domestic abuse project
DAP

INTERVENTION AND PREVENTION PROGRAM CONTACT INFORMATION

Contact Information

Last Name:	**First Name**:	**Middle Name:**
Preferred Name:	**Preferred Language:**	**Today's Date:**
Street Address:	**City, State:**	**ZIP:**
Billing Street Address (if different):	**Billing City, State:**	**Billing ZIP:**

Home Phone:	**Work Phone:**	**Cell Phone:**
Person to Contact in an Emergency:	**Relationship to you:**	**Phone:**

Demographics

Date of Birth:

Marital Status:

Married Separated Divorced Single Partnered Prefer not to say

SSN:

Country of Origin:

Gender:

Male Female

Non-binary

Self-Identified Gender:

Sexual Orientation:

Pronouns:

Race:

- ☐ African American
- ☐ African Immigrant
- ☐ Asian American
- ☐ Latino
- ☐ Native American
- ☐ White
- ☐ Multi-Racial
- ☐ Unknown

Your individual annual income:

- ☐ Less than $10,000
- ☐ $10,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 +

Please check if you have:

- ☐ Mental illness
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Mobility impairment
- ☐ Learning disability

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Military Service

Military Service: (Please choose all that apply)

N/A Active National Guard/Reserves Active National Guard/Reserves Veteran Discharged Other

_____

Military Branch: (Please choose all that apply)

Army Air Force Marines Navy Coast Guard

Service Dates:

From: _____

To: _____

DD214:

Yes No Other

Bases stationed at:

_____

_____

Job in the military: _____

Military Deployment: Yes No **How many times?** _____

Combat: Yes No **How many times?** _____

Location: _____

Deployment(s): (Location[s], date[s] deployed, & length of deployment[s])

_____

_____

_____

History of Family Member Military Service: Yes No

Who? _____

Referral Information

How did you learn about DAP? (Please choose all that apply)

☐ Probation/Parole	☐ Hotline	☐ Self	☐ Another DAP participant
☐ Child Protection Services (CPS)	☐ Shelter	☐ Spouse/Partner	☐ Other:
☐ Courts	☐ Another agency	☐ Family member	

Have you been involved in DAP's Intervention & Prevention Program before? (Please circle one) Yes No When: _____

Ethnic/Cultural Identity: We recognize that the racial categories listed above are limiting. Please write below whatever term or phrase you find most descriptive of your ethnic or cultural identity.

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LEGAL/CHEMICAL/HEALTH HISTORY

Legal System

Does your partner or former partner have an OFP or Restraining Order that names you?	Yes	No
Have you ever been charged with violating an OFP?	Yes	No
Have you ever been arrested for domestic assault?	Yes	No
Approximate date(s) of the arrest(s):		
Were you directed by the courts to attend DAP's program?	Yes	No

Chemical Use

Have you ever felt that you ought to cut down on your drinking or drug use?	Yes	No
Have people annoyed you by criticizing your drinking or drug use?	Yes	No
Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No
Does your chemical use have a negative impact on your work or home life?	Yes	No
Have you been through chemical dependency treatment within the past six months?	Yes	No

When:	**Where:**	**Program Length:**	**Program Type:** **Inpatient** **Out-patient**

Mental Health

Are you currently under a provider's care for depression or anxiety?	Yes	No
Are you currently taking any medication for depression or anxiety?	Yes	No
If yes, what:		
Have you had serious or persistent thoughts about suicide or hurting yourself or others in any way?	Yes	No
Have had mental health services and/or inpatient hospitalization?	Yes	No

Agency:	**Therapist:**	**Approximate dates of service:**
Reason for seeking therapy:		
Hospital Admitted To:	**Approximate dates of service:**	**Reason for hospitalization:**

INTERVENTION AND PREVENTION PROGRAM PARTICIPATION AGREEMENT

Oppression is a form of violence. Racism, sexism, and any prejudices are oppressive. Racist and sexist remarks are abusive, encourage further violence, are contrary to the principles of DAP and therefore will not be tolerated.

