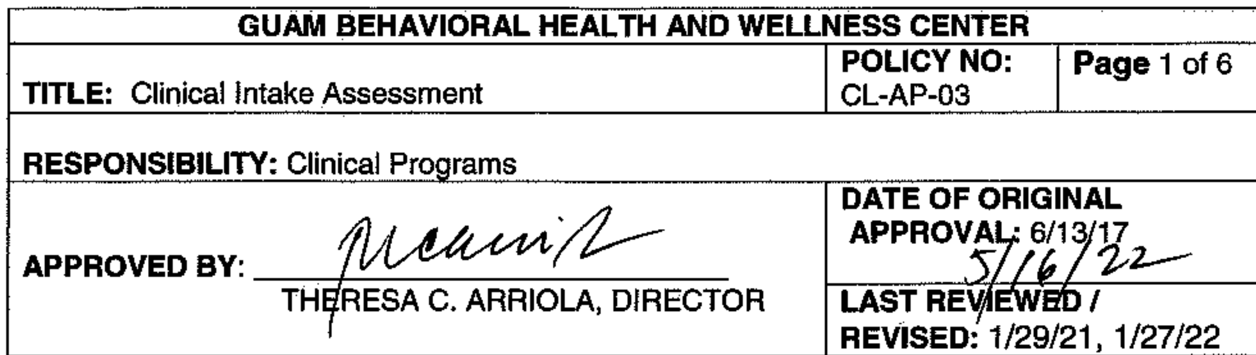

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Clinical Intake Assessment	**POLICY NO:** CL-AP-03	**Page** 1 of 6
RESPONSIBILITY: Clinical Programs		
APPROVED BY: THERESA C. ARRIOLA, DIRECTOR	**DATE OF ORIGINAL APPROVAL:** 6/13/17 5/16/22	
	LAST REVIEWED / REVISED: 1/29/21, 1/27/22	

PURPOSE:

To provide a structure that defines the process of a Clinical Intake Assessment. This policy is in compliance with Commission on Accreditation of Rehabilitation Facilities (CARF) standard 2B Screening and Access to Services and Certified Community Behavioral Health Clinic (CCBHC) Criteria 4D Screening, Assessment and Diagnosis.

POLICY:

A. GBHWC shall have a 24 hour 7 days a week screening and intake unit, providing clinical intake assessment to all new and returning discharged consumers.
   1. A clinical intake assessment shall be conducted by a qualified, trained Intake Worker knowledgeable enough to assess the specific needs of all consumers.
   2. Consumers requiring Drug and Alcohol Program services shall be assessed if they belong to D&A priority client population who are at risk which mandate expedited admission to the program (reference CL-DA-02 Priority Clients Policy).

B. The assessment process shall collect information from the consumer, family members or legal guardian, and other collateral sources adequate to result in individualized and goal-oriented person-centered planning. Information collected shall include but not limited to the following:
   1. Reason for seeking care including information regarding onset of symptoms, severity, and circumstances leading to the presentation.
   2. Medical and behavioral health history
   3. Psychosocial evaluation including housing, vocational and educational status, family, care giver and social support, legal issues and insurance status.
   4. Consumer's specific clinical care needs
   5. Identified goals and expectations and other factors to be considered in recovery planning
   6. Significant life or status changes
   7. A list of current prescriptions and over the counter medications, as well as other substances the consumer may be taking
   8. An assessment of whether the consumer is a risk to self or others, including suicide risk factors
   9. An assessment of need for medical care (with referral to their primary care provider for follow up as appropriate)
   10. A determination whether the person presently is or ever has been a member of the US Armed Services. (as needed, releases of information are obtained)

C. Evidence based assessment tool such as DSM-5 Self-Rated Level 1 Cross Cutting Symptom Measure, Columbia Suicide Severity Rating Scale (C-SSRS), and Screening Brief Intervention Referral Treatment (SBIRT) shall be used to aid in diagnostic

assessment and mental health status. For program specific, evidence-based assessment tools, refer to respective program manuals.

D. The assessment process shall include a written interpretive summary based on the assessment data and shall be used in the development of the initial treatment plan.
   1. The written interpretive summary shall include the identification of any co-occurring disabilities, co-morbidities, and/or disorders.

E. The clinical intake packet including EBHR documentation should be completed and signed before case presentation. An intake packet must be completed and signed to include the following documents:
   1. *Screening Referral for Services*
   2. *Covid-19 Screening*
   3. *Informed Consent for Evaluation and Treatment*
   4. *Statement of Consumer Rights and Responsibilities*
   5. *Notice of Privacy Practices*
   6. *Acknowledgement of Receipt of Notice of Privacy Practices*
   7. *Verification of Identification*
   8. *Map to Home*
   9. *Authorization to Release Mental Health Records*
   10. *Universal Clinical Intake*
   11. *Personal Safety Plan*
   12. *Take Home Instructions*
   13. *DSM-V Level 1 Cross-Cutting Symptom Measure that are applicable*

F. The Intake Worker shall notify Child or Adult Protective Services if the clinical intake assessment determines any suspicion or evidence of abuse and/or neglect.

G. All intake processes shall be documented under the Intake and Registration module in AWARDS.

DEFINITIONS:

Qualified Personnel	Determined by the organization's leadership and may base its determination on the skills, experience, and/or education of personnel, and by state, federal, provincial, or regulating guidelines.
Clinical Intake Assessment	Process used to collect consumer information adequate to result in individualized and goal-oriented and person-centered plan related to his or her history, strengths, needs, abilities, and preferences to determine the diagnosis, appropriate services, and /or referral. This information includes previous behavioral health history, mental status, medical history, any co-occurring disabilities and disorders, current level of functioning, demographics, trauma history, substance use, risk factors, literacy level, and support services.
Consult	Process of conferring with the immediate supervisor or on-call consultation provider regarding treatment recommendations to determine appropriate level of care when clinical intake assessment determines a crisis.

Mental Health Crisis	Is any situation in which a person's behavior or mental state puts them at risk of hurting themselves or other and or prevents them from being able to care for themselves or function effectively in the community (NAMI, 2018) .
D&A priority client population	Are consumers seeking or needing Drug and Alcohol services that are considered at risk which mandate expedited treatment, demanding immediate admission and access to services. These priority clients are: Women who are pregnant intravenous drug (IV) users, pregnant and parenting women, IV drug users and parents referred from Child Protective Services.

PROCEDURE:

A. Routine 24/7 Intake Protocol
   1. The Registration Personnel/Screener shall verify the consumer record in EBHR, and create an AWARDS referral, filling out the demographics.
   2. Registration shall notify the Intake Worker that the consumer has arrived for a clinical intake assessment.
   3. The Intake Worker shall conduct and complete a clinical intake assessment, gather information, and completes the Universal Clinical Intake form.
   4. Evidence based assessment and screening tools shall be used to determine the level of care, intensity of service, and provisional diagnosis
   5. If necessary, the Intake Worker shall consult with their immediate supervisor or on-call consultation provider to receive clinical guidance and recommendations for treatment.
   6. An Interpretive summary narrative based on the assessment shall be completed and signed. Interpretive summary shall include the co-occurring morbidities and provisional diagnosis.
   7. Upon completion of the clinical intake assessment, results and treatment recommendations are communicated to the consumer and legal guardian.
   8. The clinical intake assessments will remain valid for thirty (30) calendar days if the consumer declines services. The face sheet and following forms will need to be updated if the case is reopened:
      a. Informed Consent for Evaluation and Treatment
      b. Statement of Consumer Rights and Responsibilities
      c. Notice of Privacy Practices
      d. Acknowledgment of Privacy Practices
      e. Authorization to Release Mental Health Records
      f. Map to Home
      g. Verification of Identification
      h. Screening Referral for Services
   9. The intake worker shall present the case to the Treatment Team Meeting in the next clinical endorsement meeting for staffing.
   10. The supervisor of the admitting program shall identify the Lead Provider and transfer the electronic case record from intake registration module to the admitting program in the Electronic Behavioral Health Record (EBHR) system.
   11. A Lead Provider will be assigned within 3 business days from clinical intake assessments.

12. Once assigned, the Lead Provider has up to 2 business days to make initial contact with the consumer/legal guardian if applicable to schedule their first meeting.

