4131 S. Braeswood Blvd
Houston, TX 77025
Tel.: 713-667-9336
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Email: jweiner@jfshouston.org

Welcome to Jewish Family Service

Our goal is to make your counseling/case management experience as productive and beneficial as possible. Counseling/case management is a form of treatment in which you and your counselor/case manager develop a partnership to help you explore and gain an understanding of your feelings, motivations, thoughts and behaviors. This will enable you to create changes which will help you to cope better with current and future problems. Counseling is sometimes combined with medication for optimal results.

Please take a moment to read this information regarding our services and your relationship to JFS. Your signature indicates that you have read this material and understand the conditions governing your services provided by JFS. A copy will be given to you for your records.

GETTING STARTED

JFS professional counseling staff is made up of masters level social workers, social worker associates, licensed professional counselors and medical doctors who are psychiatric residents. All staff are supervised by senior level staff.

The first few sessions with your counselor/case manager will be for the purposes of assessing your situation and evaluating which kind of services are best for your. Your participation in this process is critical. If at any point in receiving services your counselor/case manager feels that physical, psychological or psychiatric evaluation is necessary for effective treatment, JFS reserves the right to make further services contingent upon you receiving the requested evaluation. You retain the right to refuse services at any time.

JFS reserves the right to refuse services to anyone who comes to a session under the influence of alcohol or other drugs or who is deemed to be a danger to anyone at the agency. We also reserve the right to refuse or discontinue services to anyone who, in our professional opinion, cannot be helped by the type of outpatient treatment/case management we can provide. In such cases, a referral to a more appropriate resource will be made.

EMERGENCY SITUATIONS

JFS' regular hours of operation are 8:30 am until 9:00 pm on Monday, 8:30 am until 5:30 pm on Tuesday through Thursday, and 8:30 am until 4:00 pm on Friday. JFS does not provide 24 hour emergency coverage. If you experience a mental health emergency outside of our regular business hours, you will need to get help immediately in another facility. We recommend that you call 911 or go to the nearest hospital emergency room. You may also call Crisis Hotline at 713-228-1505 twenty-four hours a day.

CONFIDENTIALITY

The confidentiality of your services at JFS will be respected and safeguarded to the limits of the law. Service/treatment records and the verbal content of your sessions are held in strictest confidence. Information will be released only with your written permission, or as required by Federal or State law or professional ethics. All professionals are supervised in individual sessions during which cases are discussed. In addition, professional ethics and JFS practice standards require our professional staff to seek case consultation and support when deemed necessary. Cases presented for consultations do not include names or other identifying information.

In certain situations, the Staff of JFS is required by law to report information to the appropriate State protective and regulatory agency. These situations are:

1. Suspicion or knowledge of neglect and/or abuse of a child;
2. Suspicion or knowledge of neglect and/or abuse of an elderly or disabled individual;
3. Concern that you may be at imminent risk of harming yourself or someone else.

DISCLOSURE OF RECORDS TO CLIENTS

A client may, upon written request to the Executive Director, inspect his case record in the offices of the agency in the presence of the social worker assigned to the case. The client may comment on the accuracy of the record and may, if he wishes, insert his own statement. The agency will make note in the record of a client's agreement or disagreement.

In order to further assure confidentially in those cases where a number of family members are being seen individually, a supplemental case file will be maintained for each family member. A family member requesting to review the case record will have access only to their file.

When the agency determines (following case review and consultation) that disclosure of record would be injurious to the client, the client may present a written request to have the record reviewed by a qualified professional on their behalf. The qualified professional must meet with the caseworker and Director of Professional Services in advance of the record review to establish mutually agreeable guidelines regarding information to be transmitted to the client.

FEES

Our cost is $50.00 for a 50 minutes intake session. The fee for sessions may be adjusted according to a sliding fee scale which is based on your gross income or the nature of the service you are receiving. If there are extenuating circumstances, you and your counselor/case manager may negotiate a lower fee than that appearing on the sliding fee scale.

JFS will not refuse services to anyone due to inability to pay. During your initial session, you and your counselor/case manager will agree upon a fee for services and complete a FEE AGREEMENT.

Payments may be made in the form of cash, personal check, VISA or MasterCard. Professional ethics prohibit our professional staff from accepting personal gifts from clients, business transactions, buying or selling of goods, or bartering between clients and any JFS staff is not permitted.

