Southwest Mississippi
MENTAL HEALTH COMPLEX
P.O. Box 768 • McComb, MS 39649 • (601) 684-2173

You must complete a Pre-Intake Assessment Form to receive services from our facility. Also, you will be required to return the following required information personally to our office before an intake appointment can be made for you. PLEASE do not attempt to fax or email these forms.

Required Information:
(Please see next page for a detailed list of accepted forms of income and residency)

1. **Proof of all household income OR the income of the person who supports you.**
2. **Proof of insurance, if you have insurance.**
3. **Proof of residency.**
4. **Any prescription medication(s) that you are currently taking.**
5. **Current Photo I.D.**
6. **Social Security Card.**

We cannot open your case without this information. If you arrive without it, we will have to reschedule your appointment for your intake to be completed.

Payment (if any) will be due **prior** to receiving services. **Payment is accepted in forms of cash, personal check, money orders, and credit cards.** You should be prepared to pay for 1-1/2 hours of service. With proof of income and other information, the front office staff will be able to provide you with the amount of your payment, if any, prior to your appointment.

If you do not arrive for your scheduled appointment within ten minutes of your scheduled time, we will assume that you chose to not initiate a record and your Pre-Intake package, along with any other information you provided, will be destroyed.

Telehealth Services are also available on a daily basis, with extended hours on Tuesday and Thursday, 5:00 pm – 7:00 pm. Telehealth appointments must be pre-scheduled.

If you have any additional questions or concerns, please contact our office between the hours of **8:00 am – 5:00 pm, Monday thru Friday at (601) 684-2173.**

WHAT TO BRING TO YOUR FIRST APPOINTMENT

- **ALL PRESCRIPTION MEDICINES**
- **ANY OVER THE COUNTER MEDICATIONS YOU TAKE REGULARLY**
- **DRIVER'S LICENSE OR OTHER PHOTO IDENTIFICATIONS**
- **INSURANCE CARDS, IF YOU HAVE INSURANCE**
- **PROOF OF RESIDENCY**
  - **Utility bills (gas, electric, water/sewer, phone, cable, or satellite)**
  - **Voter's Registration**
  - **Homeowner or tenant deed or lease**
  - **Motor vehicle registration or title**
- **PROOF OF INCOME (Any of the following, but not limited to):**
  - **Current Check Stub(s)**
  - **Current Tax Return**
  - **Current W-2 or 1099**
  - **Government Benefits (Child support, food stamps, or unemployment)**
  - **Retirement/Pension**
  - **SSI/SSDI Check Benefits letter or statement from Social Security Office)**
  - **Worker's Compensation**

CASH, PERSONAL CHECKS (with valid ID), money orders, and debit/credit cards will be accepted as a form of payment.

revised 4/21/15

Client ID_____

Southwest Mississippi Mental Health Complex

Client Data Entry Packet

Date _____/_____/_____

Person Seeking Services:

Date of Birth: _____ **Social Security Number:**_____

Name: _____

Last First Middle "Nickname" Maiden Name Suffix

Physical Address: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:**_____

Phone(s) Home: _____ **Work:**_____ **Cell:** _____

County of Residence: _____

Mailing Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Ethnicity (Race):

___Alaskan Native (Aleut, Eskimo, Indian)
___Asian
___Black/African American
___Multiple Race
___Native American Indian
___Native Hawaiian/Pacific Islander
___White/Caucasian
___Other
___Unknown or Not Available

Hispanic Origin:

___Cuban
___Mexican
___Not of Hispanic Origin
___Other Hispanic
___Puerto Rican
___Unknown or Not Available

Marital Status:
___Single (Never Married/Marriage Annulled)
___Married
___Divorced
___Remarried
___Separated
___Widowed
___Unknown

Veteran Status: _____Yes _____No _____Unknown

Gender: _____Female _____Male _____Other _____Transgender _____Unknown

---

revised 4/21/15

Client ID_____

Primary Source of Household Income:

___wages/salary
___public assistance
___retirement/pension
___disability income
___other
___unknown
___none

Primary Source of Household Payment:

___None
___Personal Resources
___Service Contract
___Blue Cross/Blue Shield
___CHAMPUS/TRICARE
___Other Commercial Health Insurance
___Other Source of Payment
___Medicare
___Medicaid
___VA
___Workmen's Compensation
___ Other Public (government resources)
___CHIP
___Unknown

Are you eligible for SSI/SSDI?:

___Eligible/ Receiving Payment
___Eligible/Not Receiving Payment
___Determined as Ineligible
___May be Eligible/Under Review
___Unknown
___Not Applicable

Are you eligible for Medicaid?

