LOWELL HOUSE, INC.

☐ Adolescent Program Packet

New Client Information

Date: _____

Client Name _____ DOB _____

Social Security#: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Phone#: _____

Additional Phone #: _____

Emergency Contact Name: _____
Phone#: _____

Email: _____

Insurance: _____

Member#: _____Group#: _____

Please make sure to bring the following with you on your first appointment:

- **Driver's License/Identification**
- **Insurance Card**
- **Referral (if any)**
- **Any pertinent information**

Please be prepared to have your photo taken.

Please make sure to sign and date all pages that have signature lines

Adolescent Informed Consent Form

The purpose of entering treatment is to get help with difficulties or challenges that may be impacting important parts of your life. You may have asked to meet with and talk to a clinician or this could have occurred because your parents, teachers, doctor, or someone else has concerns about you. The process of treatment involves hearing from you, in your own words, about these difficulties or challenges, getting a better understanding of them, and even creating or learning ways to deal with them in healthier ways.

Sometimes these difficulties or challenges involve topics you do not want your parents or guardian to know about. For most people, knowing that what they say will be kept private helps with sharing thoughts, feelings, and perceptions and having more trust in who they are working with. As a teenager, you have certain rights to privacy that are not equal to those of an adult (the legal definition of which is 18 years old), but privacy, also called confidentiality, is a critical part of this process. As a general rule, information you share in substance use treatment is confidential, unless you give consent to disclose certain information (known as 42 CFR Part 2).

However, there are exceptions to this rule that are important to understand prior to starting the process of treatment. In some situations, it is required by law or professional guidelines that information discussed in treatment has to be disclosed. Some of those situations are described below. Most involve your protection and the protection of others from the potential to be hurt or harmed:

l. If you report having a plan to harm yourself, based on the evaluation of that plan, confidentiality can be broken in order to protect you from harming yourself.

2. If you report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person you intend to harm.

3. If you are involved in activities that could cause harm to yourself or someone else, even if you do not intend to harm yourself or someone else, based on the evaluation of that behavior, confidentiality can be broken.

4. If you report that you are being abused (physically, psychologically, emotionally, or sexually) or that you have been abused in the past, the law requires that this be reported to the Massachusetts Department of Children and Families (DCF).

5. If you are involved in a court case and a request is made for information about your treatment, information will be disclosed with your written consent unless the court requires that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with YOLI.

6. If you agree that information can be shared with a specific person or entity, then you and the clinician will discuss the limits of what will be shared, how that information will be shared, and processes you can go through to revoke the consent at a later date.

Except for situations above, your parents/guardians will not be told of specific information you share in treatment. This includes activities and behavior that your parents/guardians would not approve of or be upset by, but that do not put you or others at risk for immediate harm. It may be important to let your parents know some information that is protected by confidentiality, and you may be encouraged to share that information. Part of the clinician's job is to discuss this with you and to decide together the best way to communicate the information.

Also, parents and guardians may be able to be more helpful if they have general ideas about themes of treatment (such as your autonomy, important privileges, achievement, or the status of symptoms) and the clinician may have specific suggestions for parents that do not involve breaking your privacy. Parents are strongly urged to respect the privacy of your treatment.

Schools and Teachers: Information will not be shared with your school, including that you are even seeing a clinician, unless you give permission. If someone from your school wants to talk about your treatment, or if it is decided that talking to someone at your school would be beneficial, then you will be asked to give their permission for that. If your parents or school want information about the treatment, and you do not want to give permission, then that will be discussed further with you.

Physicians/Doctor's Offices: Your medical doctor may have been involved in referring you for treatment, may have prescribed medication for you, or maybe considering prescribing medication. For that reason, it may be Important to coordinate with your doctor or doctor's office regarding your progress or status, especially when medication is involved or there are other health issues. Again, your permission will be required for such a consultation to occur and it will be important to discuss in treatment what information will be disclosed, especially since some information can be disclosed to a doctor that is not disclosed to your parent/guardian. The only time information can be shared with your medical doctor without your permission is if you are engaged in harmful or risky behavior that creates a concern about safety.

