Official Use Only

☐ ID

☐ Ins Card

Last: _____First:_____ MI: ____Date of Birth: _____Age: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Cell Phone: _____ Last 4 digits Social: _____

US Citizen: _____Lawful Perm US Resident: _____Township you live in: _____

Race/Ethnicity: Black ☐ White ☐ Hispanic ☐ Asian ☐ Native America ☐ Other: _____

Sex: _____ Gender: _____ Pronouns: _____

Education Level: Less than high school ☐ High school graduate/GED ☐ Some college ☐ College Graduate ☐

Marital Status: Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐

Housing: Own your home ☐ Rent ☐ Homeless ☐ Other_____

Emergency Contact: Name_____ Phone_____

How did you hear about us? _____ Email _____

What support needs do you have today:

_____

_____

_____

Are you court-ordered, out of jail, or on probation? ☐ Yes ____No ☐

Do you have a Probation Officer? Yes No PO Name: _____ #:_____

Court:_____ Judge:_____

Do you have a felony? ☐ Yes ☐ No Faith Based? ☐ Yes ☐ No

Did you ever serve in the military? ☐ Yes ☐ No # of years of service? _____

Do you currently have a primary care physician? Yes ☐ No ☐ Who? _____Year last seen: _____

Please list any mental health or addiction services you have been enrolled in:

FINANCIAL ASSISTANCE ELIGIBILTY

Self Pay Sliding Fee Scale	HHI Minimum	HHI Maximum	Fee Per Service
1	$0	$10,000	$1
2	$10,001	$20,000	$2
3	$20,001	$30,000	$3
4	$30,001	$40,000	$4
5	$40,001	$50,000	$5
6	$50,001	$75,000	$10
7	$75,001	$99,999	$25
8	$100,000	$150,000	$75
9	$150,001	$200,000	$135

1. *Does the client have active Medicaid?* ☐ No ☐ Yes
2. *Does the client or the client's parent(s) receive food stamps?* ☐ No ☐ Yes
3. *Does the client or the client's parent(s) receive TANF?* ☐ No ☐ Yes
4. Is the client under the age of 18? ☐ No ☐ Yes
5. Size of family unit: _____ (Number of individuals supported by the family income)
6. Explain annual income- Wage Earner #1 _____ Wage Earner #2_____

   Wage Earner #3_____ Wage Earner #4_____
7. Total annual gross household income: _____
8. Verification of income: *(Check all that apply)*
   - ☐ Paycheck stub(s)
   - ☐ Unemployment
   - ☐ Other Income
   - ☐ Social Security Disability
   - ☐ Child Support. Alimony
   - ☐ Supportive documentation of income unavailable
9. Explain "Other" Income: _____
10. *Is the client's income less than 200 % of poverty considering the size of the family unit?* ☐ No ☐ Yes

Review the table below:

Check one:

☐ My signature certifies that the total gross household income is accurate. _____
Client Signature Date

☐ My signature certifies I have no income. _____
Client Signature Date

This form was completed and the information updated in computer by: _____
Staff Name Date