B. For Emergent/Urgent Cases (Crisis Assessment)

1. The Registration Personnel/Screener shall verify the consumer record in EBHR, and create an AWARDS referral, filling out the demographics.
2. Registration shall notify the Intake Worker that the consumer has arrived for a clinical intake assessment.
3. If a screening determines a crisis case and possible admission to Crisis Stabilization Unit, or Detox 3.7 Unit, intake worker shall assess the consumer, gather as much information as possible to complete the assessment judiciously.
4. Intake Worker shall consult with their clinical supervisor or on–call consultation provider on shift to receive clinical guidance and recommendations for treatment.
5. After all information has been gathered, staff shall consult with the on-call Psychiatrist for proper disposition of consumers.
    a. Consumers who are not eligible for admission to the Crisis Stabilization Unit and are not given any medication will be provided with a *Personal Safety Plan* and *Take Home Instructions* including a follow-up with an assigned Lead Provider.
    b. Consumers who are not eligible for admission to the Crisis Stabilization Unit and are given or prescribed medication will be placed under 23-hour limited admission, as appropriate. Upon discharge, consumers shall be provided with *Take Home Instructions* including a follow-up with an assigned Lead Provider.
    c. Consumers who are eligible for admission to Crisis Stabilization and or Detox 3.7 Unit and voluntarily consents to treatment shall:
        i. Be referred to a medical facility for medical clearance
        ii. Sign the Consent to Psychotropic Medication and/or Other Medication.
        iii. Sign GBHWC Request for Voluntary Admission to the Inpatient Unit and Authorization for Treatment
        iv. Be administered the first dose of medication at Medication Clinic prior to transfer to the Crisis Stabilization Unit or 3.1 Unit as appropriate

    d. Consumers who are eligible for admission to the Crisis Stabilization Unit and refuse treatment, after all efforts for voluntary treatment have been made, must be involuntarily hospitalized (for specific criteria and protocol see 72-Hour Hold and 28-Day Certification: Involuntary Hospitalization for Evaluation and Treatment Policy).
6. All consumers admitted to the unit must first be cleared medically.

C. Healing Hearts Crisis Center (HHCC)

1. The Intake Worker shall conduct a full assessment, gathering information from client as well as parent/guardian when indicated and utilizing evidence-based assessment and screening tools to assist in determining the level of care, intensity of service and provisional diagnosis.

a. For minors, the Intake Worker will ensure that the parent/legal guardian presents a legal document (i.e. birth certificate, ex parte order or custody agreement) as evidence of legal guardianship.
b. The Intake Worker will consult with the HHCC Program Manager for clinical guidance and treatment recommendations.

2. The Intake Worker shall complete portions of the social work intake checklist as indicated by completion deadlines to ensure the following:
   a. Complete intake documentation on EBHR including interpretive summary and service plan.
   b. Complete documentation of forms to be submitted to Medical Records including Authorization to Release Mental Health Records.
   c. Referral for Child Protective Services for all minor clients.
   d. Update of HHCC patient listing.
   e. Documentation of interview recording and custody receipt when indicated.
   f. Complete intake summary.

3. The Intake Worker will refer client for forensic/multidisciplinary team/forensic experiential trauma interview if client consents to participate. Upon completion of the interview, the Interviewer will complete interview summary for inclusion in client's record.
4. Based on information gathered in the intake assessment and interview process, client may be referred for medical services if client consents to participate.
   a. For emergent and urgent cases (in which the assault occurred within 72 hours for minors and 96 hours for adults) an abbreviated intake assessment will be conducted in conjunction with medical services to prioritize medical intervention. Intake completion and interview will be scheduled for a later time.

5. Upon completion of the clinical intake assessment, results and treatment recommendations are communicated the client and family.
6. The Intake Worker (unless otherwise indicated) is the client's case manager and will conduct a follow up with client and/or parent/legal guardian within 2 weeks.

D. Drug and Alcohol Program
   1. Intake follows the same procedure for routine and urgent cases
   2. If consumer is determined to need Drug and Alcohol Program Services, intake worker presents the case to the clinical team and transfer the electronic records under D&A New Beginnings intake.
   3. If consumer is a D&A priority client, intake worker shall inform the D&A program supervisor immediately to prioritize admission and treatment and not be on a wait list.
   4. D&A supervisor shall assign a D&A lead provider to conduct American Society of Addiction Medicine (ASAM) assessment and determine the level of care placement.
   5. LP shall transfer the AWARDS records to the appropriate D&A level of care once ASAM level of care is determined.
   6. The LP shall conduct a full assessment and gather information using ASAM to determine the appropriate level of care.

7. Based on the assessments, an interpretive summary shall be written that addresses the six dimensions of the ASAM as well as other required elements stated in this policy.
8. If the consumer's level of care and needs require additional wrap-around services, the Screener shall provide an initial orientation to the program and assign them to the Drug & Alcohol (ROSC) Recovery Oriented Systems of Care Social Worker.

REFERENCE

NAMI. (2019). *Navigating a mental health crisis.* National Alliance on Mental Illness.

REVIEWED /REVISED DATES: 6/13/2017. 1/13/2020, 1/20/22

ATTACHMENTS: Clinical Intake Packet

F-CL-AP-03.1 Clinical Intake Assessment
F-CL-AP-03.2 Informed Consent to Treatment Evaluation and Services
F-CL-AP-03.3 Statement of Consumer Rights and Responsibilities
F-CL-AP-03.4a Notice of Privacy Practices
F-CL-AP-03.4b Acknowledgement of Receipt of Notice of Privacy Practices
F-CL-AP-03.5 Personal Safety Plan
F-CL-AP-03.6 Take Home Instructions
F-CL-AP-01.1 Screening Referral for Services
F-CL-AP-01.4 Verification of Identification
Covid-19 Awareness Screening
F-CL-AP-01.3 MAP to Home
F-AD-MR-01.1 Authorization to Release Mental Health Records

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
790 Governor Carlos G. Camacho Road Tamuning, Guam 96913
Tel.#: (671) 647-5325 / 5440 Fax#: (671) 647-0250

SCREENING REFERRAL FOR SERVICES

CONSUMER'S FULL NAME:		DATE OF BIRTH:	AGE:	BIRTHPLACE:
SOCIAL SECURITY NUMBER:	SPOKEN LANGUAGE AT HOME: INTERPRETER NEEDED: □ Yes □ No If Yes, type of spoken language assistance needed:	PHONE #:	OTHER CONTACT #:	

Sex at Birth: □ Male □ Female □ Intersex □ Unknown
Gender Identity: □ Male □ Female □ Non-binary □ Trans-Male □ Trans-Female □ Bigender □ Choose not to disclose
Sexual Orientation: □ Straight □ Gay □ Lesbian □ Bisexual □ Pansexual □ Asexual □ Prefer not to say □ Don't know

MAILING ADDRESS:

PHYSICAL ADDRESS:

PARENT/GUARDIAN(s) (IF APPLICABLE):	RELATIONSHIP:

Please check all that apply:

______ Intake
______ CASD – I Famagu'on-ta (5 – < 18yrs old or up to 21 if in SPED services)
______ Project LINC (5-18 yrs. old experiencing homelessness)
______ Project Tulaika (16 – 25yrs old)
______ Drug & Alcohol Assessment (New Beginnings)
______ Adult Outpatient Services (18yrs or older)
______ Healing Hearts / Rape Crisis
______ P.E.A.C.E.

What Brings You Here Today? Reason for Referral: (List behavioral, emotional or mental condition and duration)

Is this your 1st time here? □ Yes □ No □ I'm not sure
Services Sought: □ Shelter/Housing □ Drug Treatment □ Mental Health Care □ Medical Care

Are you enrolled in school? □ Yes □ No **Highest Level of Education Completed:** ____________________

If yes, Name of School ______________________________ Grade __________

Employment Status: □ Full-Time □ Part-Time □ Unemployed-Actively Seeking □ Unemployed-Not Actively Seeking □ Homemaker □ Student □ Retired □ Chronically Disabled □ Volunteer □ Sheltered Non-Competitive Employment □ Supportive Employment □ Declined to Specify

Known or Suspected Use of Drugs and/or Alcohol:

Current Legal Involvement/status (victim, perpetrator, offense, sentence):

Medical Insurance Coverage (name of plan or benefit):
□ Medicaid □ Medicare □ Calvo's SelectCare □ StayWell □ TakeCare □ Netcare □ TRICARE □ VA
□ Aetna □ Blue Cross/Blue Shield □ Other: ________________
Insurance #: ________________________ **Effective Date:** ______________
If Medicare: □ Part A □ Part B □ Part D □ N/A

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Race: □ American Indian / Alaskan Native □ Asian □ Black /African American
□ Native Hawaiian / Pacific Islander □ White □ Declined to specify

Ethnicity: □Caucasian □African American □Am. Indian/Alaskan □Native Hawaiian □Hispanic/Latino □Chamorro
□Filipino □Japanese □Chuukese □Kosraean □Chinese □Vietnamese □Carolinian
□Korean □Yapese □Indian (Asian) □Pohnpeian □FSM □Palauan □Taiwanese
□Thai □Samoan □Marshallese □Other: ____________________ □Declined to specify

Marital Status: □ Single □ Married □ Common Law □ Divorced □ Separated □ Widow(er)

Citizenship: □ U. S. □ CNMI □ FSM □ Republic of the Marshall Islands □ Republic of Palau □ China □ India
□ Japan □ Korea □ Permanent Resident □ Philippines □ Other: ____________________
□ Declined to Specify

