KINGS VIEW

Message to Consumers:

Please be advised that this packet is intended to guide you during your over-the-phone screening and assessment with Kings View staff.

There is no need to fill this packet out as it will be for your reference only.

Please call: (559) 582-4481

Please note the days and time for phone screenings below:

Monday 8:00am – 2:00pm

Wednesday 8:00am – 2:00pm

Thursday 8:00am – 2:00pm

Friday 8:00am – 2:00pm

For an Online Version of the Consumer Packet please visit our website at: https://www.kingsview.org/services/mental-health/

KINGS COUNTY
Distribution of Mental Health Plan (MHP) Informing Materials

Name of Client: _____ **EHR #:** _____

DOB: _____ **Date:** _____

Beneficiary Preferred Language: _____

Were Materials given/offered in the beneficiary preferred language: _____

Material must be given/offered in preferred language. Where material is not available in preferred language, use on-site interpreter or your entities interpretation services such as Language Line to interpret.

Initial upon distribution of or offer of each		**Informing Materials Provided**
Staff Initial	**Client Initial**	
*The following materials are **given at intake to all individuals**.*		
		Notice of Privacy Practices - Tells you how Kings County Behavioral Health and its Providers/Contractors may use or disclose information about your physical and/or mental health. The county is required by federal law to give you this notice.
		Beneficiary Rights - Provides you with information of your right to receive medically necessary specialty mental health services from the MHP.
		Consent to Treat - Outlines the expectations regarding the treatment you may receive. It also explains that the risks, benefits, and alternatives to treatment have been explained to you.
		Taglines and Auxiliary Aides - Assists you in identifying the language that you may need services provided in by way of either on-site bilingual or interpreter services, telephonic interpreter services via a language line, or through an auxiliary aid.
		Non- Discrimination Notice - Informs you that Kings County MHP follows the federal civil rights law, and provides information on how you can file a complaint if you believe you've been discriminated against.
		Grievance and Appeal Form and Procedure - Helps you file a complaint about your services if you need to at some point. The procedure tells you how to file the complaint.
*The following materials are **given at intake to all individuals accessing child/youth services**.*		
		Early & Periodic Screening Diagnosis Treatment (EPSDT) Mental Health Services - Explains the Medi-Cal EPSDT services for children and young adults and their caregivers or guardians.
		Therapeutic Behavioral Services (TBS) Information Brochure – Summarizes TBS services that are available to children/youth with serious emotional challenges who may need a supplemental service to their to their mental health services.
		Foster Child Mental Health Bill of Rights - Provides information to the foster child/youth of their rights to receive mental health services.

Refer to page 2 for continued list of required materials

*The following materials are **offered to all individuals at intake**, and given upon request. A copy of each must also be maintained in the lobby for public use.*		
		Kings County Behavioral Health MHP "Guide to Medi-Cal Mental Health Services" - Contains information eligibility for specialty mental health services through Medi-Cal, as well as how to access those services, what services are available, what your rights and responsibilities are, and how to file a grievance, appeal, or file for a state fair hearing. *This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
		Medi-Cal Beneficiary Handbook – Kings County – Explains your Medi-Cal specialty mental health services benefits, can answer many of your questions related to services, and contains important phone numbers and information related to Kings County MHP. *This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
		MHP Provider List – Kings County – Contains a list of licensed, registered, and waivered clinical providers who are employed by or contracted by the MHP to provide mental health services through Medi-Cal for Kings County residents who meet medical necessity. *This document is over 20 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
*The following materials are **offered to all 18 years of age and older, at intake**, and given upon request.*		
		Advance Health Care Directive Brochure - Explains your right to make decisions about your medical treatment. It includes how to appoint a person who can make health care decisions for you when you are unable (Health Care Agent), and how to change your directive at any time.
		Do you already have an Advance Health Care Directive or a Durable Power of Attorney for Health Care? Yes No
		If yes, will you provide a copy for our medical record? Yes No

Staff Signature upon Completion:_____ **Date:** _____

Beneficiary Signature upon Completion: _____ **Date:** _____

Instructions:

1. Give client a copy
2. Scan original into the EHR under attachments (title "Informing Materials")
3. Once scanned, this may be shredded

INDEX CARD - ALL CAPS

Client #:

Sort Name:

Last, First Middle

Legal Name:

*Last Name: | *First Name:

Middle: | Suffix:

*DOB: | Soc Sec #:

CLIENT IDENTIFYING INFORMATION - use sentence case

Effective Date: | Admission Status: ❍ Admit ❍ Pre-Register

*(6) Referral Source: Circle One | Referral Phone:

(1) Self
(2) Family
(3) Friends
(4) Employer
(5) Other
(9) Psych Hospital
(11) Hospital
(13) Jail
(21) Homeless Program
(24) Convalescent Hospital / SNF
(25) DSS
(26) Probation
(27) Outside AOD
(28) Primary Care Provider
(29) School/College
(33) MHSA
(34) CALWORKS
(41) CPS
(42) Parole
(99) Unknown/Not Reported

*Birth Name (if different from above):

Last Name: | First Name:

Middle: | Suffix:

*Physical Address: | Apt. #:

*City/State/Zip: | *(21) County:

*Home Phone: | Work Phone: | Ext.

Cell Phone:

*Mailing Address: | Apt. #:

*City/State/Zip:

*Driver's License: ❍Yes ❍No | DL No.: | State:

*Social Security #: (If SSN not entered above) | (8) Reason SSN Not Provided: (*If SSN blank)

*(7) Gender: Circle One
(F) Female (M) Male (O) Other (T) Transgender

*Is DOB: ❍ Actual? ❍ Estimated?

Born in US: ❍ Yes ❍ No

Born in California: ❍ Yes ❍ No

Place of Birth: | *(21) County: | *(22) State: | (23) Country:

*Mother's First Name

*(9) Marital Status: Circle One
(D) Divorced/Annulled (M) Married (N) Never Married (P) Domestic Partner (S) Separated (W) Widowed (U) Unknown

*(10) Ethnicity: Circle One
(1) Not Hispanic
(2) Mexican / Mexican American
(3) Cuban
(4) Puerto Rican
(5) Other Hispanic / Latino
(7) Unknown / Not Reported

*(11) Race: Circle One

(3) Mien	(F) Filipino	(N) Native American	(V) Vietnamese
(4) Other Pacific Islander	(G) Guamanian	(O) non-White – Other	(W) White
(A) Asian – Other	(H) Hawaiian Native	(P) Laotian	(Y) Hmong
(B) Black / African American	(I) Cambodian	(Q) SE Asian – Other	(U) Unknown / Not Reported
(C) Chinese	(J) Japanese	(R) Samoan	
(D) Asian Indian	(K) Korean	(T) Eskimo / Alaskan Native	

*(12) Primary Language: Circle One

(1) American Sign	(C) Chinese Dialect	(K) Korean	(S) Spanish
(2) Other Sign	(D) Cambodian	(L) Lao	(T) Turkish
(3) Samoan	(E) English	(M) Mien	(V) Vietnamese
(4) Other Chinese	(F) French	(N) Thai	(W) Filipino Dialect
(5) Tagalog	(G) Cantonese	(O) Other non-English	(X) Hmong
(6) Mandarin	(H) Hebrew	(P) Polish	(Y) Ilocano
(A) Armenian	(I) Italian	(Q) Farsai	(Z) Portuguese
(B) Arabic	(J) Japanese	(R) Russian	(U) Unknown / Not Reported

