FINANCIAL INFORMATION
PLEASE ANSWER ALL QUESTIONS & SIGN

Client Name: ☐ Male ☐ Female

DOB / / SS#

Permanent Address: City: State: Zip:

Phone: Employers Name:

Race: (Check Or X all that apply) ☐ A-Asian ☐ B-Black/African American ☐ M- Alaskan Native ☐ N-Native American Indian ☐ P-Native Hawaiian/Other Pacific Islander ☐ W-White ☐ U-Unknown

Ethnicity: (Check or X all that apply) ☐ A-Puerto Rican ☐ B-Mexican ☐ C-Cuban ☐ D-Hispanic ☐ E- Not Hispanic or Latin ☐ U-Unknown

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who referred you to LARC?

☐ Self ☐ Ashtabula Municipal Court ☐ Conneaut Municipal Court

☐ Eastern County Court ☐ Western County Court ☐ Court of Common Pleas

☐ Juvenile Court/YDC ☐ Other (Specify)____________________

Monthly Income Total : $____________ If $ 0 Income, who supports you? ____________

OTHER PERSONS LIVING IN HOUSEHOLD

NAME:	AGE:	RELATIONSHIP:	NAME:	AGE:	RELATIONSHIP:
1.)			4.)		
2.)			5.)		
3.)			6.)		

Do you have Medicaid coverage? ☐ Yes ☐ No If Yes, what is the Medicaid #?

Do you have insurance coverage? ☐ Yes ☐ No If Yes, complete the next sections.

It is OK to: Contact me by phone at my permanent address ☐ Yes ☐ No
Leave messages with anyone at my home phone or on my answering machine ☐ Yes ☐ No
Contact me by email ☐ Yes ☐ No ____________ (Specify email address)

RELEASE OF INFORMATION FOR INSURANCE AND OTHER BILLING

I hereby authorize the Lake Area Recovery Center to release any information acquired in the course of my treatment that is necessary to insure reimbursement by my insurance carrier and/or any other payer to LARC or Millennium. I further understand that I may revoke this consent anytime except where disclosure has already been made. In the event that I receive funds from my insurance company for payment of services to LARC, I agree to assign payment to the agency to pay LARC the exact amount received from the insurance company. In the event that I do not make payment to the agency, I understand that my account will be turned over to a collection agency.

ALL OF THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Person Authorized to Consent: Date:

Relationship to Client: LARC Witness:

OFFICE USE ONLY: Proof of Ashtabula Co. address? ☐ Yes ☐ No Proof of income? ☐ Yes ☐ No

Monthly income $________ Number in household______

Sliding Scale %________ Active Medicaid Managed Care Plan____________

INSURANCE INFORMATION

Contract Holder's Name:		DOB: / /		
Home Address:	City:		State:	Zip:
Phone:	Employer's Name:			
Insurance Name:			Phone:	
Address:	City:		State:	Zip:
Policy #		Group #		
Relationship to Client:		Primary Care Physician:		

FINANCIAL POLICY

The following is a statement of our Financial Policy, which we hope will clarify any questions or concerns you may have regarding your account with our agency.

Financial Forms - All clients receiving services must complete a financial form at the time of their visit and must update this information should it change. **Financial forms must be completely filled out or you will be billed at 100% for our services.**

Sliding Fee Scale - For those clients who do not have insurance or Medicaid and are self pay, the agency bills on a sliding fee scale based on your monthly income. In order to qualify for the sliding fee scale the agency must have proof of your income or proof of no income. Failure to produce proof of income will result in you being billed at 100% for our services. This fee is payable at the time of service.

Proof of Income – Proof of income is required by all clients who qualify for a sliding fee scale. Acceptable proof of income is a current paycheck stub or your most recent Federal Income Tax form. If you claim to have no income, you may be required to provide validation of your means of support.

Medicaid – If you are on Medicaid we must have a copy of your Medicaid card for every visit to the agency. Failure to present your Medicaid card will result in your being billed 100% for our services. In the event that Medicaid will not pay for you services, and you have 3rd Party Insurance, your Insurance will be billed.