By signing this form, I agree that I understand the rules and limitations of confidentiality entering treatment in Lowell House Addiction Treatment and Recovery:

Adolescent's Signature _____Date _____

LHI Witness Signature _____Date _____

Outpatient Department Individual Counseling

You will be scheduled for a 1-hour intake with one of our clinicians where you will be asked to provide your reason for seeking services and sharing some of your history. At a later meeting you and the clinician will create your individualized treatment plan. Il is your choice and, in your power, to identify your treatment goals, You and your clinician will also agree upon the expectations of your treatment here:

- How often you will meet, when those days and times are, how long your treatment will last, and what would happen for treatment to be terminated early.
- Early termination of treatment may be voluntary (your choice), or it may be involuntary (decided by the clinician due to factors such as consecutive cancellations or no-shows).

Privacy and Confidentiality:

We are committed to respecting and protecting your privacy and the confidentiality of your health care information. The code of ethics; HIPAA (Health Insurance Portability and Accountability Act); as well as CHAPTER 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records) mandates that all information about you be protected; and that any disclosure of your protected Health Information (PHI) requires your written consent.

Payments and Fee:

You may choose to self-pay or use health insurance. The following payment methods are accepted; Cash, money order, or credit/debit care. NO personal checks are allowed. If you are experiencing financial difficulties, you may qualify for certain special payment schedules or options that can be afforded on a limited income - such as a sliding scale.

Insurance:

We accept most MassHealth insurance policies and generally our services are covered in full. Our staff are available to assist you in determining your available coverage. Your insurance policy is not accepted, you may call your carrier directly to see if our providers may be covered or if there is an out-of-network benefit available. Staff may assist you with an alternative agency for referral as well.

Cancellations:

Failure to show up for or notify LHI within 24 hrs. of a scheduled appointment or group will result in a no-show fee. Cancellation notification must be made during regular business hours Monday-Friday 9am to 5pm. *Under special circumstances missed appointments/classes may be excused.* Notification of the missed session will be sent to the court/source of referral within 48 hrs. and may jeopardize your status in the program. All missed services must be rescheduled within 5 business days. Failure to do so may result in termination from the program.

Additional Fees:

Fee Type:	Cost:
Urine Screen	$30.00 each
Breathalyzer	$12.00 each

I have received, read, and understand the information provided on this document about my rights and expectations around treatment in the outpatient department.

Signature: _____ Date: _____

ALLERGY IDENTIFIER Date: _____

Lowell House, Inc.
Person Served Emergency/Contact Sheet

Name _____ DOB _____ SS# _____

Address _____
Street Name City State Zip Code

Telephone: Home _____ Cell _____ Work _____

Email Address _____

Marital Status Single Married Divorced Separated Widowed

Interpreter Needed: Yes No

Health Insurance _____ Policy _____

Adolescents — If you are under the age of 18, please fill out this section:

Parent/Guardian Name: _____

Address: _____

Phone: Home _____ Work _____ Cell _____

Medical Information

Physician's Name/PCC _____

Physician's Address _____

Physician's Telephone _____

Blood Type _____

Allergies _____

Medication/Dosages _____ _____

_____ _____

_____ _____

Psychiatrist's Name _____

Psychiatrist's Address _____

Psychiatrist's Telephone _____

Emergency Contact— Person to contact in case of Emergency.

Name _____ Relationship _____

Address _____

Telephone. Home _____ Cell _____ Work _____

Consent For the Release of Confidential Information

(Please Print)

I, _____ authorize Lowell House Inc (LHI) and its affiliates to disclose to
(Person Served/Guardian of Person Served) and/or receive from:

_____ _____
(Name of person/Organization to which disclosure is to be made) (Email/Phone)

Any of the following substance use disorder information (please check the box next to each form of information you are consenting disclosure for):

- ☐ Attendance
- ☐ Urine screen results
- ☐ Breathalyzer results
- ☐ Oral swab results
- ☐ Intake data
- ☐ Assessment data
- ☐ Evaluation results
- ☐ Treatment status
- ☐ Treatment plan
- ☐ Progress notes
- ☐ Completion confirmation
- ☐ Discharge summary
- ☐ Other _____
- ☐ Other _____

The purpose of the disclosure authorization herein is to:

_____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I agree that this release is set to expire on the following date, event, or condition:

_____
(Date, event, or condition)

_____ _____
(Date) (Person Served/Guardian signature)

_____ _____
(Date) (LHI Staff signature)

Client Telehealth Consent Form

I, _____ (client name), hereby consent to participate in Telemental health with Lowell House INC. _____ (program)as a part of my treatment. I understand that Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that I have voluntarily entered Telemental health services and that if I am under the supervision of a court or other agency (identified as "Collateral" below), they have already approved my accommodation to participate in the above mentioned services remotely.

3) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

4) I understand that any disruptions, breaches, and/or situations that impact my ability to virtually attend or remain present during my session may impact my attendance record, and it is my responsibility to communicate these situations to Lowell House and seek to rectify, potentially through a make up session. This may result in me having to pay a missed session fee or make up fee.

5) I understand it is an expectation that I make personal accommodations with my own technology to ensure I can be visible and heard (a working camera and microphone on the technology I am using) throughout the sessions, and that I am able to locate myself physically in a location which protects my own and others' (if in a group setting) confidentiality.

6) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted/ and or required by law.

7) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless exception to confidentiality applies

(i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/ emotional health as an issue in legal proceeding)

8) I understand if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a more intensive or alternative level of care is required.

I have read the information provided above and discussed with my collateral/ referral source. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Client signature Date

_____ _____

Collateral signature Date

_____ _____

Lowell House INC Staff signature Date

TB Risk Assessment and Screening Form

Name: _____ DOB: _____ Date: _____

Medical Record Number: _____

TB History and Triage (to be completed by medical provider)

TB History	Yes	No
1) Has the person had a TB test (skin test or blood test)? TB test result: ☐ Positive ☐ Negative ☐ Unknown TB test date: _____(MM/YY) Where_____(facility)	☐	☐
2) Did the person get a chest x-ray after the TB test? X-ray result _____ X-ray date:_____(MM/YY)	☐	☐
3) Did the person take medication for TB infection?	☐	☐
4) Does the person remember being sick with TB? If yes, when _____ (MM/YY) Where: Country _____ State:_____	☐	☐

Triage Plan	
☐	**Person has TB risk and has one or more TB symptoms:** Refer the person for **prompt clinical evaluation** including a chest x-ray to rule out active TB
☐	**Person has TB risk, no symptoms and has no history of previous positive TB test:** Test for TB infection or refer for testing and evaluation
☐	**Person has a history of previous positive TB test, but has no evidence of treatment:** Refer for TB evaluation and treatment

TB Test Documentation

Tuberculin Skin Test (TST) plant date:_____ (MM/DD/YY) / TST read date: _____ (MM/DD/YY)

TST Result: _____ *(Millimeters of Induration)* / TST Interpretation: ☐ Positive* ☐ Negative ☐ Unknown

Interferon-Gamma Release Assay (IGRA) performed: ___ / ___ / ___ (MM/DD/YY)

IGRA Interpretation: ☐ Positive* ☐ Negative ☐ Indeterminate/Borderline (requires repeat test)

*** Report all persons with positive TB test to the Massachusetts Department of Public Health (DPH)**

http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html

Medical Provider Signature: _____ **Date:** _____

Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: _____ DOB: _____ Date: _____

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____	☐	☐
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐	☐
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	☐	☐
4) Do you have (or have you had) any of these medical conditions? Diabetes — Kidney disease HIV infection — Colitis Cancer — Stomach or intestine surgery Rheumatoid arthritis	☐	☐
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐	☐
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	☐	☐
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)	☐	☐

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?	☐	☐
2) Coughing up blood?	☐	☐
3) Weight loss of more than 10 pounds for no known reason?	☐	☐
4) Fever of 100°F (or 38°C) for over 2 weeks?	☐	☐
5) Unusual or heavy sweating at night?	☐	☐
6) Unusual weakness or extreme fatigue?	☐	☐

If you answer "yes" to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.

Adult TB Risk Assessment and Screening Form
Instructions to Medical Providers

The purpose of the TB risk assessment and screening form is to identify persons with **increased risk for TB** who may require further testing and evaluation. Persons born in countries where TB is common are at increased risk for TB (especially, but not limited to those who arrived in the last 5 years).

The **TB Self-Assessment of TB Risk section** can be completed by the patient/client/guardian alone or with provider's assistance. The provider should review the information and discuss TB risks, symptoms, previous TB testing and treatment with the patient/client.