*(13) Communication Method: Circle One

(C) Communication Device	(S) Sign Language	(V) Verbal
(H) Translator – Hmong	(T) Translator – Spanish	(X) Translator - Other

*(12) Language Preferred (Individual): Indicate Code (from prim lang above) _____

**(12) Language Preferred (Caretaker): Indicate Code (from prim lang above) _____

*Interpreter Needed? ❍ Yes ❍ No

*(14) Employment Status: Circle One

(1) Comp Job 35+ hours/week	(8) Full Time Student	(F) Not in labor Force
(2) Comp Job <20 hours/week/	(9) Job Training	(H) Resident / Inmate
(3) Comp Job 20-35 hours/week	(A) PT School / Job Training	(I) Non-Comp Job 35+ hours/week
(4) Homemaker	(B) Volunteer	(J) non-Comp Job < 35 hours/week
(5) Rehab 35+ hours/week	(C) Unemployed, seeking work	(K) Other
(6) Rehab < 20 hours/week	(D) Unemployed, not seeking work	(U) Unknown / Not Reported
(7) Rehab 20-35 hours per week	(E) Retired	

*(15) Living Arrangement: Circle One

(01) Family	(13) House or Apt w/ Supervision	(25) Temporary Assignment
(02) Alone	(14) Supported Housing	(26) Homeless – In transit
(03) Foster Home – Child	(15) Residential Treatment Center	(27) SNF / ICF / IMD for psych
(04) SRO – hotel, motel, rooming house	(16) Comm. Treatment Facility	(28) Medical Facility – Hospital
(05) GP Quarters – dorm, brks, mig camp	(17) Adult Residential / Social Rehab	(29) Correctional Facility – Adult
(06) Group Home	(18) State Hospital	(30) Correctional Facility – Minor
(07) CRTS L/T trn house	(19) VA Hospital	(31) Homeless – no county res
(08) Satellite Housing	(20) SNF / ICF / NH Physical Health	(32) Other Institution
(09)Alt Hospital 6 beds or less	(21) MH Rehab Center	(33) Friend / Other
(10) Alt Hospital 7 beds or more	(22) PHF / Inpatient Psychiatric	(34) Board & Care
(11)House or Apartment	(23) Sober Living	(99) Other
(12) House or Apt w/ Support	(24) Specialty Transitional	(98) Unknown / Not Reported

*Number of Children under age 18 the client cares for/responsible for 50% or more of the time?

*Number of Dependents age 18 or older the client cares for/responsible for 50% or more of the time?

*(16) Education (highest grade completed): | Special Education: ❍Yes ❍No

District of Residence:

*(18) Disability: Circle One

(D) Developmentally Disabled	(H) Hearing	(O) Other Disability (not AOD)	(V) Vision
(E) Mental Health	(M) Mobility	(S) Speech	(N) None

*Veteran: ❍ Yes ❍ No | Branch:

Alias(es)/Maiden Name			
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:

EMERGENCY NOTIFICATION INFORMATION		
	*Name:	*(17) Relationship: See page 4
	Address:	Home Phone:
	City/State/Zip:	Work Phone:
	Employment Place:	
LEGAL INFORMATION		
	*(24) Legal Consent: See page 4	
	**Responsible Person:	**(17) Relationship: See page 4
	Address:	Phone:
	City/State/Zip:	
	Employment Phone:	Employment Place:
	Responsible Party SSN:	

MEDICAL INFORMATION - okay to skip			
	Personal Physician:	Phone:	FAX:
	Address:		
	City/State/Zip:		
	Pharmacy:	Phone:	FAX:
	Hospital Preference:		

ADVANCE DIRECTIVE INFORMATION
Advance Directive Given? ❍ Yes ❍ No

CLIENT CONTACT INFORMATION
May we leave message at home? ❍ Yes ❍ No
May we leave message at work? ❍ Yes ❍ No
May we leave message via emergency contact? ❍ Yes ❍ No
May we leave message on your cell? ❍ Yes ❍ No
May we contact you by mail? ❍ Yes ❍ No
NPP Given? ❍Yes ❍No Form Signed Date:
BHA – Consent Form: ❍Yes ❍No Form Signed Date: Obtained By (Agency Name): _____
If we cannot contact you by mail, then what is an alternative address or method of contact to send you clinical information such as letters and billing information? _____

Signature of Staff Obtaining Information: who filled out the form								
						❍Yes	❍No	❍N/A
*Staff ID	*Staff Name		*Date		*Time			
Signature of Staff Entering Information (If Different from Above):								
						❍Yes	❍No	❍N/A
*Staff ID	Staff Name*		*Date		*Time			
*Key: *=Required Field **=Required if the 'Legal Status' selection is Adult with Guardian or Minor with Guardian*								

(17) Relationship Types

ID	Description
A	Aunt/Uncle
B	Father
C	Child
D	Guardian
E	Spouse
F	Foster Parent
G	Grandparent
H	Cousin
I	Caretaker
J	Sibling
L	Nephew/Niece
M	Mother
N	Friend
O	Other Relation
P	Self
Q	Legal Representative
S	Stepparent
X	Domestic Partner
R	Unknown / Not Reported

(24) Legal Consent
(CSI – Conservatorship/Court Status)

ID	Description
9	Not Applicable
A	Temporary Conservatorship
B	Lanterman–Petris-Short
C	Murphy
D	Probate
E	PC 2974
F	Representative Payee w/out Conservatorship
G	Juvenile Crt0 Dependent of Crt
H	Juvenile Crt, Ward Status Off
I	Juvenile Crt, Ward Juv Off
0	Unknown / Not Reported

KINGS VIEW

PRESCRIPTION DRUGS:

Please list prescriptions taken in last six (6) months (Check here if NONE) ☐

Drug-RX No., Name, Strength	Directions

Have you ever taken someone else's prescription medicine? ☐ No
☐ Yes. If yes, give the name of the drug and reason it was taken
_____.

Have you ever taken any drug that made you sick? ☐ Yes ☐ No.
If yes, explain _____.

Have you ever had side effects or undesirable effects from drugs you have taken? ☐ Yes ☐ No
Specify _____.

NON-PRESCRIPTION DRUGS (Over The Counter):

Fill in the name of the drug(s) taken for following. Check the box which best describes frequency.

Problem	*Name of Drug*	Regular	Seldom	Never	Problem	*Name of Drug*	Regular	Seldom	Never
FOR COLDS & COUGHS					FOR INDIGESTION				
FOR ASTHMA					FOR SLEEP				
FOR CONSTIPATION					FOR SKIN PROBLEMS				
FOR DIARRHEA					FOR DIETING				
FOR HEADACHE/PAIN					FOR STAYING AWAKE				
FOR NERVOUSNESS/TENSION					VITAMINS/SUPPLEMENTS				
OTHER					HERBAL/HOMEOPATHIC				

ALLERGIES:

Are you allergic to:	No	Yes	*If yes, name the specific substance(s) and describe reaction*
ANY DRUG?			
ANY FOOD?			
ANYTHING ELSE?			

HAVE YOU EVER HAD ☐ HAY FEVER ☐ ASTHMA ☐ HIVES ☐ ECZEMA?
DOES ANY MEMBER OF YOUR FAMILY HAVE ALLERGIES? ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER

DRINKING HABITS:

DO YOU DRINK	No	Yes	Regular	Seldom	HOW MUCH?
COFFEE					
TEA					
COKE/PEPSI					
BEER					
WINE					
LIQUOR					

ARE YOU ON A SPECIAL DIET?

