# CORNERSTONE OF HOPE
# CLIENT INTAKE PAPERWORK

| Demographic / Background Information |
|---|
| **Date:** |
| **Name** (First and Last)**:** |
| **Address:** |
| **City/Zip:** |
| **County:** |
| **Cell Phone:** _____<br><br>**Home Phone:** _____<br>**May we leave a message:** □ Yes □No |
| **Email:** |
| **Date of Birth/Age:** Month_____ Day _____ Year _____ Age _____ |
| **Gender:** □ Female □ Male □ Transgender F-M □ Transgender M-F □ Undefined<br>□ Comments_____ |
| **Social Security No:** _____ - _____ - _____ |
| **Race/Ethnicity:**<br>□ African American/Black □ American Indian/Alaska Native □ Caucasian □ Asian<br>□ Hawaiian Native/Pacific Islander □ Hispanic □ Multiracial □ Other: _____ |
| **Marital Status:** □ Married □ Single □ Widowed □ Divorced □ Separated<br>□ Living Together □ Partners □ Engaged |
| **Religion/Spirituality:** □ Atheist/Agnostic □ Buddhist □ Catholic □ Christian □ Hindu □ Jewish<br>□ Muslim □ None □ Other: _____ |
| **Referral Source:** *(How or who referred you to Cornerstone of Hope?)* |

# CORNERSTONE OF HOPE
# CLIENT INTAKE PAPERWORK

## Emergency Contact Information

**Name** (First and last)**:**

**Relationship** *(to you):*

**Phone: Cell:** _____ **Home:** _____

**Work:** _____

**Do we have permission to contact in case of an emergency?** □ Yes □ No

## Advance Directive

An advance directive is a legal document (as a living will) signed by a competent person to provide guidance for medical and health-care decisions (as the termination of life support or organ donation) in the event the person becomes incompetent to make such decisions.

**Do you have an advance directive?** □ Yes □ No

**If yes, please describe:**

**Would you like assistance with an advance directive?** □ Yes □ No

## Immediate Family Members (If you need more room please write on the back)

| Name | Relationship | Age | Living/Deceased | Quality of Relationship |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Describe your past and current relationships with children, step children etc.** (strained, death, etc.) | | | | |

**CORNERSTONE OF HOPE**
**CLIENT INTAKE PAPERWORK**

## Living Situation

**Home**
□ Own □ Rent □ Other

□ Hospital* □ Temporary Housing □ Residential Care*
□ Nursing Home* Facility Name_____
□ Foster Care □ Friend's Home* □ Homeless in Shelter*/No Residence □ Jail/Prison*
□ Homeless Living with Friend* □ Relative's/Guardian's Home □ Respite Care*
□ Other: _____

***Identify Facility or Person's Name:**

## Current Loss

| **Name of loved one who died:** *(First and last name)* | **Cause of death:** |
|---|---|
| **Date of death:** | **Age:** |

**The deceased was my:** □ Spouse □ Significant Other □ Child □ Mother □ Father □ Brother □ Sister □ Grandmother □ Grandfather □ Aunt □ Uncle □ Cousin □ Other

**Relationship with the deceased:**
□ Very Close □ Close □ Not very close
□ Distant □ Estranged
Explain details about your relationship:

**The death was:**
□ Sudden □ Anticipated
Amount of Preparation:

**Were you present at the time of death?**
□ Yes □ No
*What were your reactions when you learned of the death:*

**Briefly explain the circumstances of the death:**

**Was there a funeral/memorial service for your loved one?**
□ Yes □ No □ Cremation □ Funeral Service □ Memorial □ Visitation □ Did not attend
*Share details about the service:* (*How did you participate?)*