Domestic Abuse Project agrees:

1. To provide you with a copy of the Participant Rights Statement and to respect your dignity and confidentiality, as defined by that statement.
2. To be honest with you about your treatment.
3. To provide you with group, individual, couple's, and other therapy as needed as goals are met.
4. To provide you with referrals/recommendations in response to additional needs DAP is unable to help you meet.

I agree to the following DAP expectations:

1. To work on the goals, we have agreed upon.
2. To be honest and direct about myself.
3. To attend a minimum of 24 sessions, 10 of which are specific education topics.
4. To complete an individual diagnostic intake session.
5. To follow the treatment plan, I created with provider(s).
6. To attend and be on time for group, meetings, and individual sessions.
7. To miss no more than 5 sessions over 24 sessions. Consecutive absences may result in a program dismissal.
    - If extenuating circumstances arise, a person may switch groups no more than once over the 24 sessions with approval from the Intervention and Prevention Program Supervisor.
8. To let my provider(s) know as soon as possible if I miss a group, meeting, or individual session.
9. To participate in group and other provider facilitated services.
    - This includes sharing experiences, insights, feelings, engaging in group activities and the required assignments and presentations.
10. To ask for help or support when I need it.
11. To follow through on referrals for evaluation and treatment when deemed appropriate by DAP staff
    - i.e., chemical abuse treatment, psychological evaluations, individual therapy, etc.
12. To know my fee, pay it on time, and to adjust it with the Business Office if my financial situation changes.
13. To not be under the influence of alcohol or other chemicals the night before or day of group.
14. To follow all the Intervention and Prevention Program Rules on the handout I received.

Agreement to be non-violent:

I agree to be non-violent while participating in programming at the Domestic Abuse Project. This agreement includes being non-violent with my partner, children, and others.

I have read and I understand the information provided about participant rights, confidentiality, and exceptions to confidentiality. I understand and agree to follow the DAP Intervention and Prevention Program Rules. I understand this Participation Agreement and agree to follow it.

_____ _____

Participant Name **Date**

_____

Participant Signature

TELEHEALTH PARTICIPANT AND PROVIDER AGREEMENT

Participant / Caregiver / Legal Guardian Agrees to:

_____ Attend scheduled advocacy, case management, coordinated entry, or therapy appointments:

In my home Another approved secure location: _____

_____ Attend all scheduled sessions and will call Domestic Abuse Project services provider if unable to attend.

_____ Arrive to sessions on time, if I am 15 or more minutes late, I understand I may not be seen by my provider that day and it will be considered a missed appointment.

_____ Attend sessions in a secure location and understand that if it appears to the provider that I am not at my home or previously approved secure location the session will be ended immediately.

_____ Follow Domestic Abuse Project's services participation agreement and understand that if I choose not to, I may not be able to continue telehealth services.

_____ Attend sessions free of the influence of alcohol or other illegal chemicals.

_____ Complete a participant safety/emergency plan as part of the sent program paperwork or at my first telehealth session and will follow that plan if a crisis arises.

_____ Contact my local emergency room or county crisis mental health support if I am experiencing a mental health crisis between sessions.

_____ Complete all necessary consents, screeners, releases, and additional paperwork properly, in a timely manner, and return it to the Domestic Abuse Project.

_____ Agree to not record any sessions or conversations without the written consent of everyone who is participating in the service(s) (including Domestic Abuse Project providers). ***Recording sessions, phone calls, etc. without written permission, as stated above, could result in termination from programming and restriction from service access at the Domestic Abuse Project.***

Domestic Abuse Project Provider Agrees to:

- Conduct services effectively and in accordance with standard practices.
- Conduct services in an ethical and professional manner.
- Maintain a set schedule and will let participants know as soon as possible about planned absences.
- Maintain confidentiality, with the understanding that there are situations that I cannot legally keep confidential. For example, high risk of suicide, child abuse, or harm to others that are discussed or observed.
- Agree to not record any sessions or conversations without written consent of everyone who is participating in the service(s).

Domestic Abuse Project reserves the right to terminate telehealth services at any time for any reason.

