State of South Carolina
Department of Mental Health

Berkeley Community Mental Health Center
P.O. Box 1030
Moncks Corner, SC 29461
Information: (843) 761·8282
J. Matthew Dorman, Executive Director

Thank you for choosing Berkeley Community Mental Health Center for your mental health needs.

Due to our current operations under COVID 19 we have had to modify our Intake procedures. Instead of us meeting with you face to face to complete this paperwork we are asking you to complete and return it to the email address below.

Go to www.berkeleymentalhealth.org and choose Intake Packet and complete and email to tabitha.pressley@scdmh.org. Please note that this email address is not monitored.

In addition to the forms please send in copy of all your insurance card(s), proof of household income, and your identification such as driver's license, as applicable.

If any questions please call us at 843.761.8282.

Thank you.

PLEASE BE AWARE THAT THIS EMAIL ADDRESS IS NOT MONITORED.

IF YOU ARE EXPERIENCING A PSYCHIATRIC (MENTAL HEALTH) CRISIS, PLEASE CALL OUR MOBILE CRISIS/COMMUNITY CRISIS RESPONSE AND INTERVENTION TEAM, TOLL-FREE, AT (833) 364-2274. IT IS AVAILABLE AT ALL TIMES.

AS ALWAYS, IF YOU ARE EXPERIENCING A MEDICAL EMERGENCY, PLEASE CALL 911.

EXHIBIT # UN-53
COMMUNITY MENTAL HEALTH CENTER
DETERMINATION OF ABILITY TO PAY REDUCTION

Client _____ CID _____ Guarantor of payment if other than client _____

SS#:_____ Date of Birth:_____ Prepared by:_____

Address:_____ Telephone #:_____

INCOME	CURRENT	UPDATE
Self	$	$
Spouse/ Household	$	$
Public Assistance (list each type)*	$	$
	$	$
Alimony/Child Support	$	$
Other (list each)**	$	$
	$	$
GROSS INCOME:	$	$

EXTRAORDINARY EXPENSE	CURRENT	UPDATE
Medical	$	$
Alimony/Child Support	$	$
Other Non-Discretionary (list each)***	$	$
	$	$
	$	$
	$	$
	$	$
GROSS EXPENSES:	$	$

GROSS INCOME	LESS GROSS EXPENSES	EQUALS ADJUSTED GROSS INCOME	NUMBER IN HOUSHOLD

* List each type of public assistance, such as food stamps, AFDC, etc.

** For other recent income, other liquid assets or funds available for payment of medical bills including bank accounts, assets accumulated from public benefit payments, trust, etc.

*** For recent non-recurring expenses, medical expenses, etc.

OTHER RESPONSIBLE PARTY **PARENT/GUARDIAN/OTHER**

I do hereby certify that I accept responsibility for all charges for services provided to the above client.

_____Date: _____ SSN: _____

Responsible Individual's Signature **Responsible Individual's Social Security Number**

I ACKNOWLEDGE THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE AND THAT I WILL UPDATE THE INFORMATION AS IT AFFECTS MY ABILITY TO PAY. YOU MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALITIES IF YOU GIVE FALSE OR INCOMPLETE INFORMATION.

I AUTHORIZE ANY ENTITY HOLDING FINANCIAL RECORDS OR OTHER INFORMATION IN ANY FORM PERTAINING TO THE FINANCIAL INFORMATION GIVEN BY ME ABOVE TO DISCLOSE TOT HE CENTER ANY FINANCIAL INFORMATION NECESSARY FOR THE CENTER TO DETERMINE MY ELIGIBILITY, IF ANY, FOR A REDUCTION ON MY BILL.

I have been given a completed copy of this form and understand that I may request a review of my ability to pay at any time. This information may be updated at any time but must be reviewed at least annually.

_____ _____ _____

Client Signature Date (if applicable) Guarantor

_____ _____ _____

Client Signature (Update) Date (Updated) Date

REV: BCMHC 9/06/07

IF A US FEDERAL INCOME TAX RETURN HAS NOT BEEN FILED FOR THE PREVIOUS CLAENDAR YEAR AND/OR WILL NOT BE FILED FOR THE CURRENT YEAR, I DO HEARBY SWEAR THAT MY ANNUAL INCOME IS BELOW THE LEGAL LIMIT FOR FILING FOR LAST YEAR AND IS ANTICIPATED TO REMAIN BELOW THE LEGAL LIMITS THIS CURRENT YEAR.

_____ _____

Client Signature Date

Third party payors:

_____

_____

_____

I do hereby certify that I have no third party capability; therefore I am responsible for all charges for services provided to me.

_____ _____

Client Signature Date

I do hereby certify that I accept responsibility for all charges provided to the above client

_____ _____

Responsible Individual Signature Date

Demographic Information

Sex: Race: White African/American Spanish/American Asian/American American Indian Other

Marital Status: Single Married Divorced Widowed Separated Unknown Other

Grade in School:_____

School:_____

Legal Guardian:_____

MEDICAL RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process **Medicare, Medicaid, Champus/VA, or**

Private insurance claims for _____ for services provided to
(Client's Name)

them with a starting date of _____ and request payment of benefits to:
(Admission Date/Update)

BERKELEY COMMUNITY MENTAL HEALTH CENTER
P.O. BOX 1030
MONCKS CORNER, SC 29461

_____ _____

Client's Signature (authorized person) Witness

REV: BCMHC 9/06/07

CONSENT TO EXAMINATIONS AND TREATMENT

Consent and authority is hereby given to this mental health facility and its professional staff to perform or have performed examinations and / or psychotherapy and / or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