**Other Losses:**
*Please provide relationship, name, date and cause of death:*
**Other Loss #2:**

*Name and relationship:*
_____

*Date of death:*
_____

*Cause of death:*
_____

**Other Loss #3:**

*Name and relationship:*
_____

*Date of death:*
_____

*Cause of death:*
_____

## Legal History

**Have you ever been arrested?**
□ Yes □ No
**Explain** (if yes)**:**

**Have you ever been convicted of a crime?**
□ Yes □ No
**Explain** (if yes)**:**

**Do you have any current legal issues?**
□ Yes □ No
**Explain** (if yes)**:**

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## Employment History

**Employment Status:** □ Employed □ Unemployed □ Retired □ Disabled □ Full-Time Student □ Part-Time Student

| **Currently employed?** □ Yes □ No | **If no, how long have you been unemployed?** |
|---|---|

**If yes, please list employment history below:**

| Job/Position | Employment Dates | Reason for Leaving |
|---|---|---|
| | | |
| | | |
| | | |

**Any changes of Employment since loss?**
□ Yes □ No
**Explain changes:**

## Academic History

| **Education History (check all that apply)** □ GED □ High School Graduate □ College □ Master's □ PhD | **Highest Grade Completed:** |
|---|---|

**History of Learning Difficulties (including performance/behavioral problems)**

□ None Reported
□ Learning Disability/Type: _____
□ Developmental Delays: _____
□ Special School Placement: _____
□ Other: _____

**Special Communication Needs**

□ None Reported
□ Assistive Listening Device
□ Extra Large Print paper or computer
□ Language Interpreter Services Needed/Other Spoken Language _____
□ Other: _____
□ Sign Language Interpreter □ TDD/TTY Device

| **Military Service** | | |
|---|---|---|
| **Have you ever served in the military?** □ Yes □ No | | |
| **If yes: Branch** | **Length of Service** | **Type of Discharge** |
| | | |
| | | |
| | | |
| **Have you experienced trauma related to military service?** □ Yes □ No<br>If yes, describe: | | |
| **Were you ever demoted or discharged due to substance use?** □ Yes □ No<br>If yes, describe: | | |

| **Therapy/Counseling History:** | |
|---|---|
| **Have you ever been given a mental health diagnosis?** □ Yes □ No | |
| **If yes, please specify:** | |
| **Have you ever been in counseling before?** □ Yes □ No | |
| **When** (provide dates)**:** | **Agency Name:** |
| **Reason for counseling:** | |

## CORNERSTONE OF HOPE
## CLIENT INTAKE PAPERWORK

| | |
|---|---|
| **Are you currently in therapy or counseling?** □ Yes □ No | |
| **Permission to contact?** □ Yes □ No | |
| **Counselor Name:** | **Agency Name & Phone Number:** |
| **Reason for counseling:** | |
| **Family Mental Health History:** (List immediate family, maternal and paternal parents (grandparents) what diagnosed with: | |

**Concurrent Stressors and Symptoms**

□ Addition of a parent to house
□ Anger/Difficulty controlling temper
□ Anxiety
□ Appetite Changes
□ Being a single parent
□ Children having difficulty with divorce or new marriage
□ Children having difficulty with loss of loved one
□ Custody or visitation problems
□ Depressed mood
□ Disorganized thoughts
□ Divorce or Separation
□ Employment problems
□ Fatigue/Low energy
□ Feelings of Guilt
□ Feelings of Panic
□ Financial problems
□ History of abuse
□ History of Infidelity
□ Hopelessness
□ Intense Crying
□ Irritability/Anger
□ Loneliness
□ Loss of pleasure in hobbies
□ Major difficulties with child/teen
□ Medical problems
□ Memory impairments
□ Moving to new location
□ Newly married or remarried
□ One or more family members not getting along
□ Other: Unemployment
□ Physical complaints
□ Poor concentration
□ Recurring thoughts/images
□ Sleeping changes
□ Social isolation
□ Stepfamily with children
□ Substance Abuse
□ Weight Gain
□ Weight Loss
□ Worthlessness

