



SERVICE APPLICATION PACKAGE

LIFESPRING MENTAL HEALTH SERVICES

CONFIDENTIALITY OF PATIENT RECORDS

Confidentiality Generally:

All information regarding patients is confidential and may be accessed only by authorized personnel of Lifespring or by the written consent of the patient or his/her legal representative. Exceptions to this policy are stated below.

Confidentiality of Alcohol and Drug abuse Records:

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law. (42 CFR Part 2). Generally, the program may not disclose any information regarding your treatment to any person outside the program. This includes indicating that you attend the program or disclosing any information identifying you as an alcohol or drug abuser.

Violation of federal law by a program is a crime. Suspected violation may be reported to appropriate authorities in accordance with federal regulations.

Exceptions to Confidentiality:

Communication relating to your treatment may be disclosed if:

- a. You consent in writing.
- b. The disclosure is required or allowed by a Court order as outlined in I.C. 16-4-8-3.2.
- c. The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit or program evaluation, or to others pursuant to a qualified service organization agreement.
- d. It involves information concerning suspected abuse or neglect of a child or adult dependent person. State and federal laws do not protect such information from being reported under state law to appropriate state or local authorities.
- e. It involves information concerning a crime committed by a patient either at the program or against any person who works for the program or concerns a threat to commit such a crime.
- f. A program staff person reasonably believes that you present a serious danger of violence to yourself or another person. The required steps to prevent violence may include: warning the intended victim of the danger, notifying the police, or taking whatever other steps are reasonably necessary under the circumstances.

Prohibition of Redisclosure:

For those records covered by the Federal Drug and Alcohol confidentiality Law, each disclosure made with the patient's written consent will be accompanied by a statement that further disclosure of the patient's information is prohibited unless permitted by federal regulations.



NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact LifeSpring's Privacy Officer.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your chart.
- All departments and units of LifeSpring.
- Any member of a volunteer group we allow to help you at LifeSpring.
- All employees, staff and other personnel of LifeSpring.
- All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or LifeSpring operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at LifeSpring. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by LifeSpring. Other Health Care Rehabilitation Facilities may have different policies or notices regarding use and disclosure of your medical information.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE ARE REQUIRED BY LAW TO DISCLOSE MEDICAL INFORMATION ABOUT YOU.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We will use and disclose medical information about you when we have a "Duty to Report" under state or federal law, because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public Health Risks.** We will disclose medical information about you for public health reporting required by federal or state law. These activities generally include the following:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - to notify the appropriate government authority if we believe a Client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We will disclose medical information as required by law to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we will disclose medical information about you when properly ordered to do so by a court.
- **Law Enforcement.** We will release medical information if asked to do so by a law enforcement official, and if permitted by law:
 - In response to a court order;
 - If required by state or federal law;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at a LifeSpring facility; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Protective Services for the President and Others.** We will disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, psychologists, nurses, social workers, therapists, technicians, medical students, or other LifeSpring personnel who are involved in taking care of you. Different departments of LifeSpring also may share medical information about you in order to coordinate the different things you need. We also may disclose medical information about you to people outside LifeSpring, such as other health care providers involved in providing medical treatment for you and to people who may be involved in your medical care, such as family members, clergy or others we use to provide services that are part of your care.

- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at LifeSpring, or other health care providers from whom you receive treatment, may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at LifeSpring so your health plan will pay us or reimburse you for your treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose medical information about you for LifeSpring operations or to another health care provider or health plan, if you have a relationship with that health care provider or health plan. These uses and disclosures are necessary to run LifeSpring and make sure that all of our Clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Clients to decide what additional services LifeSpring should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, social workers, therapists, nurses, psychologists, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Health Care Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific Clients are.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at LifeSpring.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release certain limited information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical 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.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all Clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with Clients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for Clients with specific medical needs, so long as the medical information they review does not leave LifeSpring. We may ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at LifeSpring.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about Clients of LifeSpring to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to LifeSpring's Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, under some circumstances you may request that the denial be reviewed. Another licensed health care professional chosen by LifeSpring will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for LifeSpring.
To request an amendment, your request must be made in writing and submitted to LifeSpring's Privacy Officer. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by or for LifeSpring;
 - Is not part of the information which you would be permitted to inspect and copy; or
 - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you.
To request this list or accounting of disclosures, you must submit your request in writing to LifeSpring's Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs 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.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a specific treatment session you had.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.



