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DEMOGRAPHIC INFORMATION

Date: _____

Name_____ **DOB:** _____

Alias _____ **Type of Residence** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address_____ **Phone** _____

SSN _____ **DL/ ID#** _____ **Race** _____

Ethnicity _____ **Veteran** _____

Referred By: _____ **Birthplace** _____

Primary Language _____ **Gender Identity**_____

Date you became homeless_____ **Number of times you have been homeless**_____

E-mail _____

Do you have Income ☐**Yes** ☐**No** **If so, what is the source of income** _____

Special Needs: ☐ **Physical Disability** ☐**Developmental Disability** ☐ **Chronic Health Condition**

☐**HIV/AIDS** ☐ **Mental Health** ☐**Substance Use** ☐ **Disabling Condition** ☐ **Domestic Violence**

Eligible Services: ☐ **TANF** ☐ **FOOD STAMPS** ☐ **SSI** ☐ **SSD** ☐ **SSA** ☐ **Medicaid** ☐

Medicare ☐ **VA**

Reasons for Visit: _____

_____

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INSURANCE INFORMATION

Name of insured_____

Insured's Workplace_____

Primary Insurance Company_____**Phone**_____**Co-Pay Amt**_____

ID#_____**Group ID#**_____

Secondary Insurance Company _____**Phone** _____**Co-Pay Amt**_____

ID#_____**Group ID#**_____

MEDICAL INFORMATION

Primary Care Physician_____**Phone:** _____

Psychiatrist_____**Phone**_____

Description of past medical problems_____

_____

_____

Please list current medications/dosages **Reason Prescribed**

_____ _____

_____ _____

BACKGROUND INFORMATION

Abuse / Violence	**Trauma**	**Depression**	**Anxiety**
Anger Management	**Self-Esteem**	**Hyperactive**	**Withdrawn**
Suicidal	**Substance Abuse**	**Withdrawn**	**Grief & Loss**
Sexuality Concerns	**Divorce**	**Sleeping problems**	

Additional Information:

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Clients' Rights and Responsibilities

All individuals who apply for services, regardless of gender, race, age, color, creed, financial status, or national origin are assured that their lawful rights as clients shall be guaranteed and protected. While receiving services, the client is assured and guaranteed the following rights and will be requested to exercise the responsibilities listed below. As a client of SPIN I have the right to:

- Be treated with respect and dignity.
- Receive full information regarding services.
- Special accommodation if required.
- Receive services in a timely manner.
- Participate in or refuse services.
- Confidentiality with the following limitations:
    - Breaching confidentiality is only permissible when not doing so puts you the client, and/or another individual, in danger. Examples would be, threats of homicide and/or suicide, disclosure of abuse/neglect/exploitation of children, elders, or disabled individuals, and in cases of medical emergency.

As a client receiving services at SPIN, I am responsible for:

- Reporting any unexpected changes in address, financial, or legal status.
- Keeping scheduled appointments and when unable to do so for any reason I will notify SPIN within 15 minutes.
- My own actions and the consequences of if I choose to refuse mandated services.
- Assuring that my financial obligations are fulfilled in a prompt manner, and when I am unable to do so, speak with the Director as soon as possible.
- Follow facility policies, and procedures that affect client services and conduct
- Providing others with the same privacy that I receive at SPIN, in other words what I see here stays here.

I certify that I have read this document or have had it read to me and explained to me in a language that I understand. I also certify that I have received a copy of this document.

Signature of Client or Representative

_____ Date: _____

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Consent for Services

I voluntarily agree that I will participate in a treatment plan by staff for SPIN. Treatment may be provided by a licensed counselor or an individual supervised by an appropriate supervisor. Services may include interviews, assessment, psychotherapy, case management, classes, individual or group therapies, referral for psychiatric services for evaluation and possible assistance with medications and other services necessary for my wellbeing.

Risks & Benefits:

Behavioral health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. A small number of clients may not improve because of treatment or may terminate before it is clinically indicated. It is important to keep you clinical advised of any difficulty you may encounter during your treatment.