Religion: □ Roman Catholic □ Protestant □ Baptist □ Pentecostal □ Methodist □ Presbyterian
□ Jewish □ Islam □ Buddhist □ Hindu □ Christian Scientist □ Jehovah's Witness □ Atheist □ Unknown
□ Other: ____________________

Military Status: □ Active-Duty Member □Guard/Reserve Member □ Veteran □ Not Applicable

Specify type of service branch: ____________________

Veteran Discharge Status: □ N/A □ Unknown □ Honorable □ Dishonorable

Living Situation in the Last 30 Days:
□ Owned or Rented House, Apartment, Trailer, Room □ Someone Else's House, Apartment, Trailer, Room
□Homeless (Shelter, Street/Outdoors, Park) □ Correctional Facility □ Nursing Home □ Transitional Living Facility
□ Other: ____________________

Previous Living Situation: final
□ Owned or Rented House, Apartment, Trailer, Room □ Someone Else's House, Apartment, Trailer, Room
□Homeless (Shelter, Street/Outdoors, Park) □ Correctional Facility □ Nursing Home □ Transitional Living Facility
□ Other: ____________________

Special Needs:
□ Mental Illness □ Drug Abuse □ Cognitive Disability □ Domestic Violence □ Alcohol Abuse □ HIV/AIDS
□ Visual Impairment □ Hx of neglect □ Hearing Impairment □ Physical Disability: ____________________
□ Court-Ordered □ Hx of sexual abuse □ Hx of verbal abuse □ Hx of physical abuse □ Aggressive/Assaultive

Other comments:

Referral Source/Agency:	**Telephone Number:**
Person making referral:	**Date:**
SIGNATURE OF CONSUMER OR PARENT/GUARDIAN:	**Date:**
Received by:	**Date of Receipt:**

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COVID-19 Awareness Screening

The purpose of this screening is to ensure that participants in your program have awareness of COVID-19 (Coronavirus). ***This is not intended to be a medical screening or diagnostic tool.*** *This screening tool is intended to help programs manage activities related to client awareness, potential personal contact, and general symptom monitoring.*

CDC information available here: https://www.cdc.gov/coronavirus/2019-ncov/about/index.html

DEMOGRAPHIC DATA

Consumer's Name: ______________________ AWARDS ID: __________

Date of Birth: ______________ Date Completed: __________

AWARENESS

Information on COVID-19 provided? Additional Details:
☐ Yes ☐ No

Education on Personal Hygiene provided? Additional Details:
☐ Yes ☐ No

Steps to avoid contracting COVID-19 discussed? Additional Details:
☐ Yes ☐ No

POTENTIAL CONTACT

Has the individual traveled outside of Guam, in the past 14 days? If yes, check all that apply and/or list locations in the Additional Details field. Additional Details:
☐ China ☐ Japan ☐ Republic of Korea ☐ Philippines ☐ Europe
☐ Middle East ☐ Other

Has the individual been in contact with anyone who has traveled outside of Guam in the past 14 days? If yes, please indicate location(s) in the Additional Details field. Additional Details:
☐ Yes ☐ No

Has the individual been in contact with anyone who has been suspected or confirmed to have contracted COVID-19? Additional Details:
☐ Yes ☐ No

Does the individual live in a group home setting? If yes, please indicate the group home in the Additional Details field. Additional Details:
☐ Yes ☐ No ☐ Not applicable

POTENTIAL SYMPTOM CHECKLIST

Is the individual age 65 or older? Additional Details:
☐ Yes ☐ No

Does the individual have a history of respiratory issues? Additional Details:
☐ Yes ☐ No

Does the individual suffer from any serious chronic illnesses, such as heart disease, diabetes, lung disease, etc.? If yes, please list details in Additional Details field. Additional Details:
☐ Yes ☐ No

Is the individual presenting with a fever, cough, or shortness of breath? Additional Details:
☐ Yes ☐ No

MEDICATION INFORMATION

When was the individual's last date of visit at GBHWC? __________

List of current medications and the amount of medication(s) currently on hand:

When was the individual's last test for COVID-19? Result:
☐ Positive ☐ Negative Date of result: __________

Staff Name & Signature: __________ Date: __________

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INFORMED CONSENT FOR EVALUATION, TREATMENT AND SERVICES

CONSUMER NAME: ______________________ **DOB:** ____________ **AGE:** ________

MR #: ____________ **DATE OF CONSENT:** ____________ **EXPIRATION DATE:** __________

LEGAL GUARDIAN NAME: ____

Consent to Evaluate/Treat: I voluntarily consent that I /my child/ward will participate in mental health evaluations, treatment, and/or services by professional staff from the Guam Behavioral Health and Wellness Center (GBHWC). I understand that following the evaluation and assessment a complete and accurate information will be provided concerning the benefits and risk of the proposed treatment intervention/service.

Consent to Telehealth Services: I voluntarily consent that I/my child / ward shall participate in Telehealth services such as videoconferencing, in the event that a traditional direct face to face encounter is not feasible and if clinically appropriate. I understand the video conference technology will be used for my behavioral health services and this will not be the same as traditional face to face contact as I will not be in the same room as the provider. Telehealth Videoconferencing will not be recorded, and taking of photograph is prohibited. I understand my information will be shared with other individuals for scheduling and set-up of the video conferencing appointments, however these individuals will maintain confidentiality per agency protocols. I have been informed if emergent issues are a concern, the video conferencing will end and crisis services will be provided.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with interviews, assessments, testing, medication management, and other evidence-based practices. It may be beneficial to me/my child/ward to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation services include diagnosis, evaluation of recovery or treatment, and rehabilitation planning. Possible benefits to treatment include improved cognitive performance, health status, quality of life, and awareness of strengths and limitations. I understand that my mental health provider cannot guarantee results (e.g., less depressed, less anxious, improved marital satisfaction, etc.) of services. However, there will be clearly stated reasons, goals and objectives for continuing/discontinuing any treatment.

Risk: I understand that there may be some risks in participating in behavioral health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; or re-uniting with family members. In case of psychiatric care, medication side effects, and alternative treatments will be discussed by the Psychiatrist.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including copayments and deductibles and may apply for the Sliding Fee Discount if eligible. Fees are available to me upon request.

Confidentiality: Information from my/my child's/ward evaluation, treatment, and/or services is contained in a confidential mental health record at GBHWC, and I consent to disclosure for use by GBHWC staff for the purpose of continuity of my care. I understand my provider(s) may need to discuss my protected health information (PHI) in a confidential manner with other GBHWC professionals for the purpose of providing quality treatment and services. I am aware that additional professional staff may be asked to participate in the evaluation and treatment. I understand my PHI will be kept confidential unless I

authorize that information be released or unless allowed by law. These exceptions to confidentiality are referenced in the Notice of Privacy Practices handout. I also understand that audio and video recording as well as photographing during the session is prohibited.

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to my Lead Provider or treatment team.

Expiration of Consent: This consent is valid for 1 year and will expire under a few conditions, including but not limited to:

1. You / Your child / Your ward, miss an appointment and do not respond to the staff's outreach efforts within a specified time frame,
2. You /Your child / Your ward do not request or have not receive services for a continuous period of ninety (90) days,
3. You / Your child / Your ward relocate off island for more than ninety (90) days,
4. You / Your child / Your Ward do not need further treatment/services (i.e., completed treatment, stable, etc.)
5. You / Your child / Your ward, choose non-GBHWC services provider,
6. You/ Your child / Your ward, refuse or chose to disengage in services by notifying the Center in writing.

Rights and Responsibilities: I acknowledge that I have been informed, understand, and have been given a copy of the Statement of Consumer Rights and Responsibilities.

By signing below, I have read and understand the above, have had an opportunity to ask questions about this information, and I voluntarily consent/ I voluntarily consent for my child /ward to participate in mental health evaluations, treatment, and services at the Guam Behavioral Health and Wellness Center (GBHWC). I understand that I have the right to ask questions about the above information at any time.

(*Note: GCA Ch. 19 allows consumers eighteen (18) years or younger, consenting to services that involve pregnancy related issues, HIV/AIDS/STDS, or substance abuse treatment, to sign this consent form)

☐ I consent to Telehealth services, and to traditional direct face to face consumer provider contact

☐ I don't consent to telehealth services, but give consent to traditional direct face to face consumer provider contact.