If the person with TB risk describes or exhibits symptoms suggestive of possible active TB:

- Isolate the patient/client immediately (if possible) and have the patient/client wear a mask.
- Refer the patient/client for prompt clinical evaluation including a chest x-ray. Ensure that the patient/client wears a mask during transport to the provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease/ Division of Global Populations and Infectious Disease Prevention at 617-983-6970.

If the person has a history of TB or TB risk, but has no symptoms suggestive of TB:

- Educate the patient/client about signs and symptoms of TB and should such symptoms develop, instruct them to seek medical follow-up.
- Consider testing the patient/client for TB infection or refer to primary care provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease, Division of Global Populations and Infectious Disease Prevention at 617-983-6970, if needed.

Resources

Information about TB evaluation, testing and treatment can be found at http://www.cdc.gov/tb/ and http://www.mass.gov/dph/cdc/tb

Guideline on the use of Interferon-Gamma Release Assay can be found at http://www.mass.gov/eohhs/gov/departments/dph/programs/id/tb/testing-screening/

Cases of suspect active or confirmed cases of active TB and TB infection are reportable to the Massachusetts Department of Public Health per Chapter 105, Code of Massachusetts Regulations (CMR), Section 300.000: Reportable Diseases, Surveillance, and Isolation & Quarantine Requirements.) http://www.mass.gov/eohhs/gov/departments/dph/programs/id/epidemiology/rdiq/reporting-diseases-and-surveillance-information.html

DPH-supported TB clinics http://www.mass.gov/eohhs/docs/dph/cdc/tb/regional-clinic-list.pdf

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.
You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

The MAST Test

The MAST Test is a simple, self-scoring test that helps assess if you have a drinking problem. Answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)
___ Yes ___ No

2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
___ Yes ___ No

3. Does any near relative or close friend ever worry or complain about your drinking?
___ Yes ___ No

4. Can you stop drinking without difficulty after one or two drinks?
___ Yes ___ No

5. Do you ever feel guilty about your drinking?
___ Yes ___ No

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
___ Yes ___ No

7. Have you ever gotten into physical fights when drinking?
___ Yes ___ No

8. Has drinking ever created problems between you and a near relative or close friend?
___ Yes ___ No

9. Has any family member or close friend gone to anyone for help about your drinking?
___ Yes ___ No

10. Have you ever lost friends because of your drinking?
___ Yes ___ No

11. Have you ever gotten into trouble at work because of drinking?
___ Yes ___ No

12. Have you ever lost a job because of drinking?
___ Yes ___ No

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
___ Yes ___ No

14. Do you drink before noon fairly often?
___ Yes ___ No

15. Have you ever been told you have liver trouble, such as cirrhosis?
___ Yes ___ No

16. After heavy drinking, have you ever had delirium tremens (DTs)[2], severe shaking, visual or auditory (hearing) hallucinations?
___ Yes ___ No

17. Have you ever gone to anyone for help about your drinking?
___ Yes ___ No

18. Have you ever been hospitalized because of drinking?
___ Yes ___ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
___ Yes ___ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
___ Yes ___ No

21. Have you been arrested more than once for driving under the influence of alcohol?
___ Yes ___ No

22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
___ Yes ___ No

C.A.G.E.

1. Have you ever thought about cutting down on drinking?
___ Yes ___ No

2. Have you ever felt annoyed when friends or members of your family expressed concern about your drinking?
___ Yes ___ No

3. Have you ever felt bad or guilty about drinking?
___ Yes ___ No

4. Do you ever drink in the morning before breakfast or before going to work?
___ Yes ___ No

Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name: **Lowell House Inc.**	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

(Check all that apply below)

1. What drugs do you usually use? ☐ N/A
☐ Heroin ☐ Other Opiates ☐ Cocaine ☐ Alcohol ☐ Methadone ☐ Benzodiazepines
☐ Inhalants ☐ Marijuana ☐ Amphetamines ☐ Other: _____

2. How do you use your drugs? ☐ N/A
☐ Inject ☐ Oral ☐ Smoke ☐ Snort ☐ Other: _____

3. If you inject drugs, how often do you use new needles? ☐ N/A
☐ Sometimes ☐ Always ☐ Never

4. If you use new needles, where do you get them? ☐ N/A
☐ Pharmacy ☐ Friends ☐ Needle Exchange ☐ Other _____

5. If you use needles, how do you dispose of them? ☐ N/A
☐ Throw Away ☐ Needle Exchange ☐ Bring to Pharmacy ☐ Disposal Site ☐ Other _____