☐ No ☐ Yes IF YES, DESCRIBE

SOCIAL/RECREATIONAL HABITS:

DO YOU, OR HAVE YOU EVER?	No	Yes	IF YES, IDENTIFY SPECIFIC SUBSTANCE, QUANTITY & FREQUENCY
SMOKED CIGARETTES			
Smoked Marijuana			
Taken Hallucinojens: PCP or LSD			
Taken Downers: Sleepers or Valium			
Taken Uppers: Amphetamines, cocaine, meth, crank			
Taken Narcotics: Heroin, Codeine, Oxycodone, Vicodin			
Do you have reactions to any medications?			

Signature of Consumer: _____ *Date* _____
(Parent or Guardian Signature if Consumer is a child or youth)

LAST NAME:	FIRST NAME:	CHART NO.

DRUG AND ALLERGY HISTORY

NOTICE OF PRIVACY PRACTICES

The County creates records of health care to provide quality care and comply with legal requirements. The County understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires the County to keep your health information private and to provide you this notice of our legal duties and privacy practices. The law also requires the County to follow the terms of this notice. This notice outlines the limits on how the County will handle your health information. Under federal law, the County must provide a copy of this notice when you receive health care and related services from the County, or participate in certain health plans administered or operated by the County. The County reserves the right to change practices and make new provisions effective for all health information it maintains. You may request an updated copy of this notice at any time.

Use and Disclosure – General

Generally, except as otherwise specified below, the County may use and disclose the following health information, as allowed by state and federal law:

For treatment

The County uses and discloses health information to provide you health care and related services. For instance:

- Nurses, doctors, or other County employees may record your health information, and they may share such information with other County employees.

- The County may disclose health information to people outside the County involved in your care who provide treatment and related services.

- The County may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.

For payment

The County may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.

For health care operations

The County may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.

For health plan administration

As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, the County may disclose limited information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

Use and Disclosure Requiring Your Authorization

On a limited basis, the County may use and disclose health information only with your permission, as required by state and federal law:

- From mental health records.

- From substance abuse treatment records.

Use and Disclosure Requiring an Opportunity for You to Agree or Object

In certain cases, the County may use and disclose health information only if it informs you in advance and provides an opportunity to agree or object, as required by state and federal law:

- The County may include your name, location in the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.

- To individuals assisting with your treatment or payment.
- To assist with disaster relief to notify your family about you.

NOTICE OF PRIVACY PRACTICES

If you have comments, questions or would like
additional information regarding this notice
or the privacy practices of

KINGS COUNTY BEHAVIORAL HEALTH,

Please contact:

Dr. Lisa Lewis, PhD, Director
460 Kings County Drive, Suite 101
Hanford, CA 93230
(559) 852-2376

Patients' Rights Advocate Line

1-866-701-5464
www.kcbh.org/patients-rights-advocacy

Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object

In specific cases, the County may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

As required by law.

For public health activities, which may include the following:

- Preventing or controlling disease, injury or disability;
- Reporting births and deaths;
- Reporting abuse or neglect of children, elders and dependent adults;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may use; or,
- Notifying a person exposed to or at risk to contract or spread a disease or condition.

For mandated reporting of abuse, neglect or domestic violence.

For health oversight activities necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.

To law enforcement

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; or,
- In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.

To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.

For organ donation once you are deceased.

For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.

To avert serious threats to the health and safety of you or others.

Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.

To determine your eligibility for or entitlement to veterans benefits.

To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.

To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.

To determine your eligibility for or enroll you in government health programs.

For Workers Compensation or similar programs, to the minimum extent necessary.
The County will not disclose your health information for marketing fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, the County will no longer use or disclose health information about you for the reasons you permitted. You understand the County is unable to retract disclosures already made with your permission, and must retain records of care already provided.

Rights and Responsibilities

With regard to health information, the County recognizes and commits to safeguard your:

Right to request restrictions on certain use and disclosure

You have the right to request restriction or limitation on the health information the County uses or discloses for treatment, payment or health care operations, though the law does not require the County to agree to your request. If the County agrees, it will comply except to provide emergency treatment. Requests must be in writing and state: the information you want to limit; whether to limit use, disclosure, or both; and, to whom limits apply. For instance, you may ask not to disclose to your spouse.

Right to confidential communications

You have the right to ask the County to communicate with you in a certain way, or at a certain location.

Right to inspect and copy records

You have the right to inspect and obtain copies of your health information. Requests must be in writing, and the County may charge you a fee for the costs of fulfilling your request. The County may deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another health care professional chosen by the County. The County will comply with the results of that review.

Right to amend health records

If information the County has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. The County may deny your request if it is not in writing, or does not include a reason supporting it. The County may deny requests if the information:

- Was not created by the County;
- Is not health information kept by or for the County;
- Is not information you are permitted to inspect and copy; or,
- Is accurate and complete.

Right to an accounting of certain disclosures

You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. The County may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.

Right to obtain a paper copy of the notice of privacy practices upon request

Right to file complaints without Fear of retaliation

Under law, the County cannot penalize you for filing a complaint. If you believe the County violated your privacy rights, you may file a complaint with the department privacy officer, County privacy office, or with the U.S. Secretary of Health and Human Services.

KINGS COUNTY behavioral health kcbh.org

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

KINGS COUNTY BEHAVIORAL HEALTH ADMINISTRATION

CONSENT TO TREATMENT (ADULT)

In order for us to provide you with mental health services, we must have your informed consent for treatment.

The laws of California have been established to protect the privilege of confidentiality between a counselor, and a patient and Kings County Behavioral Health protects the privilege of confidentiality which belongs solely to the patient. Signing this form does not constitute a waiver of any psychotherapist-patient privilege. It is only under certain very special circumstances that this privilege of confidentiality does not exist.

1. We are required by law to report any incident of child abuse (past or present); elder abuse or dependent adult abuse.
2. The law mandates that we notify others in cases where there is a threat of harm to self or others.
3. If we assess someone to be acutely suicidal, violent or homicidal, or unable to care for him/herself, we may notify appropriate authorities to arrange for hospitalization.
4. Our records may be subpoenaed by a court of law.
5. A court ordered psychological evaluation may be justified in the request for records.
6. A breach of a court order (e.g. a "no contact order", from a Temporary Restraining Order or a Violation of Custody Agreement) may justify a request for records.
7. There may be other circumstances in which a court may decide that the privilege does not exist.

We also want to inform you that your mental health record will be maintained at Kings County Behavioral Health. Our record keeping system, which include computerized statistical, billing and treatment information, is designed to protect your personal rights and insure confidentiality. However, in the process of providing you with services, there are a limited number of individuals who will have access to your records, including other County-funded mental health service providers who are or become directly involved in your treatment. In order to provide you with services which are necessary to accomplish the purpose for which you have consulted Kings County Behavioral Health, your case may be discussed with other counselors for supervision or consultation purposes. Other counselors consulted will maintain the confidentiality of privileged information provided by you. Clinic data, without client's identifying information may be analyzed as part of ongoing quality assurance and research.

I _____, have read the above informed consent information and understand it.

(Name of Client)

I hereby give my consent for treatment and acknowledge the maintenance of my records at Kings County Behavioral Health.

_____ _____ _____ _____

Signature of Client or Conservator Date Signature of Witness Date

Patient was not able to give informed consent at this time; there is no known LPS Conservator.

_____ _____ _____ _____

Therapist Signature Date Signature of Witness Date

CC: Consumer

KINGS COUNTY behavioral health kcbh.org

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

KINGS COUNTY BEHAVIORAL HEALTH ADMINISTRATION

CONSENT TO TREATMENT FOR A MINOR

In order for us to provide this minor with mental health services, we must have your informed consent for treatment of this minor.

