Valeo Behavioral Health Care
Information Sheet

Name: ____
(First) (MI) (Last)

Physical Address: ____
(Street) (City) (State) (Zip)

Mailing Address: ____
(Street) (City) (State) (Zip)

Home Phone: ________________ **Work Phone:** ________________ **Cell Phone:** ________________

Date of Birth: ________________ **Social Security #:** ________________

Are you a Veteran or active service member? Y N

Are you a family member of a Veteran or active service member? Y N

Gender: (Please circle)

Male Female Transgender Other Gender Gender not identified

Race: (Please circle)

White Black or African American American Indian or Alaskan Native Asian

Native Hawaiian or Pacific Islander Two or more races Other Race Race not identified

Ethnicity: (Please circle)

Hispanic or Latinx Non-Hispanic or Latinx

Ethnicity not identified

If Hispanic or Latinx: Puerto Rican Cuban Other Hispanic

Sexual Orientation: (Please circle)

Straight or Heterosexual Homosexual (Gay or Lesbian) Bisexual Queer

Pansexual Questioning Asexual Other Sexuality Sexuality not identified

Gender Identity:

Transgender Transsexual Cisgender Non-binary or gender queer Other: ________

If transgender: Male to Female or Female to Male

Preferred Pronouns: (Please circle)

She/her/hers He/him/his They/them/theirs Other: ________

Marital Status: (Please circle) Single Married Separated Widowed Divorced Unknown

Maiden Name: ______________________________

Employer: ______________________________
(Name) (Address, city, state, zip) (Telephone)

Emergency Contact: ______________________________
(Name) (Telephone) (Relationship)

Payee Information (If not applicable, leave blank): ______________________________
(Name of Payee)

____
(Payee address, city, state, zip) (Payee Telephone)

Guardian Information (If not applicable, leave blank): ______________________________
(Name of Guardian)

____
(Guardian address, city, state, zip) (Guardian Telephone)

Special Needs/Special Accommodations:

Language (please specify) ______________________________

Physical (please specify) ______________________________

Other (please explain) ______________________________

Primary Insurance Company: ______________________________

____
(Identification #) (Group #) (Customer Service Telephone)

____
(Name of Policy Holder) (Policy Holder Date of Birth) (Policy Holder SSN)

Secondary Insurance Company: ______________________________

____
(Identification #) (Group #) (Customer Service Telephone)

____
(Name of Policy Holder) (Policy Holder Date of Birth) (Policy Holder SSN)

Primary Care Physician: ______________________ **Telephone:** ______________

Name and Relationship of all members in your household:

____

____

Total monthly *Household* Income: ______________________________

Do you have an Advanced Directive (Living Will)? ______________________________

Do you have any spiritual and/or cultural beliefs you would like to inform us about? ______________

____

What are the main symptoms/problems that bring you in today?______________________________

____

____

What is your goal for treatment?____

____

____

Signature:________________________________ **Date:** __________________________

Name (printed): _____________________________ **Case Number:** ___________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:________________________ DATE:____________

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

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

- Not difficult at all ________
- Somewhat difficult ________
- Very difficult ________
- Extremely difficult ________

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C-SSRS Self-Report

Policy attachment B

Please place a check mark in the box for the appropriate answers	In the last 48 hours	
Please answer questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?	___	___
2) Have you actually had any thoughts of killing yourself? **If <u>YES</u>, answer all questions 3, 4, 5, and 6.** **If <u>NO</u>, skip directly to question 6.**	___	___
3) Have you thought about how you might do this? *(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")*	___	___
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them? *(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")*	___	___
5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? *(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")*	___	___
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)*	___	___
If YES, did this occur in the past 3 months?	___	___

Client Name: ____________________ Date: ____________________

Completed by: ____________________

Provider Name: ____________________

Releases of Information

Please review the list below for individuals that you would like involved in your treatment at Valeo Behavioral Health Care. For each party, please indicate if you would like to authorize verbal communication between Valeo and this party, request Valeo release written information to this party, or request Valeo obtain written information from this party. Releases of information can be revoked at any time and are valid for 2 years unless otherwise specified.

