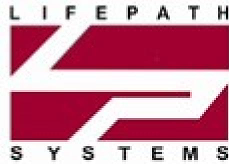


Welcome to LifePath Systems

LifePath Systems Local Behavioral Health Authority offers an extensive array of personalized services to Collin County residents. Some of these services may not be covered by your insurance or you may not have insurance, so we will provide a financial assessment to determine the charge for these services based on your ability to pay. Your ability to pay will be evaluated by considering your gross income and number of dependents. You will be considered to have an inability to pay for services if your household income is at or below 150% of the federal poverty. If your income exceeds this amount, you will be required to pay some portion of the cost for the state-funded services, in addition to any cost required by your insurance. If you live outside of Collin County, we will be happy to provide a referral to the local authority in your county.

* If you have private insurance, please call our insurance verification team at **(972) 562-9647** to have your benefits verified to ensure that our providers are contracted with your insurance plan.

Please make sure you have the following documentation with you:

- ☐ **Photo Identification** (driver's license or official photo ID)
- ☐ **Social Security Card** (if applicable)
- ☐ **Proof of Collin County Residence** (current utility bill or lease agreement)
- ☐ **Proof of Gross Household Income** (recent tax return or 30 day paystubs)
- ☐ **Proof of Number of Household Family Members** (you, spouse & biological dependents)
- ☐ **Proof of Any Extraordinary Expenses** (receipts showing paid during the past 12 months)
- ☐ **Insurance Cards** (Medicaid, Medicare, private insurance, Tricare, V.A. Outpatient card)

For children's services, these additional documents are necessary:

- ☐ **Child's Birth Certificate**
- ☐ **Child's Social Security Card** (if applicable)
- ☐ **Parent or Guardian's Photo ID** (driver's license or state/county issued photo ID)
- ☐ **Proof of Custody** (divorce decree, legal guardianship, conservatorship/custody order, adoption decree, form notarized by biological parents giving permission for nonparent to seek mental health treatment for child)
- ☐ **Insurance Cards** (Medicaid, CHIP, private insurance, Tricare)

Our Open Access clinics are open Monday through Thursday from 8 a.m. to 6 p.m. You will need to arrive before 3:00 pm to allow time to complete the paperwork. Fridays we are open from 8:00-12:00pm; please arrive before 10:00am.

WELCOME TO LIFEPATH SYSTEMS

What brings you to LifePath Systems today? Please include any current or previous symptoms, treatment history, and your hopes/expectations for services.

How did you learn about LifePath Systems?____

I believe I am currently in crisis and may be a danger to myself or to others ☐ Yes ☐ No ☐ Unsure

Intake assessments may take **several hours** to complete. If you do not have time to complete the intake assessment today please let us know. We may be able to complete a portion of the assessment today and schedule an appointment to complete the remainder when it is more convenient for you.

Insurance: ☐ No insurance ☐ Medicaid ☐ Medicare ☐ Other insurance

If you have insurance please provide the front desk staff with a copy of your insurance card. *(If you marked "other insurance" we will make every attempt to be sure our services are covered by your insurance before beginning the intake process. If we are unable to do so before we complete your intake assessment you may have to pay out-of-pocket for the assessment.)*

Name: ____ Date of Birth: ______________________

Address: ____________________________________ Apt # ______ City: _______________________ Zip: ________

County of residence: _______________ Social Security #: ________-____-_______ Phone number:_________________

Alternate phone number: ___________________ Email:____

Insurance *(if applicable)*: ____

My primary care physician is: ____

If you do not have a primary care physician we would be happy to provide a referral for you.

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown Race
- ☐ White

Ethnicity
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender
- ☐ Male
- ☐ Female

Office use only:

Adult Check-In Form	Date: ___________________	Time: ____________________	LCN: ________________

WELCOME TO LIFEPATH SYSTEMS

What brings you and your child to LifePath Systems today? Please include any current or previous symptoms, treatment history, and your hopes/expectations for services.

How did you learn about LifePath Systems?____

If any legal documents such as a divorce decree, guardianship paperwork, authorization to consent, or durable power of attorney exist regarding custody of your child, please present the documents **before** the intake assessment begins.

I believe my child is currently in crisis and may be a danger to him/herself or to others ☐ Yes ☐ No ☐ Unsure

Intake assessments may take **several hours** to complete. If you do not have time to complete the intake assessment today please let us know. We may be able to complete a portion of the assessment today and schedule an appointment to complete the remainder when it is more convenient for you.