_____

Participant Name

_____

Caregiver / Legal Guardian Name (if applicable)

_____ _____

Participant / Caregiver / Legal Guardian Signature **Date**

PARTICIPANT RIGHTS

Agency Statement

You have the right to be treated with dignity and respect and to receive the same consideration as anyone else regardless of your race, creed, color, beliefs, gender, national origin, source of payment, age, religion, disability or sexual or affectional preference.

Data Privacy

The Minnesota Government Data Practices Act requires that whenever we ask you to provide us with private or confidential information about yourself that you be told:

* The purpose for which the information will be used,
* The legal requirements, if any, of supplying it,
* The consequences to you of providing the information or refusing to supply it, and,
* The identity of other persons or agencies legally allowed to get the information.

Purposes

The information will be used in the following ways:

* To explore the usefulness of DAP services to you
* To provide results of this intake assessment in language you can understand
* To determine treatment plans and goals
* To understand possible outcomes and side effects of services
* To report deidentified program outcomes to funders
* To provide training to DAP staff and other partner agencies
* To provide accountability within the Intervention and Prevention Program through partner calls per Domestic Abuse Counseling Program or Education Program Required (MN Statute 5188.02)
* To understand if programs and services are achieving their intended goals through research and program evaluation (this includes looking up intervention and prevention program participants in MNCIS post-program completion
* To communicate with your health insurer to ensure coverage and payments for services you receive at DAP, and
* To anticipate expected length, cost, and possible outcome of services.

Legal Requirements and Consequences

You are not legally required to provide any of the information we request. In most cases, it is to your benefit to provide the information because if you do not, you may not be able to receive some or all services.

Exceptions to Confidentiality

Information cannot be kept confidential in the following circumstances:

1. MN Statutes, Section 626.556, requires that all social service agencies and their personnel report:
   a. Any incident or knowledge of suspected neglect, physical or sexual abuse of children to Child Protection Services. (We respect your privilege to report any incidents personally.)
   b. Any maltreatment of vulnerable adults as specified in the Vulnerable Adults Act (MN Statute 626.557).
2. If you sign a Consent for Release of Information.
3. If a court order requires information to be released.
4. If personnel within this agency, because of their work assignments, require access to the information.
5. We send grouped data (without identifying participants by name) to community agencies, funding sources, and for research and training purposes.
6. If you are required to be in treatment by the courts (i.e., court-ordered, probation, child protection services or parole), then DAP will be sending progress reports to the assigned probation officer or designated court contact.
7. To save your life or someone else's life, DAP will do whatever possible to prevent a suicide or homicide. DAP will also contact the police and/or the suspected victim in any case where we have reason to fear for someone's safety or wellbeing.

All other agencies or individuals must have a court order to review participant information.

Access

You may read the information in your file if you request to do so. You may also have copies of the information in your file. If you have any questions about who has access to information, please see your counselor.

_____ _____

Participant Name **Date**

_____

Caregiver Name (if applicable)

_____

Participant/Caregiver Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have been made aware of Domestic Abuse Project **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of **Domestic Abuse Project** health care operations. The Notice also describes my rights and **Domestic Abuse Project** duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Domestic Abuse Project web site at dap@mndap.org. I may request that a copy be mailed to me by calling **612-874-7063**.

Domestic Abuse Project reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing **Domestic Abuse Project** web site listed above to view the most current version.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

Date

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

INFORMED CONSENT

While you are receiving services from DAP you may be asked to participate in providing information about yourself, your family history, and private information using standardized measures and assessments that will assist our therapists in providing treatment options that may benefit your family. You will be informed in advance about which documents will be placed in your file.

SERVICES PROVIDED

Interns

Due to DAP's mission and values, the agency hosts interns in various programs. Interns may provide or observe services under the close supervision of staff members. You will be informed of a provider's status as an intern and the name of their supervisor before they are assigned to provide services to you or your family. You have the right to decline service from an intern, and staff will inform you of options to help you to access the services you are requesting.

