

Service Request Form

Consumer Information	
Consumer Name:	Birth Date:
Street Address:	City:
County:	Zip Code:
Medicaid Number:	SSN:
Phone Number:	
Developmental Disability Diagnosis:	
Level of Intellectual Disability: <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Borderline <input type="checkbox"/> N/A	
Does the person have a current mental health diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health Diagnosis:	
Does the person have a current Person Centered Plan (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No PCP Date:	
Does the person have an HCBS Plan of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medications, Dosage/Frequency and Purpose: (Attach list if needed)	
Medical Issues:	
Current placement and history of previous placements:	
Has he/she hurt someone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has he/she hurt self? <input type="checkbox"/> Yes <input type="checkbox"/> No

Parent/Guardian Information			
Parent/Guardian Name:			
Street Address:		City:	
County:		Zip Code:	
Phone Number:		Cell Number:	
E-Mail:			
Managed Care Organization (MCO) Information			
MCO:			
Name of Care Coordinator/Contact Person:			
Street Address:		City:	State: Zip:
Phone Number:		Fax Number:	E-Mail:
Agency Information			
Is a Community Developmental Disabilities Organization (CDDO) involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, has the CDDO been notified of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CDDO:			
Is there a current Developmental Disability Profile (DDP) or BASIS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Community Service Provider:			
Case Manager's Name:			
Street Address:		City:	Zip Code:
1 st Phone Number:		2 nd Phone Number:	
Fax Number:		E-Mail:	
Date CSP/QMS contacted by CDDO:			
CSP/QMS Name:		E-Mail:	
Phone Number:		Fax Number:	
Is the individual currently receiving mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other mental health services:			
CMHC:			
CMHC Case Manager:			

Person Making Contact	
Contact Name:	Phone Number:
Affiliation:	
Agency Requested: <input type="checkbox"/> KNI <input type="checkbox"/> PSH&TC	
Requested service(s) (one or more):	
<input type="checkbox"/> Admission	<input type="checkbox"/> Behavioral/Psychological Consultation
<input type="checkbox"/> Medical Consultation	<input type="checkbox"/> Outpatient Sex Offender Treatment Consultation (PSH&TC)
DDT&TS/Outreach Services: <input type="checkbox"/> Behavior Consultation <input type="checkbox"/> Staff Training Services	
Evaluation/Assessment:	
<input type="checkbox"/> OT/PT/Adaptive Equipment	<input type="checkbox"/> Speech/Hearing
	<input type="checkbox"/> Psychological
Notes on service(s) requested:	
Date of Request:	

Note: All consents must be witnessed

DUAL DIAGNOSIS TREATMENT & TRAINING SERVICES

PARSONS STATE HOSPITAL & TRAINING CENTER

IDENTIFYING INFORMATION

Person being served:

Name: _____ Birth Date: _____

Where does the person live? Please check one of the following:

- | | |
|--|---|
| <input type="checkbox"/> At home with immediate family | <input type="checkbox"/> By him/herself |
| <input type="checkbox"/> At home with a foster family | <input type="checkbox"/> In a home with 8 or fewer residents |
| <input type="checkbox"/> At home with a relative | <input type="checkbox"/> In a facility with more than 8 residents |

Other: _____

DEVELOPMENTAL DISABILITIES AGENCY INFORMATION

Developmental Disability: _____

Tier Level: _____

Community Developmental Disabilities Organization (CDDO):

Community Support Provider (CSP) Information:

Agency (ies) _____

Day Services: _____

Residential Services: _____

Developmental Disabilities Case manager _____

Case manager's office address _____

City

Zip

Case manager's phone number _____

Case manager's email address _____

MENTAL HEALTH AGENCY INFORMATION

Is the individual currently receiving mental health services? Yes No

Psychiatrist _____

Community Mental Health Center (CMHC) information, if utilized:

CMHC Name _____

Street Address

City

Zip

CMHC phone number _____

Mental Health (MH) Therapist _____

MH Case manager _____

Mental Health Diagnoses

Please list only the current mental health diagnosis

Diagnosis

Age of Onset if known

Hospitalizations

Has the person ever been hospitalized *for behavioral or emotional problems*?

No

Yes If yes, please provide the hospital name and the admission and discharge dates for each.

Hospital	Admission Date	Discharge Date

SCHOOL INFORMATION

Is the person CURRENTLY in school? Yes No Highest grade this person has completed. _____

Does this person currently have behavioral problems at school? Yes No

Would you like an outreach consultant to work with your child's school? Yes No

Name of Teacher _____

Name of School _____

School address _____

School Phone _____

BEHAVIORAL INFORMATION

Has a behavioral specialist been consulted prior to today? Yes No

If yes, please indicate the type of practitioner providing behavioral consultation.