Insurance: ☐ No insurance ☐ Medicaid ☐ Medicare ☐ Other insurance

If you have insurance please provide the front desk staff with a copy of your child's insurance card. *(If you marked "other insurance" we will make every attempt to be sure our services are covered by your insurance before beginning the intake process. If we are unable to do so before we complete your intake assessment you may have to pay out-of-pocket for the assessment.)*

Child's Name: ____ Date of Birth: ______________________

Address: ____________________________________ Apt # ______ City: _______________________ Zip: ________

County of residence: _______________ Social Security #: ________-____-_______ Phone number:_________________

Alternate phone number: ___________________ Email:____

Insurance *(if applicable)*: ____

My child's primary care physician is: ____

If your child does not have a primary care physician we would be happy to provide a referral for you.

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown Race
- ☐ White

Ethnicity
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender
- ☐ Male
- ☐ Female

Office use only:

C&A Check-In Form	Date: ___________________	Time: ____________________	LCN: ________________

Bienvenido a LifePath Systems

¿Qué lo trae a usted a LifePath Systems hoy? Incluya cualquier síntoma actual o anterior, historial de tratamiento historia y sus esperanzas/expectativas de servicios.

¿Cómo se enteró de LifePath Systems?____

Creo que actualmente estoy en crisis y puedo ser un peligro para mí o para los demás. ☐ Sí ☐ No ☐ no estoy seguro

Las evaluaciones de admisión pueden tardar **varias horas** en completarse. Si no tiene tiempo para completar la evaluación de admisión hoy, háganoslo saber. Es posible que podamos completar una parte de la evaluación hoy y programar una cita para completar el resto cuando sea más conveniente para usted.

Seguro medico: ☐ Sin seguro medico ☐ Medicaid ☐ Medicare ☐ Otro seguro medico

Si tiene seguro medico, entregue al personal de recepción una copia de su tarjeta de seguro medico. *(Si marcó "otro seguro medico", haremos todo lo posible para asegurarnos de que nuestros servicios estén cubiertos por su seguro medico antes de comenzar el proceso de admisión. Si no podemos hacerlo antes de completar su evaluación de admisión, es posible que tenga que pagar para la evaluación.)*

Nombre: ____Fecha de nacimiento:______________________

Dicección:___________________________________Apto# ______Ciudad:________________Código Postal:________

Condado de residencia: _____________Número de seguro social: ________-____-_______

Número de teléfono:___________________ Número de teléfono alternativo: _______________________

Correo electrónico:____

Seguro medico *(Si aplica)*: ____

Médico de atención primaria: ____

Si no tiene un médico de atención primaria, estaremos encantados de proporcionarle una referencia.

Raza
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown Race
- ☐ White

Etnicidad
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Género
- ☐ Masculino
- ☐ Femenino

Solo uso de oficina:

Adult Check-In Form Date: ___________________ Time: ____________________ LCN: ________________

Bienvenido a LifePath Systems

¿Qué lo trae a usted a LifePath Systems hoy? Incluya cualquier síntoma actual o anterior, historial de tratamiento historia y sus esperanzas/expectativas de servicios.

¿Cómo se enteró de LifePath Systems?____

Si existen documentos legales, como una sentencia de divorcio, trámites de tutela, autorización de consentimiento o poder notarial duradero con respecto a la custodia de su hijo, presente los documentos **antes** de que comience la evaluación de admisión.

Creo que actualmente mi hijo(a) esta en crisis y puedo ser un peligro para mí o para los demás. ☐ Sí ☐ No ☐ no estoy seguro

Las evaluaciones de admisión pueden tardar **varias horas** en completarse. Si no tiene tiempo para completar la evaluación de admisión hoy, háganoslo saber. Es posible que podamos completar una parte de la evaluación hoy y programar una cita para completar el resto cuando sea más conveniente para usted.

Seguro medico: ☐ Sin seguro medico ☐ Medicaid ☐ Medicare ☐ Otro seguro medico

Si tiene seguro medico, entregue al personal de recepción una copia de su tarjeta de seguro medico. *(Si marcó "otro seguro medico", haremos todo lo posible para asegurarnos de que nuestros servicios estén cubiertos por su seguro medico antes de comenzar el proceso de admisión. Si no podemos hacerlo antes de completar su evaluación de admisión, es posible que tenga que pagar para la evaluación.)*

Nombre de niño: ____Fecha de nacimiento:________________________

Diección:______________________________________Apto# ______Ciudad:_________________Código Postal:________

Condado de residencia: ______________Número de seguro social: ________-____-_______

Número de teléfono:_____________________ Número de teléfono alternativo: _________________________

Correo electrónico:____

Seguro medico *(Si aplica)*: ____

Médico de atención primaria: ____

Si no tiene un médico de atención primaria, estaremos encantados de proporcionarle una referencia.