Volunteers

DAP also utilizes volunteers to assist with data entry, childcare provision, front office duties, through our first call line and in counseling capacities. You will be informed of a provider's status as a professional volunteer before they are assigned to provide individual or group therapy services to you or your family. You have the right to decline service from a professional volunteer, and staff will inform you of options to help you to access the services you are requesting.

Staff

DAP employs staff of various backgrounds and experiences as well as educational levels and licensures. The educational and licensure level of your service provider may depend on the service being provided and the status of the providers progression in their educational journey. As such, we may have staff providing similar services at various levels of licensure. However, to obtain and maintain employment, staff need to maintain required licenses, supervision requirements, and continuing education requirements to maintain employment. You will be informed of a provider's status of licensure and supervisors name and information (when appropriate) at the onset of therapy services.

Observation

As DAP is a teaching facility, and utilizes various standardized interventions, we routinely teach practice methods through observation of practice methods. Observation of service provision is utilized for the following purposes:

* To learn practice methods and techniques for engaging in domestic violence intervention and prevention work.
* To receive feedback about individual practice methods and techniques.
* To ensure fidelity to the treatment model being utilized.
* To aid other DV partners and organizations in better understanding how we practice and in the creation of DV programming with our state, national and international partners.

Observation of services may include having an observer in your orientation, intake, individual or group session through either an in-person format, via video observation or recording.

Video observation

* Live stream of individual session/group session through a video camera with the observer(s) in a separate room.
* Live stream of individual/group session through a virtual platform with the observer(s) in the same virtual room with/without the observer(s) camera on.

Recording

Individual/Group session may be recorded and stored on DAP property, following HIPAA compliant processes. The recording will be permanently deleted immediately after review and/or within two weeks of recording.

All participants will be informed prior to an observation session. By agreeing to obtaining services at DAP, you are agreeing to having aspects of your treatment observed for the purposes listed above.

All other agencies or individuals must have a court order to review participant information in any format. Minnesota law provides that this kind of information cannot be collected, used, stored, or released to others without your permission or advising you of the way this information is treated by DAP.

You have received a copy of DAPs participant rights notice and therapy informed consent that provides this information to you.

CONSENT TO ASSESSMENT AND TREATMENT:

_____ I give my permission to DAP, to provide mental health assessment using standardized measures and other evaluation tools, therapy and/or consultation services for me and/or my child.

_____ I understand the nature of the mental health services that I have requested.

_____ I understand the potential benefits and risks explained to me and that I have the right to decline any service that is being offered.

_____ I understand that by agreeing to services at DAP, observation of services provided in the format listed above, for the purposes listed above, will be part of my experience.

_____ By signing this Informed Consent as the Participant or the Guardian of said Participant, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to V9.13.18 me. I am voluntarily agreeing to receive mental health assessment and treatment services for myself (or my child, if said child is the participant), and I understand that I may stop such treatment services at any time.

_____

Participant Name

_____

Caregiver Name (if applicable)

_____ _____

Participant / Caregiver Signature **Date**

INFORMED CONSENT FOR TELEHEALTH SERVICES

Participant Name: _____ DOB: _____

Telehealth services do not change your rights to privacy or your protected health information. Domestic Abuse Project Telehealth Services involve the use of HIPAA compliant, live, two-way interaction between the participant and provider using audio-visual technology for the delivery of mental health services to and from remote locations. These interactive systems are compliant with current privacy regulation.

By signing this consent form:

- I consent to receive outpatient mental health services by means of Telehealth technology
- I understand that I/my child and I will not physically be in the same room as my telehealth provider
- I understand that while the session is conducted via HIPAA compliant software, factors in my own environment (others present, privacy of the location) may impact the confidentiality of my sessions
- I understand that all documentation and storage of my protected health information will take place in the electronic health record utilized by Domestic Abuse Project
- I understand that either my Telehealth provider or I can discontinue the visit if the Telehealth services are not adequate for my situation
- I understand that I will be informed if individuals other than my Telehealth provider are present in the room at the time of service, and I have the right to request non-service-related personnel to leave the room and/or terminate the service
- I understand that my provider can terminate Telehealth services if they determine that I would receive a greater benefit from in-person services. My provider will assist me in locating the appropriate resources and will complete the referral.