Psychologist Autism Specialist School Behavioral Consultant
 Behavioral Analyst Positive Behavior Supports Specialist Other _____

Please indicate whether this individual has been involved with any of the following in the **past 3 months**

- The Judicial system Yes No
- Social Services Yes No
- Inpatient Mental Health Treatment Yes No

Has the person previously received services from DDT&TS? Yes No

If yes, please provide the date(s) for pervious consultations:

In the past THREE Months (ONLY):

- | | | |
|--|------------------------------|-----------------------------|
| 1. Did the person injure him/herself? For example, did the person bite him/herself, insert items into body or cavities or into the skin, bang his/her head on the wall or floor, etc.? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Did the person hit, scratch, kick, bite or otherwise physically attack others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Did the person display behaviors such as screaming, crying, tipping over furniture, knocking materials to the floor, etc.? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Did the person destroy or damage property (i.e. breaking windows, throwing furniture, tearing up clothing, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Did the person demonstrate noncompliance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Was the person verbally aggressive against others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How often do these behaviors currently occur? Hourly Daily Weekly Monthly or less often

How severe are the behaviors?

Mild: disruptive with little risk to property or health

Moderate: property damage or minor injury

Severe: Significant threat to health or safety

Situations in which behavior is most likely to occur:

Days/Times _____

Settings/Activities _____

Persons Present _____

What usually happens right Before the behavior?

What usually happens right After the behavior?

**Please return all documents to the Admissions Coordinator, Karen VanLeeuwen at fax number:
620.421.3623**

**Parsons State Hospital & Training Center
Dual Diagnosis Treatment & Training Services
2601 Gabriel Avenue, P.O. Box 738
Parsons, KS 67357-0738**

620-421-6550 x1695 Main Fax: 620-421-3623 DDT&TS Fax: 620-421-1499

**I authorize the release of information for/to Parsons State Hospital & Training Center/
Dual Diagnosis Treatment & Training Services:**

NAME _____ BIRTHDATE _____

ADDRESS _____ SSN _____

↑ TO ↓ FROM **Managed Care Organization:**

Name _____ Position/Relationship _____ Phone _____

Agency _____ Street Address _____

City _____ State _____ Zip _____ Fax _____

Information is to include:

All medical, social, psychological, behavioral, educational, psychiatric and other pertinent information **OR**

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> School |
| <input type="checkbox"/> Social | <input type="checkbox"/> Behavioral |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Psychological | |

Other _____

Information is to be used for:

- Placement purposes
- Treatment planning
- Consultation and recommendations
- To assist with legal proceedings
- To assist others in planning/providing services
- Educational planning/placement

Other _____

This Authorization expires on _____.
If left blank authorization will expire 30 days after the case is closed.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____

Consent will not be considered valid without a witness' signature and a client or parent/guardian signature. A public notary is not necessary. I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact PSH&TC in writing. I understand that PSH&TC cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any consultation recommendations provided by PSH&TC. I understand that records obtained by PSH&TC may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by PSH&TC may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if the information is collected by someone who is not a health care provider it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge PSH&TC/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization.

Form updated: 9/20/2013

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 Dual Diagnosis Treatment & Training Services
 2601 Gabriel Avenue, P.O. Box 738
 Parsons, KS 67357-0738

620-421-6550 x1695 Main Fax: 620-421-3623 DDT&TS Fax: 620-421-1499

**I authorize the release of information for/to Parsons State Hospital & Training Center/
 Dual Diagnosis Treatment & Training Services:**

NAME _____ BIRTHDATE _____

ADDRESS _____ SSN _____

↑ TO ↓ FROM The following Agency/Individual:

Name: _____ Position/Relationship _____ Phone _____

Agency _____ Street Address _____

City _____ State _____ Zip _____ Fax _____

<p>Information is to include: All medical, social, psychological, behavioral, educational, psychiatric and other pertinent information OR</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Medical <input type="checkbox"/> Social <input type="checkbox"/> Special Education <input type="checkbox"/> Psychological Other _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> School <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychiatric </td> </tr> </table>	<input type="checkbox"/> Medical <input type="checkbox"/> Social <input type="checkbox"/> Special Education <input type="checkbox"/> Psychological Other _____	<input type="checkbox"/> School <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychiatric	<p>Information is to be used for:</p> <input type="checkbox"/> Placement purposes <input type="checkbox"/> Treatment planning <input type="checkbox"/> Consultation and recommendations <input type="checkbox"/> To assist with legal proceedings <input type="checkbox"/> To assist others in planning/providing services <input type="checkbox"/> Educational planning/placement Other _____
<input type="checkbox"/> Medical <input type="checkbox"/> Social <input type="checkbox"/> Special Education <input type="checkbox"/> Psychological Other _____	<input type="checkbox"/> School <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychiatric		

This Authorization expires on _____.
 If left blank authorization will expire 30 days after the case is closed.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____

Consent will not be considered valid without a witness' signature and a client or parent/guardian signature. A public notary is not necessary. I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact PSH&TC in writing. I understand that PSH&TC cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any consultation recommendations provided by PSH&TC. I understand that records obtained by PSH&TC may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by PSH&TC may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if the information is collected by someone who is not a health care provider it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge PSH&TC/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization.