Raza
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown Race
- ☐ White

Etnicidad
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Género
- ☐ Masculino
- ☐ Femenina

Solo uso de oficina:

C&A Check-In Form	Date: ____________________	Time: _____________________	LCN: _________________

Confidentiality Statement

Name: ____________________________________ LCN: __________________ Date: ______________

I understand that I have the right to confidentiality. Information about me or the services I receive will not be released without my written consent.

Stipulations to confidentiality include:

- Reports of suspected abuse, neglect, and/or exploitation of a child, elder, or disabled person will be reported to the appropriate officials and/or state agency.
- Threats of harm to self or others may be reported to appropriate officials to ensure safety of all individuals involved.
- A court order and/or subpoena of records.
- In the case of a medical emergency, pertinent information may be release to emergency personnel in order to ensure appropriate medical treatment.

_________________________________ _______________ _________________________________
Printed Name of Individual/LAR Date Individual/LAR Signature

_____________________________________ _______________ _________________________________
Printed Name of Workforce Member/Title Date Workforce Member Signature

Behavioral Health Consent for Services and Treatment Agreement

Name: ____________________________________ LCN: __________________ Date: ______________

_____ I authorize and consent for LifePath Systems to provide behavioral health services to me/my child.

_____ Consenting for a child:

- _____ I attest that I have the authority to provide legal consent for services at this time and should that legal authority change, I will immediately inform LifePath Systems' staff and halt all services until appropriate consent may be obtained. In case of divorce and/or child custody issues, I agree to provide a copy of the court documentation to LifePath Systems' staff prior to the delivery of service.

- _____ I understand that a parent/guardian must attend appointments prescriber for minors (under 18).

_____ I understand my relationship with LifePath Systems and its representatives is professional and therapeutic. In order to preserve this relationship, it is imperative that LifePath Systems or its representatives not have any other type of relationship with me and/or my family. Personal and/or business relationships (gifts, bartering, and trading services) between me/my family and LifePath Systems, undermine the effectiveness of the therapeutic relationship and is not appropriate.

_____ I understand I may bring a family member or other person of my choice to my appointments and I (or my LAR) am willing to sign releases of information for those persons, as long as their presence is not disruptive to my treatment.

_____ I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits, and alternatives to each service proposed for my treatment. I understand that the results of services including assessment, evaluation, treatment, or other services cannot be guaranteed.

_____ I agree that I will participate in assessing, planning, developing and the monitoring of my recovery plan. I will participate in the identified interventions as a means of reaching my recovery plan goals.

_____ I understand that LifePath Systems is a comprehensive service provider. A program of services is recommended based upon my needs assessment. I understand that maximum benefit can only occur with consistent attendance and my active involvement in the recovery process. I understand that in the event that I fail to keep appointments and remain out of contact for 90 days, services may be discontinued or interrupted.

_____ I understand that I have the right to refuse or discontinue services and/or negotiate treatment options at any time. In cases where treatment has been ordered by a court, I may still refuse to participate in recommended treatment; however, there may be legal consequences from failure to follow the court ordered treatment. It is best to discuss treatment options with providers prior to discontinuing any treatment.

_____ I understand that the goal of participating in services with LifePath Systems is ultimately to achieve recovery and to discharge from services. This process is different for every individual. Discharge planning will begin at the time of admission and will continue to be reviewed throughout recovery planning.

Behavioral Health Consent for Services and Treatment Agreement

Name: ____________________________________ LCN: __________________ Date: ______________

Discharges from Behavioral Health Services may occur for any of the following reasons:

- I and program staff mutually agree to the termination of services.
- I move outside of Collin County.
- I achieve my recovery plan goals.
- I no longer meet the criteria for services, or the services are no longer medically necessary.
- I do not respond to treatment and/or choose not to participate in treatment
- 2 consecutive no-shows and failure to respond to engagement attempts.

