
Grants Pass, Oregon 97527
Office (458) 257-2001
Fax (541) 772-0966

Walk-in Hours

Monday – 8:00am to 12:00pm

Friday – 12:00pm to 3:00pm

Crisis- Please call Josphine County
Mental Health at 541-474-5365
Emergency – 911

Josephine Services
1750 Nebraska Ave, Suite B
Grants Pass, OR 97527
(458) 257-2001 Fax(541) 772-0966

Admission Consent and Release Form

Josephine 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 seriousharm 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.

KAIROS Health History—Josephine 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

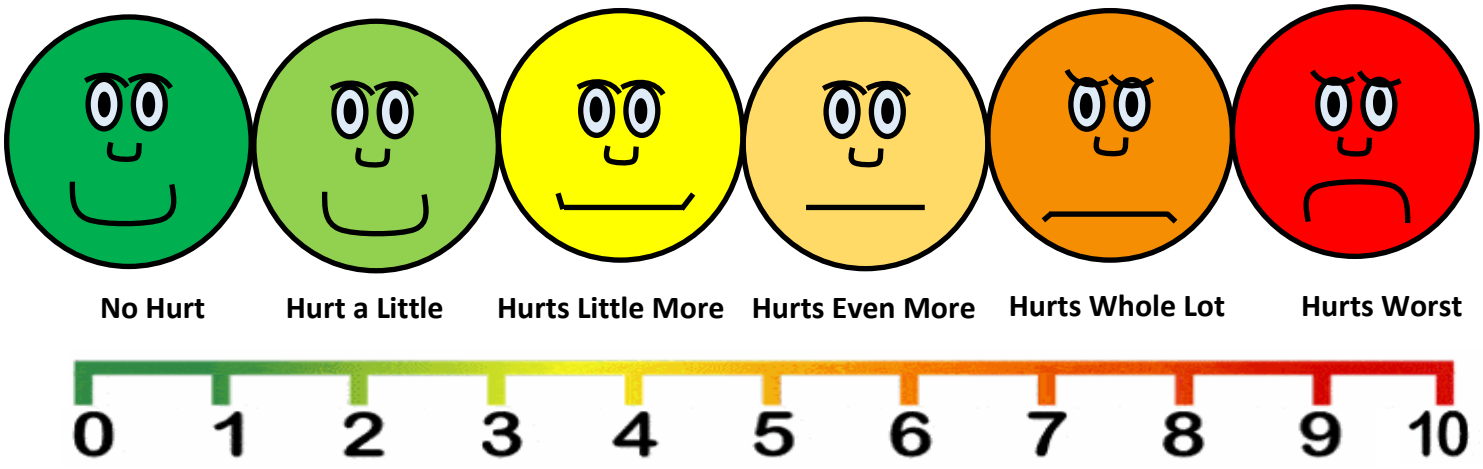
Eyes	❑	**Blurred Vision?**
	❑	**Seeing Double?**
	❑	**Seeing Halos?**
	❑	**Eye Pain?**
	❑	**Watering?**
	❑	**Itching?**
	❑	**Wear Glasses/Contacts?**
Ears	❑	**Difficulty Hearing?**
	❑	**Buzzing or Ringing?**
	❑	**Frequent Earaches/Infections?**
	❑	**Motion Sickness?**
	❑	**Drainage?**
	❑	**Use Hearing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

Youth Name:_____

Pain Screening:

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

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



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

Josephine Services
1750 Nebraska Ave, Suite B
Grants Pass, OR 97504
(458) 257-2001 Fax (541) 772-0966

Youth and Family Information Attestation Josephine 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)