**Please provide details to any checked items above:**

# CORNERSTONE OF HOPE
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| Medical History | | | | | |
|---|---|---|---|---|---|
| **Physician Name:** | | | | | |
| **Phone:** | | | | | |
| **List any health issues:** (Current and past) | | | | | |
| **Medication Name** *(please use back if more room is needed)* | **Dosage (mg/daily)** | **Purpose** | **Effective?** | **Dates Taken** | **Prescribed by:** |
| | | | □ Yes<br>□ No | | |
| | | | □ Yes<br>□ No | | |
| | | | □ Yes<br>□ No | | |
| **Allergies:** | | | | | |

**Availability for counseling:** (Check all that apply)

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

Morning _____ Afternoon _____ Evening _____

**Client Signature:** _____ **Date**: _____

# CORNERSTONE OF HOPE
# CLIENT RIGHTS AND RESPONSIBILITIES

Client ID_____

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
2. The right to service in a humane, least restrictive setting which is the least restrictive feasible as defined in the treatment plan;
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;
6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;
7. The right to be free from intellectual, emotional and/or physical abuse;
8. The right to be free from abuse, financial or other exploitation, retaliation, humiliation, and neglect;
9. The right to access to information pertinent to the client in sufficient time to facilitate his/her decision making;
10. The right to informed consent, refusal or expression of choice regarding service delivery, release of information, concurrent services, composition of service delivery team, and involvement in research projects, if applicable;
11. The right to access or referral to legal entities for appropriate representation, self-help support services, and advocacy services;
12. The right to freedom from unnecessary or excessive medication;
13. The right to freedom from unnecessary restraint or seclusion.
14. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan;
15. The right to be informed of and refuse any hazardous treatment procedures;
16. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs;
17. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;
18. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client;
19. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information that the client has made accessible. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;

# CORNERSTONE OF HOPE
# CLIENT RIGHTS AND RESPONSIBILITIES

20. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event;
21. The right to receive an explanation of the reasons for denial of service;
22. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;
23. The right to know the cost of services;
24. The right to be fully informed of all rights;
25. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;
26. The right to file a grievance;
27. The right to have oral and written instructions for filing a grievance, and
28. The right to investigation and resolution of alleged infringement of rights.
29. The right to not have your photo used in any form of social media, including COH's Facebook page, without your written consent.
30. Other rights as may be defined by state or federal authorities.

**Your Responsibilities**

- Actively participate in your treatment and help to develop your plan of care with a Cornerstone of Hope staff member.
- Take part in planning and participating in your own psychosocial treatment program and provide information concerning your mental health and medical history.
- Ask a question(s) when you do not understand what is happening to you.
- Let a member of the staff know when you have a problem or feel sick.
- Show respect for the property and rights of others.
- Obey the laws which apply to all citizens.
- Be familiar with and observe the rules and policies of Cornerstone of Hope.
- Accept responsibility for your actions.
- Cooperate with the goal of achieving self-sufficiency in the management of your everyday living.
- As a client of Cornerstone of Hope you have a guaranteed right to a place to come, a guaranteed right to meaningful relationships, and a guaranteed right to a place to return.
- Grievance – Perceived Violation of Client Rights: The Clinical Director shall serve as Client Rights Representatives for Cornerstone of Hope and shall function in this capacity as specified in the Client Grievance Policy.

_____ _____
Parent/Guardian Signature Date

_____ _____
Agency Representative Date

_____ _____
Client Date

❑ A copy of this form has been given to me

CORNERSTONE of Hope
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# CORNERSTONE OF HOPE
# NOTICE OF PRIVACY PRACTICES

Client ID_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

**Our Commitment to Your Privacy**
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional services and care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. A copy of this information is available at any time by contacting us at 216-524-3787. Please contact us with any questions or problems you may have.

We will use information about your health that we get from you or others mainly to provide you with treatment, to arrange payment for services, and for other business activities that are called in the law health care operations. After you have read this Notice of Privacy Practices, we will ask you to sign a consent form. The consent form will allow our agency to use and share your information. If you do not sign this consent form, we cannot treat you.