_____ I understand that LifePath Systems workforce members may refuse to see any one that presents for a session under the influence of illicit drugs and/or alcohol, and/or displaying inappropriate conduct. It is my understanding that LifePath Systems will take appropriate action to ensure safety and well-being for me and/or other individuals receiving services.

_____ I have been notified that transportation may be available to me and/or my child for the benefit of accessing necessary services. I understand that if I and/or my child access any transportation provided by a LPS employee that it will be coordinated in advance and with my consent (if transport is provided to youth).

_____ If services for myself or my family include medications, I understand the importance of taking medication(s) as prescribed. If I have questions or concerns about my prescribed medications and/or side effects, I understand the importance of communicating these concerns with my treatment team.

_____ I understand that the use of illicit drugs and/or alcohol may be dangerous for persons receiving medications, and consequently, the physician may refuse to prescribe for me under such circumstances. I further understand that I may be asked to obtain a drug test and results consistent with illicit drug or alcohol use may be grounds for the denial of medications.

_____ I understand that all psychotropic medications must be prescribed by your LifePath Systems psychiatric prescriber. If you are seeing multiple prescribers, please notify your LifePath Systems psychiatric prescriber in order to coordinate appropriate care.

_____ I understand that LifePath Systems does not prescribe controlled substances to adults for any reason.

_____ Controlled medications prescribed to children and adolescents will not be filled early. Please schedule an appointment with your prescriber if you do not have refills of your medications.

_____ I understand that I should notify LifePath Systems or its representatives at least one week in advance if my family member(s) in services or I need a refill of the medication(s) prescribed by LifePath Systems prescriber(s) in order to prevent any lapse of medications.

_____ I understand that if I miss two scheduled prescriber appointments in a row, that I may have to go without my medications until I can get back in to see the prescriber.

_____ LifePath Systems is a tobacco free campus. Smoking is not allowed anywhere on the campus, grounds, or parking lots. This includes the use of e-cigarettes or any other device that produces vapors, smoke, spit, etc.

_____ I understand that LifePath Systems' behavioral health clinics utilize video recording for the personal safety of individual's receiving services, staff and visitors. Video recording is not utilized for treatment purposes and does not become a part of my medical record.

Behavioral Health Consent for Services and Treatment Agreement

Name: ___________________________________ LCN: __________________ Date: ______________

_____ I also understand that the use of personal video or audio recording, of any kind, including cell phone recordings, is not allowed on the premises to ensure the privacy and confidentiality of all of our guests.

_____ I understand that any records that are generated while receiving services at LifePath Systems will be maintained for a period of 7 years from the date of the last service. After 7 years these records may be destroyed. For discharged individuals under the age of 18, records may be destroyed once the individual turns 21 or 7 years after the last date of service - whichever is longer. I also understand that this timeframe may be changed without notice in accordance with state and federal guidelines.

_____ I understand that I have the right to appeal clinical determinations related to my services. Appeals can be made by contacting :

- Utilization Management Department at 972-422-5939
- Rights Officer, Jordan Planchon at 972-562-0190, if I need further assistance with my appeal

_____ I understand I have the right to provide feedback or voice a complaint or grievance at any time. I can do so in the following ways:

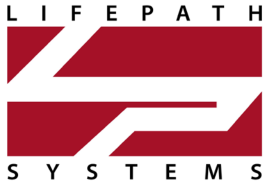
- Completing a comment box slips located in each clinic lobby
- Completing a comment form obtained from the front desk and/or a case manager
- Contacting the Quality Management Department at 972-422-5939
- Contacting the Rights Officer at 972-562-0190
- Contacting the HHSC Civil Rights Office at 888-388-6332

_____ If I am experiencing a mental health or substance use crisis in Collin County, I can contact the toll-free Crisis Hotline twenty-four hours a day, seven days a week.

Crisis Hotline: 1-877-422-5939

- Payment is expected at the time of service, prior to your appointment.
- No pets are allowed on the premises – only authorized service animals with an appropriate leash/harnesses and identification are allowed.
- Use of the lobby phone is limited to calling for your ride/transportation.
- **Late Arrival Policy:** Be on time for your appointments. Please arrive 15 minutes prior to your scheduled appointment time to allow staff the time to check you in and update your information. If you are late to your appointment, your appointment may have to be rescheduled.
- **No-Show Policy:** Canceling an appointment with less than 24 hours' notice or not showing up to your scheduled appointment is considered a "no-show" and you may incur a charge. Two consecutive no shows will result in you being directed to the Stand-By Clinic.
- **Stand-By Clinic:** Check in at the front desk between 8am and 2:30pm (Monday thru Friday). There is no guarantee that you will see your assigned provider nor that you can be seen during Stand-By Clinic hours.