6. Do you ever share needles/injection equipment? ☐ N/A
☐ Yes ☐ No

7. In the last five years, about how many people have you had sex with?
☐ 20 or more ☐ 10-19 ☐ 3-9 ☐ 0-2

8. How often do you use protection against infections? ☐ N/A
☐ Sometimes ☐ Never ☐ Always

9. Have you had sex for money, drugs or something you needed?
☐ Yes ☐ No

10. When was the last time you were tested for HIV?
☐ _____ ☐ Never

11. Did you receive your results? ☐ N/A
☐ Yes ☐ No

12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

Please check what was provided to Person Served below:
☐ HIV Fact Sheet ☐ Discussion Only ☐ Referral ☐ Viral Hepatitis Information
☐ Other STI Information ☐ Other: _____

Other Notes / Recommendations:

Person's Name (First MI Last):	Record #:

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		

Person's Name (First MI Last):	**Record #:**	**Date of Admission:**
Organization/Program Name: Lowell House Inc.	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Transgender

ASK – Systematically identify all tobacco users at every visit.

☐ Never used tobacco	→	Encourage continued abstinence / Proceed to the signature section.
☐ Recovering tobacco user	→	Do you need any further help at this time? ☐ No, Proceed to the signature section. ☐ Yes - Proceed to the Assist section.

☐ Average number of Cigarettes _____ / Cigars _____ / Pipe Bowls _____ smoked per day?
☐ Average use of Snuff _____ / Chew _____ / Other: _____ - _____ per day?
How soon after waking do you use tobacco? _____

ADVISE – Strongly urge all tobacco users to quit.

☐ This program cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for tobacco users with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.

ASSESS – Determine willingness and readiness to make an attempt to quit.

1. On a scale of 1-10, with 1 being not at all important and 10 being extremely important, how important would you say it is for you to stop using tobacco?	*Not at all* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *Extremely*
2. On the same scale, how interested are you in quitting?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
If uninterested, ask: What would make you more interested?	
If you decided to be tobacco free, on a scale of 1-10, how confident are you that you could successfully do it?	*Not at all* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *Extremely*
If unconfident, ask: How could the program help you become more confident?	
If you were to quit, what would be some reasons?	

STAGE OF CHANGE

☐ Not considering quitting (*Pre-contemplation*)
☐ Thinking about quitting (*Contemplation*)
☐ Ready to quit in next 30 days (*Preparation*)
☐ Tobacco Free 1 day to 6 months (*Action*)
☐ Tobacco Free 6 mos or more (*Maintenance*)

If in preparation, ask: What steps have you taken to prepare for your attempt to quit?

ASSIST – Aid the person served in quitting or planning for the future.

☐ Evaluate past quitting experience:
How many times have you tried to quit using tobacco?
What kinds of Nicotine Replacement Therapy (NRT) have you tried? (gum, patches, inhaler, Zyban/Wellbutrin)
☐ Discuss available programs: * Individual counseling and NRT on site * Referral to local tobacco treatment specialist off-site * Support for tapering * Support for going "cold turkey" * Self-help materials * Nicotine Anonymous Information

Give materials and encourage support including the use of telephone counseling at:
Tobacco-Free Helpline 1-800-QUIT-NOW or website www.makesmokinghistory.org

ARRANGE – Schedule follow-up contact.

☐ Offered referral for on-site tobacco treatment:	☐ The person served would like to be referred ☐ The person served does not want to be referred
☐ Will follow-up as part of regular treatment planning.	

Person's Name (First MI Last):			**Record #:**
Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		

Massachusetts Gambling Screen (MAGS)

Please circle the response that best represents your answer.

Questions	*Responses*
1. Have you ever gambled (for example, bet money on the lottery, bingo, sporting events, casino games, cards, racing or other games of chance)?	1. No Yes
2. Have you ever experienced social, psychological or financial pressure to start gambling or increase how much you gamble?	2. No Yes
3. How much do you usually gamble compared with most other people?	3. Less About the same More
4. Do you feel that the amount or frequency of your gambling is "normal"?	4. Yes No
5. Do friends or relatives think of you as a "normal" gambler?	5. Yes No
6. Do you ever feel pressure to gamble when you do not gamble?	6. No Yes

If you never have gambled, please skip to question #29 now.