______________________________	______________________________
Signature of Consumer/Legal Guardian	Date

______________________	______________________	______________
Witness Printed Name	Witness Signature	Date

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STATEMENT OF CONSUMER RIGHTS AND RESPONSIBILITIES

The Guam Behavioral Health and Wellness Center (GBHWC) has adopted the following consumer rights and responsibilities; and GBHWC staff and contracted agency staff performing consumer treatment activates and/or services shall observe the following consumer rights:

STATEMENT OF CONSUMER RIGHTS

The Statement of Consumer Rights includes, but is not limited to, the consumer's right to:

- A safe environment that meets the needs of the consumer and ensure the greatest amount of freedom and opportunity with the least amount of risk.
- Participate fully in decisions about treatment and services, to the extent permitted by law; this includes the right to refuse medications, treatment/services (unless ordered by the Court to participate); etc.
- Adequate routine and emergency psychiatric mental health services and psychological and behavioral services, as needed.
- Have all information and records kept confidential except for cases outline in the Center's Notice of Privacy Practices.
- Become informed of his/her rights as a consumer in advance of, or when discontinuing services. The consumer may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, race, national origin or cultural, economic, educational or religious background or the source of payment for treatment/services.
- Considerate, dignified and respectful treatment, provided in a safe and humane environment, free from all forms of abuse (including physical, sexual, emotional, or psychological abuse), neglect, harassment and/or exploitation.
- Have his/her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues will be included during initial assessments.
- Receive treatment in the least restrictive setting- one that provides the most freedom appropriate for his/her treatment needs.
- Access protective and advocacy services of his/her choice or have these services accessed on the consumer's behalf.
- Have access and accommodation for religious and spiritual services attendance.
- Remain free from seclusion and undue bodily restraint of any form that are not clinically necessary or are not clinically necessary or are used as punishment, in lieu of habilitation or skills training, as a behavior support plan, or as a learning-based contingency to reduce the frequency of a behavior.
- Knowledge of the name of the Provider who has primary responsibility for coordinating his/her treatment and the names and professional relationships of other Providers who will see him/her.
- Receive information from his/her Provider about his/her mental health status, purpose and course of treatment, his/her prospects for recovery, and possible consequences of treatment in terms that he/she or the consumer's representative can understand.

- Obtain information on the Center's Notice of Privacy Practices regarding the confidentiality and disclosure of protected health information (PHI).
- Formulate advance directives regarding his/her healthcare, and to have GBHWC staff comply with these directives (to the extent provided by local laws and regulations).
- If the consumer is admitted to the Adult Inpatient Unit (AIU), have a family member/personal representative and personal physician notified promptly.
- Have his/her family involved in treatment, if he/she chooses.
- Full consideration of privacy concerning his/her treatment. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly.
- The consumer has the right to be advised as to the reason for the presence of any individual involved in his/her treatment planning.
- Receive information in such a manner, as to promote a complete understanding of the treatment, including the right to consult with his/her Provider.
- Reasonable responses to any reasonable request he/she may make for service.
- Know the name of all the medications he/she is taking, why he/she is taking them, and the possible side effects.
- Reasonable continuity of treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats of mistreatments as a result.
- Be advised of GBHWC grievances process, should he/she wish to communicate a concern regarding the quality of the treatment he/she receives.
- Be informed by his/her provider or another treatment team member of the continuing treatment requirements following his/her discharge from the GBHWC.
- Examine and receive and explanation of his/her bill regardless of source of payment.
- Exercise all civil legal rights afforded to citizens of the United States; (i.e voting, marriage, drivers' license, etc.)
- Have all consumer rights apply to the person who may have legal responsibility to make decisions regarding mental health treatment on behalf of the consumer.

THE STATEMENT OF CONSUMER RESPONSIBILITIES

The outcome of treatment depends partially on the consumers' effort. Therefore, in addition to these rights, a consumer has certain responsibilities as well. These responsibilities should be presented to the consumer in the spirit of mutual trust and respect. The consumer's responsibilities include, but are not limited to:

- The consumer has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, medications and other matters relating to his/her health.
- The consumer is responsible for reporting perceived risks in his/her treatment and unexpected changes in his/her condition to the responsible treatment team member.
- The consumer and family are responsible for asking questions about the consumer's condition, treatments, and procedures.

- The consumer and family are responsible for asking questions when they do not understand what they have been told about the consumer's treatment or what they are expected to do.
- The consumer and family are responsible for immediately reporting any concerns including reporting all allegations of abuse, neglect and exploitation by staff or another consumer and reporting allegations of rights violations while receiving treatment at GBHWC.
- The consumer is responsible for following the treatment plan established by his/her treatment team.
- The consumer is responsible for keeping appointments and for notifying GBHWC when he/she is unable to do so.
- The consumer is responsible for his/her actions should he/she refuse treatment or not follows his/her treatment team's orders.
- The consumer is responsible for assuring the financial obligations of his/her treatment and services at GBHWC are fulfilled as promptly as possible.
- The consumer is responsible for following GBHWC policies and procedures.
- The consumer is responsible for being considerate of the rights of other consumers and GBHWC staff.
- The consumer is responsible for being respectful of his/her personal property and that of other persons at GBHWC.
- The consumer is responsible for dressing appropriately (i.e. no bare feet, no swimsuit, etc.) and not bringing contraband in to the Center (i.e. weapons, drugs, alcohol, etc.).

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Guam Behavioral Health and Wellness Center (GBHWC) is required by law to maintain the privacy of your PHI and to provide you with this notice of its legal duties and privacy practices with respect to your PHI. If you have any questions about any part of this notice or if you want more information about the privacy practices at GBHWC please contact:

Medical Records Clerk, GBHWC
790 Gov. Carlos G. Camacho Rd. Tamuning, GU 96913
Tel: (671) 647-5422

Understanding Your Health Record and Information:
GBHWC collects information about your health and stores it in a chart, which is your mental health record. We need this information to provide you with quality care and to create a record of the care, treatment, and services you receive at GBHWC. Each time you receive services at GBHWC, documentation is made containing health and financial information. Typically, your mental health record contains information about your condition, the treatment we provide and payment for the treatment. Understanding how your health information is used helps you to make more informed decisions when authorizing disclosure to others.

<u>Effective Date of This Notice: July 5, 2013</u>

I. How GBHWC may Use or Disclose Your Health Information

GBHWC is committed to protecting the privacy of your health information. The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall into one of the categories. The law permits GBHWC to use or disclose your health information for the following purpose:

A. <u>Treatment</u>. We may use mental health information about you to provide you with treatment and services. We may disclose mental health information about you to the psychiatrists, psychologist, pharmacists, nurses, social workers, therapists, technicians, or other GBHWC professionals involved in providing services to you. GBHWC professionals may also share mental health information about you to coordinate the services and treatment you need.
B. <u>Payment</u>. We may use and disclose mental health information about you so that the treatment and services you receive at GBHWC or other providers from whom you receive treatment or services, may be billed to, and payment may be collected from, you, an insurance company, a third party, Medicaid, or another payer. To the extent possible, our staff and outside contractors or consultants will make reasonable efforts to assure that the use and disclosure of your personal health information is conducted in a secure and confidential manner.

C. Quality Control and Everyday Operations. We may use and disclose mental health information about you for our day-to-day operations. This is necessary to ensure that all consumers receive quality care. For example, we may use mental health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine mental health information about many consumers to help determine what additional services we should offer, what services should be discontinued, and whether certain new treatments are effective. Mental health information about you may be used by our administrative division (i.e., finance division, Director's office, information systems division, etc.) for cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of mental health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review, and auditing, including compliance reviews, medical reviews, legal services, and compliance programs. Your mental health information may be used and disclosed for general activities of the Center including resolution of internal grievances and customer service. In limited circumstance, we may disclose your mental health information to another entity subject to Health Insurance Portability and Accountability Act (HIPAA) for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without disclosing your identity.

D. Person's involved in your care. Unless you object, we may disclose your mental health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or in the event of your death. We may also give information to someone who helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to do so prior to making this notification. If you are unable or unavailable to agree or object, our professionals will use their best judgement in communication with your family and others. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

E. Business associates. There may be services provided by GBHWC through contracts with business associates. When these services are contracted, we may disclose your health information so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

F. Center directory. We do not maintain a directory for our consumers who are actively receiving outpatient services and for those in the Residential Recovery Program. If asked, we will not confirm orally, in writing or through any other medium that you are our current or former consumer, with the exceptions listed under "persons involved in your care." We may include information about you in the Inpatient Center Directory while you are actively receiving inpatient services. This information may include your name, location, your general condition, and

your religion. The Inpatient Directory Information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. A statement of your general condition may, for example, state that you are stable or informed a caller of your visitation and telephone privileges but will not disclose the diagnosis or type of treatment you are receiving. This is so your family, friend and clergy can visit you and generally know how you are doing.

G. Appointments. We may contact you to provide appointment reminders or notifications when an appointment is cancelled or rescheduled. You hold the right to request to receive communications regarding your personal health information from GBHWC by alternative means or alternative locations. For instance, if you do not want appointment reminders to be left at a particular phone number or to be sent to a particular address, we will accommodate reasonable requests.