FEES CONTINUED

JFS accepts third party payment from Medicare, Medicaid, some private insurance carriers and certain Employee Assistance Programs. Otherwise, you are expected to pay for the services at the time they are rendered. If you wish to file for reimbursement for expenses covered by your personal insurance, you will be furnished the necessary documentation by your counselor.

In addition to counseling and case management services, Jewish Family Service offers psychiatric consultation and medication management, services to adults with chronic mental illness, adoption, information and referral services and employment services. If you are interested in receiving any of these services, or if your counselor/case manager feels any of these services are necessary, the exact nature and associated fees will be discussed with your prior to referral. You have a right to refuse any offer of services.

KEEPING YOUR APPOINTMENTS

Your appointment time is reserved exclusively for you. You must cancel an appointment with at least 24 hours advance notice or you will be charged the fee stated in your Fee Agreement. Appointments can
be cancelled by calling our office at 713-667-9336. You may leave a message via Voice Mail if the office is closed. Consistency is important for effective services and if you do not keep your appointments consistent, your counselor/case manager will evaluate whether or not service can or should continue.

COMPLETEING THE DISABILITY SERVCIES INTAKE FORM

Please continue to the next page where the Disability Services Intake form begins. You may fill out the form electronically by typing directly in the text boxes provided. You may also choose to print the form, using the print form button located on the next page and fill it out manually and either fax the form to JFS or mail it. Please complete the form in its entirety. A thorough answer to all questions is essential. Upon completion of the form electronically or faxing, you will be contacted by the intake therapist within 24 hours. If you mail the form, you will be contacted within 24 hours after your form has arrived at Jewish Family Service.

If you have any questions please feel free to contact Jamie Weiner by phone at (713)667-9336 ext. 127 or by email at jweiner@jfshouston.org. TTY users please dial 711.

Date _____

Disability Services Intake Form

Client's Full Name _____ Date of Birth _____

Did client complete this application? _____ Yes ____ No

If no, please indicate who completed the form _____

Social Security Number _____Sex _____Male ____Female

Address _____ City _____

State _____ Zip Code _____

Home Phone_____ Cell Phone _____

Work Phone _____ Email _____

Are you Jewish? _____ Yes ____ No Marriage Status _____Married ____Single

Spouse's Name _____

Do you live with your spouse? _____ Yes ____ No

If you have children please list them from oldest to youngest in the chart below

Name	Date of Birth	Sex

Please list siblings in the chart below from oldest to youngest

Name	Date of Birth	Sex

Mother's Name _____Date of Birth _____

Address _____ City _____

State _____ Zip Code _____

Home Phone_____ Cell Phone _____

Work Phone _____ Email _____

(Family information continued)

Father's Name _____Date of Birth _____

Address _____ City _____

State _____ Zip Code _____

Home Phone_____ Cell Phone _____

Work Phone _____ Email _____

Does the client have a Power of Attorney? _____ Yes ____ No

If no, please name who does: _____

Is client his/her own legal guardian? _____ Yes ____ No

If no, please name guardian _____

Legal Guardian (Other than Parent)

Name _____Relationship _____

Address _____ City _____

State _____ Zip Code _____

Home Phone_____ Cell Phone _____

Work Phone _____ Email _____

Emergency Contact

Name _____Relationship _____

Address _____ City _____

State _____ Zip Code _____

Home Phone_____ Cell Phone _____

Work Phone _____ Email _____

Do we have your consent to contact this person in case of an emergency? _____ Yes ____ No

How did you hear about JFS Department of Disability Services?

____ Friend/relative/coworker ____Newspaper ____Online _____Synagogue

____ Other _____

What services are you interested in?

____ Employment ____ Celebration Company ____ Social ____ Residential ____Counseling/Support

____ Other _____

Health & Medical History

What is your disability or diagnosis? _____

Please describe _____

_____

_____

_____

When delays / symptoms were first noticed? _____

_____

_____

_____

Describe any significant health problems _____

_____

_____

_____

Are you prone to (or have you had) any of the following medical issues? Please indicate by checking Yes or No. If yes, please explain in space provided.

Seizures ___yes ___no explain_____

Diabetes ___yes ___no explain_____

Hearing Impairment ___yes ___no explain_____

Vision Impairment ___yes ___no explain_____

Describe/List any adaptive equipment used. _____

_____

_____

_____

Please answer the questions below regarding your abilities by checking Yes or No. If no, please explain help needed in the space provided.

