**CONTRACT FOR SUBSTANCE ABUSE TREATMENT SERVICES**
**between**
**LARAMIE COUNTY, WYOMING and SPECIALTY COUNSELING AND CONSULTING, LLC**

THIS AGREEMENT is made and entered into by and between Laramie County, Wyoming, P.O. Box 608, Cheyenne, WY, 82003 ("COUNTY") and Specialty Counseling and Consulting, LLC, located at 4025 Rawlins Street, Cheyenne, Wyoming 82001 ("CONTRACTOR"). The parties agree as follows:

## I. PURPOSE

The purpose of this Agreement is for CONTRACTOR to provide substance abuse and mental health treatment services, drug testing, and other treatment related services for Laramie County Drug Court program participants.

## II. TERM

This Agreement shall commence on the date last executed by the duly authorized representatives of the parties and shall remain in full force and effect until June 30, 2025.

### (A) RESPONSIBILITIES OF COUNTY

COUNTY shall pay CONTRACTOR one-hundred sixty-two thousand, one hundred forty-eight dollars ($162,148.00) for substance abuse treatment, mental health treatment, drug testing, and for other support services provided to the Laramie County Drug Court program as described in subsection (B), below. Payment will be made monthly upon receipt of CONTRACTOR'S invoice to the COUNTY, or submission of other documentation certifying completion of the services, and upon review and approval by the Director of the Laramie County Treatment Court programs. Payments shall be in accordance with Wyo. Stat. § 16-6-602 (as amended).

### (B) RESPONSIBILITIES OF CONTRACTOR

1. CONTRACTOR shall provide and complete the services described in "Proposal No.0008-3/14/24," which is incorporated into this agreement by this reference as Attachment "A", and a copy of which is retained in the Treatment Court program office.

2. CONTRACTOR shall notify the Drug Court Team within twenty-four (24) hours of any known or suspected Drug Court program rule violation, probation violation, or any law violation committed by any Drug Court participant whether substantiated or not.

3. The CONTRACTOR agrees to maintain appropriate national accreditation and State of Wyoming Department of Health certifications for substance use disorders. CONTRACTOR is obligated to notify COUNTY immediately of any loss of accreditation or certification. The CONTRACTOR'S accreditation/certifications are material

components of the Agreement. Loss of accreditation/certification constitutes a breach and will result in termination of the Agreement and termination of payment. COUNTY will be responsible for payment for services received prior to the loss of accreditation/certification.

4. The CONTRACTOR will maintain and provide as necessary any accreditation or certification report for substance abuse disorder services resulting from the most recent accreditation or certification visit. If accreditation or certification occurs during the term of this agreement, the CONTRACTOR will provide a PDF copy of the accreditation or certification report, Quality Improvement Plan (QIP), or any other accreditation or certification related documents to the COUNTY.

5. The CONTRACTOR shall provide a PDF copy of the Annual Conformance to Quality Report (ACQR) and documentation that the ACQR was accepted by the accrediting body to the COUNTY.

6. The CONTRACTOR shall provide a PDF copy of any ongoing communication of administrative issues, significant events, or corrective action plans that may be required for accreditation or certification to the COUNTY.

7. The CONTRACTOR agrees to enter substance use and mental health treatment data, drug testing data, or any other data that may be collected and/or required in the Wyoming Judicial Branch Case Management System in support of the Laramie County Drug Court program.

8. CONTRACTOR agrees to retain all required records for three (3) years after the County makes final payment and all other matters relating to the Agreement are concluded. CONTRACTOR agrees to permit access by the COUNTY or any of its duly authorized representatives to any books, documents, papers and records of the CONTRACTOR which are directly pertinent to this specific Agreement for purposes including but not limited to audit, examination, excerpts, and transcriptions. It is agreed that finished or unfinished documents, data or reports, prepared by CONTRACTOR under this contract shall be considered the property of the COUNTY and upon completion of the services to be performed, or upon termination of this Agreement for cause, or for the convenience of the COUNTY, will be turned over to the COUNTY.

## (C) GENERAL PROVISIONS

1. Independent Contractor: The services to be performed by CONTRACTOR are those of an independent contractor and not as an employee of COUNTY. CONTRACTOR is not eligible for Laramie County Employee benefits and will be treated as an independent contractor for federal tax filing purposes. CONTRACTOR assumes responsibility for its personnel who provide services pursuant to this contract and will make all deductions required of employers by state, federal and local laws and shall maintain liability insurance for each of them. CONTRACTOR is free to perform the same or similar services for others.

