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CENTERS FOR PEOPLE WITH DEVELOPMENTAL & BEHAVIORAL HEALTH CHALLENGES

712 South Ave.
Pittsburgh, PA 15221
412-243-3400

777 Penn Center Blvd.
Building 7, Suite 200
Pittsburgh, PA 15235
412-731-9707

Welcome to Milestone Centers Inc. We offer a comprehensive network of service provided by experienced, professional staff. This letter confirms your first scheduled appointment, which will last approximately 1 ½ hours.

It is very important that you arrive at your scheduled appointment time. If you are unable to keep the appointment that has been scheduled for you, please contact the office at least 24 hours prior to your scheduled appointment.

If you have insurance, please bring your insurance card(s) so we may make a copy for your records. If your insurance requires a co-pay, you will be responsible to bring it to your appointment.

If you are uninsured, you will need to bring all of the following items that apply to you:

- Three most recent pay stubs, or Social Security verification (bank statement).
- Verification of child support or alimony that you pay.
- Verification of mandatory retirement payments or union dues (if not included in your pay stub).
- Letter from Public Assistance/Welfare that states you are not eligible for benefits through that program.
- Copies of Health Insurance premiums or bills.
- Verification letters or copies of checks or bank statement showing payments made to anyone in your household: pension, alimony, child support, unemployment compensation.
- Statement showing real estate tax amounts.
- Medical expenses.
- Copy of last Federal Income Tax Return.
- Workman's compensation.

If you have any questions or concerns about your insurance information, please call one of our offices.

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Personal Identification Policy

It is the policy of Milestone Centers Inc. to take reasonable steps to validate and protect personally identifiable information that is provided by individuals seeking and/or receiving our services. As part of our commitment, you will be asked to provide at least one form of identification (from the list below) at the time of your first appointment.

Subsequent requests to provide information will be made annually and/or when you report a change to your name, change in your address, or when you report a change in insurance coverage. A copy of the provided identification will be maintained in your client record.

- Driver's License
- School Photo ID
- U.S. Military Card
- Social Security Card
- U.S. Passport
- U.S. Citizen ID Card
- School Report Card
- Clinic/Doctor Record
- Daycare School Record
- Employment Authorization Document
- State Photo ID Card
- Voter's Registration Card
- Military Dependent's ID Card
- Native American Document
- Nursery School Record
- Permanent Resident Card
- School Record
- Hospital Record
- Birth Certificate

What can I do if I need someone to listen?

Milestone is here to respond by phone to your emergency needs 24/7/365. Call the office anytime. After business hours, calls will be forwarded to an on-call clinician who will provide assistance.

Allegheny County Peer Support Warm Line Services also provide operators who offer support and information to persons 18 years of age and older. Hours of service are 2 p.m. – 10 p.m.
The phone number is **1-866-661-WARM (9276)**.

Have you received treatment before or are you on medications?

Please bring with you the contact information for the providers from whom you received treatment and/or a list of your current medications.

Thank you

Please check: **VOTER REGISTRATION**

_____ Application

_____ Reapplication/Recertification/Renewal

_____ Change of Address

PREFERENCE FORM

Name (Please print: Last Name, First, M.I.)

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

☐ Yes

☐ No OR ☐ No, I'm already registered to vote where I live now.

IF YOU DECIDE NOT TO CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you apply to register to vote, the office at which you submit this registration application form will remain confidential.

No information relating to a preference to register to vote will be used for any purpose other than for voter registration.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day of the next election, you must have been a citizen of the United States for at least one month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election.

If you believe that someone has interfered with your right to register or your application to register to vote, or your right to choose your own political party preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, PA, 17120, or call the Department of State, toll free, at 1-877-VOTESPA (1-877-868-3772).

_____ _____

Signature Date

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Notice of Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Client Name _____ Date of Birth _____

(Please print)

Client Signature _____ Date _____

OR

Legal Representative _____ Date _____

If you are the legal representative of the person listed above, please check off the basis for your authority:

_____ Power of Attorney (attach copy) _____ Parent of Minor _____

_____ Guardianship Order (attach copy) _____ Other _____

_____Unable to provide the Notice of Privacy Practices

_____ Consumer/Client Refused to Accept Explanation _____

Associate Signature _____ Date _____

Client ID #:

_____

CLIENT BILL OF RIGHTS

1. You have the right to be treated with dignity and respect.
2. You have the right to receive medically necessary treatment regardless of age, sex, ethnicity, national origin, marital status, sexual orientation, disability, or religion.
3. You have the right to participate in the development and review of your Individualized Service Plan (ISP).
4. You have the right to confidentiality and privacy regarding your treatment in accordance with State and Federal law. See the Notice of Privacy Practices for more details.
5. You have the right to expect reasonable safety in respect to agency practices and the environment.
6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish treatment goals.
7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.
8. You have the right to be unrestricted and private communication including:
    a. being assisted by an advocate of your choice in the assertion of your rights
    b. seeing a lawyer at any time
    c. filing and complaint and having your complaint heard and adjudicated in a timely manner
9. You have the right to request, in writing, to review your clinical record. Upon receipt of the request and appropriate approval, you will be granted access.
10. You have the right to refuse services and to be informed of the medical consequences, if any, of this action. If you have been ordered to our agency by a court of law, your right to refuse service may be limited by the court.
11. You have the right to know our method of determining fees for service and your responsibility for payment.

CLIENT RESPONSBILITIES

1. You are responsible for providing accurate information about your current issues and past illnesses.
2. You are responsible for following your ISP. If you do not understand your plan, you need to speak to your treatment team.
3. You are responsible for reporting unexpected changes in your condition to your provider.
4. You are responsible for your actions if you do not follow your provider's instructions or refuse treatment.
5. You are responsible for keeping all your appointments, and when unable to do so, notify your provider 24 hours in advance.
6. You must assure that financial obligations of your healthcare are fulfilled and that any changes in your insurance are reported immediately.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Bill of Rights Client Name: _____ ID #: _____

VOLUNTARY CONSENT TO RECEIVE SERVICES

A representative of Milestone Centers Inc. has explained to my satisfaction what services are available for me, any biological child or other individual for whom I have legal custody/guardianship. I understand the rights, responsibilities and liabilities of a client of Milestone Centers Inc. I am also aware of the agency grievance policy and procedures to resolve complaints regarding personnel or services.

I am aware Milestone Centers Inc. is required to report information about services rendered here to Managed Care Companies, County, and State Governments.

I voluntarily consent to receive services as a client of Milestone Centers Inc. or authorize delivery of services by Milestone Centers, Inc. to the individual(s) for whom I have legal custody/guardianship.

_____

Print name of Client, Parent or Guardian

_____ _____

Signature of Client, Parent or Guardian Date

_____ _____

Witness/Title Date

☐ Copy received by Client

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Initial Assessment Form

Name: _____

DOB: _____

In order to best serve you, we would like to know some things about you (or your child or the person receiving services). If you have any questions about anything we've asked, please ask your clinician for assistance.

1. **Living Arrangements (Please check one)**

☐ Homeless

☐ With natural or adoptive family member(s) in family residence

☐ Independently alone with spouse or non-relative

☐ CYF foster care/group home

☐ CRR/CLA supported living

☐ Drug/Alcohol facility

☐ Nursing care facility

☐ MH or I&DD state facility

☐ Personal Care Home/IF/MR

☐ Other

2. **Household Members**

Name	Relationship	Date of Birth

3. **Employment (Check One)**

☐ I work full time over 30 hours

☐ I work part time under 30 hours

☐ I am unemployed, looking for work

☐ I am unemployed, not looking for work

☐ Homemaker

☐ Disabled

☐ Retired/Ongoing volunteer work

☐ Subsidized employment/employment training

☐ Full time student

4. Are you a Veteran?

☐ Yes From _____ to _____

☐ No

5. **Education**

☐ Preschool (0-3)

☐ Kindergarten-4th grade

☐ 8th grade

☐ Special School (1-3 years)

☐ Special School (4-6 years)

☐ Special School (7 or more years)

☐ 1-3 years high school/vocational/technical

☐ 4 years high school/vocational/technical

☐ 1-3 years college/business/technical

☐ 4 years college/business/technical

☐ Graduate/professional school (1 or more years)

☐ Graduation Date: _____

6. Legal

☐ Paroled from prison:_____

☐ Probation:_____

☐ Juvenile Detention Center:_____

☐ Court Supervision:_____

☐ Awaiting Trial:_____

☐ Awaiting Sentencing:_____

☐ Refuse to provide information:_____

7. Prior State Service

☐ No prior state MH/I&DD/DA service

☐ Both PA state mental hospital and PA state I&DD center

☐ PA state corrections

☐ PA state mental hospital

☐ PA state restoration center

☐ PA state mental retardation center

☐ Unknown

8. **Mental Health History:** Have you or any of your relatives (related by blood) had any of the following mental health problems? If a blood relative, please write down the relationship to you (i.e. parent, brother, sister, etc.) in the comment section.