________________________________	______________	________________________________
Printed Name of Individual/LAR	Date	Individual/LAR Signature
________________________________	______________	________________________________
Printed Name of Workforce Member/Title	Date	Workforce Member Signature



LifePath Systems Local Behavioral Health Authority (LBHA)
Provider Selection Process

I, ____________________________________, have been informed, both verbally and in writing that I may choose to receive services from any available provider in LifePath Systems Local Behavioral Health Authority's (LBHA) network that offers the authorized services. LifePath LBHA has provided, with neutral presentation the available in-network providers and explained the following information:

➢ I may change providers at any time

➢ I have been given the provider list and provider profiles (see attached)

➢ I have been allowed a reasonable period of time and had an area made available to review the materials to be able to make a decision on a provider

➢ My choice of provider has been documented and will be maintained by LifePath Systems LBHA

I also understand that if I am unable to select a provider, LifePath Systems LBHA shall provide me with an appointment for ongoing services at an assigned provider, and I have been provided the information about how to have the appointment rescheduled with a different provider if I choose to do so at a later time.

After completing the intake with LifePath Systems LBHA, reviewing the provider profiles, and being informed of the recommended level of care, I have chosen ____ to be my provider for all ongoing mental health services. My appointment with this provider has been scheduled with ____________________________________ on ____________ at _______________ .

Please select one of the following providers for your mental health services:

- **Child and Family Guidance Center**
  ____4031 West Plano Parkway, Suite 211, Plano, Texas 75093 (1-866-695-3794)

- **LifePath Systems (972-422-5939)**
  ____7308 Alma Drive, Plano, Texas 75025
  ____1515 Heritage Drive, Suite 110, McKinney, Texas 75069

You will be asked to sign this form electronically during your intake appointment.

LIFEPATH SYSTEMS

Provider Selection Process
Mental Health Provider Profiles

Child and Family Guidance Center

Established in 1896, Child & Family Guidance Center (CFGC), is the oldest child guidance center in Texas and 2nd oldest in the nation. CFGC's mission is to provide quality, accessible mental health services to strengthen children, families and communities.

The Child and Family Guidance Center in Plano is a key provider and referral source for mental health and related services in North Texas. They offer a wide array of all encompassing services and are dedicated to providing these services to adults and children experiencing mental illness. CFGC continues to provide quality care and remains dedicated to serving individuals and meeting all of their mental health needs.

LifePath Systems Behavioral Health

LifePath Systems has been in operation since 1986, meeting the needs of the people of Collin County and the surrounding areas. Our professional staff are highly trained and credentialed, and most importantly they care about each individual they serve.

LifePath Systems Behavioral Health is a comprehensive service provider for both mental health and substance abuse services in Collin County. We specialize in providing services to those individuals diagnosed with a serious mental illness, substance use disorder, or both. We provide services to children aged 3-17 and adults of any age. Our goal is to provide the highest quality services in a respectful and caring environment focused on the needs of each individual.

LIFEPATH SYSTEMS

OPPORTUNITY TO REGISTER TO VOTE

Name: ___________________________________ LCN: _________________ Date: ______________

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

   Yes No

2. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

3. IF YOU HAVE NOT CHECKED EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO VOTE AT THIS TIME AND WILL BE ASKED TO SIGN BELOW.

4. 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 form in private and put it in the mail yourself.

5. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Elections Division of the Secretary of State, P. O. Box 12060, Austin, Texas 78711, 1-800-252-8683.

6. If you decline to register to vote, this decision will remain confidential and be used only for voter registration purposes.

7. If you decide to register to vote, information regarding the office to which the application was submitted will remain confidential and be used only for voter identification purposes.

___________________________________ _______________ ___________________________________
Printed name of Individual/LAR Date Individual/LAR Signature

___________________________________ _______________ ___________________________________
Printed Name of Workforce Member/Title Date Workforce Member Signature

Declination of Voter Registration

___________________________________ _______________ ___________________________________
Printed name of Individual/LAR Date Individual/LAR Signature

___________________________________ _______________ ___________________________________
Printed Name of Workforce Member/Title Date Workforce Member Signature

Acknowledgement of Receipt

Name: ____________________________________ LCN: __________________ Date: ______________

By signing below, I verify that the following items have been explained to me, and materials containing information on the following items has been provided to me. I understand the information provided and have been given an opportunity to ask any questions I may have.