"People
helping people
help
themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Mental Health and Addiction
402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

You have just been registered in the Hoosier Assurance Plan (HAP). HAP is the primary system used by the state to fund public mental health and addiction services. HAP is intended to ensure service availability to the Indiana population in greatest need of mental health and addiction services.

As a participant in HAP, you are eligible for a continuum of services as they are needed. This continuum includes individualized treatment planning, 24 hour crisis intervention, case management, outpatient services, acute stabilization services, residential and day treatment programming, family support services, medication monitoring and services to prevent unnecessary hospitalization.

DMHA contracts with HAP provider organizations who provide the continuum of care, at the most appropriate level based on individual need, for all individuals who meet diagnostic, functioning level and income criteria. In most cases, HAP will not cover 100% of the cost of your care. Individuals registered with HAP are expected to participate in paying for their care based on their financial ability through a sliding fee schedule. The HAP provider organization you choose will help you determine the amount of your share of treatment costs.

As a consumer of publicly funded mental health and/or addiction services, you have certain rights and responsibilities. You should receive a formal list of patient rights from your HAP provider organization.

Rights:

- You have the right to the privacy and the confidentiality of your clinical records with the few exceptions built into the Indiana Statute (IC 16-39), Confidentiality of Drug and Alcohol Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You have the right to appropriate treatment that allows you the opportunity to improve your condition.
- You have the right to at least an annual review of your treatment.
- You have the right to have your complaints investigated.
- You have the right to join a support group.
- You have the right to change your case manager, therapist or doctor if you have a conflict that cannot be resolved.

Responsibilities:

- You must ask for treatment.
- You must actively participate in your treatment and work with your care provider.
- You should call when you have a problem.
- You must pay your part of the cost of your treatment and/or have your insurance billed.

If you have concerns or compliments about the services you receive from your HAP provider, please call the toll free consumer service line at 1-800-901-1133. The consumer service line has been established for consumers, families, and others to express their thoughts or concerns related to mental health and/or addiction service delivery. Also, please be aware that there are resources available to provide support to people with mental health or addiction disorders. Ask your provider for more information about mental health and/or addiction self help groups such as Indiana Alliance on Mental Illness, Mental Health America, Depression and Bipolar Support Alliance, Key Consumer Organization or other similar support groups.

Date Received: _____

www.IN.gov/fssa
Equal Opportunity/Affirmative Action Employer



Client's Initials: _____

To request restrictions, you must make your request in writing to LifeSpring's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to LifeSpring's Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.lifespr.com. To obtain a paper copy of this notice, contact LifeSpring's Privacy Officer.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each of our facilities. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to LifeSpring for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with LifeSpring or with the Secretary of the Department of Health and Human Services. To file a complaint with LifeSpring, contact LifeSpring's Privacy Officer at (812) 280-2080. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Name of Client

Witness's Signature

Client's Signature

Date

Date

Reason Given by Client for Refusing to Sign this Notice



CLIENT NAME _____ (Please print)

1. CONSENT FOR TREATMENT:

I the undersigned do hereby consent to diagnostic and treatment procedures deemed necessary by the clinical/medical staff of LifeSpring Mental Health Services and Turning Point Center.

2. CONFIDENTIALITY OF CLIENT RECORDS AND PATIENT RIGHTS:

I have received the following information from LifeSpring/Turning Point: "Confidentiality of Client Records," and the "LifeSpring Patient Handbook" which includes Patient Rights and Patient Responsibilities information. I understand that I should read these notices as soon as possible. I further understand that I should feel free to ask my therapist/physician any questions regarding these items.

3. SPECIAL SERVICES (Turning Point Center):

I understand that the cost of any special services, such as special medication, emergency medical transportation, physician office calls, dental visits, etc., will be my personal responsibility.

