CAFA
...Making A Safer Place for Children
921 Country Club Road, Suite 222, Eugene, OR 97401
Phone: 541-686-6000 Fax: 541-344-8239

OFFICE USE

OPAC Intake Therapist: _____ Date of Intake: _____

Service Code: _____ Diagnosis Code: _____ Start Date: _____

Photo ☐ OPAC#_____

Client Information - *PLEASE PRINT*

Client Name: _____|_____|_____
(First) (Middle) (Last)

Gender: M ☐ F ☐ Identifying Gender _____ Date of Birth: _____

Phone: _____ Alternative Phone: _____

Address:

_____|_____|_____|_____|_____
(Street) (Apt/Space#) (City) (State) (Zip)

Email:_____@_____.(com or net)

Relationship Status: Single Partner Married Separated Divorced

Current Partner's Name: _____

Children: Age _____Gender M ☐ F ☐ Age _____Gender M ☐ F ☐
Age _____Gender M ☐ F ☐ Age _____Gender M ☐ F ☐
Age _____Gender M ☐ F ☐ Age _____Gender M ☐ F ☐

Fees: $160.00 for intake; $55 each group

Your Fee: _____

Comments:

Responsible Party: Self ☐ Other ☐ If Other: Name _____

Relationship to Client: _____

Phone: _____

Fee is subject to increase with advance notice. Each group session is scheduled for 90 minutes. Payments for group sessions are expected at the time of service unless other arrangements have been made with the OPAC Administrator. YOU ARE RESPONSIBLE TO PAY YOUR BILL IN FULL.

Signed: Date:

My signature indicates that the above statements are true and that I agree to the above terms.

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OPAC GROUP CONFIDENTIALITY

Confidentiality is a particularly serious issue in OPAC groups. The general rule is that what is said in group stays in group. Because confidentiality is a basis for group safety, any breach will result in immediate expulsion from the group. However, the State of Oregon requires that the therapist breach confidentiality in the following instances:
1) any kind of child abuse, 2) any form of elder abuse, 3) any form of abuse toward disabled persons, 4) when a person is a danger to themselves or others.

STATEMENT OF COMMITMENT AND CONFIDENTIALITY

(Please initial each item)

- ___ The undersigned, as the client, hereby authorizes and consents to any and all treatment as may be deemed advisable.
- ___ I agree to attend all of the sessions and to be prompt. If I have a good reason for not attending or for arriving late, I shall notify the leaders as soon as possible and accept their decision to excuse or not excuse the tardiness or absence.
- ___ I understand the importance of confidentiality in the OPAC program. I agree never to disclose to anyone outside the group the identity of or information about the other participants.
- ___ I agree not to drink alcohol or use any unlawful drug 12 hours prior to coming to group.
- ___ I agree to pay a fee of $160 for the initial assessment and $55 per session for the OPAC program to be paid at the time of service or through an arrangement made with the program manager. Except in the instance that I have made special arrangements with the program manager or if my insurance is to be billed.

Client's Printed Name

Client Signature Date

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OPAC CONSENT FORM

I, the undersigned, authorize CAFA to:

(Please initial each item)

_____ Counsel me and enter me into (DV, AM, or Parenting) treatment (*required)*

_____ Test and conduct assessment

_____ Use basic information (non-identifying) for research purposes

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Client Signature Date

Staff Signature Date

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GRIEVANCE POLICY

You have the right to address problems and seek resolution to them. The therapists and staff will assist you in this process to the best of their ability. The following are the steps to take if you feel your client rights have been violated, and/or that you have dissatisfactions, complaints or problems with the services you receive. Remember that an effective mental health treatment program requires an investment in self-change, openness and an attitude of collaboration. Thus, the best place to start in dealing with your concerns regarding your client rights and/or services you receive is with the person providing those services.

1. Begin by speaking directly to the therapist or facilitator involved or the service provider who is your primary contact.

2. If satisfaction is not mutually achieved, ask to speak with the service provider's supervisor.

3. Again, if satisfaction is not mutually achieved, you can proceed to talk with the Director.

4. If the above procedure has not redressed your concerns, you may then seek legal counsel. You may also contact the State Professional Organization of the respective provider involved or the State Attorney General's office.

Each client shall be offered a copy of the grievance policy and procedure at the time of admission.

I have read and understand the above policy.

Client's Printed Name

Client Signature Date

Witness Signature Date

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Acknowledgement of Access to Mental Health Declaration

I acknowledge that I have been given an opportunity to complete a declaration for mental health treatment. "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

Copies of mental health declaration are offered at time of intake and are made accessible in CAFA's main office in the reception area.

I have been provided access to mental health declaration forms.

Client's Printed Name

Client Signature Date

Witness Signature Date

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Privacy Policy
Acknowledgement and Consent

I understand that **Christian As Family Advocates** will use and disclose health information about me. I understand that my health information may include information both created and received by the agency, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that **Christians As Family Advocates** may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related health information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the agency's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how **Christians As Family Advocates** will handle health information about me. This written description is known as a notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Christians As Family Advocates, and my rights regarding my health information.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that **Christians As Family Advocates** is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand that information above and that <u>I have been offered the opportunity to have a copy of the Notice of Privacy Practices.</u>

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Client Signature Date

Staff Signature Date

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Release Form to Contact Partner
(This form is required by the State of Oregon OARs)

It is the policy of CAFA to ask that you give CAFA written permission to contact your partner, ex-partner, etc. We ask this for the following reasons:

- We may call your partner if you leave the group angry or escalated and we have reason to fear for your partner's safety.
- CAFA has a strict policy regarding confidentiality and we do not discuss with your partner the content of your work in group or details of what you discuss. We share information with your partner only if we have doubts about your progress in the program or concerns for your partner's safety.

A signature is needed on this page even if you check the "I do got give permission box."

☐ I **do not** give my permission for CAFA to contact my partner.

☐ I give my permission for CAFA to contact my partner if staff become concerned:

Partner/Victim's Name: _____

Address: _____

_____|_____|_____|_____|_____
(Street) (Apt/Space#) (City) (State) (Zip)

Phone: _____

_____
Client's Printed Name

_____
Client Signature Date

_____
Facilitator Signature Date

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Client's Name: _____

If there was a specific event that led to you coming to CAFA, please describe it below. If there were a series of events or circumstances, please describe the situation to the best of your ability.

Was this violence with a partner? _____ Were the police called? _____

Who called police? _____ Were there children present? _____

Was this an isolated incident or a normal part of your relationship?

_____

When did it happen? Where did the event happen?

Who was involved?

Were drugs and /or alcohol involved?

What happened? Do not leave this page blank. We need to know why you are coming to CAFA for services.