**For Treatment**
We use medical information to provide you with psychological services or treatment. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

With your consent, we may share or disclose your PHI to others who provide treatment to you, or we might share your information with your personal physician. If you are being tested by a team, they can share some of your PHI with us so that services you receive will be coordinated. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment. If your PHI is transmitted via email, your information will be kept confidential by the use of encryption that meets the requirements of current regulations. Mobile apps to share PHI should not be utilized.

**For Payment**
We may use your information to bill you, your insurance, or others so we can be paid for the treatment or services we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we have met your progress, and similar sorts of information.

**For Health Care Operations**
There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

**Other Uses in Healthcare:**
**Appointment Reminders**
We may use and disclose information to reschedule or remind you of appointments for treatment or care. If you want us to call or write to you only at home or work or prefer some way that we reach you please let us know.

**Treatment Alternatives**
We may use and disclose your PHI to tell you about or recommend possible treatment alternatives that may be of help to you.

**Other Benefits and Services**
We may use and disclose your PHI to tell you about health related benefits that may be of interest to you.

# CORNERSTONE OF HOPE
# NOTICE OF PRIVACY PRACTICES

**Business Associates**
There are some jobs that we might hire other businesses to do for us. In the law they are called our Business Associates.
Examples include a telephone answering service or a billing agency. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information, and follow all applicable laws, rules, and requests to endure security of your PHI.

**Uses and Disclosures That Require Your Authorization**
If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. If you do authorize us to use or disclose your PHI, you can revoke or cancel that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes we agreed upon. Of course, we cannot retract any information we have already disclosed with your permission.

**Exceptions to Confidentiality and Privacy of Information**
There are certain situations where we are unable to keep information private by law. They are as follows:

1. When there is a serious threat to your health or safety or the health or safety of another individual or the public.
2. When we are required by a court of law to disclose information
3. Some instances where a law enforcement official requires us to disclose information to maintain your safety or that of others.
4. For Worker's Compensation and similar benefit programs
5. When we receive information about abuse or neglect of a child, disabled adult, or person over age 65.

**Your Rights Regarding Your Health Information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you; however, we do not discuss PHI informant via text or email.
2. You have a right to ask us to limit what we tell people involved in your care or the payment for your care such as family members and friends. While we do not have to honor your request, if we do honor it we will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as medical or billing records. You can even get a copy of these records, but we may charge you. Contact us at the location above to make such arrangements.
4. If you believe the information in your records is incorrect or missing important information, you can request us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to us at the location listed above. You must tell us in your request the reasons you are requesting the changes.
5. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures prior to April 14, 2003. If you make an accounting request more than once in a twelve month period, we will charge you $0.25 per page for the accounting statement.
6. You have a right to a copy of this notice. If we change this Notice of Privacy Practices, you may obtain a copy of the new notice from the address listed above.
7. If you have a problem with how your PHI has been handled or feel your privacy rights have been violated, contact the Clinical Director at 216-524-3787. You have a right to file a complaint with us and the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care or take any actions against you if you file such a complaint.

_____ _____
Parent/Guardian Signature Date

_____ _____
Agency Representative Date

_____ _____
Client Date

❑ A copy of this form has been given to me

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# CORNERSTONE OF HOPE
# CONSENT FOR TREATMENT

Client ID_____

NAME: _____ DATE: _____ TIME: _____ am/pm

Consent for Treatment

1. I, the undersigned, hereby give my permission to undergo any assessments, treatment or other procedure deemed reasonable and necessary by Cornerstone of Hope staff for my diagnosis, treatment, follow-up or referral at Cornerstone of Hope. This may include, but is not limited to, emergency care, psychosocial assessment, psychiatric assessment, counseling, and any other behavioral health services provided as part of my treatment. My consent shall also include a personal history, which will assist the staff in developing a treatment plan, and in providing treatment. I give my consent for individual, couple, family and or group therapy as deemed necessary by the Cornerstone of Hope Program staff. I give my consent for the staff of Cornerstone of Hope to share information with one another about my treatment.