H. Required by Law. As required by law, we may use and disclose your health information as describe below:
   a. Public health. We may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to Food and Drug Administration (FDA) problems with productions and reactions to medications; reporting births and deaths; notifying people of recalls of products; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and reporting disease or infection exposure.
   b. Health oversight activities. We may disclose your health information to health agencies during audits, investigations, inspections, licensures, and other proceedings. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
   c. Judicial and administrative proceedings. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health 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.
   d. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, providing information about criminal conduct on GBHWC property, providing information about a death we believe may be a result of criminal conduct; and under certain limited circumstances, information about you, if we have significant reason to believe you are the victim of a crime and we are able to obtain your agreement; and other law enforcement purposes.
   e. Deceased person information. We may disclose your health information to coroners, medical examiners, and funeral directors. This may be necessary to identify a deceased person or determine the cause of death. We may also

disclose medical information to funeral directors as necessary to carry out their duties.

f. Public safety. We may disclose your health information to appropriate persons to prevent or lessen a serious and imminent threat to the health and safety of a particular person or to the public.
g. Specialized government functions. We may disclose your health information for military, national security, and prison purposes.
h. Military and veterans. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
i. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.
j. Reporting abuse, neglect, or domestic violence. We may disclose your health information as necessary to notify the appropriate government agency if we believe you have been a victim of abuse, neglect, or domestic violence (10 GCA Ch. 2 and PL 20-209; 5-Child Protective Act).
k. Correctional institution. You should be an inmate of a correctional institution; we may disclose to the institution or it's agents' health information necessary for your health and the health and safety of others.

Note: Only the minimum necessary health information will be disclosed to accomplish the above purposes.

II. Confidentiality of Privileged Information (42 CFR Part 2)

As a general rule we may not share information with someone outside of GBHWC regarding treatment, diagnosis or referral for treatment for drug or alcohol abuse, abortion, HIV testing and related information , AIDs or an AIDs-related condition, genetic testing, sexually transmitted infections, domestic/sexual abuse, or developmental disabilities. The confidentiality of this privileged information is protected by federal law and regulations. Specifically, we may not share with a person outside the center that you attend any of the drug or alcohol abuse programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

- You authorize the disclosure in writing; or
- The disclosure is permitted by a court order; or
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, auditor program evaluation purposes; or
- You threaten to commit a crime either at GBHWC or against any person who works for GBHWC; or
- As permitted by federal law to report suspected child abuse or neglect to appropriate local authorities.

III. When GBHWC May Not Use or Disclose Your Health Information

Expect as described in the Notice of Privacy Practices, GBHWC will not use or disclose your health information without your written authorization. If you do authorize GBHWC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your permission, we will no longer use

or disclose health information about you for the reasons covered by your written authorization. You understand that we are able to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

IV. Your Health Information Rights

A. Right to inspect and copy. With some expectations, you have the right to inspect and receive a copy your health information. We ask that such requests be made to the medical records office, in writing, on the Authorization for Release of Mental Health Record form. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

B. Right to request restrictions. You have the right to request restrictions or limitations on certain uses and disclosures of your health information. GBHWC is not required to agree to the restriction that you requested. We ask that such requests be made to the medical records office, in writing, on the Request to Restrict Use and Disclosure of PHI form.

C. Right to amend. You have a right to request that GHBWC amend your health information that is incorrect or incomplete. We ask that such requests be made to the medical records office, in writing, on the Request for Amendment of PHI form. GBHWC is not required to change your health information and will provide you with information about GBHWC denial procedure and how you requested a review. We may deny your request for amendment if you ask us to amend information that was not created by us, information that is not part of the health information kept by GBHWC, or information that is accurate and complete.

D. Right to an accounting of disclosures. You have the right to receive an accounting of disclosures of your health information made by GBHWC, except that GBHWC does not have to account for the disclosures regarding treatment, payment, health care operations, information provided to you, and certain government functions. We ask that such requests be made to the medical records office, in writing, on the Request for an Account of Disclosures of PHI form. Your request must state a time period which may not be longer than six (6) years from the date the request is submitted and may not include dates before April 14, 2003. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

E. Right to request alternate communications. You have the right to request that we communicate with you about mental health matters at a specific location or by alternative means. For example, you may ask that we only communicate with you via telephone. We ask that such requests be made to the medical records office, in writing, on the Request for Communication by Alternative Means/Location form. We will not ask you the reason for your request. We will accommodate all reasonable requests.

F. Right to a paper copy of this notice. You have a right to a paper copy of this Notice of Privacy Practices. To obtain a paper copy of this Notice use the contact

information below. You may obtain a copy of this Notice at our website, www.GBHWC.guam.gov

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Medical Records Clerk, GBHWC
790 Gov. Carlos G. Camacho Rd. Tamuning, GU 96913
Tel: (671) 647-5422

V. Changes to this Notice of Privacy Practices

GBHWC reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of amendment. Until such amendment is made, GBHWC is required by law to comply with this Notice. Revised Notices will be communicated by staff or through other distribution channels.

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with GBHWC all complaints must be submitted in writing on the Complain of Privacy Violation form. An electronic version of the form can be found on the Center's website. You will not be penalized for filing a complaint. Complaints about this Notice of Privacy Practices or how GBHWC handles your health information must be in writing and directed to:

Director, GBHWC
790 Gov. Carlos G. Camacho Rd. Tamuning, GU 96913
Tel: (671) 647-5330

If you are not satisfied with the manner in which the Center handles a complaint, you may also address your complaint to the Secretary of the Department of Health and Human Services. For more information on how to file a complaint visit, http://www.hhs.gov/ocr/privacy/hippaa/complaints

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER

790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5440 FAX: (671) 649-6948

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Last Name		First Name		Chart Number		DOB	

I have been given a copy of GBHWC's *Notice of Privacy Practices ("Notice")* Version _____, Effective Date____________, which describes how my protected health information (PHI) is used and shared. I understand that GBHWC has the right to change this *Notice* at any time. I may obtain a current copy by contacting Medical Records at the address above, or by visiting GBHWC's website at dmhsa.guam.gov

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices.*

______________________________ ______________
Signature of Consumer or Personal Representative Date

______________________________ ______________________________
Print Name Personal Representative's Title (e.g., Guardian)

______________ ______________ ________ ________AM/PM
Witness Name Witness Signature Date Time

→**Routing:** Original to consumer's chart.

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
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Verification of Identification

I, ______________________, hereby authorize Guam Behavioral Health Wellness
(Name of Consumer)

Center to make a copy of my Identification Card or to be photographed for my Guam

Behavioral Health and Wellness Center Medical Record.

______________________	______	______________________
Signature of Consumer or Parent/Legal Guardian	Date	Relationship to Youth/Young Adult, if applicable

(Place photo here)

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
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MAP TO HOME

(PLEASE USE ANY AND ALL LANDMARKS SUCH AS SHOPPING CENTERS, BUILDINGS, ETC.)

Consumer's Name: ______________________________ MR# __________________________

Home Address: ________________________________ Contact Number: ____________

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER

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GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

Purpose: This form is used when you want information from your mental health record to be released to yourself or someone else. Once you complete and sign this form, the information you identify on this form will be prepared and released. This form is not completed for releases already addressed in the Notice of Privacy Practices (i.e., for treatment, payment, and daily operations).

Hours for requesting and picking up records: Monday- Friday 8:00 AM to 5:00 PM, excluding Government of Guam holidays.

Length of time to process requests: Once the request is approved, GBHWC will prepare the documents within 5-30 calendar days, with a few exceptions. Please understand we **do not** release records on the same-day we receive your request, so make sure you make your request at least five (5) days prior to needing the records.

Requirements for picking-up records: The person picking up the records must provide picture identification prior to the release of the records; this also applies to consumers picking up their own records.

Denying requests: The clinician who was/is in charge of the consumer's treatment may deny the request in limited circumstances. We will notify the requestor and inform them how to appeal a denial. If your request is denied, we will notify you within 30 calendar days. If the request is denied, a clinician may prepare a summary instead of allowing access to the requested information, as long as the requestor agrees to the summary alternative.

Summary Alternative: If you are requesting a lot of information for your personal records we suggest you ask for the summary alternative. This option is best if you would like an easy to understand explanation of your treatment rather than attempting to understand the clinical terms commonly found in mental health records. If you want this alternative, you will **not** receive copies of your record; instead you will receive a written summary of the information you identified above by a clinician. This option usually takes 10-30 calendar days. If you would like this option, notify the medical records staff.

Releasing entire records: We only release a consumer's entire record when it is specifically justified as the amount that is reasonably necessary to accomplish the intended purpose.

Requesting information from non-GBHWC providers: To obtain a copy of test results, procedures and/or notes that were done at another organization, please contact that organization directly. GBHWC is only authorized to release information produced by GBHWC staff.

HIPAA: This Authorization Form is HIPAA compliant.