Eats meals independently? ___yes ___no

explain_____

Bathes independently? ___yes ___no explain_____

Dresses independently? ___yes ___no explain_____

Uses restroom independently? ___yes ___no explain_____

(Health and Medical History continued)

Describe any other physical limitations _____

_____

_____

_____

Please list all medications you are currently taking in table below

Name of Medicine	Dosage	Frequency	Prescribed by

Please list any allergies to food, medication or other_____

_____

_____

_____

Please list your primary physicians' information below

Name_____ Type _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Name_____ Type _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

(Any Other Physicians)

Name_____ Type _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Name_____ Type _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Mental Health

Are you currently in therapy? ____Yes ____ No

If yes, please answer the following questions.

How long have you been in therapy? Please list months/years

_____

_____

_____

_____

How often?

_____

_____

_____

_____

If you have/had a diagnosis(es) please list those here.

_____

_____

_____

_____

Please list therapist's information below. If you have been in therapy in the past, please fill out the information below with your previous therapist's information.

Name _____ Phone _____

Address _____ City _____ Zip Code _____

(Mental Health continued)

Do you see a psychiatrist? ___ yes ___ no

If yes, how often? _____

Please list psychiatrist's information below. If you have seen a psychiatrist in the past, please fill out the information below.

Name _____ Phone _____

Address _____ City _____ Zip Code _____

History of Significant Hospitalization/Surgery

Have you ever been hospitalized? ____Yes _____No

If yes, please complete the chart below for each you have been hospitalized.

When (Month/Year)	Hospital	Reason	How long

Education

Please check the highest level of education

_____ High School/GED _____Associates _____Bachelors ____Masters

Name of High School_____ Year Graduated _____

Did you have any accommodations?

_____ yes _____ no

Name of University_____ Year Graduated_____

Major/Minor _____

Did you have any accommodations?

_____ yes _____ no

(Education continued)
Have you taken any special classes or training? If yes, please describe.

_____

_____

_____

_____

Transportation

Do you drive? _____Yes _____ No _____ No, but working toward license

Do you have a car or have access to one? _____Yes _____No

If yes, do you drive on freeway? _____Yes _____No

If no, what type of transportation do you have? _____ Bus _____ MetroLift _____Cab _____ Driver

Employment

Are you a DARS client? _____Yes _____No

Were you a DARS client in the past? _____Yes _____No

DARS Counselor Name _____ Phone _____

DARS Office _____

Are you employed now? _____Yes _____No

Place of Employment _____

Please describe job duties _____

_____

_____

_____

Pay/Salary _____

(Employment continued)

Have you been employed in the past? _____Yes _____No

If yes, please fill out the information below for your last two most recent jobs

Place of Employment _____ Dates_____

Please describe job duties _____

_____

_____

Reason for leaving _____

_____

_____

Pay/Salary _____

Place of Employment _____ Dates_____

Please describe job duties _____

_____

_____

Reason for leaving _____

_____

_____

Pay/Salary _____

Do you volunteer anywhere? _____Yes _____No

If yes, where and for how long?

_____

_____

_____

_____

What type of job are you looking for? Please describe

_____

_____

_____

_____

Do you have a resume? _____Yes _____No If yes, please email to jweiner@jfshouston.org

Social

Tell me about your interests & hobbies _____

_____

_____

_____

_____

Tell me about your friends and how often you see them._____

_____

_____

_____

Are you comfortable in group settings away from your parents or guardian? _____Yes _____No

Financial Information

Are you on SSI or SSDI? _____ SSI _____SSDI _____Neither

If yes, how much per month? _____

Please list other sources of income _____

_____

_____

_____

Parent's/Guardian's annual income (If applicant is living at home) _____

Are you on food stamps? _____Yes _____No

Are you registered to receive HCS funds? _____Yes _____No

Do you have health insurance? _____Yes _____No

_____Medicaid _____Medicare _____Private

If private, please indicate type/name

_____

If submitting the form electronically please type your name in the provided signature box. If you are completing form manually please sign in the space provided.

_____ Date _____

Signature of Client
(if appropriate)

_____ Date _____

Signature of Parent/Guardian

_____ Date _____

Signature of person who completed this form
(if other than parent or guardian)

JEWISH FAMILY SERVICE, HOUSTON, TEXAS
NOTICE OF PRIVACY POLICIES AND PRACTICES Effective Date**: January 1, 2011**

If you have questions about this policy, please contact Terri Bartlett, Clinical Supervisor, Family and Children at 713-667-9336

Each time you visit with your counselor or case manager, he or she makes a record of your visit. Typically, this record contains some information about your mental health and/or health history, your current symptoms, a diagnosis, treatment, and a plan for future treatment. This information serves as: a basis for planning your care and treatment, a legal document describing the care you received, the means by which you or a third-party payer can verify that you actually received the services billed for, a tool to assess the appropriateness and quality of care you received, and a tool to improve the quality of services we provide and to achieve better treatment outcomes.

