CORNERSTONE OF HOPE
CHILD/TEEN CLIENT INTAKE PAPERWORK

Demographic / Background Information	
Date:	
Child's Name (First and Last)**:**	
Address:	
City/Zip:	
Date of Birth/Age: Month_____ Day _____ Year _____ Age _____	
Gender: **Referral Source:** *(Who referred you to Cornerstone of Hope?)*	
Annual Household Income: $	**Number of Persons in Household:**
Race/Ethnicity: □ African American/Black □Multiracial □Asian □ White/Caucasian □Hispanic/Latino □ Hawaiian Native/Pacific Islander □ American Indian/Alaska Native □ Other: _____	
Religion/Spirituality: □ Atheist/Agnostic □ Buddhist □ Catholic □ Christian □ Hindu □ Jewish □ Mormon □ Muslim □ None □ Orthodox □Protestant □Other: _____	
Parent/Guardian Contact Information	
Name (First and last)**:**	
Relationship *(to child):*	
Phone: Cell: _____ **Home:** _____ **Work:**_____	
Email:	
School Contact Information	
Name of School:	**Phone:**
Name of Teacher:	
Name of Guidance Counselor:	
Education Service Document(s): □ IEP and/or □ 504 Plan	

Family Members at Home

Name	Relationship	Age

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Family Members not Living at Home		
Name	**Relationship**	**Age**

Concurrent Stressor

□ Divorce/Separation □ Illness/Injury □ Move to new home/school □ Limited Finances
□ Other Recent Deaths □ Other _____

Current Loss

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

The deceased was my child's : □ Aunt □ Uncle □ Cousin □ Sister
□ Grandmother □ Mother □ Father □ Brother
□ Grandfather □ Other_____

Child's relationship with the deceased: □ Very Close □ Close □ Not very close □ Distant □ Estranged

The death was: □ Sudden □ Anticipated

Was your child present at the time of death? □ Yes □ No

Was there a funeral/memorial service for your child's loved one?
□ Yes □ No □ Cremation □ Funeral Service □ Memorial □ Visitation □ Did not attend

Other Loss #2:

*Name and relationship:*_____

Date of death: _____

Cause of death: _____

Other Loss #3:

Name and relationship: _____

Date of death: _____

Cause of death: _____

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Social Support System

Family: □ Good □ Fair □ Poor

School: □ Good □ Fair □ Poor

Other: □ Church □ Sports □ Clubs/Activities

Additional Comments:

Communication Needs

Special Communication Needs

□ None □ Assistive Listening Device □ Sign Language Interpreter □ TDD/TTY Device

□ Language Interpreter Services Needed/Other Spoken Language □ Other

Medical History

Physician Name and phone:

List any health issues (current and past)**:**

Medication Name	Dosage (mg/day)	Purpose	Effective?	Dates Taken	Prescribed By
			□ Yes □ No		
			□ Yes □ No		
			□ Yes □ No		

Therapy/Counseling History:

Has your child ever been given a mental health diagnosis? □ Yes □ No

If yes, please specify:

Has your child seen a school or private counselor before? □ Yes □ No

When (provide dates)**:**	**Agency/School Name:**

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Reason for counseling:	
Is your child 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:	

Problem Areas or Concerns:

EMOTIONAL	✓	COMMENTS
Sadness		
Anger		
Guilt		
Fear		
Shock/Denial		
Panic		
Loneliness		
Helplessness		
Hopelessness		
Separation Anxiety		
Apparent lack of feelings		
Other		

BEHAVIORAL	✓	COMMENTS
Regression (bed wetting, baby talk, thumb sucking)		
Withdrawn (from family, friends, activities)		
Clinging behavior		
Bad language		
Violence		
Disruptive at home or school		
Skipping school		
Absence from school		
Overly tired/sleepy		

BEHAVIORAL CON'T	✓	COMMENTS
Behavior "too good"		
"Man of the house" attitude		
"Woman of the house" attitude		
Giving away belongings		
Other		

COGNITIVE	✓	COMMENTS
Preoccupation with death/illness		
Confusion		
Daydreaming		
Homework		
Paying attention in class		
Concentration		
Academic performance		
Suicidal thoughts		
Other		

SOCIAL	✓	COMMENTS
Changes in relationships with parents		
Changes in relationships with siblings		
Changes in relationships with friends		
Lack of support system		
Other		

PHYSICAL	✓	COMMENTS
Eating (increase or decrease)		
Sleep problems		
Somatic complaints (headaches, stomach aches)		
Other		

CORNERSTONE OF HOPE
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Availability for counseling: (Check all that apply) Please note that your preferred time slot is not guaranteed.