Insurance – If you have insurance, we must have a copy of your insurance card at the time you are admitted. Failure to produce your card will result in our agency billing you at 100% of the cost of our services. If your insurance company is one with whom we are a contracted provider, we will gladly file your insurance. **You must provide us with all of your insurance information. You are required to pay your co-pays/ co-insurance/deductibles at the time of service.** If this is not possible, arrangements must be made with our billing department. The balance of your account is your responsibility whether or not your insurance company pays in full. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company is one with whom we are not a contracted provider, we will inform you of your options.

Pre-certification – If you are covered under a managed care insurance plan or your regular insurance requires it, our office MUST obtain prior authorization before we can render services. Please inform the receptionist if you are covered under such a plan so that pre-certification can be done to assure that these services will be paid for. Your insurance plan may not cover your treatment if authorization is not obtained before the visit.

Billing – Payment in full is required at the time of service, unless arrangements have been made with our billing department. Clients who have made payment arrangements will receive a statement each month. All payments are due within 10 days of receipt of the statement. All accounts over 90 days past due will be placed with our collection agency. To avoid this, please make your payments as agreed.

I understand and agree to this Financial Policy.

Signature	Date / /

PartnerSolutions
Health Informatics

RELEASE OF INFORMATION
FOR
PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM (PSHIC)

I, ______________________ *authorize* ***LAKE AREA RECOVERY CENTER***

(Name of Client)

and the other members of the PartnerSolutions Health Informatics Consortium, ***as listed on the back of this form,*** *to communicate with and disclose to one another the following information about me:*

- *My name, contact information and other personal identifying information*
- *My status as a services recipient*
- *Initial and subsequent evaluations of my service needs*
- *Medications and allergies*
- *My treatment history, including mental health and alcohol/drug services*
- *Discharge plans and outcomes*
- *Enrollment, eligibility and payment information*

The purposes of this exchange of information is to enable the members of PSHIC to better evaluate my need for services, to enable the coordination of services provided to me, to allow for billing and payment of those services and to enhance the care that I receive. All disclosures will be limited to the information necessary to fulfill these purposes.
I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), CFR Parts 160 & 164, and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health treatment records are protected by HIPAA but if the recipient of my information is not subject to HIPAA, they may no longer be protected by state or federal law and therefore subject to re-disclosure by a third party.
I understand that I may revoke this authorization at any time, except to the extent that the entity(ies) authorization to make the disclosure has taken action in reliance on it, and that in any event this authorization expires automatically when I am no longer receiving services from any member of PSHIC and no longer have an active case record.
I understand that I may refuse to sign this authorization, if it is for purposes other than alcohol and/or drug treatment and payment for that treatment, and that my refusal to sign it for other purposes will not otherwise affect my ability to obtain treatment, my eligibility for benefits, or the payment provided for those services. I understand that refusing to sign this form does not prohibit disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

Signature of Client/Legal Representative	*Date*	*Client Date of Birth*

Printed Name and Authority of Person Signing on Behalf of Client (if applicable)

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

MEMBERS OF THE PARTNERSOLUTIONS HEALTH INFORMATICS CONSORTIUM

ASHTABULA COUNTY:

- **Ashtabula County Mental Health and Recovery Services Board** - 4817 State Road, Suite 203, Ashtabula, Ohio 44004
- **Lake Area Recovery Center**- 2801 C Court, Ashtabula, Ohio 44004

JEFFERSON COUNTY:

- **Jefferson Behavioral Health System** - 380 Summit Avenue. Steubenville, Ohio 43952

MONTGOMERY COUNTY:

- **ADAMHS Board for Montgomery County** - 409 E. Monument Avenue, Suite 102, Dayton, OH 45402
- **Addiction Services** - 1 Elizabeth Place SE 3rd Floor, Dayton, OH 45417
- **Nova Behavioral Health, Inc.** - 732 Beckman Street, Dayton, Ohio 45410
- **PLACES Inc.** - 11 West Monument Ave, 7th Floor, Dayton, OH 45402
- **Project Cure, Inc.** - 1800 North James H. McGee Blvd., Dayton, Ohio 45417