PATIENT ACKNOWLEDGEMENTS / CONSENTS

1. I agree to be evaluated by a member of the Turning Point clinical staff. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.
2. I understand these services are voluntary and that I may revoke consent at any time.
3. I understand therapy sessions are private and conversations during therapy cannot be recorded without consent from both the patient and provider.
4. I understand that for my safety, my medication fill history may be obtained electronically from the pharmacy database to ensure thorough medication reporting.
5. I understand student nurses/therapists may be involved in my treatment and I can refuse treatment that is provided by them at any time.
6. I have been offered a copy of my Turning Point SOC Rights and Responsibilities regarding services being provided. A copy of these Rights and Responsibilities will be posted in the office in which I will be receiving treatment, or I may review them on Turning Point's website: www.turningpointsoc.org.
7. I have received a summary of Turning Point's Notice of Privacy Practices. I am aware that detailed information is available upon request and is available on Turning Point's website: www.turningpointsoc.org
8. I and/or the patient being admitted will be financially responsible to pay Turning Point for any costs incurred to collect this debt, including but not limited to collection fees, interest fees, and attorney fees. I understand that some services may be court mandated. I understand also that some services may include preparation of reports, testimony, and other non-direct patient services.
9. **Financial (Payment, Charges & Billing)**
   - I understand these services will be charged at the rate discussed with me.
   - I agree to notify Turning Point of changes that may affect my fee.
   - **I understand that payment is due at the time of service, and that all co-pays are due at each visit.** Any other arrangements must be approved in advance.
   - I understand that I am responsible for any remaining balance after insurance has paid or if insurance does not pay.
   - I agree that in order for Turning Point Systems of Care to collect any amounts I may owe; you may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of adialing service, as applicable.
   - This is to advise you that unless otherwise requested, the Turning Point will file all services with your insurance company and/or Medicaid/Medicare. If you request, we not bill your insurance company, you will be responsible for your entire balance or can request scholarship if available.

By signing below, I acknowledge that the corresponding statements and information have been explained and reviewed with me, and I understand them. I voluntarily consent to participate in treatment.

Client Signature Date	Client Printed Name
Client Representative Signature (if applicable) Date	Representative's Relationship to Patient

For Office Use Only: ☐ Client refused to sign per _____ *(Staff Initials)* ☐ Client unable to sign per _____ *(Staff Initials)*

Turning Point System of Care

CLIENT RIGHTS AND RESPONSIBILITIES

Client:_____ DOB:_____ SS#:_____

Welcome to Turning Point System of Care! You are entitled to certain rights during your treatment. These rights are guaranteed by your provider, by TPSOC and, in certain respects, by state and federal law statute. Your rights include:

1. Access to equal treatment without regard to gender, race, religion, age or handicap, including the right to practice your religion.
2. Treatment that is free from abuse, financial or other exploitation, retaliation, humiliation and neglect.
3. A full and clear explanation of services available. Your right to make informed consent, refusal, or expression of choice about: service delivery, release of information, concurrent services, composition of the service delivery team, and involvement in research projects, if applicable.
4. Protection of your privacy and confidentiality under state and federal guidelines. In most cases this means that records cannot be released unless you specifically authorize that release. Please be aware that information about possible child abuse, including physical and sexual abuse, neglect and/or threats to the direct safety of your child must be reported to the responsible state agency. Also, if it is learned that you or your child intends to harm themselves or someone else, your treatment providers are required to take steps to attempt to prevent such harm. Your information will not be used for any type of marketing purposes.
5. A clear and complete description of the treatment proposed, as well as your obligation in carrying out that treatment.
6. Access to your or your child's record, unless portions of the record are determined by medical staff to be detrimental to you or your child. Access to information pertinent to care will be provided in sufficient time for you to make decisions regarding your treatment.
7. Cooperation in obtaining an independent second opinion and/or legal counsel at your own expense at any point in the treatment process.
8. To know the credentials of your provider(s) and the scope of services they can deliver.
9. Access to a clear description of the process through which you may express any concerns or complaints about your care. To be able to express concerns and grievances without reprisals and a process to appeal the decision of the grievances. The right to investigation and resolution of any alleged infringement of rights.
10. To send and receive mail, telephone calls and receive visitors unless counter-indicated by your treatment and when these occur be fully explained.
11. To have access or referral to legal entities for appropriate representation, self-help and advocacy support services, and for your provider to adhere to research guidelines and ethics if you would choose to participate in any form of research and/or experimental procedures.
12. To access DMHA, call 800-901-1133, for TDD, call 317-232-7844 or for Indiana Disability Rights call 317-722-5555 (local), 800-622-4845, 317-722-5563 (Local TTY), 800—838-1131 (Toll Free TTY) or www.indianadisabilityrights.org.