We understand that information about you and your mental health and/or health is personal. We are committed to protecting all information about you. This notice applies to all of the records of your care generated by Jewish Family Service or records provided to Jewish Family Service by other providers for the purpose of coordinating care. We are required by law to make sure that any information that identifies you is kept private; to give you this notice of our legal duties and privacy practices with respect to mental health and/or health information about you, and to follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MENTAL HEALTH AND/OR HEALTH INFORMATION ABOUT YOU

For Treatment: We may use mental health and/or health information about you to provide you with counseling and/or case management services. We may disclose mental health and/or health information about you to agency personnel who are involved in your care. For example, your counselor or case manager may share information about you with his or her supervisor for the purposes of case consultation or supervision.

For Payment: We may disclose mental health and/or health information about you so that the services you receive may be billed to and payment may be collected from you, an insurance company or a third party such as an Employee Assistance Program. For example, if you have Medicaid or Medicare we may need to give your mental health and/or health plan information about the services you received at our agency so that your mental health and/or health plan will pay us for the services we provided to you. You will be asked to sign a specific consent before any such information will be released to a third party, however.

For Mental Health and/or Health Care Operations: We may use and disclose mental health and/ or health information about you for agency operations. These disclosures are necessary to make sure that you receive quality care. For example, we may use mental health and/or health information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Appointment Reminders and Customer Satisfaction Surveying: We may use and disclose mental health and/or health information to contact you as a reminder that you have an appointment for counseling or case management, or to follow-up on missed appointments. We may also mail to your home address a questionnaire to determine your satisfaction with our programs.

To Avert a Serious Threat to Mental Health and/or Health or Safety: We may use and disclose mental health and/or health information about you when necessary to prevent a serious threat to your mental health and/or health and safety or the mental health and/or health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

As Required by Law: We will disclose mental health and/or health information about you when required to do so by federal, state or local law. Examples include to report child or elder abuse and/or neglect, or to report specified communicable diseases to the Health Department.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose mental health and/or health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Texas Law (THSC 241.153) permits disclosure of mental health and/or health information without written authorization in the following cases:

- **To a transporting emergency medical service provider**. For example, if you became seriously ill and had to be transported, we could share mental health and/or health information with the ambulance team.

  To the American Red Cross to fulfill its duties. The American Red Cross is responsible for providing evacuation during natural disasters. We would release information to them to coordinate a plan to evacuate you if you requested such assistance.

YOUR RIGHTS REGARDING MENTAL HEALTH AND/OR HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to inspect and copy your clinical record and any billing records. To inspect and copy such information, you must submit your request in writing to the Custodian of Records, Jewish Family Service 4131 S. Braeswood, Houston, TX 77025. If you request a copy of the information, we will charge a fee for the labor and material costs of copying and mailing associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your mental health and/or health information, you may request that the denial be reviewed. Another licensed mental health and/or health care professional chosen by Jewish Family Service will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the agency. To request an amendment, your request must be made in writing and submitted to the Chief Program Officer/Custodian of Records. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (a) was not created by us, (2) is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an account of disclosures. This is a list of the disclosures we made of mental health and/or health information about you. To request this list or accounting, you must submit your request in writing to the Custodian of Records. Your request must state a time period which may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions: You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment or mental health and/or health care operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about prior treatment that you may have had. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to your counselor or case manager. In your request, you must tell us (1) what information you want to limit, and (2) to whom you want the limits to apply (for example, disclosures to your spouse).

Right to Request Confidential Communications: You have the right to request that we communicate with you about mental health and/or health matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail. To request confidential communications, you must make your request in writing to your counselor or case manager. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask the professional with whom you are working, that professional's supervisor or any receptionist of Jewish Family Service.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health and/or health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in every Jewish Family Service location. This notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you come back to Jewish Family Service for a new episode of treatment, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the agency or with the Department of State Health Services at 1 800 942-5540. To file a complaint with the agency, contact Terri Bartlett, Clinical Supervisor – Family and Children, at (713) 667-9336. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MENTAL HEALTH AND/OR HEALTH INFORMATION

Other uses and disclosures of mental health and/or health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provided us permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.