2. Acceptance Not Waiver: COUNTY approval of the reports, and work or materials furnished hereunder shall not in any way relieve CONTRACTOR of responsibility for the technical accuracy of the work. COUNTY approval or acceptance of, or payment for, any of the services shall not be construed to operate as a waiver of any rights under this Agreement or of any cause of action arising out of the performance of this Agreement.

3. Termination: This Agreement may be terminated (a) by either party at any time for failure of the other party to comply with the terms and conditions of this agreement; (b) by either party, with thirty (30) days' prior written notice to the other party; or (c) upon mutual written agreement by both parties.

4. Entire Agreement: This Agreement (9 pages, including Exhibit 1 which is 4 pages) represents the entire and integrated agreement and understanding between the parties and supersede all prior negotiations, statements, representations and agreements, whether written or oral.

5. Assignment: Neither this Agreement, nor any rights or obligations hereunder shall be assigned or delegated by a party without the prior written consent of the other party.

6. Modification: This Agreement shall be modified only by a written agreement, duly executed by all parties hereto.

7. Invalidity: If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction, or if the COUNTY is advised of any such actual or potential invalidity or unenforceability, such holding or advice shall not invalidate or render unenforceable any other provision hereof. It is the express intent of the parties that the provisions of this Agreement are fully severable.

8. Applicable Law and Venue: The parties mutually understand and agree that this Agreement shall be governed by and interpreted pursuant to the laws of the State of Wyoming. If any dispute arises between the parties from or concerning this Agreement or the subject matter hereof, any suit or proceeding at law or in equity shall be brought in the District Court of the State of Wyoming, First Judicial District, sitting at Cheyenne, Wyoming. The foregoing provisions of this paragraph are agreed by the parties to be a material inducement to CONTRACTOR and to COUNTY in executing this Agreement. This provision is not intended nor shall it be construed to waive COUNTY's governmental immunity as provided in this Agreement.

9. Contingencies: CONTRACTOR certifies and warrants no gratuities, kickbacks or contingency fees were paid in connection with this Agreement, nor were any fees, commissions, gifts or other considerations made contingent upon the award of this Agreement.

10. Discrimination: All parties agree they will not discriminate against any person who performs work under the terms and conditions of this Agreement because of race,

color, gender, creed, handicapping condition, or national origin.

11. ADA Compliance: All parties agree they will not discriminate against a qualified individual with disability, pursuant to a law as set forth in the Americans with Disabilities Act, P.L. 101-336, 42 U.S.C. § 12101, *et seq.*, and/or any properly promulgated rules and regulations relating thereto.

12. Governmental/Sovereign Immunity: COUNTY does not waive its Governmental/ Sovereign Immunity, as provided by any applicable law including W.S. § 1-39-101 *et seq.*, by entering into this Agreement. Further, COUNTY fully retains all immunities and defenses provided by law with regard to any action, whether in tort, contract or any other theory of law, based on this Agreement.

13. Indemnification: To the fullest extent permitted by law, CONTRACTOR agrees to indemnify and hold harmless COUNTY, its elected and appointed officials, employees and volunteers from any and all liability for injuries, damages, claims, penalties, actions, demands or expenses arising from or in connection with work performed by or on behalf of CONTRACTOR for COUNTY except to the extent liability is caused by the sole negligence or willful misconduct of COUNTY or its employees. CONTRACTOR shall carry liability insurance sufficient to cover its obligations under this provision, including all insurance required in ***Exhibit 1****: Insurance Requirements* (attached and incorporated herein) and shall file certificates of such insurance satisfactory to the County and approved by the County.

14. Third Parties: The parties do not intend to create in any other individual or entity the status of third-party beneficiary, and this Agreement shall not be construed so as to create such status. The rights, duties and obligations contained in this Agreement shall operate only between the parties to the Agreement and shall inure solely to the benefit of the parties to this Agreement.

15. Conflict of Interest: COUNTY and CONTRACTOR affirm, to their knowledge, no CONTRACTOR employee has any personal beneficial interest whatsoever in the agreement described herein. No staff member of CONTRACTOR, compensated either partially or wholly with funds from this Agreement, shall engage in any conduct or activity which would constitute a conflict of interest relative to this Agreement.

16. Force Majeure: Neither party shall be liable to perform under this Agreement if such failure arises out of causes beyond control, and without the fault or the negligence of said party. Such causes may include, but are not restricted to, Act of God or the public enemy, fires, floods, epidemics, quarantine restrictions, freight embargoes, and unusually severe weather. In every case, however, a failure to perform must be beyond the control and without the fault or the negligence of said party.

