DEPENDENT INTAKE QUESTIONNAIRE

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

EMPLOYEE ASSISTANCE PROGRAM

PLEAE PRINT

Office Use Only	
Client # :	Date :

LAST NAME _____ FIRST NAME _____ M.I. _____

Sex: ☐ Male ☐ Female Last 4 digits of Social Security #_____

D.O.B._____ Age: _____

Commercial Driver's License: ☐ YES ☐ NO Contact by mail: ☐ YES ☐ NO

_____

Address Street City Zip

_____ _____

Home phone cell/pager

Ethnicity: _____

Household

MARITAL STATUS: ☐ single ☐ married ☐ divorced ☐ widowed ☐ cohabitating

_____# of Years # Marriages _____ # of Children _____

Spouse's Name: _____

Spouse's Employment: _____

Children's Names (living at home) & ages

1._____ 2. _____

3. _____ 4. _____

Your Income_____ Household Income_____

Employment Information

Location Name: _____

Position: _____ Length of Employment: _____

Health Insurance Information

☐ Aetna HMO ☐ PPO ☐

Social Security/Policy #: _____

School Board Employee Name: _____

How were you referred? _____

Clinical Information

Previous therapy? ☐ YES ☐ NO

If yes, when/how long _____

Suicidal/Homicidal thoughts/ideation

Current ☐ YES ☐ NO

Past ☐ YES ☐ NO

Suicidal/Homicidal Plans?

Current ☐ YES ☐ NO

Past ☐ YES ☐ NO

Current Medical Conditions

Under Psychiatric care? ☐ YES ☐ NO

Current medical conditions? ☐ YES ☐ NO

Medications ☐ YES ☐ NO

_____

(if yes, what)

Substance Use

Alcohol ☐ YES ☐ NO _____wkly average

Smoke ☐ YES ☐ NO _____wkly average

Recreational drugs ☐ YES ☐ NO _____wkly average

Type (s) of recreational drugs: _____

Have you ever felt you should cut down on drinking/drug use? YES ■ NO ☐

Do you sometimes get angry or disappointed at yourself for not being able to quit using alcohol or drugs? YES ☐ NO ☐

Has a major area of your life been negatively affected by your alcohol or drug use (work, close relationships, health, school, self esteem)? YES ☐ NO ☐

Do you have blackouts-times you cannot remember? YES ☐ NO ☐

Would your life be better if you quit drinking or got off drugs? YES ☐ NO ☐

Have you ever been in trouble with the law due to alcohol or drug use? YES ☐ NO ☐

Do you get annoyed by comments people make about your drinking/drug use? YES ☐ NO ☐

What are the times of day/days of the week that you drink/use drugs? _____

Personal History

Mother Living ☐ YES ☐ NO

Father Living ☐ YES ☐ NO

If no, cause of death:

_____

# of sisters_____ # of brothers _____

Birth placement: ☐ Oldest ☐ Middle ☐ Youngest

Is there a history of abuse? ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual

Work Satisfaction

1. # of days taken off over last three months Related to work/personal problems _____
2. # of days taken off over last three months for true illness _____
3. # of supervisory warnings _____
4. # of suspensions _____

How much stress does the job itself cause?

☐ Extreme Stress ☐ Very Stressful ☐ Low Stress ☐ Almost No Stress

To what extent are you satisfied with your job?

☐ Highly Satisfied ☐ Satisfied, with Minor Problems ☐ Basically Satisfied, But with some serious problems

☐ Dissatisfied ☐ Very Dissatisfied

How would you rate your job performance now?

☐ Excellent ☐ Good ☐ Excellent to Poor (Uneven) ☐ Fair ☐ Poor

How often are your problems affecting your job performance?

☐ All the time ☐ Frequently ☐ Sometimes ☐ Not Often ☐ Very Rarely or Never

The three things bothering me the most:

1. _____
2. _____
3. _____

Check ones that apply to your current feelings

☐ sad	☐ overwhelmed	☐ frustrated	☐ optimistic
☐ lonely	☐ guilty	☐ confused	☐ drained
☐ nervous	☐ helpless	☐ numb	☐ bored
☐ irritable	☐ hopeless	☐ distrustful	☐ fearful
☐ angry	☐ grief	☐ happy	

My overall sense of emotional strength is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

I understand that once I am assigned a therapist for ongoing services I will be responsible for paying any co-payments or deductibles in accordance with my insurance contract.

_____

Client Signature
Thank you for your cooperation.