Name (Printed): _____ DOB: _____

Signature: _____Date: _____

Name of Witness (if Client signs with an X): _____

Signature of Witness: _____Date: _____

This consent will expire at the time of discharge from services at SPIN. Information regarding our policies and procedures is provided as part of this informed consent.

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CONSENT TO ASSIGN BENEFIT PAYMENTS

I, _____, herein known as Patient, do hereby assign benefits payable for eligible insurance claims to my Provider, Supporting People in Need, responsible for submitting my claims electronically or in paper form to the group benefits plan.

I authorize the insurer/plan to issue payment directly to the Provider for services rendered. In the event my claim (s) are declined by the insurer/plan, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan of its obligation with respect to that benefit payment. In the event the benefit payment is made to me the insured/plan will also be discharge of its obligation with respect to the benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically or by paper form by the Provider and that I may revoke it at any time by providing written notice to the insured/plan.

Printed Name of Client_____Date_____

Signature_____

If plan member is minor or unable to sign. If I am a spouse, dependent, parent of other authorized party, I confirm that I am authorized by the plan member to execute an assignment of benefits payments to the Provider.

Printed Name of Authorized Agent _____Date_____

Signature_____

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HIPPA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time, and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke my consent is not affected.

Signed this _____ day of _____, 20___

Printed Patient Name_____

Signature_____

Relationship to Patient_____

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Health Statement

The proposed activities, provided by Supporting People in Need, may require participation. In physical exercises. If there is any doubt about your ability to safely participate in this experience, you should consult a physician for a complete examination. (If you have any current medical conditions or history of heart problems, you will need a physical release from a physician.)

Contact your Primary Care Physician within 30 days of intake date: _____

Current Physical and Dental Health: _____

Special Health Needs/Issues or Disabilities: _____

Name of Primary Care Physician: _____

Physician Phone Number: _____

1. Do you have any current medical conditions? _____

2. Have you had or currently have any heart problems? _____

3. Do you suffer from pains in your chest? _____

5. Have you been diagnosed with high blood pressure? _____

6. Are you a smoker? _____

7. Do you have arthritis, joints, or back problems? _____

8. Have you had any operations or serious injuries? _____

9. Do you have any disabilities or chronic illnesses? _____

10. Are there any activities to be limited/discouraged by physician advice? _____

_____

11. Are you allergic to any medicines, insects or pollen? _____

12. Do you have epilepsy? _____

13. Do you have diabetes? _____

14. Do you have any prescribed meal plans or dietary restrictions? _____

15. Are you currently sick or using medication not listed above? _____

16. Do you have infectious disease(s)? _____

17. Please explain any answers marked yes to the above questions:

_____

If a relevant medical condition exists, complete the Collaboration Form.

Advanced Directives: Yes: _____ No: _____

Client/Parent/Guardian Signature: _____ Date: _____

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PHQ-9

Patient Name: DOB: Date of Referral:

PHQ9 Over the last <u>two weeks</u> how often have you been bothered by the following problems?		0 Not at all	1 Several Days	2 More than half the days	3 Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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GRIEVANCE PROCESS

Step 1: Submission of Grievance

- Complete the **Grievance Form** provided by the agency (attached). You can submit the form in person, by mail or email. Contact information is listed on the grievance form.
- Include as much detail as possible about your concern or complaint.

Step 2: Acknowledgment

- Upon receipt of your grievance, the agency will acknowledge receipt within **5 business days** via your preferred contact method.
- If information is missing from your form, the agency may contact you for clarification.

Step 3: Investigation

- The agency will review and investigate your complaint thoroughly and fairly.
- Depending on the nature of grievance, this process may involve interviewing involved parties and reviewing relevant documentation.

Step 4: Resolution

- The agency aims to resolve grievances within **20 business days**.
- You will be informed of the outcome and any actions taken.
- If additional time is needed for the investigation, you will be notified and provided an updated timeframe.

Step 5: Follow-up

- After resolution, the agency may follow up to ensure your concern has been addressed satisfactorily.
- You have the right to appeal the decision if you are unsatisfied with the outcome.