____ Consent for services

____ Treatment Agreement

____ Grievance Process

____ Privacy Practices

____ Client Handbook

____ Rights and Responsibilities

____ Confidentiality Statement

____ Individual Fee Agreement and Fee Schedule

____ Opportunity to Register to Vote

____ Provider Selection Form

____ Psychiatric Advance Directives

____________________________________	_______________	__________________________________
Printed name of Individual/LAR	Date	Individual/LAR Signature
____________________________________	_______________	__________________________________
Printed Name of Workforce Member/Title	Date	Workforce Member Signature

Individual Medical History

	Yes	No	Unsure	Comments (Year Diagnosed, etc)
Anemia				
Arthritis				
Asthma				
Cancer				
COPD				
Diabetes				
Glaucoma				
High Blood Pressure				
Heart Disease				
Hepatitis				
Hyperlipidemia				
HIV				
Kidney Disease				
Liver Disease				
Obesity				
Stroke				
Seizures				
Ulcers				
Other:				
Other:				
Other:				

History of Head Injury (With/Without loss of consciousness) ? Yes No

For Females

Number of Pregancies _________ Live Births: _____ Miscarriages: _____ Abortions: _____

Breast feeding (Currently) _____Yes _____No

Tubal Ligation _____Yes _____No
Hysterectomy _____Yes _____No
Birth Control _____Yes _____No

Individual Psychiatric History

	Yes	No	Unsure	Year
ADHD				
Alcoholism				
Anxiety				
Autism				
Bipolar				
Depression				
Dementia				
IDD				
Learning Disorder				
Panic Disorder				
Schizophrenia				
Substance Use				
Suicide Attempt				
Other				
Other				

Any Previous INPATIENT Psychiatric Hospitalizations? _____ Yes _____ No

Hosptial	Address/ City / State	Date Admitted

Any Previous OUTPATIENT Psychiatric Hospitalizations? _____ Yes _____ No

Hosptial	Address/ City / State	Date Admitted

Did you participate in any Medication Trials? _____ Yes _____ No

Medication Name	Date	Duration	Did it help?

L I F E P A T H
S Y S T E M S

Family Medical History

	Mother	Father	Sister	Brother	(M) Grand mother	(M) Grand father	(P) Grand mother	(P) Grand father	Uncle	Aunt	Cousin
Alive											
Deceased											
Current Age or Age at Death											
Alzheimers											
Anemia											
Arthritis											
Asthma											
Cancer											
COPD											
Diabetes											
Glaucoma											
High Blood Pressure											
Heart Disease											
Hepatitis											
Hyperlipidemia											
HIV											
Kidney Disease											
Liver Disease											
Obesity											
Stroke											
Seizures											
Ulcers											
Other:											
Other:											
Other:											
Other:											

LIFEPATH SYSTEMS

Family Psychiatric History

	Mother	Father	Sister	Brother	(M) Grand mother	(M) Grand father	(P) Grand mother	(P) Grand father	Uncle	Aunt	Cousin
ADHD											
Alcoholism											
Anxiety											
Autism											
Bipolar											
Depression											
Dementia											
IDD											
Learning Disorder											
Panic Disorder											
Schizophrenia											
Substance Use											
Suicide Attempt											
Suicide Completed											
Other:											
Other:											

Employment Survey

Please mark response.

Education/Training

I understand the educational and training opportunities available to me and I am able to access them	Agree	Agree Some what	Neutral	Some what disagree	Disagree

Personal Career Planning

I understand how to access services to assist me in career-related issues to gain employment	Agree	Agree Some what	Neutral	Some what disagree	Disagree

Employment Opportunities

I am able to identify and find employment opportunities consistent with my strengths, abilities, and preferences.	Agree	Agree Some what	Neutral	Some what disagree	Disagree

Support Employment and Work Practices

I understand my role at work and use job coaching and support at my work site.	Agree	Agree Some what	Neutral	Some what disagree	Disagree

Work history

I have worked consistently in the past and I am able to maintain employment.	Agree	Agree Some what	Neutral	Some what disagree	Disagree

Gainful Employment

I understand how employment income will affect benefits.	Agree	Agree Some what	Neutral	Some what disagree	Disagree
I have been successful in the interview process and I am able to get and maintain a job.	Agree	Agree Some what	Neutral	Some what disagree	Disagree