This authorization expires one year from the date indicated below.

_____ _____

Signature of Participant/Parent/Legal Guardian **Date**

ATTENDANCE POLICY

Purpose

Your success in the DAP program is dependent on consistent attendance, participation, and engagement. DAP understands that unexpected life events may impact your ability to attend group. Therefore, this attendance policy is designed to provide you some flexibility to respond to these events while also encouraging regular attendance. If you feel your specific needs require additional accommodation outside of this policy, please contact your group facilitator.

Absences

For absences to be considered as "excused", you must contact your group facilitator(s) *within 24 hours of the missed group* and *provide official documentation containing the reason for your absence*. Please contact your group facilitator(s) with questions about what's considered official documentation.

Examples of EXCUSED absences:

- Court/Probation Meeting
- Emergency medical care for self, partner, kids and family members; urgent care, hospital
- Medical surgery for self, partner, kids and family members
- Illness that is contagious such as COVID, strep throat, etc.
- Death of a loved one
- Not attending the whole session; you only attend an hour of group or are late to group

Examples of UNEXCUSED absences:

- Car breaks down/transportation issues
- No childcare
- Illness that doesn't require a visit to urgent care or the hospital
- Sick child
- Medical appointment

On your 5th unexcused absence, you will be required to restart programming.

Arriving Late to Group:

The expectation is to arrive to group on time. There is a 15-minute grace period at the beginning of group. This means that if something unexpected happens right before group, you have 15-minutes to join group and have it count as an attended group. If there is a consistent pattern of misusing the 15-minute grace period, a discussion with your group facilitator(s) may be warranted to identify barriers to arriving to group on time. If you know you'll be arriving to group outside of the 15-minute grace period (16+ minutes after the group start time) we encourage you to come to group. Your presence will be counted as an EXCUSED absence (will not have any adverse effects). If you decide not to come, this will count as an unexcused absence.

Program Hold/Pausing Programming

You allowed **ONE** hold per round of programming. Holds can be up to 4 groups in length which pauses your programming. Holds cannot be split up, it must be used all at once. For example, if you only use two weeks of your hold, the other two weeks are lost. Holds do not count as absences.

Process for requesting a hold:

* Contact your group facilitator(s) in advance of the desired hold
* Formally request a hold
* Identify:
  - Hold start date
  - Length of hold (max is four groups)
  - Reason for the hold

Your group facilitator(s) will bring the request to the next team meeting where it will be discussed by the IP team. Each request is determined on a case-by-case basis and the IP team will come to a decision as a collective. Reasons a participant may need to request a hold include: 1) attending an inpatient chemical dependency treatment program, 2) regular medical appointments to treat an ongoing health concern, or 3) coping with a traumatic or stressful life event.

I have REVIEWED and AGREE to the terms of the program Attendance Policy.

_____ _____

Participant Name **Date**

_____

Participant Signature

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INTERVENTION AND PREVENTION PROGRAM GOALS

A. To accept *full responsibility* for my use of abusive and violent behavior.
B. To *stop* my use of abusive and violent behavior.
C. To *change any of my attitudes or beliefs* that give permission or support my use of threatening, abusive, and violent behavior.
D. To *learn new skills* of self-control, non-violence, positive communication, and conflict resolution.
E. To actively *practice my skills* in place of using threatening, abusive, and violent behavior.
F. To actively *use my group for support* and to build a better support network.

Additional personal goals I want to focus on while in programming:

1.

2.

3.

Treatment Plan

Group sessions: Attend a minimum of 24 group session with the following requirements:

1. A minimum of 10 sessions comprised of education topics.
2. Participants are to complete 3 assignments which are broken down into 5 presentations.

Additional treatment may include any of the following:

- Individual Counseling
- Alcohol or Drug Assessment
- Aftercare Program
- Psychological Assessment

I understand and agree to work on my program goals. I understand and agree to my treatment plan. I understand that I can be terminated from my group if I do not work my treatment program or follow program rules.