4. PARTICIPATION IN RECREATIONAL ACTIVITIES:

I hereby relieve LifeSpring/Turning Point Center of any liability from injury/illness which may result from group recreational activities as conducted off the LifeSpring/Turning Point Center premises.

5. RELEASE OF INFORMATION FOR THIRD PARTY PAYMENT (INSURANCE):

I authorize LifeSpring/Turning Point Center to release copies of any of my medical records and or financial information necessary to file any claim for payment of my account by any health, sickness or accident insurance company, or in connection with worker's compensation, to others responsible for insurance claims and investigations, upon presentation to LifeSpring/Turning Point Center of reasonable evidence that said carrier has in effect a policy or policies covering my healthcare services.

I understand that this release will include but not be limited to the following (1) Diagnosis, (2) Admission history to include family, social and PSYCHIATRIC/medical history, (3) Discharge Summary to include dates of treatment, outcome of treatment, prognosis, response to treatment, (4) Physical examination, (5) Laboratory and x-ray reports, (6) and DRUG AND/OR ALCOHOL information.

6. FINANCIAL RESPONSIBILITY:

I understand and agree that I (the patient) am responsible for any eligible, accumulated charges/balance not covered and/or paid by insurance or other third party payor. This includes co-payments, deductibles, and usual and customary allowances. It is further agreed that, in the event legal action is required in order to enforce payment of this account, I (the patient) will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceedings.

7. ASSIGNMENT OF INSURANCE BENEFITS:

I (the patient) authorize payment directly to LifeSpring/Turning Point Center of the medical benefits, if any, otherwise payable to me for LifeSpring's/Turning Point Center's services as described but not to exceed the reasonable and customary charge for these services.

Patient or guardian

Date

Relationship to patient

Witness

Please list any medical problems that affect you, past or present:

Problem	current	past	Name of Treating Doctor

Have you had a physical exam in the last 6 months? Yes ____ No ____ If yes, when & by whom? _____

Have you had a dental check-up in the past year? Yes ____ No ____

Are your immunizations up-to-date? Yes ____ No ____

Do members of your family have a history of the following?

____ gastrointestinal disease ____ alcoholism/drug disease ____ heart disease ____ high cholesterol
 ____ kidney disease ____ cancer ____ seizure disorder
 ____ liver disease ____ emotional/psychiatric ____ diabetes

Please list all medical hospitalizations, other than childbirth, you have had within the past 5 years:

Name of Hospital	Date

Are you currently taking any medication (including over-the-counter)? Yes ____ No ____ If yes, specify:
 Medication Why taking it Who prescribed

Have you ever taken any psychiatric medication? Yes ____ No ____ If yes, specify:
 Medication Why taking it Who prescribed

Previous Treatment: Psychiatric/Substance Abuse

Facility	Level of Continuum	Dates	MD/Therapist	Diagnosis	Outcome

Nutritional Screening: Do you experience any of the following?

	Yes	No	Describe
Binging			
Purging			
Excessive exercising			
Laxative use			
Absence of Menses			
Compulsive overeating			
Other			
Changes in eating habits			

Weight loss ____

Number of pounds ____

Weight gain ____

Within ____ days ____ weeks ____ months

*Any problems identified in this section will result in referral to the Nutritionist for a more thorough assessment.

Continued on reverse side...

Patient Name _____ Patient Number _____

Pain Assessment:

Do you hurt? Yes _____ No _____

How bad is your pain? Please circle the face that best describes your pain.

(Severity of 3 or more requires further assessment.)

**0****No
Pain****1****Hurts A
Little****2****Hurts A
Little More****3****Hurts
Even More****4****Hurts A
Whole Lot****5****Hurts The
Worst**

Where is your pain? _____

Are you being treated for your pain? Yes _____ No _____ If yes, is the treatment Helpful? Yes _____ No _____

Client Signature _____ Date _____

To be completed by interviewing clinician:Patient has listed a medical condition necessitating further follow-up.
LifeSpring physician review requested.**Yes****No**

Patient has listed a pain condition of 3 or more.
LifeSpring physician review requested.