Question: If you have questions about this Authorization Form or the process of releasing your records, please contact any staff member before signing this form.

TURN OVER FOR INSTRUCTIONS

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5440 FAX: (671) 649-6948

GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS INSTRUCTIONS

<u>All sections</u> must be completed for your request to be processed

1. You must complete name, date of birth and/or social security number.
2. You must tell us who we are disclosing the information to
3. You must tell us what program you want us to share information from and then identify what specific information you want us to share
4. You must tell us the dates you want your information from. If you want as much information as possible, we release information no more than two (2) years back from the date of signature.
5. If your record contains or might contain privileged information (i.e., substance abuse information) you must initial each line indicating the information can be included in the release. If you do not want privileged information released or you don't have any privileged information, check the box that says you "don't authorize the release/ Not Applicable"
6. You must tell us how the information will be used- is it for your personal use, does another provider need it to help coordinate your care, etc.
7. You must tell us how you want the information handled- by mail, verbally or picked up at our medical records office.
   - We do not fax records (except to the social security office)
8. The Authorization will expire 1 year from the date of your signature unless you write a specific date or identify an event such as upon termination of family counseling.
9. Please read the acknowledgement and then sign and date
   - **If the consumer is 18 years or older, the consumer *must* sign the authorization unless** the consumer has a legal representative (i.e., guardian), a disability and cannot sign the form, or the consumer is deceased. If the consumer is deceased, the surviving spouse or legal representative with legal proof must sign.
   - **If the consumer is fourteen (14) years or older** <u>and</u> the records being released involve treatment for mental illness, alcoholism, pregnancy, abortion, drug dependence, or AIDS/HIV/STD testing, he/she must sign.
   - **Anyone other than the consumer** who signs this Authorization must <u>state their relationship</u> to the consumer and provide <u>proof of legal authority</u> (i.e., guardianship papers) to sign on behalf of the consumer.

If you are not known to the staff who is witnessing you complete this form, they will ask for your photo identification. This is one way we do our best to protect your confidentiality.

GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

1. CONSUMER INFORMATION

Last Name:____________________First Name:____________________M.I.:______

Birth Date:__________S.S. #:______________Former Names:________________

2. RECIPIENT'S INFORMATION
I authorize Guam Behavioral Health and Wellness Center (GBHWC) to release information from my mental health record to the person or facility stated below:

____
Full name of person or facility to receive the mental health record

____
Mailing Address City, State, Zip Telephone #

3. INFORMATION TO BE RELEASED
3a. Those portions pertaining to: ☐Outpatient services ☐Inpatient Services

3b. Check what information you want to be released:
☐ Verification of Disabilities Psychiatric Summary ☐ DPHSS Physicians Certification for Public Assistance
☐ Diagnosis ☐ Medication list ☐ Case summary
☐ Treatment plan ☐ Transition plan ☐ Discharge summary
☐ All Progress Notes **-OR-**
☐ Only Progress Notes by:☐ Nurse ☐ Social Worker ☐ Counselor ☐ Psychologist ☐ Psychiatrist ☐ Other:______
☐ All Assessments **-OR-**
☐ Only Assessments by: ☐ Nurse ☐ Social Worker ☐ Counselor ☐ Psychologist ☐ Psychiatrist ☐ Other:______

☐ Other information (be specific):____

4. DATES OF INFORMATION

Covering from (date)__________to (date)__________**-OR-** ☐All past (up to 2 years), present & future info

5. INCLUSION OF PRIVILEGED INFORMATION
☐I **DO NOT** authorize the release of any privileged info/Not Applicable **-OR-**
The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation 42 CFR §§2.11 and 2.13 protect the following information. If the record contains the information below, such information will only be included in this disclosure if you initial on the line. *(Initial each line)*

______Alcohol and/or drug abuse______HIV/AIDs/STD related information______Genetic test results

______Domestic violence victim counseling & sexual assault counseling ______Pregnancy/abortion

6. PURPOSE
☐ At the request of the consumer/personal representative ☐ To coordinate care ☐ Obtain benefits

☐ Legal ☐ Other (specify):____

7. DELIVERY METHOD
☐ Mailed to the recipient's address above ☐Verbally
☐ Pick-up at the Medical Records Office. ****If the person on #2 is **different** from the person picking up the records, **complete the authorization below**. The information you provide below must match the information on their photo identification****

I authorize **GBHWC medical records staff** to release the information to the person stated below:

____
First and last name of person picking up the records Telephone #

GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

8. EXPIRATION

This Authorization will expire one (1) year from the signature date, upon discharge from all GBHWC programs, or at the date or event stated below:

☐Specific date:____________________ ☐Event: ____

9. ACKNOWLEDGEMENT & SIGNATURE

I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization, I must do so by contacting the medical records staff. I understand the revocation will not apply to information that has already been released in response to this Authorization.

Once this information is released it is subject to re-disclosure by the recipient and is no longer protected by Federal privacy regulations. GBWHC is not responsible for unauthorized disclosure by the recipient.

I understand authorizing the release of this information is voluntary. I do not need to sign this form to receive services from GBHWC. However; lack of ability to share information may prevent GBHWC from providing appropriate and necessary care.

Signature:________________________________ **If Representative, Title:** ____________________

Printed Name:______________________________ **Date:**____________ **Tel #:**______________

If signed by Representative: ☐ID/Proof of authority provided. **Comments:**______________________

Witness Signature:_____________________________ **Title:** ______________________

Printed Name:______________________________ **Date:** ______________

OFFICIAL USE ONLY

Date rcvd:__________ **Rcvd by:**____________________ **MR#:**____________ **EBHR#:**______________

DISPOSITION: ☐Approved ☐Denied *(Check all that apply below)*

Administrative Issues:

☐We are unable to identify this consumer. Please provide additional information (#1)

Incomplete: ☐Recipient's information (#2) ☐Information to be released (#3) ☐Dates of information (#4) ☐Privileged Info (#5) ☐Purpose (#6) ☐Delivery method (#7) ☐Signature portion (#9)

☐Proof of legal authority not valid/validated

Unreviewable Grounds for Denial:

Requested info: ☐Involves psychotherapy notes ☐Compiled in anticipation of litigation ☐Not maintained by GBHWC

☐Request made by inmate of correctional institution

☐Information obtained from non-healthcare provider pursuant promises of confidentiality

Reviewable grounds for Denial:

☐The request for the entire record is not justified to accomplish the intended purpose.

☐Disclosure would cause endangerment of the consumer or another person

☐Requests made by a personal representative where disclosure is likely to cause substantial harm

Other:____

RELEASING: MED RECORD STAFF USE ONLY

Ready for release on (date):__________________ **Pick-up ONLY: Notified on** (date):__________________

MAIL: Mailed by:______________ on (date):__________ via: ☐USPS ☐Fed Ex ☐Other:______________

VERBAL: Verbalized by:__________________ on (date):__________ via: ☐In person ☐Tel ☐Other:__________

PICK-UP: Released by:__________________ on (date):__________ Verified I.D.: ☐Yes ☐Other:______________

Receiver (Print):______________________ Signature:______________________ Date:______________

IF REVOKED: Date:__________ Signature:______________________ Rcvd by:______________________

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UNIVERSAL CLINICAL INTAKE

CONSUMER INFORMATION

Interviewer Name: ______________
Client Record Number: ______________ Date: ________ Start time: ________ End time: ________
Last Name: ______________ First Name: ______________ Middle Name: ______________

CLINICAL INFORMATION

History and Development of Presenting Problem (address role in life, goals, experiences, challenges, the need of change, purpose of visit, referral, description of symptoms, onset of symptoms, severity/frequency of symptoms)

____

Past Behavioral Health History (include any past diagnosis or treatment and if successful/not successful)

____

Family Behavioral Health History

____

Pertinent Social History (current living environment, spiritual/religious, legal, employment issues, school performance and school concerns to include history of Special Education or currently enrolled in Special Education)

____

MEDICAL INFORMATION

Medical Health (include pertinent medical & surgical history, chronic medical conditions, nutritional information including regular diet, history of TB, STDs, infectious disease, dental history, transgender issues, list any developmental delays or if they were premature or pregnancy to term)

____

Medical History: ☐ Diabetes (☐ Type 1 ☐ Type 2) ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Problem ☐ Eating Problem ☐ Vitamin B or D Deficiency ☐ Heart Problem ☐ Kidney Problem ☐ Loss of Consciousness Due to Head Trauma ☐ Date of last menstrual cycle ________ ☐ Other: ________

Surgical History: ☐ Low Back Pain ☐ Heart ☐ Joint ☐ Organ Transplant ☐ Other: ________

Medical Clearance: ________ **Pregnant:** ________ **Level of Functioning:** ________