___Eligible/ Receiving Payment
___Eligible/Not Receiving Payment
___Determined as Ineligible
___May be Eligible/Under Review
___Unknown
___Not Applicable

Are you eligible for Medicare? ____Yes ____No

Are you applying for disability? ____Yes ____No

Responsible Party Record:

Relationship to Client: _____

Responsible Party Name: _____

Prefix Last First Middle Suffix

Address: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone(s) Home: _____ **Work:** _____ **Cell:** _____

Social Security Number: _____ **Employer:** _____

Client ID_____

Legal Guardian / Emergency Contact Information:

Name: _____

Address: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone(s): Home: _____ **Work:** _____ **Cell:** _____

Relationship to you: _____

If relationship is Legal Guardian, Conservator, or Healthcare Power of Attorney, is legal document attached? _____Yes _____No

Allergies:

Please list allergies, if any, including the reaction, and date of onset:

_____

_____

_____

_____

_____

_____

_____

_____

Client ID_____

CURRENT MEDICATIONS: (Please list ALL known and/or reported medications you are currently taking regardless of type or purpose. Include over-the-counter (OTC) medications (use back of page if necessary).

Name of Medication	**Dose** (mg/mL)	**Route** (oral, inj, etc,)	**Frequency** (how often)	**Prescribing Doctor**

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING CLIENT STATEMENTS AND CONSENT:

Consent To Receive Services	Name _____ ID Number _____ Service(s) _____

The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I consent to receive services as may be recommended by the professional staff. I understand the professional staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.

I understand that I have the freedom of choice to receive services in a setting that is integrated in and supports full access to the greater community; and is a setting that facilitates individual choice regarding services and supports, and who provides them.

I understand that State and federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations.

I understand that confidential information may be released without my consent when necessary for continued services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect, or by court order.

_____ _____

Individual/Legal Representative Signature Date

_____ _____

Staff Signature/Credentials Date

RIGHTS OF INDIVIDUALS RECEIVING SERVICES

NAME _____

ID NUMBER _____

I, _____, began receiving services provided by
NAME
SOUTHWEST MISSISSIPPI MENTAL HEALTH COMPLEX, REGION XI, on _____
INTAKE/ADMISSION DATE
and have been informed of the following:

1. My options within the program and or other services available; additionally, options/services within the program and other services available regardless of cultural barriers and limited English proficiency.
2. The right to access services that support an individual to live, work and participate in the community to the fullest extent of the individual's capability.
3. The program's rules and regulations, and the right to services and choices that support recovery/resiliency and person-centered services and supports;
4. The responsibility of the program to refer me to another agency if this program becomes unable or unequipped to serve me or meet my needs.
5. My right to refuse treatment and withdraw from this program at any time.
6. My right to ethical treatment, including but not limited to: the right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse, neglect, exploitation or harassment and my right to be free from restraints of any form that are not medically necessary, or, are used as a means of coercion, discipline, convenience or retaliation by staff.
7. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution.
8. My right to be informed of and provided a copy of the local procedure for filing a grievance at the local level or with the DMH Office of Consumer Support.
9. My right to personal privacy and confidentiality in respect to facility visitors in day programs, residential treatment programs, and community living programs as much as physically possible.
10. My right regarding the program's nondiscrimination policies including but not limited to those related to HIV infection and AIDS status.
11. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth by all employees of the provider program.
12. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times.
13. My right to review my records, except when restricted by law.
14. My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Services and Supports or Activity Plan. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment/services; this right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate; (2) having access to information in my case records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel.