The laws of California have been established to protect the privilege of confidentiality between a counselor, and a patient and Kings County Behavioral Health protects the privilege of confidentiality which belongs solely to the patient. Signing this form does not constitute a waiver of any psychotherapist-patient privilege. It is only under certain very special circumstances that this privilege of confidentiality does not exist.

1. We are required by law to report any incident of child abuse (past or present); elder abuse or dependent adult abuse.
2. The law mandates that we notify others in cases where there is a threat of harm to self or others.
3. If we assess someone to be acutely suicidal, violent or homicidal, or unable to care for him/herself, we may notify appropriate authorities to arrange for hospitalization.
4. Our records may be subpoenaed by a court of law.
5. A court ordered psychological evaluation may be justified in the request for records.
6. A breach of a court order (e.g. a "no contact order", from a Temporary Restraining Order or a Violation of Custody Agreement) may justify a request for records.
7. There may be other circumstances in which a court may decide that the privilege does not exist.

We also want to inform you that the minor's mental health record will be maintained at Kings County Behavioral Health. Our record keeping system, which include computerized statistical, billing and treatment information, is designed to protect the minor's personal rights and insure confidentiality. However, in the process of providing the minor with services, there are a limited number of individuals who will have access to the minor's records, including other County-funded mental health service providers who are or become directly involved in the minor's treatment. In order to provide the minor with services which are necessary to accomplish the purpose for which you have consulted Kings County Behavioral Health, the minor's case may be discussed with other counselors for supervision or consultation purposes. Other counselors consulted will maintain the confidentiality of privileged information provided by you. Clinic data, without client's identifying information may be analyzed as part of ongoing quality assurance and research.

I _____, as _____ to _____

Name | Relationship to Minor | Name of Minor

(who is _____years of age), have read the above informed consent information and understand it. I hereby give my consent for treatment of the minor by Kings County Behavioral Health and acknowledge the maintenance of the minor's records at Kings County Behavioral Health.

_____	_____	_____	_____
Parent, Guardian, Conservator or Patient (If 12 to 18 years of age)	Date	Signature of Witness	Date
_____	_____	_____	_____
Other Parent Signature	Date	Signature of Witness	Date

CC: Consumer

Advance Health Care Directives

What is an Advance Directive?

An Advance Health Care Directive is a legal document that enables people to make their wishes known even when they are incapacitated and unable to communicate. You can use an Advance Directive to spell out your wishes regarding physical and mental health care.

In California, an Advance Directive is made up of two parts: (1) Appointment of an Agent for health care; and (2) Individual Health Care Instructions. Either part is legally binding by itself.

What is a healthcare Agent?

A Healthcare Agent is a person you appoint in your Advance Directive to make health care decisions for you should you lose the ability to make these decisions for yourself. You do not have to appoint an Agent in order to complete an Advance Directive.

What are Individual Health Care Instructions?

Individual Health Care Instructions are verbal or written directions about health care. These can cover both physical and mental health treatment. You can let your health care provider know what you want done and under what circumstances.

What are the benefits from completing an Advance Directive?

Completing an Advance Directive can improve communication between you and your doctor. Completing and filing an Advance Directive is a good way to open a discussion with your health care providers about treatment plans and the full range of choices in treatment.

Completing an Advance Directive creates an opportunity for you to discuss your wishes in detail with family and/or friends. This may help your family and/or your friends advocate more effectively for you if you are ever found to lack the capacity to make health care decisions for yourself.

An Advance Directive can empower you to make your treatment choices known in the event you need health care and are found to be incapable of making health care decisions.

An advance Directive may prevent forced treatment and may reduce the need for long hospital stays.

Who can fill out an Advance Directive?

Any person 18 years or older who has the "capacity" to make health care decisions may fill out an Advance Directive. "Capacity" in this situation means the person understands the nature and consequences of the proposed health care, including the possible risks and benefits, and is able to make and communicate decisions about that health care. Legally a person is assumed to be competent unless proven otherwise.

When does an Advance Directive go into effect?

An Advance Directive goes into effect when your primary physician decides that you lack the capacity to make health care decisions. The fact that you have been admitted to a mental health facility does not, in itself, mean that you lack capacity to make health care decisions.

The Advance Directive is no longer in effect as soon as you regain the capacity to make health care decisions.

Does a health care provider have to follow an Advance Directive?

In general, the law is clear that health care providers must follow your Individual Health Care Instructions, as well as the decisions made on your behalf by a Health Care Agent.

Who can help if an Advance Directive is ignored/not followed?

If a health care provider refuses to follow your Individual Health Care Instructions, or refuses to comply with the decisions of your Agent, contact the County's Patients' Rights Advocate at 1-866-701-5464 and/or Protection & Advocacy, Inc. at 1-800-776-5746. The County Patients' Rights Advocate and PAI can work with you and/or your Agent to make sure that the Advance Directive is followed.

Kings View Counseling Services for Kings County

Hanford Clinic	Avenal Clinic	Corcoran Clinic
1393 Bailey Drive	228 E. Kings St.	1002 Dairy Ave.
Hanford, CA 93230	Avenal, CA 93204	Corcoran, CA 93212
559-582-4481	559-386-2295	559-992-2833

ABOUT YOUR FEE

The amount of money you will be charged for our professional services is based on your ability to pay. We call this amount your yearly deductible, or your UMDAP amount. To figure the amount you will be charged, we use the California Department of Mental Health's schedule called "Uniform Method of Determining Ability to Pay" (UMDAP), which is required by all community mental health centers.

Your YEARLY DEDUCTIBLE (UMDAP) is: $ _____

This means the most you will be charged from _____ to _____ is $ _____.

You may only come for professional services for a short time, but you will be responsible for the charges for any services you receive up to your yearly deductible amount shown above. If your treatment ends before you have used up the deductible, you will only be responsible for the charges for services you received. You can take up to the full UMDAP year to pay your deductible provided you make a payment **every month.**

Based on your income, your MONTHLY PAYMENT will be: $ _____.

You are expected to pay at least this amount every month until your deductible has been paid for the year. If your financial information changes, please notify us. You may call 582-4481 if you have any questions about your bill.

I understand I am expected to pay the amount shown above each month and to notify Kings View if my financial information changes.

_____	_____	_____	_____
Signature of Client	Date	Agent for Mental Health	Date

ABOUT YOUR FREEDOM OF CHOICE

Your acceptance and participation in our Mental Health Service is voluntary and shall not be required for access to other health care services.

In receiving our services, you retain a free choice of providers of other covered services of the Medi-Cal program; you are not limited to service providers of the Short – Doyle system (i.e., you may choose to receive services from any provider of choice, such as a private psychiatrist).

You have the right to request a change of a Mental Health provider, staff person, therapist and/or case manager. I have been informed and acknowledge receipt of a copy of this document, "About Your Freedom of Choice".

I have received a copy of the Confidentiality Statement. ☐ Yes ☐ No

_____	_____	_____	_____
Signature of Client	Date	Agent for Mental Health	Date

MENTAL HEALTH PATIENTS' RIGHTS

MOSAIC FOREST — Alice Washington, 2004

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.