PHQ-9 for ADULTS
Patient Health Questionnaire

Name: ____ Date:________________________

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **MARK** to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

10. If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

____Not Difficult At All ____Somewhat Difficult ____Very Difficult ____Extremely Difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues

PHQ-9 for ADOLESCENTS
Modified Patient Health Questionnaire

Name:____ Date:________________

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **MARK** to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite, weight loss, or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues

Name:____LCN:_______________________ Date:_________________

Consent for Financial Responsibility

Please initial below:

Financial Responsibility

[Everyone must read and initial]

I understand that LifePath Systems as the Local Behavioral Health Authority is a Community Center that offers an extensive array of individualized services based on my clinical assessment as outlined in the Health and Human Service Commission (HHSC) - Texas Administrative Code (TAC) guidelines. All individuals seeking services with LifePath Systems participate in a financial assessment to determine a maximum monthly fee (MMF) for accessing services that may not be covered by your insurance. The MMF is based on your household income and the number of individuals in your family.

Financial Consent for Disclosure of Confidential Information

[Everyone must read and initial]

I authorize LifePath Systems to disclose to or receive from the named agencies, organizations, and person(s) any and all records, including alcohol/drug treatment and HIV status, if applicable, for the purpose of obtaining financial information, including verification of income, to establish charges for services provided; to determine benefits eligibility; and, to file/pursue insurance claims for services received by the individual named.

Assignment of Benefits (AOB)

[Everyone must read and initial]

In executing this assignment of benefits, I am directing the health insurance carrier to pay LifePath Systems directly for all services provided to me during the course of treatment. In consideration of center services rendered or to be rendered, I hereby irrevocably assign and transfer to LifePath Systems, all monies due, or to become due or payable to me under my insurance company, Medicaid, Medicare or other third party payer. I hereby appoint LifePath Systems as my authorized representative to pursue, if it so chooses, all administrative actions on my behalf against any responsible third party insurer for purposes of collecting any and all benefits due for the payment of charges. ***It has been explained to me, LifePath Systems is not in-network with most private insurance carriers and if I choose to receive care from this provider, I understand that I will be charged at a rate of 100% for all services.***

Services not covered by any insurance

[Anyone with insurance must read and initial]

I understand that under the Medicare, Medicaid, State/Federal government insurance or any other payer's guidelines, I may be limited to the number of visits for the same services. Therefore, any payments not covered or denied for exceeding yearly visit limitations per carrier guidelines will be my responsibility. Most private insurances are likely to deny payment for some mental health services, including but not limited to: case management, skills training, and psychosocial rehabilitation. For these services, I agree to be personally and fully responsible for payment up to my maximum monthly fee. I understand that I am responsible for costs associated with coinsurance, deductible, non-covered benefits due to policy limits or policy exclusion as well as failure to comply w/my insurance plan requirements. I understand that even under the State/Federal government insurance program I may be subject to co-payments based on income guidelines set by the governing authority.

Notification to Medicare Beneficiaries of Liability for Non-covered Services

[Anyone w/Medicare must read and initial]

Medicare will only pay for services that it determines to be reasonable and medically necessary under Section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable or necessary" under Medicare program standards, or a service is not a covered benefit of the Medicare program, than Medicare will deny payment for that service. Medicare is likely to deny payment for case management services, some physician, therapy, counseling, and ancillary services for the reasons expressed above. ***I have been notified by LifePath Systems that Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment, based upon my ability to pay.***

I choose not to provide financial information. I understand that I will be charged at a rate of 100%.

Name:____LCN:________________________ Date:_________________

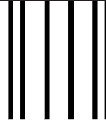
The information on this financial statement is true and correct to the best of my knowledge.

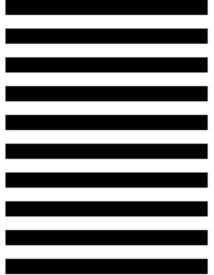
* I will inform staff of any changes in my income or household during my services.
* I will inform staff of any changes to my insurance information in a timely manner; any non-reimbursed services due to failure to update insurance status will become my financial responsibility.
* I have received a copy of the Fee Schedule & my Financial Statement, with my maximum monthly fee listed.
* I have received a copy of Assignment of Benefits, Notice of Privacy Practices, HIPAA Acknowledgement & Voter's registration guidelines.
* I understand that I may choose to pay more than my maximum monthly fee.
* I acknowledge that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned.