Nutritionist Referral Indicated.

Date: _____ Time: _____

Immunizations Up-to-Date?

If no, specify: _____

Comments: _____

Signature of Interviewing Clinician _____ Date _____

Follow-Up Action:

This Medical Questionnaire was reviewed today. The patient _____ was present _____ was not present

Recommendations:

_____ No intervention by LifeSpring physician indicated.

_____ Patient will be instructed to have follow-up with personal physician for _____.

_____ Patient will be instructed to have appointment with LifeSpring physician.

Signature of Reviewing Physician: _____ Date _____

SWB Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree

D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

- | | |
|---|-----------------|
| 1. I don't find much satisfaction in private prayer with God. | SA MA A D MD SD |
| 2. I don't know who I am, where I came from,
or where I am going. | SA MA A D MD SD |
| 3. I believe that God loves me and cares about me. | SA MA A D MD SD |
| 4. I feel that life is a positive experience. | SA MA A D MD SD |
| 5. I believe that God is impersonal and not interested in
my daily situations. | SA MA A D MD SD |
| 6. I feel unsettled about my future. | SA MA A D MD SD |
| 7. I have a personally meaningful relationship with God. | SA MA A D MD SD |
| 8. I feel very fulfilled and satisfied with life. | SA MA A D MD SD |
| 9. I don't get much personal strength and support
from my God. | SA MA A D MD SD |
| 10. I feel a sense of well-being about the direction
my life is headed in. | SA MA A D MD SD |
| 11. I believe that God is concerned about my problems. | SA MA A D MD SD |
| 12. I don't enjoy much about life. | SA MA A D MD SD |
| 13. I don't have a personally satisfying relationship with God. | SA MA A D MD SD |
| 14. I feel good about my future. | SA MA A D MD SD |
| 15. My relationship with God helps me not to feel lonely. | SA MA A D MD SD |
| 16. I feel that life is full of conflict and unhappiness. | SA MA A D MD SD |
| 17. I feel most fulfilled when I'm in close communion with God. | SA MA A D MD SD |
| 18. Life doesn't have much meaning. | SA MA A D MD SD |
| 19. My relation with God contributes to my sense of well-being. | SA MA A D MD SD |
| 20. I believe there is some real purpose for my life. | SA MA A D MD SD |

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Pt. Name _____

Pt. Number _____ Date _____

Staff Signature _____

Pt. Signature _____



Subsidy/Discount Application

Verified/Non Verified Income
(Check all boxes as appropriate)

Clients who use the documents below to qualify by income and Indiana residency and complete the affidavit, may receive a discount. First, ask the client what their yearly family income is and the number of persons that is supported by that income. Next, check the subsidy scale, if they fall within the scale, ask if they would like to apply for a subsidy. Then, complete the affidavit.

Date: _____ Client Name: _____ Client ID#: _____

Documents used to verify yearly family income:

- ☐ Current Check Stub
- ☐ W-2 Form
- ☐ Food Stamp/AFDC
- ☐ Tax Return
- ☐ Medicaid Scan Strip indicating Eligibility
- ☐ Non Verified: complete affidavit
- ☐ Other _____

Documents used to verify Indiana residency:

- ☐ Indiana Drivers License
- ☐ Current Utility Bill
- ☐ Food Stamp Card/AFDC
- ☐ Medicaid
- ☐ Rent Receipt
- ☐ None: complete affidavit
- ☐ Other _____

- ☐ **Medicare/Insured/Non-Insured Clients:** Clients will be responsible for any deductibles, co-pay, and/or non-covered services as indicated by the third party carrier.
- ☐ **AFDC/Medicaid Entitlements:** If yes, attach copy of Medicaid Scan/AFDC check stub
Have the client complete the Affidavit. Clients will be responsible for the full amount of Spenddown as required by law.
- ☐ **Unable to verify income:** Indigent, not in work force. (Complete Affidavit) refer to Entitlement Specialist.
- ☐ **Client declines to complete Affidavit: Full Fee, no discount** (Notify Clinician and refer client to Entitlement Specialist).