Problem	Self	Family	Comment
Anxiety			
Attention Deficit Disorder			
Bipolar Disorder			
Eating Disorder			
Emotional Abuse			
Hallucinations			
Panic Attacks			
Paranoia			
Schizophrenia			
Depression			
Sexual Abuse			
Suicidal Ideas/Attempts			
Anger Problems/Violence			
Thoughts of Harming a Living Creature			

9. Have you had any Hospitalizations in the past?

☐ Yes (please complete below) ☐ No

Hospital	City	Date	Reason

10. Medical History

PCP: _____ Phone: _____

Address: _____ City: _____

When did you last see your PCP? _____ Reason: _____

If you are female, are you pregnant? ☐ Yes ☐ No ☐ Unsure

Do you have any medical problems? (i.e. –heart, liver, thyroid, diabetes, cancer, etc.?)

_____

_____

Does pain currently interfere with your activities?

☐ No ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Are you taking any prescribed medication? ☐ Yes ☐ No

Name of Medication	Dose	When Taken	Reason	Prescribed By

Do you currently, or have you ever had, medication or other allergies?

☐ No ☐ Yes, please describe:

_____

_____

Do you currently have any side effects from medication you are taking?

☐ No ☐ Yes, please describe:

_____

_____

Weight: _____ Height: _____

Has your weight changed? ☐ No ☐ Yes

If yes, by how much? (- or +) _____

Nutritional Screening (please check) ☐ Other: _____

☐ No Problem ☐ Not Eating ☐ Liquids Only ☐ Change in Appetite

☐ Nausea ☐ Vomiting ☐ Trouble Chewing/Special Diet ☐ Special Diet

11. <u>Substance History/Current Use (Please indicate level of use for each substance)</u>

Substance	No Use	Past Use	Current Use	Family History	Comments/Frequency
Alcohol					
Caffeine					
Cocaine					
Hallucinogens					
Hashish					
Heroin					
Inhalants					
Marijuana					
Stimulants					
Tobacco					
Other					

Is there anything else about your medical/health history and safety issues that you would like to tell us about?

_____

_____

_____

_____

Signatures:

_____	_____	_____
Person Completing Form	Date	Relationship to client

_____	_____	_____	_____
Other	Date	Other	Date

Name: _____

Date of Birth: _____

Initial Assessment Date: _____

Child Development: Must be completed for children 1-18 years of age

(To age 21 if IEP or with developmental disabilities) ☐ Does Not Apply

Pregnancy: ☐ Planned ☐ Unplanned ☐ Normal ☐ Complications ☐ Premature ☐ Unknown

Explain: _____

Delivery: ☐ Natural ☐ Prepared ☐ Unprepared ☐ Difficult ☐ Uneventful Labor was _____ hours

Birth weight: _____ Apgar score: _____ Birth Defects: _____

Family stressors during pregnancy: _____

Explain: _____

Exposure to Toxins: ☐ Drugs ☐ Alcohol ☐ Disease ☐ None

Insults: ☐ Prenatal ☐ Perinatal ☐ Post-natal Explain: _____

Development: Post-natal Difficulties: ☐ Weight gain ☐ Eating ☐ Sleeping ☐ Daily routine ☐ None

Milestones: Timing/Delay in development in _____ area(s)

☐ Crawling ☐ Walking ☐ Toilet training ☐ Speech and language ☐ Other (Explain):

_____

Strengths, Interests, Activities:

_____

_____

Problem	N/A	Past	Present	Comments
Parent/Child Conflict				
Sibling Conflict				
Peer Problems				
Attention Seeking				
Temper Tantrums				
Nightmares				
Cheating				
Lying				
Assaultive Behavior				
Cruelty to Animals				
Fire Setting				
Run-away				
Stealing/Shoplifting				

Is client involved with gang activities or knows someone who is? ☐ Yes ☐ No ☐ Not Sure

Is client involved in satanic cults/rituals or knows someone who is? ☐ Yes ☐ No ☐ Not Sure

Academic History: Involvement in special education classes: ☐ Yes ☐ No

When? _____ Why? _____

Names and Dates of Schools: _____

School Behavior: Suspensions/Expulsions/Poor Conduct Reports ☐ Yes ☐ No

Do you get along with teachers and peers? ☐ Yes ☐ No

Number of days absent from school and why/compared with last year _____

Period of time when client missed a significant amount of school _____

Number of days tardy and why _____

Has client ever taken a weapon to school? ☐ Yes ☐ No

Academic Performance: Current grades _____

How grades compare with last year/semester _____

How much time is spent on homework? _____

Could grades better/how? _____

_____

Signature:

_____ _____ _____

Person completing form | Date | Relationship to client

INITIAL ASSESSMENT	Client Name:	DOB:
Revised 6/9/17	Client ID:	