15. My right to retain all Constitutional rights, except when restricted by due process and resulting court order.
16. My right to have a family member or representative of my choice notified promptly should I be admitted to a hospital.
17. My right to receive care in a safe setting.
18. The right to involve or not involve family and/or others is recognized and respected; and the right to engage in planning, development, delivery and the evaluation of the services an individual is receiving.
19. If applicable, the right to have visitors of his/her choosing at any time, to the greatest extent possible. Visitation rights cannot be withheld as punishment or in any other manner that unreasonably infringes on the individual's stated rights.
20. If applicable, the right to daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated. If restrictions to communication are put in place, the individual has the right to following:
    (a) Any restrictions on private telephone use must be reviewed daily.
    (b) All actions regarding restrictions on outside communication must be documented in the individual's record.
    (c) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the the individual's stated rights.
21. My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable.

I have been informed of, understand, and have received a written copy of the above information.

INDIVIDUAL RECEIVING SERVICES	DATE	LEGAL REPRESENTATIVE, IF ANY	DATE

STAFF/CREDENTIALS	DATE

CONSUMER GRIEVANCE PROCEDURE

Any person that believes that he/she has received unfair or inappropriate treatment because of race, ethnicity, national origin, religion, sex, age, handicap, income, or any other reason has a right to make the management staff aware of his/her concerns so that they may be addressed.

1. The individual should first attempt to informally discuss and resolve the problem with the staff.
2. If this does not resolve the problem, the consumer may initiate the formal grievance process by requesting in writing to discuss the problem with the program coordinator.
3. If the problem remains unresolved, the program coordinator will arrange a meeting with the Service Area Director in a timely manner.
4. If the problem remains unresolved, the Service Area Director will arrange a meeting with the Executive Director in a timely manner.
5. If the problem remains unresolved, the Executive Director will arrange a meeting with the Commission at the next regularly scheduled board meeting, or at a time when the Commission's calendar permits.

CONSUMERS MAY CONTACT FOR ASSISTANCE by calling toll-free:
Mississippi Protection and Advocacy
533 Executive Place, Suite A
Jackson, MS 39206
1-800-772-4057

Mississippi Department of Mental Health/Constituency Services
1101 Robert E. Lee Bldg.
239 North Lamar Street
Jackson, MS 39201
1-877-210-8513

ACKNOWLEDGMENT OF GRIEVANCE PROCEDURES

NAME_____

ID NUMBER_____

I HAVE BEEN INFORMED OF THE POLICIES AND PROCEDURES FOR REPORTING A GRIEVANCE CONCERNING ANY TREATMENT OR SERVICE THAT I RECEIVE.

_____
Individual/Legal Representative Signature Date:_____

_____
Staff Signature/Credentials Date:_____

STATEMENT OF RESPONSIBILITY

As a consumer at Southwest Mississippi Mental Health Complex, you have a responsibility to work with us to make your treatment more effective. Failure to accept your responsibilities in the following areas may result in a delay in receiving services or in termination of services. The consumer has the responsibility to:

- Attend all appointments as scheduled.
- Pay all fees which are due at the time of service.
- Inform the office in advance of any inability to keep a scheduled appointment with any provider.
- Inform the office immediately of any change in address, phone number, etc.
- Meet with staff at specified times in order to update required paperwork.
- Notify the office of any ideas or intention to harm self or others.

PLEASE note the following policy regarding appointments:

- A cancelled appointment – with prior notification from the client - may be rescheduled one time. Second cancellation requires telephone contact with the clinician to authorize rescheduling.
- Failed appointments (those resulting from late arrival of the client, or client not attending without prior notification) will not be automatically rescheduled. Telephone contact – by the client with the clinician – is required before the client may be rescheduled.
- Clients who miss three appointments in three months, or any three consecutive appointments, may have their cases closed immediately after the third missed appointment.

This policy has been endorsed and approved by the Southwest Mississippi Mental Health/Mental Retardation Commission as of August 26, 2002, re-adopted by the Commission on March 24, 2011, and is effective immediately. It is imperative that you attend each appointment as scheduled in order to maintain access to mental health services.