Rev. 8/6/19 tg

ACE Questionnaire

The ACE Questionnaire explains a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes/No If yes enter 1 _____
2. Did a parent or other adult in the household **often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes/No If yes enter 1 _____
3. Did a parent or a person at least five (5) years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to actually have oral, anal, or vaginal sex with you?
   Yes/No If yes enter 1 _____
4. Did you **often** feel that…
   No one in your family loved you, or thought you were important or special?
   or
   You family didn't look out for each other, feel close to each other, or support each other?
   Yes/No If yes enter 1 _____
5. Did you **often** feel that…
   You didn't have enough to eat, wear dirty clothes, and had no one to protect you?
   or
   Your parent(s) were too drunk or too high to take care of you or take you to the doctor if you needed it?
   Yes/No If yes enter 1 _____
6. Were your parents ever separated or divorced?
   Yes/No If yes enter 1 _____
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Ever repeatedly hit over a least a few minutes or threatened with a gun or knife?
   Yes/No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes/No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes/No If yes enter 1 _____
10. Did a household member go to prison?
    Yes/No If yes enter 1 _____

Thank you for your cooperation.
Rev. 7/19/17 bme

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA'S NOTICE OF PRIVACY PRACTICES RELATED TO ITS EMPLOYEE ASSISTANCE PROGRAM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU BE MAY USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The School Board of Broward County, FL (SBBC) Employee Assistance Program (EAP) is required by federal law – the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) – to take reasonable steps to ensure the privacy of all medical records and other individually identifiable health information used or disclosed by EAP in any form and to inform you about:

- EAP uses and disclosures of Protected Health Information **(PHI)**;
- Your privacy rights with respect to your **PHI**;
- EAP duties with respect to your **PHI**;
- Your right to file a complaint with SBBC and with the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about EAP's privacy practices.

The law requires EAP to give this Notice of Privacy Practices to you and fully comply with the practices outlined in this privacy notice currently in effect. SBBC is required by law to maintain the privacy of PHI, to provide you with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. . EAP reserves the right to change the terms of this notice and to make the new provisions effective for all **PHI** that it maintains. In the event EAP changes the terms and practices of this notice, EAP will immediately change this notice and post a new copy within the EAP office. You may also request a copy of this notice or you can view a copy of the notice on the EAP website at **www.broward.k12.fl.us/benefits/eap,** or by writing to EAP, 5400 S.W. 90th Avenue, Cooper City, FL 33328.

HOW WILL EAP USE AND SHARE YOUR PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information, or **PHI**, includes demographic and medical information about the past, present, or future health or condition, the provision of healthcare services to you, or the payment for such healthcare. Demographic information could include your name, address, telephone number, social security number and/or any other unique ways of identifying you.
PHI may be information created, received, used, disclosed, and/or maintained by EAP. As an example, EAP may provide your eligibility information to a Health Care Provider, as well as maintain confidential records within the EAP Department.

EAP will use and disclose your PHI for treatment, payment and healthcare operations. (Health care operations are activities compatible and directly related to treatment and payment, including day-to-day office business, administrative, and customer service activities.) Except for the purposes listed below, EAP will use and disclose **PHI** only with your written permission. *You may revoke such permission at any time or request restricted disclosure of your health information. See "Individual Rights" section for the process.*

- To a Health Care Provider for purposes of your treatment. For example, if information is requested by your physician, and your physician needs the information to provide you with medical care;
- To a Health Care Provider for purposes of payment. For example, when information is provided confirming your health insurance coverage.
- To Business Associates (including insurance carriers), with written assurances they will protect the information;
- To EAP attorneys, accountants, consultants, and others to make sure that EAP is in compliance with applicable standards and laws and to conduct quality assessments and improvement activities. For example, EAP may conduct an internal review to assure quality assurance or to evaluate the performance of the employee assistance professionals who provided you with these services.
- When necessary to comply with Workers' Compensation or other similar programs.
- For internal investigations and audits by EAP;
- For investigations and audits by the State's Inspector General, Department of Education, or Auditor General;
- For public health purposes including vital statistics, disease reporting, and regulation of health professionals;
- For medical examiner investigations;
- For research approved by EAP;
- To response to court orders and/or subpoenas (SBBC will make reasonable efforts to provide notice to you for an opportunity to seek a protective order);
- For judicial and administrative proceedings; and

- When and as required by law. Restrictions by the most protective law (whether state or federal) will be met.

Unless specified above, EAP will not share your **PHI** unless you provide your written authorization for the disclosure. This authorization will have an expiration date; additionally, you may revoke the authorization in writing at any time. Most uses and disclosures of psychotherapy notes require written authorization. Uses and disclosures of PHI for marketing purposes as well as disclosures that constitute a sale of PHI require written authorization.