17. Limitation on Payment: COUNTY's payment obligation is conditioned upon the availability of funds which are appropriated or allocated for the payment of this obligation. If funds are not allocated and available for the continuance of the services

and equipment provided by CONTRACTOR, the Agreement may be terminated by COUNTY at the end of the period for which funds are available. COUNTY shall notify CONTRACTOR at the earliest possible time of the services which will or may be affected by a shortage of funds. At the earliest possible time means at least thirty (30) days before the shortage will affect payment of claims if COUNTY knows of the shortage at least thirty (30) days in advance. No penalty shall accrue to COUNTY in the event this provision is exercised, and COUNTY shall not be obligated or liable for any future payments due or for any damages as a result of termination under this provision. If the available funds dedicated to this agreement are depleted prior to the expiration date of this agreement, the CONTRACTOR agrees to continue to provide services to Drug Court participants as specified in this agreement and in the CONTRACTOR's RFP until the expiration of this agreement or until new funds become available. Any additional services provided to the COUNTY in accordance to this Agreement, which remains uncompensated at the end of the fiscal year shall be documented and provided to the Director of the Laramie County Treatment Court programs to be used as in-kind donations in future funding applications.

18. Notices: All notices required and permitted under this Agreement shall be deemed to have been given, if and when deposited in the U.S. Mail, properly stamped and addressed to the party for whom intended at such parties' address listed herein, or when personally delivered to such party. A party may change its address for notice hereunder by giving written notice to the other party.

19. Compliance with Laws: CONTRACTOR shall comply with all applicable laws, regulations and ordinances, whether Federal, State or Local.

20. Agreement Controls: Where a conflict exists or arises between any provision or condition of this Agreement, and any provisions and conditions set forth in its attachments this Agreement shall control.

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**CONTRACT FOR SUBSTANCE ABUSE TREATMENT SERVICES**
**between**
**LARAMIE COUNTY, WYOMING and SPECIALTY COUNSELING AND CONSULTING, LLC**

*Signature Page*

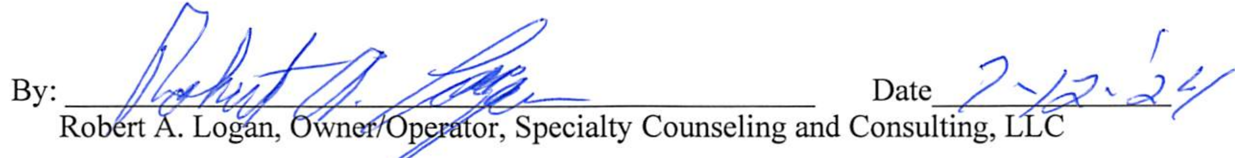
LARAMIE COUNTY, WYOMING

By:_______________________________________ Date_____________
Brian Lovett, Chairman, Laramie County Commissioners

ATTEST:

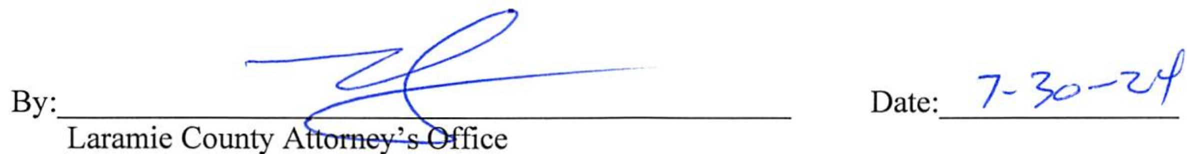
By: _______________________________________ Date _____________
Debra Lee, Laramie County Clerk

CONTRACTOR: FOUNDATIONS COUNSELING AND CONSULTING OF WYOMING, LLC



By: _______________________________________ Date 7-12-24
Robert A. Logan, Owner/Operator, Specialty Counseling and Consulting, LLC

REVIEWED AND APPROVED AS TO FORM ONLY:



By:_______________________________________ Date: 7-30-24
Laramie County Attorney's Office

**Exhibit 1**
**Insurance Requirements**

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder and the results of that work by the Contractor, his agents, representatives, employees or subcontractors.

**MINIMUM SCOPE AND LIMIT OF INSURANCE**

Coverage shall be at least as broad as:

1. **Commercial General Liability** (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal and advertising injury with limits no less than **$2,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.

2. **Automobile Liability**: ISO Form Number CA 00 01 covering any auto (Code 1), or if Contractor has no owned autos, hired, (Code 8) and non-owned autos (Code 9), with limit no less than **$1,000,000** per accident for bodily injury and property damage.

3. **Workers' Compensation**: as required by the State of Wyoming with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$1,000,000** per accident for bodily injury or disease.