Witness _____ Signature of Patient _____

Date _____ Signature of Parent or Legal Guardian _____

I have been provided copies of the SCDMH Notice of Privacy Practices and Client Rights and an opportunity to ask questions:

Signature _____ Date _____ (If not signed, staff to state reason on line and initial)

SIGNIFICANT OTHER PARTICIPANTS INVOLVED IN THE IDENTIFIED PATIENT'S SERVICES

I agree to participate in therapy focused on the patient signing above. I understand that any information that I give may be included in the patient's record and disclosed as allowed by law. I also understand that if I want to receive therapy or other treatment services, a separate consent to examination and treatment is required.

Participant / Relationship	Date	Staff Initials

The staff who obtain the other participant signature above enter initials and signature here.

Staff Initials _____ Staff Signature _____ Staff Initials _____ Staff Signature _____

Berkeley Community Mental Health Center

Client Orientation Checklist

I have received the following information about the Center via a client handbook, separate brochure, and/or orally, and I have been given the opportunity to ask questions.

- Rights and Responsibilities
- Complaint and appeal procedures
- Ways to give input
- Services and activities; coordination with other agencies
- Expectations; importance of family involvement in treatment
- Hours of operation
- Access to after-hour and emergency services
- Code of Ethics and professional conduct
- Confidentiality Policy
- Requirements for reporting and follow-up if court-ordered to treatment
- Financial obligations, fees, and arrangements
- Familiarization with premises including emergency exits and/or shelters, fire extinguishers, and first aid kits
- Program's health and safety policies regarding:
    - use of seclusion/restraint
    - use of tobacco products
    - illegal and legal drugs
    - prescription medication brought into the program
    - weapons
    - drug screens
- Identification of your primary contact staff person
- Program rules and expectations, including:
    - restrictions
    - events, behaviors, or attitudes leading to loss of privileges
    - means by which rights or privileges that have been restricted can be regained
- Education regarding Advance Directives
- Purpose and process of the assessment and potential course of treatment
- Development of the Plan of Care and your participation including discharge/transition criteria and procedures
- Assistive technology that might be helpful in treatment

Client Signature	Date	CID#

Staff Signature	Date

SOUTH CAROLINA

VOTER REGISTRATION DECLINATION FORM

If you are not registered to vote where you live now, would you like to register to vote here today?

☐ YES ☐ NO

☐ Already registered to vote

☐ Will use registration by mail application.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application from in private.

If you decided to register to vote, that decision will remain confidential and be used only for voter registration purposes.

If you register to vote, information regarding the office in which the application was submitted will remain confidential, again, to be used only for voter registration purposes.

_____

Signature of Declinee/Applicant

_____

Date

If you believe that someone has interfered with your right to register or to decline to vote, your right to privacy in deciding whether to register or in applying to vote, you may file a complaint with the following:

Executive Director
State Election Commission
P.O. Box 5987
Columbia, S.C. 29250
(803) 734-9060

Berkeley Community Mental Health Center

CLIENTS WHO ARE COURT ORDERED TO TREATMENT

If you have been court ordered to treatment, this means that the Mental Health Center has a responsibility to work with the Court to ensure that you are in compliance with the order to treatment. We will need to contact the Court to let them know that you have entered treatment and that you are or are not following treatment recommendations. If you should cease your compliance with the order from the Court, we are required to contact the Court with this information. This may result in a supplementary hearing by the Court to decide the next course of action. The Mental Health Center desires a good working relationship with clients who are court ordered to treatment; however, clients should be aware of the requirements of their court order. If records or your counselor are subpoenaed to court information may be released by court order without your permission. All information requested by the judge must be released, but only the specific information requested is released.

I have read and understand the above information.

_____ _____

SIGNATURE DATE

_____

WITNESS

_____ _____

CLIENT NAME **CID**

BERKELEY COMMUNITY MENTAL HEALTH CENTER
PATIENT EMERGENCY INFORMATION

In an effort to better serve you, please help us by providing us with the following information.

Patient's Name: _____ Today's Date: _____

Patient's Birth Date: _____ Patient's Social Security Number: _____

Patient's Phone Number(s): Home: _____ Cell: _____ Work: _____

Patient's Physical Address: _____

Patient's Mailing Address: _____
(if different from above)

Patient's Email Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____Relationship:_____

Address: _____Telephone Number(s):_____

I agree for BCMHC to contact the above person for notification of appointments and to leave messages/voice mail concerning appointments. **Please initial: _____**

ALLERGY INFORMATION: (Please list all known allergies.)_____

_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Race:** _____

Military: ☐ Current ☐ Past Branch of Military: _____

Family Size: _____ **How many children does the patient have?** _____

Registered Voter? ☐ Yes ☐ No but ☐ Would like to register to vote
☐ Would **Not** like to register to vote

Highest Grade of School Completed: _____

Primary Care Physician (Name, Address and Phone Number): _____

_____

May we contact you by phone, text, and/or email for appointment reminders?

I hereby give Berkeley Community Mental Health Center permission to send appointment reminder messages to me via phone, email and/or text messaging. **Please initial: _____**

(CHILDREN ONLY) Name of School Attending: _____ Current Grade: _____

Thank you for choosing Berkeley Community Mental Health Center. CID: _____