_____ _____

Participant Name **Date**

_____

Participant Signature

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AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Participant Information

Last Name:	**First Name:**	**Date of Birth:**

Information to be Released to or Exchanged With

Name:		**Organization or Affiliation:**
Street address:		**City, State, Zip:**
Phone:	**Fax:**	**Email:**

Type of Information to be Released

The purpose of exchanging information is to improve service delivery, enhance treatment planning and enhance the safety of all involved.

Yes	No	Care Coordination (including attendance, participation, services received, service recommendations, and progress in programming)
Yes	No	Group topics / Participation in group
Yes	No	Summary of participant records / Completion letter
Yes	No	Psychological testing results
Yes	No	School/Education files
Yes	No	Police reports and/or Pre-Sentencing Investigation (PSI)
Yes	No	Copies of any court documents pertinent for advocacy in criminal and/or civil court
Yes	No	Other (specify):

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Type of information to be Obtained

The purpose of obtaining information is to improve service delivery, enhance treatment planning and enhance the safety of all involved. Information will be shared via phone contact and/or letters via mail or fax.

Yes	No	Care Coordination (including attendance, participation, services received, service recommendations, and progress in programming)
Yes	No	Group topics / Participation in group
Yes	No	Summary of participant records / Completion letter
Yes	No	Psychological testing results
Yes	No	School/Education files
Yes	No	Police reports and/or Pre-Sentencing Investigation (PSI)
Yes	No	Copies of any court documents pertinent for advocacy in criminal and/or civil court
Yes	No	Other (specify):

Purpose for Release

I understand that this release will remain in effect for ***one year*** from the date of signing unless revoked by me in writing. I understand that my written cancellation will become effective when the provider receives my written notice. A photocopy of this authorization will be treated in the same manner as the original.

I understand that if applicable, if my probation officer and/or new CPS worker changes within the same county, this release covers the exchange of information with the new probation officer and/or new CPS worker.

I hereby authorize the identified individual or agency to release, obtain, or exchange the requested information within the time frame above, unless revoked in writing.

Signatures

Participant:	**Date:**
DAP Representative:	**Date:**

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AUTHORIZATION AND CONSENT TO CONTACT PARTNER AND/OR FORMER PARTNER

Participant Information

Last Name:	**First Name:**	**Date of Birth:**

Name of Partner Involved in Incident of Abuse:

Please choose one: Current Partner Former Partner

Will your partner involved in the incident of abuse be attending DAP? Yes No

Partner's / Former Partner's Name:	**Home Phone:**	**Other Phone:**

Street Address:	**City, State, Zip:**

Name of Current Partner if different from above:

Do you have a current partner? Yes No

Will your current partner be attending DAP? Yes No N/A

Current Partner's Name:	**Home Phone:**	**Other Phone:**

Street Address:	**City, State, Zip:**

Purpose of Partner Contact:

It is the policy of the Domestic Abuse Project to require that you give DAP written permission to contact your partner, ex-partner, etc. We require this for the following reasons:

- We attempt to call your partner to introduce ourselves and our programs (Victim Survivor Program, Child and Adolescent Program) and extend an invitation to your partner to sign up for these services.
- We call your partner to briefly explain the Intervention and Prevention Program and encourage your partner to call if they have any questions and concerns.
- We might call your partner if you leave the group angry or escalated and we have reason to fear for your partner's safety.
- We call your partner about six months after you complete group to ask questions about any behavior changes since group. This information is used strictly to evaluate the effectiveness of DAP's services.
- DAP has a strict policy regarding confidentiality, and we do not discuss with your partner the content of your work in group or details of what you discuss. We share information with your partner only if we have concerns about your progress in the program or worries about your partner's safety.

Contact Authorization:

I understand that this authorization will remain in effect for one year unless canceled by me in writing. I understand that my written cancellation will become effective when the provider receives that written notice from me. A photocopy of this authorization will be treated in the same manner as the original.