4. **Professional Liability (Errors** and **Omissions)**: Insurance appropriates to the Contractor's profession with limit no less than **$1,000,000** per occurrence or claim, $2,000,000 aggregate. *(If applicable – see footnote next page)*

If the contractor maintains higher limits than the minimums shown above, the Entity requires and shall be entitled to coverage for the higher limits maintained by the contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the Entity.

**Other Insurance Provisions**

The insurance policies are to contain, or be endorsed to contain, the following provisions:

***Additional Insured Status***

The Entity, its officers, officials, employees and volunteers are to be covered as additional insured's on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10 11 85 or if not available, through the addition of both CG 20 10 and CG 20 37 if a later edition is used).

***Primary Coverage***

For any claims related to this contract, the Contractor's insurance coverage shall be primary insurance as respects the Entity, its officers, officials, employees, and volunteers. Any insurance of self-insurance maintained by the Entity, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

***Notice of Cancellation***

Each insurance policy required above shall provide that coverage shall not be cancelled, except with notice of Entity.

***Waiver of Subrogation***

Contractor hereby grants to Entity a waiver of any right to subrogation which any insurer of said Contractor may acquire against the Entity by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Entity has received a waiver of subrogation endorsement from the insurer.

***Deductibles and Self-Insured Retentions***

Any deductibles or self-insured retentions must be declared to and approved by the Entity. The Entity may require the Contractor to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claims administration, and defense expenses within the retention.

***Acceptability of Insurers***

Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the Entity.

***Claims Made Policies (note – should be applicable only to professional liability, see below)***
If any of the required policies provide claims-made coverage:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.

2. Insurance must be maintained, and evidence of insurance must be provided ***for at least five (5) years after completion of the contract work.***

3. If coverage is cancelled or non-renewed, and not replaced ***with another claims-made policy form with a Retroactive Date prior to*** the contract effective date, the contractor must purchase "extended reporting" coverage for a minimum of ***five (5)*** years after completion of work.

***Verification of Coverage***

Contractor shall furnish the Entity with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved the Entity before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The Entity reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

***Special Risks or Circumstances***

Entity reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

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Corporate Office: 4025 Rawlins St, Cheyenne, WY 82001
Phone: 307-426-4797 Fax: 307-426-4799
www.specialtycounseling.com

# Proposal to the Laramie County Drug Court

**RFP No. 0008-3/14/24**

Submitted by Specialty Counseling & Consulting, LLC.
May 13, 2024

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Primary Contact:

Robert A. Logan, MS, LPC, Owner/Operator
Specialty Counseling & Consulting, LLC.
4025 Rawlins St. Cheyenne, WY 82001
Office: 307.426.4797 Cell: 307.275.2483
blogan@specialtycounseling.com

| WYOMING | Cheyenne East | Cheyenne West | Laramie | Wheatland | Casper | Douglas |
|---|---|---|---|---|---|---|
| OFFICES | 307-426-4797 | 307-426-4797 | 307-459-3670 | 307-322-8122 | 307-222-3042 | 307-717-0002 |
| COLORADO | Fort Collins | Wellington | Loveland | Greeley | | |
| OFFICES | 970-942-3031 | 970-942-3031 | 970-942-3031 | 970-672-4667 | | |

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- Attachment A, *List of Licenses and Certificates for Current Staff designated for Project*
  - Gary King, LPC -- Therapist and Supervisor
  - Tyler Bartow, LPC – Therapist and Program Manager
  - Stephanie Keller, CSW – Case Coordinator/Support Services Program Manager
  - Amy Mavy, LCSW – Therapist and Clinical Intake Coordinator
  - Joee Speicher, -- Case Manager and Peer Specialist
  - Rachel Ball PPC -- Therapist and Case Manager
  - Brian Blake, BS – Case Manager
  - Robert Logan, LPC – Therapist and Supervisor/Agency Owner and Operator
- Attachment B, CARF Accreditation Letter
- Attachment C, State of Wyoming Accreditation Letter
- Attachment D, Program Operations/Staff Training
- Attachment E, Community Contracts/MOU's, Partnerships
- Attachment F, Program Operations/Curriculum

- Attachment G, Program Operations/On-site Drug Testing
- Attachment H, Program Operations/Formal Grievance Procedures
- Attachment I, Program Operations/Emergency Services Protocol
- Attachment J, Program Operations/ Medication Provider Contract and Services
- Attachment K, Program Operations/ Forms
    - Complete Intake Packet
    - Client Rights
    - Quality Assurance Review Form
    - Release of Information/Confidentiality/HIPAA
    - Clinical Intake/Diagnostic Assessment Form
    - Service/Treatment Plan Form
    - Discharge Plan
    - Group Rules and Agreement
- Attachment L, Cost Proposal and Verification Form
- Exhibit 1 -- Agency Insurance Requirements

## Statement of Qualification

***Specialty Counseling & Consulting, LLC.,*** (SCC), is a privately-owned, Wyoming and Colorado - based Agency, incorporated in November of 2010, EIN 27-399-5406.