YOU HAVE THE RIGHT:

- To dignity, privacy and humane care
- To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect
- To receive information about your treatment and to participate in planning your treatment
- To consent or refuse to consent to treatment, unless there is a legally- defined emergency or a legal determination of incapacity
- To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities
- To treatment services which increase your ability to be more independent
- To prompt medical care and treatment
- To services and information in a language you can understand and that is sensitive to cultural diversity and special needs
- To keep and use your own personal possessions including toilet articles
- To have access to individual storage space for your private use
- To keep and spend a reasonable sum of your own money for small purchases
- To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you
- To have access to letter-writing material and stamps—to mail and to receive unopened correspondence
- To social interaction, participation in community activities, physical exercise and recreational opportunities
- To see visitors every day
- To wear your own clothes
- To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services
- To religious freedom and practice
- To participate in appropriate programs of publicly supported education
- To be free from hazardous procedures
- And all other rights as provided by law or regulation

FOR MORE INFORMATION, CONTACT YOUR

LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE:

Kings County Patient Rights Advocate
BHPRA@co.kings.ca.us
(559) 852-2423

California Office of Patients' Rights
1831 K Street, Sacramento, CA 95811-4114
(916) 504-5810, http://www.disabilityrightsca.org/

Department of Health Care Services
Mental Health Services Division Ombudsman
(800) 896-4042 or Email: mhombudsman@dhcs.ca.gov

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-xxx-xxx-xxxx]* (TTY: *[1-xxx-xxx-xxxx]*).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call *[1-559-852-2444]* (TTY: *711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-559-852-2444]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-559-852-2444]* (TTY: *[711]*).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-559-852-2444]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-559-852-2444]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-559-852-2444]* (TTY: *[711]*)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք [*1-559-852-2444*] (TTY (հեռատիպ)՝ *[TTY 711]*).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-559-852-2444]* (телетайп: *[TTY: 711]*).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. ب (*1-559-852-2444]* (TTY: *711]*) تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-559-852-2444]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-559-852-2444]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। *[1-559-852-2444]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *[1-559-852-2444]*

(*TTY: 711* (رقم هاتف الصم والبكم: -

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-559-852-2444]* (TTY: *[711]*) पर कॉल करें।

Call your MHP at [559-852-2444]
~~[Kings County Behavioral Health] is here [M-F and 8AM- 5PM]. The call is free.~~

Or visit online at [http://www.kcbh.org/].

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-559-852-2444]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមនន កភាសា រោយមិនគិក្ខ ល្ហន គឺអាចមានសំរា ់ ំរ អុើ នក។ ចូ ទូ សព្ទ *[1-559-852-2444]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-559-852-2444]* (TTY: *[711]*).

Call your MHP at [559-852-2444]
~~[Kings County Behavioral Health] is here [M-F and 8AM- 5PM]. The call is free.~~

Or visit online at [http://www.kcbh.org/].

NONDISCRIMINATION NOTICE

Discrimination is against the law. *Kings County Behavioral Health* follows Federal civil rights laws. *Kings County Behavioral Health* does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Kings County Behavioral Health provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact *Kings County Behavioral Health* 24 hours a day, 7 days a week by calling 1-800-655-2553. Or, if you cannot hear or speak well, please call 711 *TYY/TDD*.

HOW TO FILE A GRIEVANCE

If you believe that *Kings County Behavioral Health* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with *Kings County Behavioral Health Patients' Rights Advocate*. You can file a grievance by telephone, in writing, in person, or electronically:

- By phone: Contact *Patients' Rights Advocate* between *8:00 AM-5:00 PM, Monday-Friday* by calling *559-852-2423.* Or, if you cannot hear or speak well, please call 711 TYY/TDD.

- In writing: Fill out a grievance form, or write a letter and send it to:

  Kings County Behavioral Health-Patients' Rights Advocate
  460 Kings County Drive Ste. 101, Hanford, CA 93230

- In person: Visit your provider's office or *Kings County Behavioral Health-Patients Rights Advocate* and say you want to file a grievance.

- Electronic email: BHPRA@co.kings.ca.us Or, Online at http://www.kcbh.org/patients-rights-advocacy.html

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OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

GRIEVANCE/COMPLAINT PROCESS

Grievance means the expression of dissatisfaction about any matter other than a **Notice of Adverse Benefits Determination (NOABD).** Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested. All Mental Health Beneficiary's have the right to file a grievance or a complaint about any aspect of their mental health treatment. A beneficiary may file a grievance or complaint *in-person*, *by telephone*, *in writing*, *fax* or *online.* Self-addressed envelopes are also available, addressed to the Patients' Rights Advocate. You may use a representative you authorize (family member, patients' right's advocate, or significant support person) to assist on your behalf.

Standard Resolution of a Grievance: 90 Days

Patients' Right's Advocate

460 Kings County Drive suite 101, Hanford, CA. 93230.

Office: 1-559-852-2423 Fax: 1-559-584-6037

Website: http://www.kcbh.org/patients-rights-advocacy.html (temp loc)

For assistance with your grievance, you may contact the Patient Right's Advocate at

1-866 -701-5464

APPEAL PROCESS

All mental health consumers have the right to file an appeal after receiving a **Notice of Adverse Benefit Determination (NOABD)**, which states you do not qualify for Specialty Mental Health Services. NOABD also includes when previously approved services are reduce or terminated. An appeal can be requested verbally; however, a written appeal form must be completed and returned to the Patients' Right's Advocate. Appeal forms are available in the waiting room of the clinic. Self-addressed envelopes are also available, addresses to the Quality Assurance Clinician.

Standard Resolution of Appeal: 30 days.

EXPEDITED APPEAL

These apply in instances where a provider indicates or the MHP determines that the standard timeframe for appeals may seriously jeopardize the beneficiary's life or health or ability to sustain, maintain, or regain maximum functioning. An expedited appeal may be requested verbally without a need for written request,

In these instances, you have the same rights as the standard appeal process. For question, call the Quality Assurance Clinician at 1(559) 852-2297.

Standard Resolution of Expedited Appeals: if approved, 72 hours.

Filing an Appeal, contact:

Quality Assurance Clinician

In-Person or by mail:

460 Kings County Drive Suite 101, Hanford, CA. 93230.

Phone: 1-559-852-2297

STATE FAIR HEARING

If you are dissatisfied with the outcome of an appeal, you have the option of requesting a State Fair Hearing. To do so contact the State Haring Division, State Department of Social Services; 744 P Street, Mail Station 19-37; Sacramento, CA 95814; 1(800)-952-5253 or 1(800) 952-8349 TDD/TDY

You have 120 days after the postmark date of a decision denying your Appeal to request a State Fair Hearing.

Please note you must exhaust the County's Grievance/Complaint Process prior to filing for a State Hearing.

Grievance, Appeal, and Expedited forms are available in the waiting room of each mental health clinic or online. Self-addressed envelopes are also available.

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Patients Rights Advocate* by calling *559-852-2423*.

IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISODER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.

HOW TO FILE AN APPEAL

You have **60 days** from the date of this "Notice of Adverse Benefit Determination" letter to file an appeal. **If you are currently getting treatment and you want to keep getting treatment, you must ask for an appeal within 10 days** from the date on this letter OR before the date your Plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- To appeal by phone: Contact *Patients Rights Advocate* by calling *559-852-2423*. Or, if you have trouble hearing or speaking, please call TTY/TTD number 7-1-1 for help.

- To appeal in writing: Fill out an appeal form or write a letter to your plan and send it to:

  Kings County Behavioral Health: Patients' Rights Advocate
  460 Kings County Dr. Suite 101 Hanford, California 93230

  or **Email**: BHPRA@co.kings.ca.us

or **Fax**: (559) 584-6037

Your provider will have appeal forms available. The *Patients Rights Advocate* can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an "authorized representative." You can send in any type of information you want your Plan to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Plan has 30 days to give you an answer. At that time, you will get a "Notice of Appeal Resolution" letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan's decision within 30 days, you can ask for a "State Hearing" and a judge will review your case**. Please read the section below for instructions on how to ask for a State Hearing.

EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an "**expedited appeal."**

STATE HEARING

If you filed an appeal and received a "Notice of Appeal Resolution" letter telling you that your Plan will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days,** you can ask for a "State Hearing" and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the "Notice of Appeal Resolution" letter. You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.

- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

Authorized Representative

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

LEGAL HELP

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.

Burns Depression Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
Thoughts and Feelings					
1. Feeling sad or down in the dumps					
2. Feeling unhappy or blue					
3. Crying spells or tearfulness					
4. Feeling discouraged					
5. Feeling hopeless					
6. Low self-esteem					
7. Feeling worthless or inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
10. Difficulty making decisions					
Activities and Personal Relationships					
11. Loss of interest in family, friends, or colleagues					
12. Loneliness					
13. Spending less time with family or friends					
14. Loss of motivation					
15. Loss of interests in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
Physical Symptoms					
18. Feeling Tired					
19. Difficulty sleeping or sleeping too much					
20. Decreased or increased appetite					
21. Loss of interest in sex					
22. Worrying about your health					
Suicidal Urges					
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
Please Total Your Score on Items 1 to 25 here →					

Burns Anxiety Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
Anxious Thoughts and Feelings					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated, or on edge					
8. Feeling stressed					
9. Feeling uptight					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
Anxious Physical Symptoms					
13. Feeling dizzy, lightheaded, or off balance					
14. Rubbery or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing, or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
Please Total Your Score on Items 1 to 25 here →					

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Short Screening Scale for PTSD

DSM- IV items that constitute the 7-item screening scale. In: Breslau N, Peterson EL, Kessler RC. Short screening scale for DSM-IV posttraumatic stress disorder. Am J Psychiatry 1999;156:908-911.[17]

C2 Did you avoid being reminded of this experience by staying away from certain places, people or activities? (Remind respondent of life event if necessary)

1. Yes
2. No

C4 Did you lose interest in activities that were once important or enjoyable? (Remind respondent of life event if necessary)

1. Yes
2. No

C5 Did you begin to feel more isolated or distant from other people? (Remind respondent of life event if necessary)

1. Yes
2. No

C6 Did you find it hard to have love or affection for other people? (Remind respondent of life event if necessary)

1. Yes
2. No

C7 Did you begin to feel that there was no point in planning for the future? (Remind respondent of life event if necessary)

1. Yes
2. No

D1 After this experience were you having more trouble than usual falling asleep or staying asleep? (Remind respondent of life event if necessary)

1. Yes
2. No

D5 Did you become jumpy or get easily startled by ordinary noises or movements? (Remind respondent of life event if necessary)

1. Yes
2. No

Based on the Diagnostic Interview Schedule for DSM-IV (DIS-IV), Washington Univ., St Louis, 1995).

The 7-item scale screens for DSM-IV PTSD in persons exposed to traumatic events as defined in DSM-IV. It is intended to be used only after establishing that the respondent has experienced a qualifying event. Please read the paper carefully. It contains all the information needed for using the scale. As we emphasise in the paper, the screening scale is not an adequate substitute for a psychiatric diagnosis.

Severity of Posttraumatic Stress Symptoms—Adult*

*National Stressful Events Survey PTSD Short Scale (NSESSS)

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

Please list the traumatic event that you experienced: _____

Date of the traumatic event: _____

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**	**Item score**
1.	Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	Being "super alert," on guard, or constantly on the lookout for danger?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1----------2----------3----------4----------5

almost never	sometimes	about half the time	most of the time	almost always
(0-10%)	(11-35%)	(36-65%)	(66-90%)	(91-100%)

_____ 1) I am clear about my feelings.
_____ 2) I pay attention to how I feel.
_____ 3) I experience my emotions as overwhelming and out of control.
_____ 4) I have no idea how I am feeling.
_____ 5) I have difficulty making sense out of my feelings.
_____ 6) I am attentive to my feelings.
_____ 7) I know exactly how I am feeling.
_____ 8) I care about what I am feeling.
_____ 9) I am confused about how I feel.
_____ 10) When I'm upset, I acknowledge my emotions.
_____ 11) When I'm upset, I become angry with myself for feeling that way.
_____ 12) When I'm upset, I become embarrassed for feeling that way.
_____ 13) When I'm upset, I have difficulty getting work done.
_____ 14) When I'm upset, I become out of control.
_____ 15) When I'm upset, I believe that I will remain that way for a long time.
_____ 16) When I'm upset, I believe that I will end up feeling very depressed.
_____ 17) When I'm upset, I believe that my feelings are valid and important.
_____ 18) When I'm upset, I have difficulty focusing on other things.
_____ 19) When I'm upset, I feel out of control.
_____ 20) When I'm upset, I can still get things done.
_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.
_____ 22) When I'm upset, I know that I can find a way to eventually feel better.
_____ 23) When I'm upset, I feel like I am weak.
_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.
_____ 25) When I'm upset, I feel guilty for feeling that way.
_____ 26) When I'm upset, I have difficulty concentrating.
_____ 27) When I'm upset, I have difficulty controlling my behaviors.
_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
_____ 29) When I'm upset, I become irritated at myself for feeling that way.
_____ 30) When I'm upset, I start to feel very bad about myself.
_____ 31) When I'm upset, I believe that wallowing in it is all I can do.
_____ 32) When I'm upset, I lose control over my behavior.
_____ 33) When I'm upset, I have difficulty thinking about anything else.
_____ 34) When I'm upset I take time to figure out what I'm really feeling.
_____ 35) When I'm upset, it takes me a long time to feel better.
_____ 36) When I'm upset, my emotions feel overwhelming.

Reverse-scored items (place a subtraction sign in front of them) are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34.

Calculate total score by adding everything up. Higher scores suggest greater problems with emotion regulation.

SUBSCALE SCORING:** The measure yields a total score (SUM) as well as scores on six sub-scales:

1. Nonacceptance of emotional responses (NONACCEPT): 11, 12, 21, 23, 25, 29
2. Difficulty engaging in Goal-directed behavior (GOALS): 13, 18, 20R, 26, 33
3. Impulse control difficulties (IMPULSE): 3, 14, 19, 24R, 27, 32
4. Lack of emotional awareness (AWARENESS): 2R, 6R, 8R, 10R, 17R, 34R
5. Limited access to emotion regulation strategies (STRATEGIES): 15, 16, 22R, 28, 30, 31, 35, 36
6. Lack of emotional clarity (CLARITY): 1R, 4, 5, 7R, 9

Total score: sum of all subscales

**"R" indicates reverse scored item

REFERENCE:

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41-54.

KINGS VIEW

Treatment Agreement

OUR GOALS:

- To provide quality mental health services to people who live in Kings County
- To teach you new skills for a healthy life.

TREATMENT: Kings View provides many mental health services. Our main services are skills groups or therapy groups. First you will have an in-depth interview with a therapist. Then we will connect you to the service(s) that will help you to make changes. If we are unable to serve you, then we will refer you to the right provider.