Participant Signature:	**Date:**

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AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION VIA EMAIL

Contact Information		
Last Name:	**First Name:**	**Today's Date:**
Street Address:	**City, State:**	**ZIP:**
Billing Street Address (if different):	**Billing City, State:**	**Billing ZIP**
Home Phone:	**Work Phone:**	**Cell Phone:**
Email:		

We understand contact information and phone numbers may change. It is your responsibility to always keep DAP aware of your update information. If we cannot reach you, it may be grounds for dismissal. If your contact information changes again, please contact DAP and have us update your information using the information below.

612-874-7063 x232 / firstcall@mndap.org

I understand that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. By signing this I am authorizing DAP staff to send and respond to emails from me which may include the sharing and releasing of private health care information. I am stating that I understand and am releasing DAP from any financial or legal obligation associated with the sharing and release of my private healthcare information. I understand that DAP is unable to protect any information that is shared via email.

_____ _____

Participant Signature **Date**

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THERAPY FEE CONTRACT

Participant Name:	
Monthly Gross Income:	**Fee Per Session:**

How Your Fee Is Determined

Fees for DAP therapy sessions are set according to a sliding scale that is based on the participant's individual income. We do not adjust your income based on your expenses. Instead, we keep our scale lower than comparable agencies. You are responsible for notifying the Domestic Abuse Project if there is a change to your income.

Payment Expectations

All participants are required to contribute to their therapy through payment of services rendered. While DAP will not turn a participant away due to inability to pay, each participant is responsible for alerting DAP staff if there is need for financial accommodation while engaged in programming. You are responsible for notifying the Domestic Abuse Project if there is a change to your income.

INABILITY TO PAY FEES:

1. Participants will be allowed two-week grace for no payment rendered.
2. Upon third week of non-payment, participants will need to check in with their therapist.
3. Failure to comply with the payment plan may result in a hold or dismissal from programming.

Authorizations

This contract shall be valid as of the day I sign it, and it shall remain in effect for 12 months thereafter. A photocopy of the contract will be as valid as the original.

I have read and agreed to the terms of this Therapy Fee Contract.

Signatures

Participant:	**Date:**

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TELEHEALTH CAREGIVER/PARTICIPANT EMERGENCY PLAN

Participant/Parent/Legal Guardian: _____

Warning signs or activators	• • •
Internal coping strategies	• • •
People and social settings that provide a distraction	• • •
People/ Professionals who I can ask for help	• • •
People a provider can call if they are concerned	• **Name:** **Contact #:** • **Name:** **Contact #:** • **Name:** **Contact #:**
Ways I can make my environment safe	• • •

_____ _____

Signature of Participant/Parent/Legal Guardian **Date**

_____ _____

Provider Signature **Date**

_____

Provider Name

domestic abuse project
DAP

INSURANCE REGISTRATION FORM

Patient's Name (Last, First, MI): _____

Patient's Phone: _____ **Alternate Phone (** ☐ cell or ☐ work**):** _____

E-Mail Address: _____

Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Social Security Number:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Address: _____ **Phone number:** _____

HEALTH INSURANCE INFORMATION (Insurer)

Primary Insurance: _____

Member ID: _____

Group ID: _____

Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Secondary Insurance: _____

Member ID: _____

Group ID: _____

Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ **Relationship to Patient:** _____

Address: _____

Social Security Number: _____ **Date of Birth:** _____

Their Employer: _____ **Work Phone Number:** _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient:

Name(s): Domestic Abuse Project Staff **Relationship to Patient:** Service Provider

_____

Participant Name / Caregiver Name (if applicable)

_____ _____

Participant / Caregiver Signature **Date**

AUTHORIZATION FOR CLAIMS PAYMENT AND REVIEWS

1. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Domestic Abuse Project (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Domestic Abuse Project (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** – I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission, or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Domestic Abuse Project for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** – I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students** – I understand residents, interns, medical students, and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Domestic Abuse Project education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by **Domestic Abuse Project**. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to* ***Domestic Abuse Project****, unless specifically rescinded in writing by me.*

_____ _____

Patient Signature **Date**

_____

Relationship to Patient