Income:

Affidavit

I, _____ hereby certify that on this date, ____/____/____, I am unable to pay the full and customary fee for charges as my yearly family income is \$_____. This income supports _____ # of family members. I understand that I am to report any changes in my income and/or residency to LifeSpring. Failure to do so may result in retroactive billing of services at the Center's full fee. In no event will a subsidy cover the full cost of treatment. All charges to a third party will be billed at the full rate. Upon notification from a third party payer you will be billed accordingly. All Subsidies are based upon the full fee.

Residency:

I, _____ hereby certify I am an Indiana resident and understand that a subsidy/discount only applies to Indiana residents. I must report any changes in my residency and/or income immediately.

Admission Staff to circle discount percentage:

Based upon the information reported above, your subsidy/discount is approximately: 90% 75% 50% 25% 0% (full fee)
(NOTE: The minimum fee for any charge is \$10.00)

All Responsible Party payers are to initial each box:

☐ I understand that my subsidy amount is due at the time services are rendered (NOTE: The minimum fee for any charge is \$10.00)

☐ All Third Party benefits (Insurance/Medicare Part B) are assigned to LifeSpring.

Changes in the above information will render this agreement null and void. If the income information provided is purposefully understated to increase the subsidy amount, all assistance will be forfeited and the full cost will be charged. Failure to honor this agreement with payments as agreed will render this agreement invalid. Accounts referred to a collection agency will be charged an additional 20% and/or attorney fees. By my signature I attest that the above statements are true and correct.

Signature of Patient/Guardian

Signature of Responsible Party/Address/City/St/Zip

Support Signature/RU: _____ Witness/Date: _____ / ____ / ____

White-Clinical Chart

Yellow - A/R

Pink - Client

MH-152 (Rev. 6/01 NP)

LIFESPRING, INC.
460 Spring St., Jeffersonville, IN 47130 (812) 280-2080
AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION
(Please Circle)

Patient Name _____ **Date of Birth** _____

Address _____

Authorization to Disclose (patient/guardian must initial appropriate item)

_____ I authorize LifeSpring/Turning Point Center to release confidential patient information to:

_____ I authorize the release of confidential patient information to LifeSpring/Turning Point Center from:

Agency/Person: _____

Address: _____

Phone: _____

Purpose or Need for Disclosure (patient/guardian must initial appropriate item)

_____ Continuity of Care	_____ Social Security Disability Determination
_____ Legal Proceedings	_____ Medicaid Application
_____ Insurance (Third-party Reimbursement)	_____ Armed Services Application
_____ Insurance (Application)	_____ Personal Copy
_____ Other, explain: _____	

Type of Information to be Disclosed (patient/guardian must initial appropriate item)

_____ Any and all treatment records including evaluations of psychiatric, and/or psychological conditions, **alcohol & drug use**, treatment summaries, referral information, progress notes, lab tests including **HIV or AIDS** testing, medications, diagnoses and billing information.

_____ Other, specify any limitations: _____

I understand this authorization will expire as noted below.

☐ At the end of 60 days from signing

☐ At termination of my treatment or at the end of 180 days from signing, whichever is first

☐ On the happening of the following event: _____

Signature of Patient
(Patient must sign if alcohol or drug abuse is involved, even if patient is under 18)

Authorized Signature & Relationship to Patient

Check Status _____ Parent _____ Legal Guardian
_____ Legally Assigned Custodian
_____ Other _____

Date of Signature: _____

Witness: _____

Revocation/Expiration:

This authorization is not required as a condition of treatment and may be revoked at any time. However, revocation does NOT affect information released by this authorization prior to revocation, nor information to be released for billing purposes or other purposes according to law. Unless revoked, this authorization expires upon LifeSpring's/Turning Point Center's termination of patient care and receipt of payment for all services.

Prohibition of Redisclosure:

This release does not authorize subsequent disclosure by its recipients. If the record contains drug or alcohol information, it may be protected by Federal Confidentiality Rules (42CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revoked by: _____ Date: _____