Monday: ___Morning ___Afternoon ___Evening

Tuesday ___Morning ___Afternoon ___Evening

Wednesday ___Morning ___Afternoon ___Evening

Thursday ___Morning ___Afternoon ___Evening

Friday ___Morning ___Afternoon ___Evening

Parent/Guardian Signature: _____ **Date**: _____

CORNERSTONE OF HOPE BEREAVEMENT CENTER
INDIVIDUAL/COUPLES COUNSELING FEES

Cornerstone of Hope is committed to providing professional counseling services with excellence and compassion to the bereaved in a way that is cost-effective.

Payment: Cornerstone of Hope offers a Flat Fee rate of $40 per session for individual counseling and $60 per session for couples counseling, due at the time of service. Cornerstone of Hope is aware that clients may experience financial challenges after the loss of a loved one; therefore financial assistance is accessible for individual counseling through the Compassionate Care Fund. To obtain more information regarding the Compassionate Care Fund, please contact Francine Artiste at 216-524-4673 or by email at compassionatecare@cornerstoneofhope.org.

Insurance: Cornerstone of Hope does not currently accept or bill insurance for individual counseling services.

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

Cancellation Policy: You will be expected to pay the full cost of the session if you do not show up for your scheduled appointment and have not notified Cornerstone of Hope at 216-524-4673 at least 24 hours in advance. Exceptions and extenuating circumstances will be considered upon scheduling your next appointment.

By signing below, I acknowledge that I have read and understood the above fee structure of Cornerstone of Hope.

_____ _____
Client Signature (if 14-17 years old) Date

_____
Client Name (Please print)

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please print)

_____ _____
Counselor Signature Date

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CORNERSTONE OF HOPE
INFORMED CONSENT

Client ID_____

Name: _____ Date: _____ _ Time: _____ _am/pm

Clinical services are intended to aid each individual client in their personal grief journey. Please initial each item below, sign and date below to indicate you have read and understood this consent document. By signing this form, you willfully consent to counseling services.

_____ I acknowledge that everything I discuss in counseling is private and confidential. Exceptions to confidentiality include but are not limited to: if I intend to hurt myself (e.g. self-harm behaviors, suicide, etc.) or if I intend to hurt someone else. My clinician will review with me the other limits to confidentiality.

_____ I, the undersigned, hereby give my permission to undergo any assessments, treatment or other procedure(s) 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 clinical team members of Cornerstone of Hope to consult with one another with regard to my treatment.

_____ 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.

_____ I am aware that if I do not show for my appointment, and have not notified Cornerstone of Hope at least 24 hours in advanced, I will be given an opportunity to reschedule my counseling appointment without incurring fees. However, if I do not show or do not provide 24 hours in advanced for another appointment at any point in the future, I will be required to pay the full cost of my counseling session.

_____ *For Clients under the age of 18 only:* I know that if I am under 18, Ohio law gives my parents/legal guardian(s) the right to my clinical records from my counseling.

By signing below I acknowledge that I have read, understood, and consent to counseling services from Cornerstone of Hope. For clients under the age of 18, I acknowledge that I am the legal guardian responsible for the client receiving services from Cornerstone of Hope.

_____ _____
Client Signature (if 14-17 years old) Date

_____
Client Name (Please print)

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please print)

_____ _____
Counselor Signature Date

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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.

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.

CORNERSTONE OF HOPE
NOTICE OF PRIVACY PRACTICES

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. Youkan 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.

_____ _____
Client Signature (if 14-17 years old) Date

_____
Client Name (Please print)

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please print)

_____ _____
Counselor Signature Date

☐A copy of this form has been given to me

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;
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.

_____ _____
Client Signature (if 14-17 years old) Date

_____
Client Name (Please print)

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please print)

_____ _____
Counselor Signature Date

☐A copy of this form has been given to me