2. I hereby acknowledge that mental health treatment is not an exact science and I further acknowledge that no guarantee or assurance has been made to me with respect to or concerning treatment to be given to me at Cornerstone of Hope.

3. I hereby authorize payment directly to Cornerstone of Hope of benefits due to me for reason of treatments and procedures afforded to me and further assign any major benefits due, all of which payment shall not exceed the regular services of the Cornerstone of Hope or the staff thereof for the treatment afforded to me. I agree that a photocopy of this authorization is as valid as the original.

4. MEDICARE PATIENTS ONLY
   I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers, any information needed for this or any subsequent Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment of such claim.

_____ _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE STAFF SIGNATURE

Date: _____ Date _____

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# BEHAVIORAL HEALTH
# ADVANCED DIRECTIVES

## WHAT **YOU NEED TO KNOW**

### WHAT IS A BEHAVIORAL HEALTH ADVANCE DIRECTIVE?

Behavioral health advance directives are instructions you make about behavioral health treatment you want to receive in the future, in case you become ill and are not able to speak for yourself. Basically, it is a tool to make sure your requests and wishes are always known!

In Ohio, there are two types of behavioral health advance directives that you may want to consider:

- Durable Power of Attorney for Health Care
- Declaration for Mental Health Treatment

### SHOULD I HAVE A BEHAVIORAL HEALTH ADVANCE DIRECTIVE?

There are many advantages to having a behavioral health advance directive:

- You have more control over what happens to you during periods of crisis and decompensation.
- Providers and others will know what you want, even if you can't express yourself well, you always have a voice!
- Your directive helps your CPST, prescriber and other members of your treatment team be aware of what you want them to do if you can't speak for yourself.
- You always have a say in treatment decisions, even when you cannot speak for yourself!
- The law requires providers, including us, to respect what you write in a behavioral health advance directive to the fullest extent possible.

### WHAT'S INCLUDED IN A BEHAVIORAL HEALTH ADVANCE DIRECTIVE?

Anything that might be involved in your treatment can be a part of a mental health advance directive. For example:

- Consent for, or refusal of and withdrawal of consent for behavioral health treatment, including particular medications.
- Who can visit you if you are in the hospital
- Who you appoint to make decisions and take actions for you (your agent);
- Anything else you want or don't want in your future care.

### SHOULD I HAVE AN AGENT?

You have the option of naming an agent:

- Who is at least 18 years old
- Who knows you and knows what you want when you are doing well
- Who can inform treatment providers about your preferences and can advocate for you

Some people cannot act as your agent. These include:

- Persons under age 18
- Someone with a court-appointed guardian
- Your attending physician
- The employee of any facility where you are receiving treatment services – including group homes, nursing homes and residential treatment centers.

### WHO SHOULD GET A COPY OF BEHAVIORAL HEALTH ADVANCE DIRECTIVES?

If you name an agent, that person must be given a copy. After that, it is up to you who you give a copy to. Think about giving one to your current behavioral health provider, your lawyer (if you have one), and trusted family members. Bring a copy if you are being admitted to a behavioral health facility-such as a hospital. Any treatment provider who gets a copy is required to make it a part of your medical record, so they always know.

CORNERSTONE of Hope

A CENTER FOR GRIEVING CHILDREN, TEENS AND ADULTS

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216.524.4673

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# BEHAVIORAL HEALTH
# ADVANCED DIRECTIVES

### TIMES WHEN THE BEHAVIORAL HEALTH ADVANCE DIRECTIVE MIGHT NOT BE FOLLOWED?

It is important to remember that there are times when Ohio law says your behavioral health advance directive might not be followed, in order to protect you and others. Here are the instances when your behavioral health advance directive may not be followed:

- Your instructions are against hospital policy or are unavailable
- You are appointed a guardian to make treatment decisions for you
- Following your directive would violate local, state or federal laws

### CAN I CHANGE OR REVOKE MY MENTAL HEALTH ADVANCE DIRECTIVE?

As long as you have capacity, you can change or revoke your behavioral health advance directive at any time. If you are incapacitated, you can only change or revoke the advances directive if you have specified an ability to do so in your behavioral health advance directive. Remember, changes need to be made in writing. Be sure to notify everyone who has a copy if you revoke it or make any changes.