Printed Name of Individual	Date	Individual Signature
Name of LAR/Responsible Party & Relationship to Individual	Date	LAR / Responsible Party Signature
Staff's Name / Title	Date	Staff's Signature

***<u>Verbal Consent obtained due to COVID-19</u>**

Fold on line and seal before mailing





BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 4511 AUSTIN, TX

POSTAGE WILL BE PAID BY ADDRESSEE

SECRETARY OF STATE
ELECTIONS DIVISION
PO BOX 12887
AUSTIN TX 78711-9972

Fold on line and seal before mailing

Qualifications

- You must register to vote in the county in which you reside.
- You must be a citizen of the United States.
- You must be at least 17 years and 10 months old to register, and you must be 18 years of age by Election Day.
- You must not be finally convicted of a felony, or if you are a felon, you must have completed all of your punishment, including any term of incarceration, parole, supervision, period of probation, or you must have received a pardon.
- You must not have been determined by a final judgment of a court exercising probate jurisdiction to be totally mentally incapacitated or partially mentally incapacitated without the right to vote.

Filling out the Application

- Review the application carefully, fill it out, sign and date it and mail it to the voter registrar in your county or drop it by the Voter Registrar's office.
- All voters who register to vote in Texas must provide a Texas driver's license number or personal identification number issued by the Texas Department of Public Safety. If you don't have such a number, simply provide the last four digits of your social security number. If you don't have a social security number, you need to state that fact.
- Your voter registration will become effective 30 days after it is received or on your 18th birthday, whichever is later. Your registration must be effective on or before an election day in order to vote in that election.
- If you move to another county, you must re-register in the county of your new residence.

Please visit the Texas Secretary of State website, **www.sos.state.tx.us**, and for additional election information visit **www.votexas.org.**

Este formulario está disponible en español. Favor de llamar a su registrador de votantes local para conseguir una versión en español.

Texas Voter Registration Application

Prescribed by the Office of the Secretary of State VR30.2011E.I3

For Official Use Only

Please complete sections by printing LEGIBLY. If you have any questions about how to fill out this application, please call your local voter registrar.

1 These Questions Must Be Completed Before Proceeding

Check one

☐ New Application ☐ Change of Address, Name, or Other Information ☐ Request for a Replacement Card

Are you a United States Citizen?	☐ Yes	☐ No
Will you be 18 years of age on or before election day?	☐ Yes	☐ No

If you checked 'No' in response to either of the above, do not complete this form.

Are you interested in serving as an election worker?	☐ Yes	☐ No

2 **Last Name** Include Suffix if any (Jr, Sr, III)	**First Name**	**Middle Name** (If any)	**Former Name** (if any)

3 **Residence Address:** Street Address and Apartment Number. If none, describe where you live. (Do not include P.O. Box, Rural Rt. or Business Address)	**City**	**TEXAS**
	County	**Zip Code**

4 **Mailing Address:** Street Address and Apartment Number. (If mail cannot be delivered to your residence address.)	**City**	**State**
		Zip Code

5 **Date of Birth: (mm/dd/yyyy)**	6 **Gender** (Optional)	7 **Telephone Number** (Optional) Include Area Code
☐☐/☐☐/☐☐☐☐	☐ Male ☐ Female	(☐☐☐)☐☐☐–☐☐☐☐

8 **Texas Driver's License No. or Texas Personal I.D. No.** (Issued by the Department of Public Safety)

☐☐☐☐☐☐☐☐

If no Texas Driver's License or Personal Identification, give last 4 digits of your Social Security Number

XXX-XX- ☐☐☐☐

☐ **I have not been issued a Texas Driver's License/Personal Identification Number or Social Security Number.**

9 **I understand that giving false information to procure a voter registration is perjury, and a crime under state and federal law. Conviction of this crime may result in imprisonment up to 180 days, a fine up to $2,000, or both. Please read all three statements to affirm before signing.**

- **I am a resident of this county and a U.S. citizen;**
- **I have not been finally convicted of a felony, or if a felon, I have completed all of my punishment including any term of incarceration, parole, supervision, period of probation, or I have been pardoned; and**
- **I have not been determined by a final judgment of a court exercising probate jurisdiction to be totally mentally incapacitated or partially mentally incapacitated without the right to vote.**

X ______________________ **Date** ___/___/___

Signature of Applicant or Agent and Relationship to Applicant or Printed Name of Applicant if Signed by Witness and Date.