INDIVIDUAL RIGHTS

- **You have the right to request restrictions.**
You have the right to request restrictions or limitations on the **PHI** EAP may use and disclose for treatment, payment or health care operations. You also have the right to request a limit on the **PHI** EAP discloses to someone involved in your care or the payment of your care, like a family member or friend. For example, you could ask that EAP does not share information about your care with a family member, friend or other individual who you indicated is involved in your care. To request a restriction, you must make your request, in writing, to the EAP Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse. *EAP will consider all of your requests, but is not required to agree to them except as follows: EAP is required to agree to your restriction request: (1) if, except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and/or (2) if the protected health information pertains solely to a health care item or service for which the health care provider has been paid in full by you or another person. .*

- **You have the right to request confidential communications.** You have the right to request that EAP communicate with you about medical matters in a certain way or at a certain location. For example, you can ask EAP only to contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the EAP Department. We will accommodate reasonable requests.

- **You have the right to review and receive a copy of your PHI.** With limited exceptions (including psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding), you have the right to inspect and receive a copy of the **PHI** that may be used to make decisions about your care or payment for your care. Your review of the **PHI** will be supervised and will be at a time and place that is convenient to you and a representative of EAP. If EAP does not have your PHI, but knows who does, EAP will advise you how you can get the PHI. To inspect and receive a copy of your Protected Health Information, you must make your request, in writing, to the EAP Department. If you request a copy, you may be charged a reasonable fee for the costs of copying and/or mailing. For PHI not maintained in one or more designated record sets (defined as a group of records maintained by or for a covered entity that is the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan), we will provide you access to the PHI in the form and format requested by you if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as mutually agreed to. For PHI maintained in one or more designated record sets, we will provide you access to the PHI in the electronic form and format requested by you, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as mutually agreed to. We will provide the access (review and/or copy) requested within 30 days; however, within that 30-day period, we may notify you of a one-time 30-day extension if necessary. If we request the 30-day extension, we will include the reason for the extension and the date by which the information will be provided.

- **You have the right to correct or amend your PHI**. If you feel **PHI** maintained by EAP is incorrect or incomplete, you may request to amend the information. You have the right to request an amendment for as long as the information is maintained by EAP. Your request to correct your **PHI** must be in writing and provide a reason to support your requested correction. EAP may deny your request, in whole or part, if it finds the **PHI**:
- Is not maintained by EAP;
- Is not **PHI**;
- Is by law not available for your review; or,
- Is accurate and complete.

If your correction is accepted, EAP will make the correction and advise you and other appropriate parties about the correction. If your request is denied, EAP will place your statement regarding the corrections with your **PHI**. You may also send a letter detailing the reason you disagree with the decision. EAP will respond to your letter in writing. Another recourse is to file a complaint, as described below in the section titled Complaints.

- **You have the right to receive a list of the individuals and/or agencies with whom** EAP has shared your **PHI**. All requests for this list (also known as an accounting of disclosures) must state a time period that may not include a date earlier than six (6)

years prior to the date of the request. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. The list will **not** include:

- Information disclosed to carry out treatment, payment and/or health care operations;
- Information shared with you;
- Information incidental to otherwise permitted or required disclosures, pursuant to applicable regulations;
- Information you authorized to be disclosed;
- Information disclosed to individuals involved with your care;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions or law enforcement officials when the disclosure was permitted without authorization;
- Information in a limited data set (which is PHI that excludes certain direct identifiers, such as name, address, social security number, etc.).

- **You have the right to receive a paper copy of this notice upon request.** To obtain a paper copy, contact EAP or the SBBC Privacy Officer.

FOR FURTHER INFORMATION

Requests for further information about the matters covered in this notice may be directed to the person who gave you this notice or the SBBC Privacy Officer, Risk Management Department, who can be reached at (754) 321-1914.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the SBBC Privacy Officer, at 600 S.E. 3rd Avenue, 11th Floor; Ft. Lauderdale, FL 33301 / Telephone (754) 321-1914 or Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909/ HIPAA Privacy Hotline: Voice Phone: 800-368-1019, Fax (404) 562-7881, TDD 800-537-7697. Please be advised the SBBC will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective **January 13, 2014**, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

ACKNOWLEDGEMENT

I hereby acknowledge that I have received this SBBC Notice of Privacy Practices Related to the Employee Assistance Program.

Client's Name

Client's Signature Date