Appeals

- If you wish to appeal the grievance decision, contact the agency directly at the phone number or email provided in the grievance form.
- Appeals will be reviewed by a designated supervisor or the agency's grievance committee.

Submission Instructions

Supporting People in Need:
PO Box 325, Silver City, NM 88062

Phone: 575-956-6131 Email: director@spinhousingnm.org

External Complaint Process

If you are not satisfied with the agency's resolution, you may file a complaint with the **New Mexico Human Services Department (HSD) Behavioral Health Services Division**.

Contact information: **Phone:** (505) 476-8420

Email: BHSComplaints@state.nm.us **Mail:** P.O. Box 23480, Santa Fe, NM

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GRIEVANCE FORM

CLIENT INFORMATION

Full Name**:** _____

Address**:** _____

Phone Number**:** _____Date of Birth_____

Email: _____

Details of the Concern or Complaint: (Attach pages if necessary)

_____

_____

_____

_____

_____

Date of Incident**:** _____

Preferred Contact Method for Follow-up

- Phone
- Email
- Mail

Signature: _____ **Date:** _____

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CONSENT FORM FOR AI

Client Name: _____
Date of Birth: _____
Client ID (if applicable): _____
Date: _____

This form explains how Artificial Intelligence (AI) technology may be used to support your care at SPIN. Please read it carefully and ask any questions before signing.

What is AI and How Is It Used in Your Care?

Artificial Intelligence (AI) refers to computer software that can assist with certain tasks, such as: - Helping your provider take notes or summarize sessions

- Organizing scheduling, assessments, or treatment planning
- Identifying patterns or trends in your care (using secure and anonymized data) -improving administrative efficiency (e.g., transcriptions or reminders)

IMPORTANT: AI tools are used to assist your provider -not replace them. All clinical decisions and therapeutic interactions remain the responsibility of licensed professionals.

What Are You Consenting To? By signing this form, you acknowledge and agree that:

- AI tools may be used to assist with documentation, scheduling, or treatment planning in a way that supports your care.
- Your personal information will only be used with AI systems that comply with HIPAA and other federal privacy laws.
- Only authorized staff will access your data, and all outputs from AI tools will be reviewed by a qualified provider.
- You may ask questions, refuse consent, or withdraw your consent at any time without affecting your care.

Limits and Safeguards

- No AI tools will make final decisions about your diagnosis or treatment plan. - Your information will not be shared with any external or third-party AI systems without written permission.
- All AI tools used are encrypted, secure, and approved by SPIN.
- Optional Use of Session Transcription (if applicable)

Do you consent to the use of AI transcription tools (such as speech-to-text) during your sessions, solely for documentation purposes?
[ ] Yes [ ] No

Acknowledgment and Signature

I have read (or had read to me) the information above. I understand the potential benefits and risks of using AI in my behavioral health care, and I give my informed consent. I understand that I may revoke this consent at any time in writing.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

Staff Witness Signature: _____ Date: _____

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Permission Form for Outings

Child's Name: _____
Parent/Guardian Name: _____
Emergency Contact Name and Number: _____
Date: _____

Activity Details:
Outings can and do occur often. Locations may include a park, a hiking trail, playgrounds, restaurants, movie theaters, etc.

I, the undersigned parent/guardian of the child named above, give my permission for my child to participate in the outing organized by Supporting People in Need. I understand that these outings may involve activities that could result in injury.

In consideration of my child's participation in this outing, I hereby release Supporting People in Need, its employees, agents, and volunteers from all liability for any injuries, damage, or losses that may occur because of my child's participation in this event. This form is valid for 1 year from date of signature.

I acknowledge that I have been informed about the nature of the outing and the potential risks involved. I affirm that my child is in good health and capable of participating in the activities planned for this outing.

Medical Information (if applicable):
Allergies: _____
Medications: _____
Other Relevant Information: _____

Emergency Medical Treatment Authorization:
In the event of an emergency, I authorize representatives of Supporting People In Need to seek emergency medical treatment for my child as necessary.