Having read the foregoing information, I hereby acknowledge that I understand the appointment policy of Southwest Mississippi Mental Health Complex and accept my responsibilities to follow the above guidelines.

_____ _____

INDIVIDUAL/LEGAL REPRESENTATIVE DATE

_____ _____

STAFF/CREDENTIALS DATE

Client ID#_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Southwest Mississippi Mental Health Complex reserves the right to modify the Privacy Practices outlined in the Notice.

I have received a copy of the Notice of Privacy Practices for Southwest Mississippi Mental Health Complex and further acknowledge my right to receive an access report that indicates who has accessed my electronic protected health information.

_____ _____

INDIVIDUAL/LEGAL REPRESENTATIVE DATE

_____ _____

STAFF SIGNATURE/CREDENTIALS (POSITION) DATE

ADVANCED DIRECTIVE

I have been requested to provide a copy of my Advanced Directive, if any, to be made a part of my record. However, if I do not have an advanced directive, I have been given the benefit of obtaining information on advanced directives if I choose to receive such information.

_____ _____

INDIVIDUAL/LEGAL REPRESENTATIVE DATE

_____ _____

STAFF SIGNATURE/CREDENTIALS (POSITION) DATE

CONSENT TO RELEASE/OBTAIN INFORMATION

NAME_____

ID NUMBER_____

****

DATE:_____

I hereby give my consent/permission for _____

_____

_____TO release information to:_____

(Agency/Person Name/Title and Address)

_____TO obtain information from:_____

(Agency/Person Name/Title and Address)

For the specific purpose of: _____ Treatment

_____ Coordination of Services

_____ Other _____

The extent and nature of the information to be disclosed/obtained must be indicated, **(check all that apply):**

_____Evaluations

_____Progress Notes

_____Substance Abuse Records

_____Contact Summaries

_____Identifying Information

_____Other_____

_____Diagnosis/Prognosis/Recommendations

_____Psychiatric Records

_____Admission/Discharge Summary

_____Activity/Recovery Support Plan

_____Individual Service Plan

_____Continuity of Care

Dates of service for which the information/record is requested or will be released:

From:_____ To:_____

I understand that I may revoke this consent at any time except to the extent that action has been taken. I also understand that to revoke this authorization, I must provide a specific written request to revoke the authorization in writing **to Southwest Mississippi Mental Health Complex, Attention: Privacy Officer, Post Office Box 768, McComb, Mississippi 39649-0768,** and that the revocation will not apply to action or information that has already been released/obtained in response to this authorization. I further understand that this consent will expire upon

_____

(Specific Date/Event/Condition)

And, this consent cannot be renewed without my consent. I acknowledge that agency staff has clearly explained to me and/or to my legal representative actions, conditions and limits of this consent, specifically conditions under which confidential information may be released without consent. I acknowledge that confidential information may be released without consent when necessary for continued services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if I, or my legal representative, should communicate to the treating physician, psychologist, master social worker, licensed professional counselor or staff an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents or suspected child abuse or neglect or by court order.

Re-Disclosure of Confidential Information: Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity receiving confidential information from re-disclosing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by laws and regulations, however, I understand that any disclosure of information carries with it the potential for a re-disclosure and that the information may no longer be protected by federal confidentiality laws. **Reference is made to 42 CFR, part 2, and same is incorporated herein for all purposes intended.** I further understand the information I authorize for release may include information related to history/diagnosis and/or treatment of HIV, AIDS, communicable or sexually transmitted disease, and alcohol/drug use, abuse or dependency. If I have questions about disclosure of my health information, I can refer to the program's Notice of Privacy Practices for Protected Health Information or contact SMMHC Privacy Officer. By signing below, I acknowledge receipt of a copy of the signed authorization.

INDIVIDUAL RECEIVING SERVICES	DATE	LEGAL REPRESENTATIVE	DATE

WITNESS/CREDENTIALS DATE

CLIENT IDENTIFYING INFORMATION:

SOCIAL SECURITY NUMBER

DATE OF BIRTH