PORTAGE COUNTY:

- **Health & Recovery Board of Portage County** - 155 E. Main Street, PO Box 743, Kent, Ohio 44240
- **Children's Advantage** - 520 North Chestnut Street, Ravenna, Ohio 44266
- **Townhall II** - 155 N Water St, Kent, Ohio 44240

STARK COUNTY:

- **Stark County Mental Health & Addiction Recovery** - 121 Cleveland Avenue SW, Canton, Ohio 44702
- **Child and Adolescent Behavioral Health** - 919 Second Street NE, Canton, Ohio 44704
- **CommQuest Services, Inc.** - 625 Cleveland Avenue NW, Canton, Ohio 44702
- **Crisis Intervention and Recovery Center, Inc.** - 832 McKinley Avenue NW, Canton, Ohio 44703
- **Domestic Violence Project, Inc.** - PO Box 9459, Canton, Ohio 44711
- **Stark County TASC** - 1375 Raff Road SW, Canton, Ohio 44710

TRUMBULL:

- **Trumbull County Mental Health and Recovery Board** - 4076 Youngstown Road SE, Suite 201, Warren, Ohio 44484
- **Homes for Kids** - 165 E. Park Avenue, Niles, Ohio 44446

WAYNE/HOLMES COUNTIES:

- **Mental Health & Recovery Board of Wayne & Holmes Counties** - 1985 Eagle Pass Drive, Wooster, Ohio 44691

Anazao Community Partners - 2587 Back Orrville Road, Wooster, Ohio 44691

SmartCareMCO Residency Verification Form

The purpose of this form is to clarify which PartnerSolutions board is responsible for adjudicating claims for behavioral health services provided to the client being enrolled in SmartCareMCO. The form should be completed at the time the client first presents for treatment/services at the submitting agency and whenever a change in the client's residency occurs. The form should be presented to the appropriate PartnerSolutions board enrollment contact when:

1.) The county of the submitting agency does not match the legal county of residence of the client as noted on the enrollment form.

2.) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client.

3.) The minor's physical address as noted on the enrollment form does not match the legal custodian's address.

4.) The board staff person responsible for processing the enrollment requests the form, such as in cases when a client needs to be transferred from one PartnerSolutions board's coverage plan to another's in SmartCareMCO.

A client or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Instructions: Fill out only the "Adult" section and the associated signature and date fields if the client is a legal adult or emancipated minor. Fill out only the "Minor" section and the associated signature and date fields if the client is a legal minor. If the form is completed by hand rather than electronically, please print legibly.

Adult

Client Name

Enter the client's street address, city, state, and ZIP for residency determination purposes.

Address 1 | Address 2

City | State | ZIP | County of Residence

Minor

Indicate if minor is in legal custody of the following:

○ Parent ○ CSB ○ DYS ○ Court ○ Other (specify):

Client Name

Legal Custodian Name

If legal custodian is Parent, enter the Parent's street address, city, state, and ZIP if different from the client's physical address on the enrollment form.

Address 1 | Address 2

City | State | ZIP | County of Residence

Signatures

Signatures must be handwritten rather than electronically signed.

Client Signature (if Legal Adult or Emancipated Minor) | Date | Legal Custodian Signature (if Legal Minor) | Date

* For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

Version 1.0

BILLING MANAGEMENT INFORMATION SYSTEM NOTICE OF ENROLLMENT

To be eligible to receive public funds to help pay for the cost of your mental health and/or addiction services, your personal information must be entered into the billing management information system used by the Ashtabula County Mental Health and Recovery Services Board. This information will be used by the Board to:

- Enroll you in the Board's Behavioral Health Care Plan
- Determine your eligibility for publicly-funded services
- Pay the provider for those services
- Fulfill the Board's legal responsibilities

If applicable law requires you to consent to the disclosure of this information to the Board, your information will not be entered into the system without your written consent. Once in the system, your information will only be used or disclosed by the Board as authorized by you or as permitted by applicable law.