OFFICE HOURS: Our main office, at 1393 Bailey Drive in Hanford, is open from 8:00 AM until 5:00 PM. If you need to talk with your provider, you may call (559) 582-4481 during business hours. If you have a mental health crisis, please call our after-hours line, (559) 582-4484 or 1-800-655-2553 and talk with a crisis worker. The after-hours line is only for a mental health crisis. The crisis worker is unable to look up or reschedule an appointment, so please call during business hours for that kind of information. If you have a life-threatening emergency, please call 911.

TREATMENT PARTICIPATION: It may help you to meet your goals when the important people in your life participate. You decide who will be involved. You and your provider agree on goals to work on for change to happen. It is very important that you commit to your treatment by doing the following:

1. **Attend all appointments on time.** Appointments may be canceled by telling your therapist, doctor, or case manager at least 24 hours before the scheduled session. Remember that poor attendance and tardiness will keep you from meeting your goals. Missing appointments again and again will result in closing your case.

2. **Work together on treatment goals.** Full participation in your treatment is very important. “Full participation” means being on time for each session, finishing homework, and working with your therapist, doctor, or case manager to meet your goals.

3. **Keep a current financial account.** You are responsible for making the payments you agreed to when we opened your case. Accounts that are “overdue” may stop you from getting the treatment you need. If your income or financial health changes, please let your provider know as soon as possible. If you are having a hard time keeping up with payments, you may ask for a “financial adjustment.”

4. **Expect Kings View Counseling Services for Kings County to:**
    - Treat you with respect and dignity.
    - Protect your privacy. But remember that everyone who works at Kings View are “mandated reporters.” That means we must tell someone if we believe a child or elderly person or an adult who has special needs is being harmed. We may have to tell others about you in crisis or emergency situations, to keep you safe. We may have to tell others about you if you make a dangerous threat, to keep others safe.
    - Provide you with mental health services or referrals that will help you reach your goals.
    - Assign a therapist, doctor, or case manager to help you reach your goals.

KINGS VIEW

Treatment Agreement Acknowledgment

I, _____, am committed to my / my child's treatment.

My signature below signifies that I accept and agree with the conditions of the Treatment Agreement and verifies that I have received a copy of the Treatment Agreement.

Client Signature: _____ Date: _____

Parent /
Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Last Name	Client First Name	Case Number

KINGS COUNTY behavioral health kcbh.org

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

AVISO DE QUEJAS

La Junta de Ciencias del Comportamiento (BBS por sus siglas en Inglés) recibe y responde a las quejas sobre los servicios prestados dentro del alcance de la práctica de (terapeutas matrimoniales y familiares, psicólogos educativos con licencia, trabajadores sociales clínicos y consejeros clínicos profesionales). Usted puede comunicarse con la junta en línea en www.bbs.ca.gov o llamando al (916) 574-7830.

My information/ Mi información:

_ _____ _ _____

*(Provider name, Title) (License or Registration #)/ (***Nombre del proveedor, título**) (**Licencia o número de registro)**

Clinical Supervisor (if applicable)/ Supervisor clínico (si aplica):

_ _____

*(Name, Title) (License #) (**Nombre, título) (Número de licencia**)*

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559)852-2424.

Para obtener más información sobre cómo presentar una queja de Medi-Cal, comuníquese con el Condado de Kings Defensor de los Derechos de los Pacientes al (559)852-2424.

By signing below, I acknowledge reciept of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/ Firma_____Date/Fetcha_____

NOTICE TO CLIENTS

The _ _____ of the _ _____
(Name of office or unit) *(Name of agency)*
receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Kings County Behavioral Health.
To file a complaint, contact
__ _____.
(Telephone number, email address, internet website, or mailing address of agency)

AVISO DE QUEJAS

El/ La _ _____ del/ de la __ _____
*(**Nombre de oficina o unidad**)* *(**Nombre de la agencia**)*

recibe y responde a las quejas sobre la práctica de psicoterapia de cualquier interno o consejero no registrado proveyendo servicios al departamento de Salud Mental de Kings.
Para presentar una queja, puede comunicarse
_ _____.
(Número telefónico, correo electrónico, domicilio, sitio de internet , o dirección postal de la agencia)

My information/ Mi información:
_____
(Provider name, Title) / **Nombre del proveedor, título**

Clinical Supervisor/ **Supervisor clínico:**
_____ _____
*(Name, Title) (License #) / **Nombre, título, número de licencia***

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559) 852-2424.
Para obtener más información sobre como presentar una queja de Medi-Cal, puede comunicarse con el Defensor de los Derechos del Paciente del condado de Kings al (559)852-2424.

By signing below, I acknowledge reciept of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/ Firma_____Date/Fetcha_____

KINGS VIEW

Process, Benefits, and Risks of Psychotherapy

Participating in psychotherapy can result in a number of benefits, including a reduction in feelings of distress and problematic behaviors, greater personal awareness and insight, increased skills for managing stress, and resolution of specific problems. However, sharing personal history or ongoing life challenges may at times create discomfort and may even lead to increased anxiety and depression for a period of time before symptoms improve.

By signing below, I am acknowledging that I have been informed about the process, benefits, and risks of psychotherapy provided by Kings View Behavioral Health Systems, Kings County.

_____ _____

Consumer signature Date

KINGS VIEW

Client Attendance Contract

1. The client will make and attend appointments according to treatment recommendations. **Zero** no-shows and **no more than two** consecutive cancellations are allowed within a 30-day period.

2. Attendance below 80% in a 90-day period will result in an issued NOABD and termination of services.

3. All cancellations will occur at least 24 hours in advance of the scheduled appointment. In case of an emergency requiring same day cancellation, the client/parent/guardian/ foster parent will contact the therapist directly with an explanation of the circumstances.

4. The client will attend all appointments on time. Any client arriving more than 10 minutes late for a scheduled appointment will not be seen and a no-show will be recorded.

5. Clients will participate in all aspects of treatment recommended by their POC (Plan of Care), which may include case management, individual rehabilitation, group rehabilitation, individual therapy, group therapy, and medication services.

6. If bus passes are requested for transportation, the assigned therapist or case manager can determine eligibility. However, the client must arrive to the first appointment to obtain their first bus pass. Bus passes can only be used for counseling/medication appointments and will no longer be provided after a missed appointment.

7. Clients and parents/guardians/foster parents will keep all members of the treatment team informed of important changes in the case, problems they may be having, and/or concerns.

By signing this form, the client / parent / guardian / foster parent is agreeing to adhere to the "No-Show" policy (items 1-4 above) to continue receiving services through Kings View.

_____ _____

Client / Parent / Guardian / Foster Parent Signature Date

_____ _____

Provider Signature (Witness) Date

OFFICE USE ONLY
☐ File Release In Chart
☐ Request Records
☐ Send Records

Kings View, Kings County ● 1393 Bailey Drive, Hanford, CA 93230 ● (559) 582-4481

AUTHORIZATION TO USE, DISCLOSE and OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Client Name: _____ Case No.: _____ DOB: _____

I authorize Kings View to use, disclose, obtain and/or exchange my PHI with:

_____ _____
Name of Person(s)/Title or Agency Recipient(s) Address – Street, City, State, Zip Code; Telephone Number

Information to be Used, Disclosed, Obtained and/or Exchanged: ☒Mark all that apply

Mental Health/Medical Treatment		**Alcohol/Drug Treatment**	**HIV Test Results**
☐ MH Assessment	☐ MH Progress Notes	Time Period (required):	☐ Include
☐ Diagnosis	☐ Nursing Notes	☐ Last Admission **OR**	**Other**
☐ Treatment Plan	☐ Physician Notes	Dates from _____	☐ Home Address
☐ Discharge Summary	☐ MD Orders/Medications	to _____	☐ Telephone
☐ Psychiatric Evaluation	Verification of:	☐ Drug Testing Results	☐ Financial Status
☐ Psychiatric History	☐ Attendance	☐ Attendance Report	**Appointments**
☐ Psychological Testing Results	☐ Progress	☐ Treatment Summary	☐ Scheduling
	☐ Compliance	☐ Treatment Plan	☐ Rescheduling
☐ Hospitalization Dates:		☐ SUD Progress Notes	☐ Canceling
☐ Previous 6 months **OR**		☐ Assessment	☐ Listing of Scheduled Appointments
☐ Dates from _____ to _____		☐ Discharge Summary	
☐ **Other Information** (specify): _____			

Format of Information to be Released: ☐ Hardcopy ☐ Electronic ☐ Verbal ☐ Verbal Exchange Only

For the Specific Purpose of: ☐ Client or Legal Representative Request ☐ Collaboration of Treatment
☐ Coordination of Treatment ☐ Reporting Program Compliance ☐ Securing Treatment History
☐ Other (specify): _____.