Primary Care Physician
Name of Provider or Practice: ______________________________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Mental Health Crisis Contact- *Someone you would like us to call in the event of a mental health crisis.*
Name: ________________________ Relationship: _____________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Mental Health Provider
Name of Provider or Practice: ______________________________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Substance Use Treatment
Name of Individual or Practice: ______________________________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Probation/Parole Officer
Name of Individual or Practice: ______________________________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Family
Name: ________________________ Relationship: _____________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Friend
Name: ________________________ Relationship: _____________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Miscellaneous/Other
Name: ________________________ Relationship: _____________ Phone Number: ___________________
Address: ____
Type of Release (check all that apply): ☐ Verbal ☐ Release Written ☐ Obtain Written

Date: ____________________ Intake [ ]

Name: ______________________________ Health Coordination [ ]
Last, First

ID Number: ____________________

Date of Birth: ____________________

MEDICAID ELIGIBILITY QUESTIONNAIRE

Please update your contact information:

Contact Information:

Address: ______________________________

Phone Number: ______________________________

You may be eligible for Medicaid. Please answer the following questions to find out.

1. Have you been on Medicaid, at any time, since 2013? ____ YES ____ NO
2. Are you receiving SSI or SSDI? ____ YES ____ NO
   a. Have you applied for SSI or SSDI? ____ YES ____ NO
   b. If so, was the application denied? ____ YES ____ NO
3. Have you lived in the state of Kansas for the last 3 months? ____ YES ____ NO
4. Are you pregnant? ____ YES ____ NO
5. Do you have a minor child in your legal custody? ____ YES ____ NO
6. Are you 65 or older? ____ YES ____ NO
7. Have you been in a psychiatric hospital within the last 2 years? ____ YES ____ NO
8. Were you in Kansas foster care at the time of your 18th birthday? ____ YES ____ NO
9. Are you currently working? ____ YES ____ NO
   a. How many hours weekly? ____________
   b. What's your hourly pay? ____________

CLINICIAN PLEASE REVIEW FOR COMPLETION and COMPLETE BELOW BOXES WITH APPROPRIATE CHECK MARKS.

Staff Use (please check all that apply):

____ SPMI ____ PRE ____ Unknown

____ DLA 20 Score

____ Homeless (Living at the TRM, shelter or outside)

____ Current SUD

Reviewed by SOAR/Benefits Specialist Staff: ____________________

If you answered YES to any of the first seven questions, you may be eligible for Medicaid. Valeo has a Benefits Specialist who can help you apply for Medicaid.

Updated 12.08.2023

Valeo Social Drivers of Health Questionnaire

Many things can help or hurt your mental health; we want to help. Please answer the questions here and let us know how we can help.

1. **What is your name?**

   First Name: ____________________ Last Name: ____________________

2. **"The food we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months?** *(USDA, The Hunger Vital Sign)*

   ☐ Often
   ☐ Sometimes
   ☐ Never true
   ☐ I want help with food

3. **Do you think you are at risk of becoming homeless?** *(WeCare)*

   ☐ Often
   ☐ Sometimes
   ☐ Never true
   ☐ I want help with food

4. **Does anyone in your life hurt you, threaten you, frighten you, or make you feel unsafe?** *(Montefiore's NCQA SDOH Resource Guide)*

   ☐ Yes
   ☐ No
   ☐ I want help feeling safe

5. **Do you have any trouble paying your heating bill for the winter?** *(WeCare)*

   ☐ Yes
   ☐ No
   ☐ I want help with my utility bills

6. **In the last six months, have you ever had to go without healthcare because you didn't have a way to get there?** *(Cunningham et al., Medical Care Journal)*

   ☐ Yes
   ☐ No
   ☐ I want help getting healthcare

7. **Do you have a job?**

   ☐ Yes
   ☐ No
   ☐ I want help getting a job

**This screening tool was created and modified with the validated questions from Health Leads' screening toolkit licensed under a Creative Commons CC BY-SA 4.0 license found at: http://creativecommons.org/licenses/by-sa/4.0/*