Other County Behavioral Health Boards that pay for your services may utilize the same billing management information system as the Board but will only access your personal information as authorized by you or as permitted by applicable law.

Name of Client: ______________________________

I have read and explained this information to the above-named individual.

______________________________ ______________________

Provider Agency Staff Date

Client has refused to sign this form but has been informed of its contents. (Check if applicable) ☐

Reason for Refusal: ______________________________

* This form must be completed for every client seeking publicly-funded services. This form must be kept with the client's record.

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION TO THE ASHTABULA COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD'S BILLING MANAGEMENT INFORMATION SYSTEM

I, ____, authorize
Name of Client

Lake Area Recovery Center to disclose to
Provider Agency Name

THE ASHTABULA COUNTY MENTAL HEALTH AND RECOVERY SERVICES BOARD (Board) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) the following information:

My name and other personal identifying information and information about the services provided to me (e.g. diagnosis, services provided, dates of services) that is necessary to accomplish the following purposes:

- Enroll me in the billing management information system used by the Board and other county behavioral health boards
- Determine my eligibility for publicly-funded services
- Pay my provider for the publicly-funded services I receive
- Permit the Board to carry out its authorized legal responsibilities

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, my enrollment or eligibility for benefits, or payment for my services, except that I must authorize disclosure of this information to receive publicly-funded alcohol and drug addiction services. I understand that my service provider may disclose information necessary to obtain payment for, and carry out authorized legal responsibilities related to, my publicly-funded mental health services, including my enrollment in the publicly-funded system and determining my eligibility for those services, even if I do not authorize disclosure.

I understand that the information contained in the Board's billing management information system will only be used or disclosed by the Board as authorized by me or as permitted by applicable law. I understand that other county behavioral health boards that pay for services provided to me will only access information about me that is maintained in the Board's system as authorized by me or as permitted by applicable law.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (45 CFR 160 & 164) and cannot be re-disclosed to a third party without my written authorization unless permitted by the regulations. I also understand that my mental health records are protected by HIPAA but if the recipient of my information is not subject to HIPAA, they may no longer be protected by state or federal law and therefore subject to re-disclosure to a third party.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time the services provided to me by the above-named Provider Agency ends.

____________________________ _______________ _______________
Signature of Client/Legal Representative ***Date*** ***Date of Birth***

____
Printed Name and Authority of Person Signing on Behalf of Client (if applicable)

Client refused to sign (check if applicable): ________ Reason for Refusal:______________________________

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR DRUG TREATMENT INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

LAKE AREA RECOVERY CENTER
CLIENT FEE AGREEMENT

Fees:

Assessment	$200.00
Group Session	$48.00 Per Hour
Individual Session	$175.00 Per Hour
Intensive Outpatient Session	$120.00 Per Day
PHP	$180.00 Per Day
Crisis Session	$200.00 Per Hour
Residential 3.5	$225.00 Per Day
Residential 3.1	$160.00 Per Day
Instant Drug Screen	$35.00 Per Screening
No Show Fee	$25.00 Per Missed Appointment
Reschedule Fee	$25.00

I understand that the above rates will be billed to the insurance carrier identified on my financial statement or, if I do not have insurance and I am eligible, to the Ohio Department of Mental Health and Addiction Services for services provided to me.

If I am eligible for payment by the Ohio Department of Mental Health and Addiction Services, based on my income, I will be responsible for ______% of all charges and I agree to pay all those charges as identified.

I agree to be responsible for and to pay all charges that are not covered by private insurance, Medicaid or by the Ohio Department of Mental Health and Addiction Services.

I also understand that I will be charged $25.00 for each missed appointment for an Assessment or for an Individual Session and $25.00 for rescheduling an appointment with less than 24 hours notice or 2 rescheduled appointments in a row. These fees must be paid before the appointment can be rescheduled.