Allergy: ☐ NKDA **Allergic to:** ________

Reaction: ☐ Anaphylaxis ☐ Hives ☐ Itching ☐ Swelling of Lips, Tongue, Eyes, Face, etc. ☐ Shortness of Breath ☐ Wheezing ☐ Tightness in Chest ☐ Difficulty Swallowing/Breathing

Primary Medical Care Provider & Contact Information: ________

Medications (Include contraceptive pills, current, & history of medications taken and discontinued): ________

How much? ________ How frequent? ________ If stopped, why? ________
How much? ________ How frequent? ________ If stopped, why? ________

UNIVERSAL CLINICAL INTAKE

Medical Record #: ____________

COVID Vaccination Status:
☐ Moderna Dose 1: ________ Dose 2: ________ Dose 3: ________
☐ Pfizer Dose 1: ________ Dose 2: ________ Dose 3: ________
☐ J&J/Jassen Dose 1: ________ Dose 2: ________
☐ Not vaccinated

If positive history of COVID infection/Date of infection or positive test: ____________

Are you up to date with your immunizations (school aged youth)? ________
History of Trauma Experienced or Witnessed:
☐ Abuse ☐ Neglect ☐ Violence ☐ Sexual Assault ☐ Denies ☐ Other: ____________
History of Trauma Comments: ____________

CHEMICAL DEPENDENCY/ALCOHOL SUBSTANCE USE

Drug and Alcohol History (including age of first use for each substance, administration, periods of abstinence, dates and length of last treatment episodes and results, last use)

____

Substance Use:
☐ Alcohol Qty used daily: ______ x ____ years Last intake (qty): ________ Date & Time: ________
☐ Opioid Qty used daily: ______ x ____ years Last intake (qty): ________ Date & Time: ________
☐ Benzo Qty used daily: ______ x ____ years Last intake (qty): ________ Date & Time: ________

Withdrawal Potential: ____________ **Relapse Potential:** ____________
Does consumer believe he/she has a substance issue? ☐ Yes ☐ No
If yes, does consumer believe he/she needs help with it? ☐ Yes ☐ No
Nicotine Use: ☐ Yes ☐ No If yes, how much nicotine? ____________
Caffeine Use: ☐ Yes ☐ No If yes, how much caffeine? ____________

SUICIDE/HOMICIDE RISK ASSESSMENT

Do you currently feel like you want to die? ☐ Yes ☐ No
When was the last time you had thoughts of dying and how often?

____

Has anything happened recently to make you feel this way?

____

Have you thought about how you will kill yourself (or others)?

____

Do you have access to potentially harmful objects or items? (e.g., guns, drugs)
When would you do it? ____________
Have you tried to kill yourself (or others)? When & how? ____________
***Suicidal** ☐ Denies ☐ Ideation ☐ Plans ☐ Means ☐ Intent ☐ History Comments: ________
***Homicidal** ☐ Denies ☐ Ideation ☐ Plans ☐ Means ☐ Intent ☐ History Comments: ________
Safety Plan: ☐ Yes ☐ No ☐ N/A **Duty to Warn:** ☐ Yes ☐ No ☐ N/A

Mental Status Examination	
General:	☐ Well-groomed ☐ Unkempt ☐ Relaxed ☐ Tense ☐ Other
Sensorium:	☐ Alert ☐ Responsive ☐ Attentive ☐ Inattentive ☐ Confused ☐ Other
Behavior:	☐ Cooperative ☐ Interested ☐ Anxious ☐ Hostile ☐ Apathetic ☐ Agitated ☐ Guarded ☐ Passive ☐ Other
Eye Contact:	☐ Good ☐ Fair ☐ Poor ☐ Other

UNIVERSAL CLINICAL INTAKE

Medical Record #: ____________

Speech:	☐ Normal ☐ Slurred ☐ Verbose ☐ Soft ☐ Loud ☐ Rapid ☐ Monotone ☐ Mute ☐ Pressured ☐ Unspontaneous ☐ Other
Thought Process:	☐ Coherent ☐ Goal Directed ☐ Rambling ☐ Blocking ☐ Preservative ☐ Loose Association ☐ Circumstantial ☐ Tangential ☐ Flight of Ideas ☐ Other
Thought Content:	☐ Relevant ☐ Preoccupation ☐ Obsessions ☐ Paranoid ☐ Grandiose ☐ Jealous ☐ Religious ☐ Somatic ☐ Delusions ☐ External Influence ☐ Ideas of Reference ☐ Phobias ☐ Other
Mood/Affect:	☐ Appropriate ☐ Euthymic ☐ Depressed ☐ Hopeless ☐ Constricted ☐ Euphoric ☐ Anxious ☐ Irritable ☐ Hostile ☐ Elated ☐ Sullen ☐ Labile ☐ Other
Sensory Perception:	☐ Illusions ☐ Derealization ☐ Depersonalization ☐ WNL
Hallucinations:	☐ Denies ☐ Visual ☐ Auditory ☐ Gustatory ☐ Tactile ☐ Olfactory
Describe Hallucinations:	

COGNITIVE FUNCTIONS

Orientation:	☐ Time ☐ Person ☐ Place ☐ Situation		
Immediate:	☐ Intact ☐ Impaired	If impaired, add comment:	
Short-Term:	☐ Intact ☐ Impaired	If impaired, add comment:	
Long-Term:	☐ Intact ☐ Impaired	If impaired, add comment:	
Ability to Pay Attention:	☐ Intact ☐ Impaired	If impaired, add comment:	
Ability to Do Simple Math:	☐ Intact ☐ Impaired	If impaired, add comment:	
Good Judgement Capacity:	☐ Intact ☐ Impaired	If impaired, add comment:	
Insight:	☐ Intact ☐ Impaired	If impaired, add comment:	

DISPOSITION

Assessment:	☐ Cannot safely be treated at another level of care ☐ Medically Stable ☐ DSM-5/ICD-10 Diagnosis ☐ Harm to Self ☐ Harm to Other ☐ Gravely Disabled		
Consultation with the Psychiatrist?	☐ Yes ☐ No ☐ Other	If yes, indicate the provider:	
Treatment Recommendation(s):	☐ Admission (AIU/CIU) ☐ Medication Clinic ☐ RRP ☐ NB ☐ ERSP ☐ ACS ☐ LINC ☐ CASD ☐ CSS ☐ HHCC ☐ Tulaika ☐ Referred Out ☐ Other		
Consultation with a Provider?	☐ Yes ☐ No	If yes, indicate the provider:	
Provisional Diagnostic Impression (DSM-V & ICD-10 Codes):			

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SAFE-T Protocol with C-SSRS - Recent

STEP 1: Identify Risk Factors
C-SSRS Suicidal Ideation Severity

	Past Month		Since Last Visit	
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	☐ Yes	☐ No	☐ Yes	☐ No
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	☐ Yes	☐ No	☐ Yes	☐ No
If YES to the second question, continue. If NO to the second question, go directly to questions for C-SSRS Suicidal Behavior.				
3) Suicidal thoughts with Method (without Specific or Intent to Act) *Have you been thinking about how you might kill yourself?*	☐ Yes	☐ No	☐ Yes	☐ No
4) Suicidal Intent (without Specific Plan): *Have you had these thoughts and had some intention of acting on them?*	☐ Yes	☐ No	☐ Yes	☐ No
5) Suicide Intent with Specific Plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	☐ Yes	☐ No	☐ Yes	☐ No

C-SSRS Suicidal Behavior	Lifetime		Since Last Visit	
Suicide Behavior Questions: **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** **Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills buy didn't swallow any, held a gun but changed your mind, tried to shoot yourself, tried to hang yourself, etc.**	☐ Yes	☐ No	☐ Yes	☐ No
If YES, was it within the past 3 months?	☐ Yes		☐ No	

Other Risk Factors (Check all applicable)	
Activating Events:	**Treatment History:**
☐ Recent losses or other significant event(s) (e.g. legal, financial, relationship, etc.)	☐ Previous psychiatric diagnosis and treatments
	☐ Hopeless or dissatisfied with treatment
☐ Pending incarceration or homeless	☐ Non-compliant with treatment
☐ Current or pending isolation or feeling alone	☐ Not receiving treatment
Other: *(please specify)*	**Clinical Status:**
☐	☐ Hopelessness
	☐ Major depressive episode
	☐ Mixed affect episode (e.g. Bipolar)
	☐ Command hallucinations to hurt self
	☐ Chronic physical pain or other acute medical problem
	☐ Highly impulsive behavior
	☐ Substance abuse or dependence

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	☐ Agitation or severe anxiety
	☐ Perceived burden on family or others
	☐ Homicidal ideation
	☐ Aggressive behavior towards others
	☐ Refuses or feels unable to agree to safety plan
	☐ Sexual abuse (lifetime)
	☐ Family history of suicide
☐ **Access to lethal methods: Ask specifically about presence or absence of firearm in the home or ease of accessing other means**	**If Access to lethal methods question was clicked, please briefly describe means and access (e.g. "access to medications in bathroom at home")**