Client Rights and Advisements: I realize that I must voluntarily and knowingly sign this authorization before any information can be released (except when mandated by law). I may inspect or copy any information used or disclosed as authorized by this release, unless good cause may be shown why not. I realize that information disclosed under this authorization may no longer be protected under the HIPAA rules, but may be protected by applicable California law. I understand that this authorization is effective immediately. I may revoke this authorization at any time, and I understand that my revocation will take effect upon receipt, except to the extent that action has already been taken. I am aware that my signature on this authorization will not be a condition of my treatment. I have the right to a true copy of this authorization. If not revoked before, this authorization expires one (1) year from the date of this release or on date _____ or event (specify): _____.
(Month/Day/Year)

I have reviewed this Authorization and have had my rights explained/read to me. I hereby consent to the release of my health information as specified above.

Client Signature: _____ Date: _____ Witness: _____
(Month/Day/Year)

Parent/Guardian Signature: _____ Date: _____
(Month/Day/Year)

If not signed by Client: Printed Name: _____ Relationship to Client: _____

As of: _____, _____ AM / PM, **I hereby revoke this release.**
(Month/Day/Year) (Time)

Signature: _____ ☐ Verbal Revocation Witness: _____

Kings County Behavioral Health

Mental Health Provider Directory

October 2022

As a Kings County Medi-Cal beneficiary, if you think you or a family member needs Mental Health services, call the Access Line at 1-800-655-2553 (toll-free). Note that all of the below Providers can accommodate persons with physical disabilities and serve Kings County Medi-Cal beneficiaries. Services may be delivered by an individual provider, or a team of providers, who is working under the direction of licensed practitioners operating within their scope of practice. Only licensed, waivered, or registered mental health providers are listed on the Plan's Provider Directory.

If you require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format, at no cost to the beneficiary, by calling the Access Line at 1-800-655-2553 (toll-free).

Provider Site	Service Type	Populations Served	Cultural Capacity	Non-English Language(s)	Hours of Operations	Disability Access
Kings View 1393 Bailey Dr Hanford, California 93230 http://www.kingsview.org (559-582-4481)	Outpatient Psychiatry, Therapy, and Rehabilitation Services in Individual, Family, and Group Modes	Adults	Multicultural Staff	Spanish	Mon-Fri 8 a.m. to 5 p.m.	Yes
Is provider accepting new clients: Yes						

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Ahmed	Zaheer	Psychiatrist	C 127721	1134330368	No	English	Psychiatry
Areias	Cassondra	Licensed Marriage and Family Therapist	LMFT 106721	1841683729	Yes	English	Recovery & FSP Team Lead – Adult Services
Boggs	Tylo	Licensed Psychiatric Technician	LVN 715157			English	Nursing Services
Cano	Isabel	Licensed Psychiatric Technician	LPT 35453	158011983	Yes	English, Spanish	Nursing Services
Cardenas	Maria Veronica	Associate Marriage and Family Therapist	AMFT 130355	1922337658	Yes	English, Spanish	Clinician – Adult
Carrico	Tracy	Licensed Marriage and Family Therapist	LMFT 42980	1760608889	Yes	English	Clinician – After Hours Crisis
Gascon	Natalia	Associate Clinical Social Worker	ASW 109358	1801518089		English	Clinician – Adult
Garivay	Denivie	Associate Marriage and Family Therapist	AMFT 133462	1962075861	Yes	English	Clinician – Adult

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Gonzalez	Sandra	Licensed Marriage and Family Therapist	LMFT 104755	1962829879	Yes	English, Spanish	Clinician – Adult
Hall	Stefani	Licensed Psychiatric Technician	LPT 34655	1548751753	Yes	English	Nursing Services- Case Manager
Hanna	Malia	Licensed Clinical Social Worker	LCSW 107402	1184115610	Yes	English	Clinician – Adult
Leger	Constance	Licensed Clinical Social Worker	LCSW 76698	1619399904	Yes	English	Clinician – After Hours Crisis
Licon	Anna	Licensed Psychiatric Technician	LPT 36367	1811244528	Yes	English, Spanish	Supervisor – Nursing Services
Lynn	Nora	Licensed Marriage and Family Therapist	LMFT 49807	1265616320	Yes	English	Assistant Regional Director
Mejia	Natalie	Associate Marriage and Family Therapist	AMFT 125890	1326506965	Yes	English, Spanish	Clinician – Adult
Martinez	Kathryn	Licensed Psychiatric Technician	LPT 37896	1902544703	Yes	English	Nursing Services

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Miller	Janice	Licensed Marriage and Family Therapist	LMFT 125158	1699299891	Yes	English, Spanish	Clinician – Adult
Munguia	Isabel	Associate Marriage and Family Therapist	AMFT 125602	1972047439	Yes	English, Spanish	Clinician – Adult
Palma	Doxie	Psychiatric Nurse Practitioner	95010769	1265998850	Yes	English	Furnishing – Controlled Substances II
Reis	Selena	Licensed Psychiatric Technician	LPT 33084			English	Nursing Services
Ramstad	Ashley	Licensed Marriage and Family Therapist	LMFT 134214	1982178984	Yes	English	Clinician – Juvenile Probation
Rodrigues	Luz	Associate Marriage and Family Therapist	AMFT 97581	1962915702	Yes	English, Spanish	Clinician – Access & Crisis
Rodriguez	Stephanie	Associate Clinical Social Worker	ASW 109745	257867		English, Spanish	Clinician – Access & Crisis

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Rogers	Lisa	Licensed Marriage and Family Therapist	LMFT 99767	1467794206	Yes	English	Regional Director
Rolfsema	David	Licensed Clinical Social Worker	LCSW 16614	1013136175	Yes	English	Clinician – Access & Crisis
Schenley	Agnes	Licensed Marriage and Family Therapist	LMFT 41233	1760513766	Yes	English	Clinician – After Hours Crisis
Smith	Anisha	Doctor of Osteopathy	20A9398	1245351568	No	English	Psychiatry – Stable Services
Taylor	Thomas	Licensed Clinical Social Worker	LCSW 17355	1891910527	Yes	English	Clinician – Adult
Truta	Mircea	Psychiatrist	A75064	1033230537	No	English	Psychiatry
Williams	Jason	Licensed Marriage and Family Therapist	LMFT 121679	1720409329	Yes	English	Program Manager – Access/Crisis
Zepeda	Lisa	Licensed Marriage and Family Therapist	LMFT 92541	1104121854	Yes	English	Program Manager – Adult Services