I understand that if periodic payments are not made on any self-pay balance due on my account that I may not be allowed to complete the specified program and if there is any unpaid self-pay balance on my account at the time I finish my program, I may not receive a certificate of completion **AND MY REFERRAL SOURCE MAY NOT BE NOTIFIED UNTIL PAYMENT IS MADE.**

This client has a standing physician's order to adhere to random drug screens during the entire duration of his/her treatment services at Lake Area Recovery Center.

Dr. Edward A. Carrillo, MD

Client Name: ______________________________
Please Print

Responsible Party (If Different): ______________________________
Please Print

______________________________ ______________
Signature Date

LARC-F-121-621R

F

ASHTABULA COUNTY MENTAL HEALTH
AND RECOVERY SERVICES BOARD
4817 STATE ROAD, SUITE 203
Ashtabula, Ohio 44004

Telephone: (440) 992-3121
Fax: (440) 992-2761

QUALITY IMPROVEMENT CONSENT FOR FOLLOW-UP FORM

I____ (Client's Name) consent to participate in evaluation and follow-up to assist the Board in assessing and improving the quality of services. I understand that a representative from the Board may interview me during my time in treatment about the services I receive. I understand that I may also be contacted and interviewed by a Board representative after I finish treatment and that I may be asked about my progress since ending treatment. For purposes of participating in this follow-up, I authorize ***Lake Area Recovery Center*** to disclose my name and phone number or address to the Ashtabula County Mental Health and Recovery Services Board so that a board representative can interview me.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event **this consent expires 12 months following date of discharge**.

____

Signature of Consumer/Guardian Date

____

Street Address

____

City State Zip Code

____

Home Phone Work/Other Phone

(WF: QualImpConsentFollow-upFormFY04)

LARC-F-135-408R

Client Name:____________________ Date:______________ Score:______

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		YES	NO
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

O None O Stimulants – Methamphetamine *(meth)*
O Alcohol O Synthetic Cathinones *(Bath Salts)*
O Cannaboids – Marijuana *(weed)* O Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
O Cannaboids – Hashish *(hash)* O Dissociative Drugs – Ketamine/PCP *(Special K)*
O Synthetic Marijuana *(K2/Spice)* O Hallucinogens – LSD/Mushrooms *(acid)*
O Natural Opioids – Heroin *(smack)* O Inhalants – Solvents *(paint thinner)*
O Synthetic Opioids – Fentanyl/Iso O Prescription Medications – Depressants
O Stimulants – Powder Cocaine *(coke)* O Prescription Medications – Stimulants
O Stimulants – Crack Cocaine *(rock)* O Prescription Medications – Opioid Pain Relievers
O Stimulants – Amphetamines *(speed)* O Other (specify) ____________________

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	O	O	O	O	O
b. Cannaboids – Marijuana *(weed)*	O	O	O	O	O
c. Cannaboids – Hashish *(hash)*	O	O	O	O	O
d. Synthetic Marijuana *(K2/Spice)*	O	O	O	O	O
e. Natural Opioids – Heroin *(smack)*	O	O	O	O	O
f. Synthetic Opioids – Fentanyl/Iso	O	O	O	O	O
g. Stimulants – Powder cocaine *(coke)*	O	O	O	O	O
h. Stimulants – Crack Cocaine *(rock)*	O	O	O	O	O
i. Stimulants – Amphetamines *(speed)*	O	O	O	O	O
j. Stimulants – Methamphetamine *(meth)*	O	O	O	O	O
k. Synthetic Cathinones *(Bath Salts)*	O	O	O	O	O
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	O	O	O	O	O
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	O	O	O	O	O
n. Hallucinogens – LSD/Mushrooms *(acid)*	O	O	O	O	O
o. Inhalants – Solvents *(paint thinner)*	O	O	O	O	O
p. Prescription Medications – Depressants	O	O	O	O	O
q. Prescription Medications – Stimulants	O	O	O	O	O
r. Prescription Medications – Opioid Pain Relievers	O	O	O	O	O
s. Other (specify) ____________	O	O	O	O	O