### WHAT IF I ALREADY HAVE A LIVING WILL OR DURABLE POWER OF ATTORNEY?

Where there is a conflict between a behavioral health advance directive and any previous directive (such as a living will), the newer document will have legal priority. To reduce confusion, it is probably best to have one person act as your behavioral health advance directive agent and durable power of attorney.

### WHERE CAN I GO FOR MORE INFORMATION ABOUT BEHAVIORAL HEALTH ADVANCE DIRECTIVES?

Ohio Legal Rights Services: 800.282.9181
Ohio Bar Association: 614.487.2050
Ohio State Legal Services Association: 866.529.6446

### TWO TYPES OF BEHAVIORAL HEALTH ADVANCE DIRECTIVES

Durable Power of Attorney for Health Care–You name an attorney-in-fact to make behavioral health treatment decisions for you, in care your doctor determines you are not able to make decisions for yourself. You are entitled to state specific instructions to your attorney-in-fact, including when you want to consent to treatment, when to refuse treatment and when to withdraw consent to treatment.

Declaration for Mental Health Treatment–You declare your instructions for the use of or termination of behavioral health treatment services. As part of this declaration, you can indicate when to withhold or withdraw behavioral health treatment. You may also designate a proxy to make behavioral health treatment decisions, in accordance to your wishes, as documented in the Declaration of Mental Health Treatment.

### HOW DO I CREATE A BEHAVIORAL HEALTH ADVANCE DIRECTIVE?

You can find the forms to complete at:
olrs.ohio.gov/sites/olrs.ohio.gov/files/u5/MHDeclare.pdf

Please ask your worker about Behavioral Health Advance Directives if you need more information or help setting one up!

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**CORNERSTONE OF HOPE**
**BEREAVEMENT CENTERS**
**FEE SCALE**

Cornerstone of Hope is committed to providing professional counseling services to the bereaved in a way that is cost-effective. If finances are a concern, we will work with each family accordingly. What is paramount is to serve those who grieve with excellent care and compassion.

Typical clinical counseling fees range from $125 to $150/hour or $30 co-pays with limited sessions covered by insurance plans. These plans often prohibit an individual or family's ability to access quality care and to complete the emotional work they've begun. Our rates are the following:

**Payment:** Expected prior to session. For alternate arrangements contact counselor.

**EAP** – Employee Assistance Plan
(Your employer may cover a portion of the counseling cost through an EAP program, ask your Human Resource Department if this benefit is available to you/your family.)

I understand that fees must be paid at the time of service unless other arrangements are made.

## Rate per Individual per Session

| Total Family Income | 1 Person | 2 Persons | 3 or more | Total |
|---|---|---|---|---|
| □ $100,001 and above | $70 | +$20 | +$10 | $_____ |
| □ $80,001 - $100,000 | $60 | +$20 | +$10 | $_____ |
| □ $70,001 - $80,000 | $50 | +$20 | +$10 | $_____ |
| □ $60,001 - $70,000 | $40 | +$20 | +$10 | $_____ |
| □ $50,001 - $60,000 | $30 | +$10 | +$10 | $_____ |
| □ $40,001 - $50,000 | $20 | +$10 | +$10 | $_____ |
| □ Below $40,000 | $10 | +$10 | +$10 | $_____ |

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client Name (Please print) Counselor (Please print)

_____ _____
Parent/Guardian Name (Please Print) Date

CORNERSTONE of Hope
5905 Brecksville Road, Independence, Ohio 44131 • 216.524.4673
1550 Old Henderson Road, E262, Columbus, Ohio 43220 • 614.824.4285
CORNERSTONEOFHOPE.ORG