In signing this, I indicate that I understand and accept the rights and responsibilities outlined above. I have had an opportunity to ask questions and discuss this information.

_____	_____	_____
Signature/Custodial Parent/Legal Guardian	Date	Relationship
_____	_____	
Witness	Date	

Turning Point System of Care

Authorization for Communication via Text

Turning Point recognizes the need to protect the privacy of your Protected Health Information (PHI). It is important that you understand texting is not a secure mode of communication.

If you choose to participate in text communication with Turning Point, please note:

- Because text communications are not secure, they should contain limited information.
- For your protection, do not send personal identifiers via text messages, such as your last name, age, birth date, social security number, etc.
- Staff response to text message will not contain any protected health information.
- Texting should not be used as a means to reach staff after regular hours, on the weekends, or when staff is on leave. (This may be different for Crisis Navigation Clients)
- In the case of an after hours emergency, please call the Turning Point Main line at (765) 860-8365 or dial 911.

By signing below, I give Turning Point permission to communicate with me via text. I am aware that texting is not secure, and that the confidentiality of the texts I send cannot be guaranteed. I understand and agree to the terms listed above.

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Client/Parent/Guardian Name

turning point
A SYSTEM OF CARE

Client's Clinical History

Client Name: _____ **Date of Birth:** _____

Guardian Name *(if applicable):* _____

Race / Ethnicity:

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Two or More Races ☐ Asian

☐ Native Hawaiian and Other Pacific Islander ☐ Prefer not to disclose ☐ Other _____

Marital History:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Re-Married ☐ Prefer not to disclose

☐ Other _____

Gender Identity / Expression:

☐ Male ☐ Female ☐ Male-to-Female/Transgender ☐ Female-to-Male/Transgender

☐ Genderqueer, neither exclusively male nor female ☐ Prefer not to disclose

☐ Other _____

Sexual Orientation:

☐ Straight or Heterosexual ☐ Homosexual, Gay, or Lesbian ☐ Bisexual ☐ Prefer not to disclose

☐ Other _____

Current Living Situation *(check* 1):

☐ Own Home ☐ Foster Care ☐ Relative Placement ☐ Legal Guardian ☐ Pre-Adoptive Home

☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention

☐ Other _____

History of Living Situations (check any that have ever applied}:

☐ Own Home/parent's home as an adult ☐ Foster Care ☐ Relative Placement as a child

☐ Legal Guardian ☐ Pre-Adoptive Home ☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention

☐ Other _____

Supportive Individuals:

Name:	Relationship:	Age:	Quality of Relationship:
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent

Education History: *(Highest Completed Education)*

☐ High School ☐ GED ☐ Some College ☐ College ☐ Masters/PHO

☐ IEP - Individualized Education Program ☐ Dropped Out

Legal Status / Criminal History:

☐ None Reported ☐ Arrested ☐ Current Probation/Parole ☐ Past Probation/Parole

Charges: _____ ☐ Sentencing ☐ Dismissed

Time Served: _____

☐ Current Court Involvement (details) _____

☐ Previous Court Involvement (details) _____

☐ Previous Child Welfare Services Involvement (details) _____

Employment History:

☐ Part-Time ☐ Full-Time ☐ Unemployed ☐ Retired ☐ Veteran ☐ Active Duty ☐ N/A

Current Employment: _____

Previous Employment: _____

Mental Health Diagnosis & Treatment History:

Diagnosis _____ Treatment _____ Length of Treatment _____

Is this current? = How do you feel you are doing & is Diagnosis being managed: ☐ Good ☐ Fair ☐ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

Is this current? = How do you feel you are doing & is Diagnosis being managed: ☐ Good ☐ Fair ☐ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

Is this current? = How do you feel you are doing & is Diagnosis being managed: ☐ Good ☐ Fair ☐ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

Is this current? = How do you feel you are doing & is Diagnosis being managed: ☐ Good ☐ Fair ☐ Poor