7. Do you ever feel guilty about your gambling	7. No Yes
8. Does any member of your family ever worry or complain about your gambling?	8. No Yes
9. Have you ever thought that you should reduce or stop gambling?	9. No Yes
10. Are you always able to stop gambling when you want?	10. Yes No
11. Has your gambling ever created problems between you and any member of your family or friends?	11. No Yes
12. Have you ever gotten into trouble at work or school because of your gambling?	12. No Yes
13. Have you ever neglected your obligations (e.g., family, work or school) for two or more days in a row because you were gambling?	13. No Yes
14. Have you ever gone to anyone for help about your gambling?	14. No Yes
15. Have you ever been arrested for a gambling related activity?	15. No Yes
16. Have you been preoccupied during the past 12 months with thinking of ways to get money for gambling or reliving past gambling experiences (e.g., handicapping, selecting a number)?	16. No Yes
17. During the past 12 months, have you gambled increasingly larger amounts of money to experience your desired level of gambling excitement?	17. No Yes
18. During the past 12 months, did you find that the same amount of gambling had less effect on you than before?	18. No Yes
19. Has stopping gambling or cutting down how much you gamble made you feel restless or irritable during the past 12 months?	19. No Yes

Massachusetts Gambling Screen (MAGS)

Questions	*Responses*
20. During the past 12 months, did you gamble to reduce any uncomfortable feelings (e.g., restlessness or irritability) that resulted from having previously stopped or reduced gambling?	20. No Yes
21. Have you gambled as a way of escaping from problems or relieving feelings of helplessness, guilt, anxiety or depression during the past 12 months?	21. No Yes
22. During the past 12 months, after losing money gambling, have you returned to gambling on another day to win back your lost money?	22. No Yes
23. Have you lied to family members or others to conceal the extent to which you have been gambling during the past 12 months ?	23. No Yes
24. Have you committed any illegal acts (e.g., forgery, fraud, theft, embezzlement, etc.) during the past 12 months to finance your gambling?	24. No Yes
25. During the past 12 months, have you jeopardized or lost a significant relationship, job, educational or career opportunity because of your gambling?	25. No Yes
26. During the past 12 months, have you relied on other sources (e.g., family, friends, coworkers, bank) to provide you with money to resolve a desperate financial situation caused by your gambling?	26. No Yes
27. During the past 12 months, have you made efforts unsuccessfully to limit, reduce or stop gambling?	27. No Yes
28. How old were you when you placed your first bet?	28. ☐
29. What is your sex?	29. Female Male
30. What is your age as of your last birthday?	30. ☐
31. How honest were your responses to each of the questions on this survey?	31. Not at all honest Somewhat dishonest Somewhat honest Very honest

Thank you for your cooperation!

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An affiliate of The National Council on Problem Gambling Inc.
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SELF-DECLARATION OF INCOME REPORT

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETED TO RECEIVE REIMBURSEMSENT

PARTICIPANT INFORMATION

I. PARTICIPANT STATUS: ☐ FAMILY ☐ INDIVIDUAL

Participant Name: _____

Address: _____City, State, Zip Code: _____

3. RACE (*please select only one*):

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native and White
☐ Asian and White
☐ Black/African American and White
☐ American Indian/Alaskan Native and Black/African American
☐ Other Multi-Racial: _____

4. HOUSEHOLD INFORMATION

l) Circle the number of family and non-family members living in your household below.
2) Circle the corresponding income level.

Household Size		(0% - 30%)	(31% - 50%)	(51% - 80%)	(8l% and above)
1		$0-$22,150	$22,151-$36,900	$36,901-$50,350	$50,351+
2		$0-$25,300	$25,301-$42,200	$42,201-$57,550	$57,551+
3		$0-$28,450	$28,451-$47,450	$47,451-$64,750	$64,751+
4		$0-$31,600	$31 601-$52,700	$52,701- $71,900	$71,901+
5		$0-$34,150	$34,151-$56,950	$56,951-$77,700	$77,701+
6		$0-$36,700	$36,701-$61,150	$61,151-$83,450	$83,451+
7		$0-$39,200	$39,201-$65,350	$65,351-$89,200	$89,201+
8		$0-$42,380	$42,381-$69,600	$69,601-$94,950	$94,951+

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____ Date: _____

(Original signature is required)