Step 2: Identifying Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal:	**External:**
☐ Fear of death or dying due to pain or suffering	☐ Belief that suicide is immoral/high spirituality
☐ Identifies reason for living (e.g. child(ren), job, etc.)	☐ Responsibility to family others/living with family
☐ Other	☐ Supportive social network of family or friends
	☐ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent	
C-SSRS Suicidal Ideation Intensity	
Frequency ***How many times have you had these thoughts?***	**Duration** ***When you have the thoughts, how long do they last?***
☐ Less than once a week	☐ Fleeting – few seconds or minutes
☐ Once a week	☐ Less than 1 hour/some of the time
☐ 2-5 times a week	☐ 1-4 hours/a lot of time
☐ Daily or almost daily	☐ 4-8/most of the day
☐ Many times each day	☐ More than 8 hours/persistent or continuous
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?***	**Deterrents** ***Are there things – anyone or anything (e.g., family, religion, pain of death) – that stopped you from wanting to die or acting on thoughts of suicide?***
☐ Easily able to control thoughts	☐ Deterrents definitely stopped you from attempting suicide
☐ Can control thoughts with little difficulty	☐ Deterrents probably stopped you
☐ Can control thoughts with some difficulty	☐ Uncertain that deterrents stopped you
☐ Can control thoughts with a lot of difficulty	☐ Deterrents most likely did not stop you
☐ Unable to control thoughts	☐ Deterrents definitely did not stop you
☐ Does not attempt to control thoughts	☐ Does not apply

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Reasons for Ideation	Total Score
<u>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</u>	
☐ Completely to get attention, revenge or a reaction from others	
☐ Mostly to get attention, revenge or a reaction from others	
☐ Equally to get attention, revenge or a reaction from others and to end/stop the pain	
☐ Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)	
☐ Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)	
☐ Does not apply	

Use Total Score to aid clinical judgment -
Moderate (6-10) 11x times the risk of suicide
Mod. Severe (11-15) – 13x times the risk of suicide
Severe (16-20) – 19x times the risk of suicide
Very Severe (21-25) – 34x times the risk of suicide

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level	
<u>High Suicide Risk</u> ☐ Suicide ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) ☐ Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)	*If High Suicide Risk* – ***1. If applicable,*** *activate on-site response and rescue measures (e.g. call 911) or offer option to come into GBHWC main facility immediately for further assessment* ***if consumer is not physically present at time of assessment;*** *2. Initiate admission process; 3/ Stay with consumer until transfer to higher level of care is complete; 4. Follow-up and document outcome of psychiatric evaluation/consultation; 5. Develop safety plan*
<u>Moderate Suicide Risk</u> ☐ Suicide ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3) Or ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) Or ☐ Multiple risk factors and few protective factors	*If Moderate Suicide Risk* - ***1. If applicable,*** *offer option to come into GBHWC main facility during normal business hours* ***if consumer is not physically present at time of assessment;*** *2. Directly address suicide risk; 3. Implement prevention strategies (e.g. Provide Local and National Crisis Line Numbers, Decrease access to means, etc.); 4. Develop safety plan*
Low Suicide Risk ☐ Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2) Or ☐ Modifiable risk factors and strong protective factors Or ☐ No reported history of Suicidal Ideation or Behavior	*If Low Suicide Risk* - *1. Referral to Outpatient Program Services; 2. Develop safety plan*

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Step 5 Documentation	
Risk Level:	**Clinical Note:**
☐ **High Suicide Risk**	☐ Clinical Observation (e.g. Intake Interpretive Summary, Progress Note)
☐ Moderate Suicide Risk	☐ MSE Information (e.g. Intake Interpretive Summary, Progress Note)
☐ Low Suicide Risk	☐ C-SSRS Form
	☐ Provision of Local 647-8833 and National Crisis Line 1-800-273-TALK(8255)
	☐ Safety Plan

Staff Name & Signature: ______________________ **Date:** ______________________

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Safety Plan

Step 1:	What is the one thing that is most important to me and worth living for?

Step 2:	What are some warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing?

Step 3:	What are some things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity, etc.)?

Step 4:	What are some social settings that can provide distraction?	
	Who are some people that can distract me?	
	Name:	Phone:
	Name:	Phone:
	Name:	Phone:

Step 5:	Who are some people I can ask for help?	
	Name:	Phone:
	Name:	Phone:
	Name:	Phone:

Step 6:	Who are some professionals or agencies I can contact during a crisis?	
	Name:	Phone:
	Name:	Phone:
	Name:	Phone:

Step 7:	What are some ways I can make my environment safer?

Client Name & Signature: ______________________ Date: ____________ Staff Name & Signature: ______________________

GBHWC Crisis Hotline: (671)647-8833

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SIGNATURE SHEET

Please sign and date each time you engage in a clinical intervention (i.e., consumer contact, evaluation, etc.)

THIS IS A LIVING DOCUMENT! KEEP ON TOP.

Filling Order for Inpatient Charts: Right Front

Outpatient Charts: Left above all Documents

DATE	EMPLOYEE LEGIBLY PRINT NAME	SIGNATURE	Initial	Title (i.e. RN)

Consumer's Name: ___________________________

Chart #: ____________ Date of Birth: ____________

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______________________ TAKE HOME INSTRUCTIONS

(Consumer's Name)

☐ Return to the Guam Behavioral Health and Wellness Center *(Open 24 hours a day)* if you being to feel like harming yourself or others.

☐ Call **Crisis Hotline** (*24 hours a day*), if you feel you need to talk to someone about your problems at **(671) 647-8833**

☐ Return to GBHWC the next working day for a *full intake appointment* with an intake counselor

Date:______________ Time:______________ Provider:_________________________

☐ Return to GBHWC the next working day for a ______________________________ appointment

Date:______________ Time:______________ Provider:_________________________

☐ Call **Medication Clinic** at the GBHWC during regular business hours *(MON-FRI 8:00 AM-5:00 PM)*, if you are experiencing side effects or have questions about your medications at **(671) 647-5345.**

☐ Call GBHWC if you feel like harming yourself or others at **(671) 647-5325 OR 647-5440** (*MON-FRI 8:00 AM – 5:00 PM)*

☐ Call Guam Police Department (GPD) at **911,** if you feel you are in danger at any time or if your child is "beyond control".

☐ Immediately go to Guam Memorial Hospital (GMH) or your family doctor for treatment of:

____

☐ Take your medications only as prescribed.

☐ Seek routine treatment for the following medical condition/symptoms with your family physician or hospital: ____

☐ Call Catholic Social Services about homeless shelter services at **(671) 637-1307**

☐ Call your private insurance provider for a list of therapist and make an appointment for follow-up treatment.

☐ Call **VARO** at **(671) 477-5552,** if you are in danger of domestic abuse.

☐ Call the following Government of Guam Department:________________________________

To request assistance with:____

☐ Attend AA/NA meetings as often a possible

☐ Call Guam Memorial Hospital (GMH) Emergency Room at **(671) 647-2489**, if you experience emergency medical issues.

Other:____

____

Instructed by:______________________________________ **on:**____________________

(GBHWC Professional Name) (Date)

I understand these instructions:______________________________**on:**____________________

(Consumer Signature) (Date)

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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Policy Title: Clinical Intake Assessment
Policy No: CL-AP-03
Initiated by: Clinical Committee / Cydsel Toledo

Date	Signature
2/1/2022	[signature]

Jennifer Cruz
Supervisor Community Support Services Division

Date	Signature
2/3/22	[signature]

Barsen Adelbai
Management Analyst III – Medical Records Supervisor

Date	Signature
2/7/22	[signature]

James Cooper-Nurse, PhD
Child Adolescent Services Division Administrator

Date	Signature
2/28/2022	[signature]

Reina Sanchez, M.A
Clinical Administrator

Date	Signature
2/28/2022	[signature]

Ariel Ismael, MD
Medical Director

Date	Signature
2-2-22	[signature]

Leonora Urbano MSN, RN-BC
Nursing Administrator

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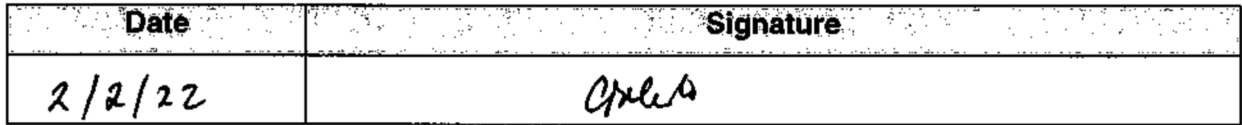

Date	Signature
2/2/22	[signature]

Cydsel Victoria Toledo

Management Analyst IV- Quality Management/Accreditation Compliance

Date	Signature
3/1/22	[signature]

Carissa Pangelinan

Deputy Director