Substance Abuse History: N/A

Substance:	Typical Amount Used:	Duration of Use/Abuse:	
			☐ Current
			☐ Current
			☐ Current
			☐ Current
			☐ Current
Drug of Choice:			☐ Current

Treatment Preferences *(include individual needs):*

☐ Individual ☐ Family ☐ Group ☐ Other _____

Personal / Family Strengths:

Abilities/Interests:

_____ _____

Client (Guardian) Signature **Date**

REACH is a safe environment for youth to gather, share, and encourage one another. To ensure safety and privacy of all participants, we ask that participants (and parents/guardians) read and sign our Member Agreements.

The following agreements apply to any of REACH's programming: Recovery Circle, Youth Wellness Recovery Action Planning, KHS and Excel Center Affirming Peer Groups, 1-1 Peer Coaching, and Academic Assistance.

Member Agreements

- I will come to group at least 24hrs sober and not currently under the influence of illicit drugs or alcohol. I understand tobacco and vapes are illegal and I will not bring/use those.
- I will not be violent or demeaning to group members.
- I will respect the privacy of others. What is said in confidence, stays in confidence.
- Recovery Circle and WRAP are safe places to discuss and learn about skills that support sobriety. I can share my past, but I will focus forward on my recovery.
- I will keep my scheduled appointments. If I can't be on time, I will contact my coach in advance.
- Cell phones and electronic devices will be stored away at the beginning of REACH activities until the activity is over.
- Knives, guns, or any weapons are not permitted on the premises. Failure to comply will result in being asked to leave or contacting authorities.
- I will attend other healthcare appointments assigned and/or necessary for my personal growth and recovery.

Failure to comply with agreements will result in being asked to leave or potentially being removed from services altogether.

I have read, understood, and will follow the above agreements. I understand I can revoke my consent for participation or social media at any time by informing Turning Point staff in writing.

_____ _____

Member Signature Parent/Guardian Signature

I consent to my picture being taken and used on Turning Point's social media accounts.

_____ _____

Member Signature Parent/Guardian Signature

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CODE OF CONDUCT

The YMCA is committed to providing a safe and welcoming environment for all members and guests. To promote safety and comfort for all, we ask individuals to act appropriately at all times when they are in our facility or participating in our programs

We expect persons using the YMCA to behave in a mature and responsible way, and to respect the rights and dignity of others. Our Code of Conduct outlines prohibited actions. The prohibited actions listed below are not totally inclusive of all behaviors that are inappropriate but include:

- Using offensive language, wearing revealing clothing, and exposing inappropriate tattoos.
- Please wear your swimsuit only in the pool area and locker rooms. Closed toed shoes, shorts (finger length) or pants and full length shirts are required in other areas of the facility.
- Making physical contact with another person in any angry or threatening way.
- Engaging in sexual activity, language, or inappropriate contact with another person.
- Harassing or intimidating by words, gestures, body language, or any other menacing behavior.
- Stealing or other behavior that results in the loss or destruction of property.
- Carrying or concealing any weapon, device, or object which may be used as a weapon.
- Abusing or defacing the YMCA building or its equipment.
- Using or possessing illegal drugs or alcohol on YMCA property.
- Smoking including vaping. All YMCA facilities and grounds are smoke-free environments.
- Displaying threatening, inappropriate or offensive conduct.
- Posting unapproved materials. Ask Membership Services Director for permission to post flyers in the YMCA facility or on the surrounding property.
- The use of cameras and cell phones is not allowed in the locker room or bathroom areas.
- Inappropriate use of video recording devices.
- Conducting or participating in paid personal training or other instructional sessions with an instructor not employed by the Y.

In addition, The YMCA reserves the right to deny access or membership to any person who has been accused or convicted of any crime involving sexual abuse; is a registered sex offender; habitually or excessively uses narcotics or dangerous drugs.

Child Print Name:_____

Parent/Guardian Signature: _____