14. How many times before now have you ever been in a drug treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]

O *Never* O *1 time* O *2 times* O *3 times* O *4 or more times*

15. How serious do you think your drug problems are?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

O *Never* O *Only a few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

17. How important is it for you to get drug treatment now?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

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SOUTH OAKS GAMBLING SCREEN

Client Name:____ **Date:**____________________

1.For each type, check ONE answer: "not at all," "less than once a week," or "once a week or more."

	Not at all	Less than once a week	Once a week or more	
a.				Play cards for money
b.				Bet on horses, dogs or other animals (at OTB, the track, or with a bookie)
c.				Bet on sports (parlay cards, with a bookie, or at Jai Alai)
d.				Played dice games (including craps, over and under, or other dice games) for money
e.				Gambled in a casino (legal or otherwise)
f.				Played the numbers or bet on lotteries
g.				Played bingo for money
h.				Played the stock, options, and/or commodities market
i.				Played slot machines, poker machines, or other gambling machines
j.				Bowled, shot pool, played golf or some other game of skill for money
k.				Pull tabs or "paper" games other than lotteries
l.				Played internet gambling games for money.
m.				Some form of gambling not listed above (Please specify)

2. What is the largest amount of money you have ever gambled with on any one day?
- ☐ Never have gambled
- ☐ More than $1 up to $10
- ☐ More $1000 up to $10,000
- ☐ $1 or less
- ☐ More than $10 up to $100
- ☐ More than $10,000

3. Check which of the following people in your life has (or had) a gambling problem.
- ☐ Father
- ☐ Mother
- ☐ Brother or sister
- ☐ A grandparent
- ☐ My spouse or partner
- ☐ My children
- ☐ Another relative
- ☐ A friend or someone important in my life

4. When you gamble, how often do you go back the next day to win back money you have lost?
- ☐ Never
- ☐ **Some of the time** (Less than half the time I lost)
- ☐ **Most of the time I lost**
- ☐ **Every time I lost**

5. Have you ever claimed to be winning money gambling but weren't really? In fact you lost?
- ☐ Never
- ☐ **Yes, less than half the time I lost**
- ☐ **Yes, most of the time I lost**

6. Do you feel you have ever had a problem with betting money or gambling?
- ☐ No
- ☐ **Yes, in the past but not now**
- ☐ **Yes**

	YES	NO
7. Did you ever gamble more than you intended?		
8.Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?		
9.Have you ever felt guilty about the way you gamble or what happens when you gamble?		
10.Have you ever felt you would like to stop betting or gambling but didn't think you could?		
11.Have you ever hidden betting slips, lottery tickets, gambling money, IOUs or other signs of betting from your spouse/partner, children or other important people in your life?		
*12. Have you ever argued with people you live with over how you handle money?	*	

13.	(If you answered "yes" to question 12) Have money arguments ever centered on your gambling?		
14.	Have you ever borrowed from someone and not paid them back as a result of your gambling?		
15.	Have you ever lost time from work (or school) due to betting money or gambling?		
16.	If you borrowed money to gamble or to pay gambling debts, who or where did you borrow it from? (Check "yes" or "no" for each)		

		Yes	No
a.	From household money		
b.	From your spouse/partner		
c.	From other relatives or in-laws		
d.	From banks, loan companies, or credit unions		
e.	From credit cards		
f	From loan sharks		
g.	You cashed in stocks, bonds or other securities		
h.	You sold personal or family property		
i.	You borrowed on your checking account (You passed bad checks)		
*j.	You have/had a credit line with a bookie	*	
*k.	You have/had a credit line with a casino	*	

CLIENT SCORE___________

INTERPRETATION

☐ **0 = No problem** ☐ **1 - 4 = Some problem** ☐ **5 or more + Probable Pathological Gambler**