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CONSENT FOR VIDEOTAPING

I/we authorize Parsons State Hospital/Dual Diagnosis Treatment & Training Services (DDT&TS) to videotape my son/daughter/ward/self _____ as deemed necessary to evaluate behavior(s). This tape will be used for evaluation and training (e.g., in-servicing staff, presentations, etc.) purposes only. I understand that I have the right to withdraw this consent at any time and that I have the right to view any videotape made of my son/daughter/ward. I understand that the videotapes may be kept for future reference by the DDT&TS team following the consultation, but will not be released to anyone without my express written consent to release any videotape(s).

This consent will expire on _____.

If left blank, this consent will expire 30 days after the case is closed except as indicated above.

Client/Consumer Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated: 9/20/2013

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CONSENT FOR EVALUATION AND TREATMENT

I/we grant permission for Parsons State Hospital and Training Center / Dual Diagnosis Treatment & Training Services (DDT&TS) team to complete a full evaluation of my son/daughter/ward/self, _____, which may include any or all of the following: observe; share information; review records, make behavior support recommendations; and, if necessary, pilot various behavior support strategies.

I realize when behavior supports are initiated there exists the possibility of a temporary (i.e., few days or weeks) of increased or worsening of behaviors for which my son/daughter/ward was referred. I understand that all of the information regarding the evaluation will remain confidential.

This consent will remain in effect until it is expressly revoked in writing or until one year from the date signed, whichever occurs first.

Client/Consumer Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated: 9/20/2013

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**Informed Consent/Assent to Allow Environmental Manipulations Procedures
by the DDT&TS Outreach Consultation Team**

I/we grant permission for the Dual Diagnosis Treatment & Training Services (DDT&TS) team to conduct environmental manipulations of the behavioral antecedents and consequences (Functional Behavior Analysis) for behavior exhibited by my son/daughter/ward/self, _____ . I understand that I may revoke this consent at any time. The behavioral antecedents and consequences of my son/daughter/ward's behavior are being manipulated so that the DDT&TS Outreach personnel can better determine the causes of behavior resulting in a referral for services. An additional purpose for these procedures is to provide the community support team with recommendations for behavioral planning that will likely lead to increased successful community living. I understand that manipulations of the antecedents and consequences of aberrant behavior can result in a temporary increase in those behaviors. I understand that the DDT&TS Outreach personnel conducting these manipulations will provide agency staff with training so that staff can be involved in this process. I further understand that these manipulations will not take place without a detailed outline provided in writing to the requesting agency and the parent/guardian (if applicable). This consent will remain in effect until it is expressly revoked or until one year from the date signed, whichever occurs first.

Client/ Consumer Signature

Date

Parent/Guardian Signature

Date

Agency Personnel

Position

Date

Witness Signature

Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature. Form updated 1/25/11. I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact DDT&TS verbally or in writing. I understand that DDT&TS cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any intervention documentation provided by DDT&TS. I understand that records obtained by DDT&TS may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by DDT&TS may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if someone who is not a health care provider collects the information, it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge DDT&TS/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization.

Form updated: 9/20/2013

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CONSENT FOR Email

I/we authorize the Dual Diagnosis Treatment & Training Services (DDT&TS) to communicate with community support team members about my son/daughter/ward/self _____ via electronic mail/communication service. I understand that this communication cannot be guaranteed to be secure.

RISKS ASSOCIATED WITH EMAIL

- Some, but not all, of the risks with email are listed here:
- Email can be immediately broadcast worldwide and received by many intended and unintended recipients;
 - Email senders can easily misaddress an email;
 - Email is easier to falsify than handwritten or signed documents;
 - Backup copies of email may exist even after the sender or recipient has deleted his or her copy;
 - Employers and on-line services have a right to archive and inspect emails transmitted through their systems;
 - Email can be intercepted, altered, forwarded, or used without authorization or detection;
 - Email can be used to introduce system computer viruses; and
 - Email can be used as evidence in court.

I understand these risks and agree to allow the use of email for communication purposes. Should I change my email address, I will notify DDT&TS. Should I decide to revoke consent for email communication, I will send written revocation by postal mail.

This consent will expire on _____.

If left blank, this consent will expire 30 days after the case is closed.

Client/Consumer Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated: 9/20/2013