SCC services the Laramie, Albany, Converse, and Platte Counties (WY) as well as Larimer and Weld Counties in Colorado, with offices in Cheyenne, Wheatland, Casper, Laramie, and Douglas, WY, and Ft. Collins, Loveland, Wellington, and Greeley, CO.

SCC is a State of Wyoming certified Substance Abuse service provider, and offers a variety of Clinical Services, including for individuals, family, groups, children & adolescents. Currently, SCC employs a total of thirty-eight (38) licensed or provisionally licensed clinical staff (therapists and clinical case coordinators), as well as eight (8) case managers and four (4) clinical interns. Current SCC active clients across all 10 SCC sites is 2,232.

SCC provides both Outpatient Substance Abuse and Mental Health services for private clients, as well as for criminal justice clients, both adult and juveniles. Currently, the Wyoming Department of Family Services (DFS) refers juvenile clients to the agency AIOP program.

SCC also provides substance abuse evaluation and treatment services to adult Federal probation clients, under a contract with the U.S. Probation Office. SCC is now the current Contractor for the Laramie County DUI Court and the Albany County Drug Court Adult Diversion. These services include Intensive Outpatient treatment, groups, individual/family/couples therapy, intensive case management, medication management, and peer support as needed for clients involved in each of the designated programs.

The following *SCC* staff members will be primarily assigned work under this Contract:

- Attachment A, *List of Licenses and Certifications of Current Staff designated for Project*
    - Gary King, LPC -- Therapist and Supervisor
    - Tyler Bartow, LPC – Therapist and Program Manager
    - Stephanie Keller, CSW – Case Coordinator/Support Services Program Manager
    - Amy Mavy, LCSW – Therapist and Clinical Intake Coordinator
    - Joee Speicher, -- Case Manager and Peer Support Specialist
    - Rachel Ball PPC -- Therapist and Case Manager
    - Brian Blake – Case Manager
    - Ashley Nowlin-Hakala – Case Manager
    - Robert Logan, LPC – Therapist and Supervisor/Agency Owner and Operator

Specialty Counseling & Consulting completed an initial CARF accreditation visit in February 2015, Survey #77096. SCC was awarded a 3-year CARF accreditation as a result of this survey. SCC has since completed full CARF surveys January 2018 and again August of 2021 resulting in full 3-year accreditations. SCC current CARF accreditation was set to expire on February 29, 2024 (See Attachment B) but was extended by CARF until April 17th due to scheduling issues on their part. The most recent CARF survey was completed on April 19th, 2024 with another full 3-year award. This most recent CARF visit covered the Cheyenne and all supporting offices, and surveyed the Agency's Case Management and Services Coordination-Family Services, Integrated Outpatient Treatment for Adults, and Integrated Outpatient Treatment for Children & Adolescents programs (see *Attachment B).*

SCC is also fully certified/accredited by the State of Wyoming, Department of Health/Behavioral Health as a Substance Use Treatment Facility. This certification is for each of the components of Intensive Case Management, and Integrated Mental Health and Substance Abuse for both Adults and Adolescents. The most recent certification was completed and the next certification is due by July 31, 2025 (see Attachment C). It is fully expected that each of the involved Levels of Care will again be approved and certified.

All involved SCC clinical staff are licensed or certified by the Wyoming State Board of Licensure (*see Attachment A)* at time of hire and every two years thereafter with a minimum of 45 state approved CEU's. All involved clinical staff in substance abuse services receive additional training and certification from SCC and a variety of other sources (*see Attachment D).*

All SCC clinical and support services staff are covered under the SCC agency insurance plan which includes individual liability / malpractice insurance with minimum coverage limits of One Million Dollars ($1,000,000.00) per incident and Three Million Dollars ($3,000,000.00) in the annual aggregate (see Attachments/Exhibit 1, for copies of required liability and malpractice insurances).

## Understanding of the Project

Specialty Counseling & Consulting staff currently handle a caseload of approximately 2,232 active clients across 10 different sites in Wyoming and Colorado.

Specialty Counseling & Consulting staff have the ability to conduct assessments, testing, and individual, family, couples, or group sessions at both of the Agency's Cheyenne facilities at 4025 Rawlins St. and 200 Dell Range Blvd.

In addition to Licensed Clinical Staff, SCC also employs Clinical Case Coordinators and Peer Support Specialists who are trained in, and work within the Intensive Wraparound Model. Clinical Case Coordinators and Peer Specialists work closely with Licensed Therapists to ensure that client needs are met both inside and outside regularly-scheduled therapy session times.