Signature of Parent/Guardian: _____
Print Name: _____
Date: _____

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Transportation Release

Date: _____

I _____ (Print Name) will allow employees of SPIN to transport myself or my children as listed below as needed. I absolve the SPIN program and its employees from any liability concerning myself or my child/children while being transported.

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Signature: _____ Date: _____

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IDENTIFICATION OF PROBLEMS

What brings you in today?

_____

_____

_____

What alcohol or drugs have you used?

	Daily	Weekly	Monthly	Occasionally	Never
Alcohol					
Fentanyl					
Cocaine					
Methamphetamines					
Heroin					
Pills					
Other					
Other					

At what age did you start using alcohol or drugs?

Have you used alcohol or drugs in the last 30 days?

Have you used alcohol or drugs in the last week?

Have you used alcohol or drugs today?

Are you suicidal?

Have you ever been suicidal?

Have you ever made any suicidal attempts?

When was the last time you felt suicidal?

When was the last time you attempted?

Client Signature: _____ Date: _____

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HMIS Consent Form

Client Name: _____

Date of Birth: _____

Client ID (if applicable): _____

Date: _____

Purpose of HMIS

The Homeless Management Information System (HMIS) is a secure database used to collect and analyze data on individuals and families experiencing homelessness. This information helps federal, state, and local agencies improve services and inform policy decisions.

Legal Requirements

Under the HEARTH Act (2009), participation in HMIS is required for recipients of Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funding. HMIS must collect unduplicated counts and service data to support community needs assessments and funding priorities.

Privacy and Security

HMIS adheres to strict privacy standards based on HIPAA and federal guidelines. Only authorized personnel may access your data, and all systems used are encrypted and approved for secure use.

Consent Terms

By signing this form, you acknowledge and agree that:
- Your personal information will be entered into HMIS.
- Data will be handled in compliance with HIPAA and other privacy laws.
- You may ask questions, refuse consent, or withdraw consent at any time without affecting your services.
- No data will be shared externally without your written permission.

Optional Consent

Do you consent to the reporting of your personal information in HMIS to be used to collect and analyze data on individuals and families experiencing homelessness?

☐ Yes ☐ No

Acknowledgment

I have read (or had read to me) the above information. I understand the purpose, benefits, and risks of HMIS participation and give my informed consent. I understand I may revoke this consent in writing at any time.

Client Signature: _____ Date_____

Parent/Guardian Signature (if under 18): _____ Date: _____

Staff Witness Signature: _____ Date: _____

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SAFETY PLAN

Know When To Get Help

What are the warning signs that you are beginning to struggle with your problem? These can include thoughts, feelings, or behaviors.

Use Coping Skills

What can you do, by yourself, to take your mind off the problem? What obstacles might there be to using these coping skills?

Reach out to Social Support

If you are struggling to handle your problem alone, contact trusted family members or friends.

NAME	CONTACT INFO

Seek Help from Professionals

If your problem persists, or if your have suicidal thoughts, reach out for professional support.

Local Emergency Number:	**911**
My Mental Health Provider:	
Someone to talk to now:	**988** If you are deaf or hard of hearing, call **711** then **988** Online chat, **https://988lifeline.org/chat**

SIGNATURE:_____DATE:_____

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RELAPSE PREVENTION PLAN

Coping skills: list activities or skills you enjoy that can get your mind off using.

1.
2.
3.

Social support: who are three people you talk to if you are thinking about using.

1.
2.
3.

Consequences: how will your life change if you relapse ?

How about if you stay sober.

Tips to avoid relapse.

- Craving will eventually pass do your best to distract yourself and rite it out.
- Don't become complacent, relapse can happen years after you've quit using. it probably won't ever be safe to (just have one)
- Avoid situations you know will put you at risk of relapse such as spending time with former buddies who still use non-prescribed alcohol/drugs or going places reminding you of past use.
- The decision to relapse is made when you put yourself in risk situation, long before you use .
- Don't view relapse as failure; falling back into old patterns because of slip will only make the situation worse.

Patient signature: _____DATE _____

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