Wraparound services ensure the implementation of meeting the individual and group needs of all participants. Factors to be addressed are in two categories.

**Criminogenic Factors**:

- Peers/Acquaintances/Companions (including family/marital)
- Employment/Education
- Antisocial Beliefs/Values
- Temperament (lack of empathy, opportunistic vs. Impulsive)
- Leisure & Recreation
- Substance Abuse

**Non-Criminogenic Factors**:

- Low Self-Esteem
- Anxiety
- Creative Abilities
- Mental Health
- Physical Health
- Culture

Substance Abuse Assessments at Specialty Counseling & Consulting consist of ASI, ASAM, SASSI, Clinical Intake (see Attachment K, Intake Form), and/or other instruments as deemed appropriate based on presenting issues. Collateral contacts and prior records are used when possible.

The Executive Director, Office and Finance Managers, HR Director/Corporate Compliance Officer, and Quality Assurance Manager ensure that client information is safe and secure. HIPAA compliance is monitored closely, to include any hard copies of client information, and electronic information. Official Release of Information Forms are completed and signed as needed (see Attachment K, ROI Form).

## Treatment Philosophy/Theoretical Orientation

The primary goal of this program is responsible living and increasing individual and family wellness. The program components are evidence-based practice, *The Change Companies and MRT* curriculum and components. They are based on cognitive behavioral therapy (CBT), social learning theory (SLT) and pro-social modeling. Strategies incorporated are designed specifically

for adults involved in the correction system and substance abuse. However, they are also proven beneficial for adults who are involved with substance abuse but are not involved in the correction system.

The treatment program design consists of all facets of evidence-based practices utilizing assessments consisting of ASAM dimensions folded into a bio-psych-social summary, validated assessment tools, and evidence-based practice curriculum. The highly skilled therapists are extensively trained in substance abuse treatment, co-occurring disorders, program curriculum and all related services.

These services are as follows:

a) Adult Intensive Outpatient Program (IOP)
b) Adult Outpatient Program
c) Individual Counseling
d) Family and Couples Counseling
e) Group Counseling
f) Case Management
g) Peer Support
h) Medication Management

## Levels of Care

**LEVEL 2.1** The Intensive Outpatient Treatment is a six-month program.
The first four (4) months are nine hours per week and are follows:

a) Three 3-hour group sessions per week
b) One individual session per week
c) One family session per week

The final two (2) months are four hours per week focused on harm-reduction and relapse prevention as follows:

a) Once weekly 3-hour group session
b) Individual session every two weeks and/or as needed
c) Family session every two weeks and/or as needed

**LEVEL 1.0** The Regular outpatient program is a three-month program. The first two months are as follows:

a) Two 2-hour group sessions per week
b) One individual session per week
c) One family session per week.

The final four weeks are three hours per week and focuses on harm-reduction and relapse prevention as follows:

a) Once weekly 2-hour group session

b) Individual session every two weeks and/or as needed
c) Family session every two weeks and/or as needed

## Program Design and Treatment Interventions

1. Individual Change Plan
   Learn specific stages of change of how people change
   Learn key techniques to help change any problem behavior
   Explore your denial
   Identify issues as to how your irresponsible behavior has affected your life
   Weigh options for responsible living
   Create a plan of action
   Learn how to maintain your behavior

2. Substance Using Behaviors
   Understand substance addiction and your relationship to alcohol and other drugs
   Understand the impact that alcohol and other drugs have on your body
   Recognize and understand terms such as primary, tolerance and switching addictions.
   Explore facts about alcohol, methamphetamine, marijuana, cocaine, opiates/narcotics, inhalants, hallucinogens, sedating pills, prescription drugs and synthetic drugs.

3. Thinking Errors.
   Examine your thinking to make certain it is objective & accurate
   Recognize errors in your thinking that can get you in trouble
   Understand how thinking errors support an irresponsible life style
   Learn what is involved in changing habits
   Consider how you will handle the reaction of others as you change your thinking

4. Life Management Personal Growth
   Examine differences between healthy and unhealthy relationships
   Learn proven ways to communicate effectively
   Identify how your irresponsible behavior has affected family members
   Explore ways you can meet your parent roles and responsibilities
   Examine feelings that may cause problems in your efforts to make behavior change
   Explore the role anger plays in your life and criminal behavior
   Understand that you have the power and responsibility to control your anger
   Look at how your actions have affected the lives of others.

5. Coping Skills
   Asking for and accepting feedback from others

Practicing effective communication
Learning how to escape from your cravings
Finding ways to reduce your stress
Learning ways to handle temptations
Improving your decision-making abilities
Identifying your anger triggers and ways to effectively deal with anger
Building healthy personal relationships

6. Relapse Prevention and Harm Reduction
   Understand the role relapse prevention plays in a successful transition
   Realize that relapse is a process not an event
   Examine your past efforts to control your behavior
   Be able to identify relapse wanting signs and develop ways to handle each one
   Develop a personalized relapse prevention and harm reduction plan

**Family Component**

The family component consists of an initial support system only group. This is a thee-hour session focused on how your support systems can assist you in treatment and permanent life changes, without unknowingly enabling unhealthy using behaviors. This is followed by weekly family sessions, which occur weekly and then bi-weekly on an as needed basis.

**Community Partnerships**

SCC strongly believes, practices, and maintains the philosophy of healthy and positive community partnerships as part of an integrated, holistic, and wraparound service model for care. SCC currently has official community partnership agreements, contracts, and MOU's with a variety of other community agencies and facilities (*see Attachment E).*

**Program Treatment Curriculum**

SCC utilizes the evidenced-based curriculum of the Change Company and MRT. Program curriculum is reviewed annually, and changes made when justified and warranted by the needs and issues of the program contract, current research findings, and the many needs of the clients involved in the different programs and services (*see Attachment F).*

## Program Operations

Specialty Counseling & Consulting (SCC), LLC provides all primary operations and supports needed for full and comprehensive outpatient care including on-site UA/Drug Testing (*see Attachment* G), Formal Grievance Procedures (*see Attachment H*), After Hours Support and Emergency Directions (*see Attachment I*), Medication Assisted Treatment (*see Attachment J*), and a full agency Quality Assurance Protocol/Committee that reviews all Intake Packet

Paperwork, Clinical Intakes, Treatment Plans, Progress Notes, and Discharges (*see Attachment K*, Forms). All SCC policies, processes, and procedures are in full compliance with current CARF and Wyoming Department of Health standards/requirements/accreditation.

## Insurances/Medicaid/Medicare/Other Financial Payor Sources

SCC accepts Wyoming and Colorado Medicaid, Medicare, most insurances, cash payments, and numerous EAP and other specific contracts. When appropriate, SCC case managers assist clients in applying for any financial assistance from all available and/or qualifying financial sources. All clients are invited to request individual payment plans to meet current financial needs when needed.

## Medication Assisted Treatment (MAT)

SCC utilizes a contracted Doctor of Nursing for assisting clients with medication needs (see Attachment J) including the use of Suboxone when justified. The SCC contracted medication prescriber utilizes virtual technology for serving clients and does not see anyone in person due to out of state location. It is the prescribing doctor's decision to refuse medication services to anyone that is deemed to be in need of an on-site or local in-person prescriber. All clients involved with SCC medication services are involved with an agency case manager that works directly with the medication prescriber to ensure proper communication, exchange of records/prescriptions, and any other support services deemed necessary for safe and coordinated care.

## Quality Assurance Mechanism/Review

Per SCC policy and CARF requirements, SCC has in place a well-developed and utilized Quality Assurance Committee and process. This team/process includes the Executive Director as the Committee Chairperson, the entire Leadership Team of supervisors/managers, and a variety of agency clinical staff that rotates to ensure all current and new clinical staff are exposed to the processes and procedures involved in full quality control requirements and needs (see Attachment K - Quality Assurance Policy and Review Form). This team meets on a monthly basis and randomly pulls client charts for review that represent all aspects of agency clinical care including Critical Incident Reports, Client/Stakeholder grievances, and individual Client Performance and Outcome Assessments/Measures including monthly ASAMS as needed and required for substance abuse clients.

Gender-specific IOP programs will be accommodated.

## Cost Proposal and Verification - Attachment L

1. **Intensive Outpatient Program** services, based on a maximum of 25 (twenty-five) clients.
   *- Includes Group, Individual, Family, and Case Management:*
   **$84,100** yearly, or $7,008.33 monthly.

2. **Regular Outpatient and Aftercare Program** services, based on a maximum of 25 (twenty-five) clients. *– Includes Group, Individual, Family, and Case Management:*
   **$57,200** yearly, or $4,766.67 monthly.

3. **Evaluations**, maximum of 25 (twenty-five) clients for a year.
   **$5000** yearly, or $416.67 monthly.

4. UA Materials, Curriculum and Course supplies, worksheets and other material:
   **$12,000** yearly, or $1,000.00 monthly.

5. Facilities / Agency overhead: 10% of contract total.
   **$15,830** yearly, or $1,320.00 monthly.

6. Total Annual Cost $174,130 **MINUS** $10,000 for Community Non-Profit Discount.
   Total Proposed Cost: $164,130 yearly, or $13,677.67 monthly.

I certify under penalty of perjury, that I am a responsible official for the person, party, or entity described in the proposal and that I have personally examined and am familiar with all of the information submitted in this disclosure and that all attachments and information disclosed are true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including criminal sanctions, which can lead to the imposition of a fine, and/or imprisonment.

ROBERT LOGAN
Printed Name

5-13-24
Date

[signature]
Signature

OWNER/OPERATOR
Title

## Cost Proposal and Verification - Attachment L

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   **$84,100** yearly, or $7,008.33 monthly.

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ROBERT LOGAN
Printed Name

[Signature]
Signature

5-13-'24
Date

OWNER/OPERATOR
Title

EXHIBIT 1A

**Employers Mutual Casualty Company**
Policy: BBB4729 - 25
Policy Term: 03/26/2024–03/26/2025

# General Liability Declarations

| Named Insured | Producer |
|---|---|
| SPECIALTY COUNSELING & CONSULTING LLC<br>4025 RAWLINS ST<br>CHEYENNE, WY 82001-1900<br>DIRECT BILL | HUB INTERNATIONAL MOUNTAIN STATES LIMITED<br>601 4 J CT UNIT A<br>GILLETTE, WY 82716-4110<br>AGENT NO. W6420<br>AGENT PHONE: 800-727-1652<br>CLAIM REPORTING: 888-362-2255<br>SERVICING CARRIER: 720-200-3700 |

## Limits of Insurance

| | |
|---|---|
| Each Occurrence Limit | $1,000,000 |
| Damage To Premises Rented To You Limit | $500,000 (any one premises) |
| Medical Expense Limit | $10,000 (any one person) |
| Personal and Advertising Injury Limit | $1,000,000 (any one person or organization) |
| General Aggregate Limit | $2,000,000 |
| Products/Completed Operations Aggregate Limit | $2,000,000 |

## Coverages Provided

| | |
|---|---|
| Other Than Products/Completed Operations | $6,545.00 |
| **Total Estimated Policy Premium** | **$6,545.00** |

See attached schedule for location of all premises owned, rented or occupied.

Date of Issue: 03/29/2024

EXHIBIT 1B

April 23, 2024

Victoria Dearing
Breckenridge Insurance Services
222 Las Colinas Blvd W
Suite 1300
Irving, TX 75039

# Specialty Counseling & Consulting, LLC

## Renewal Binder

**Provided on behalf of** Hudson Excess Insurance Company
(**Nonadmitted** in the state of Wyoming)
**Total Premium: $12,537** (Plus Surplus Lines Taxes and Fees)

### Policy Number
AAHC 9897-042724

### Coverage
Professional Liability (claims made)
Abuse Or Molestation Liability Coverage Part (claims made)
HIPAA Fines And Penalties Coverage Part (claims made)

### Form
Allied Alphapack Health Care Liability Insurance Policy AAHC01 (12/22)
Declarations Page

All-in-One specimen Declarations, Wording and Endorsements

### Carrier
Hudson Excess Insurance Company is rated **'A+' (Superior), Financial Size Category XV** by **AM Best** (see Financial Strength).
Hudson is a wholly owned subsidiary of Odyssey Group Holdings (see Financial Highlights).

## Types of Coverage / Limits of Liability

**Primary Coverage:**

*PROFESSIONAL LIABILITY COVERAGE PART - CLAIMS MADE*

| | | |
|---|---|---|
| *Limits of Liability:* | $1,000,000<br>$3,000,000 | Per Claim<br>Aggregate Limit of Liability |
| *Deductible :* | $2,500 | |
| *Retroactive Date:* | April 27, 2021 | |

*ABUSE OR MOLESTATION LIABILITY COVERAGE PART - CLAIMS MADE*

| | | |
|---|---|---|
| *Limits of Liability:* | $100,000<br>$300,000 | Per Claim<br>Aggregate Limit of Liability |
| *Deductible :* | $2,500 | |
| *Retroactive Date:* | April 27, 2021 | |

*HIPAA FINES AND PENALTIES COVERAGE PART - CLAIMS MADE*

EXHIBIT 1-C

| | | |
|---|---|---|
| *Limits of Liability*: | $250,000<br>$250,000 | Per Claim<br>Aggregate Limit of Liability |
| *Deductible* : | $2,500 | |
| *Retroactive Date:* | April 27, 2021 | |

**Defense Costs**

| | |
|---|---|
| [X] Included in and reduce the Limits of Liability | [ ] In addition to the Limits of Liability |
| [ ] In addition to the Limits of Liability but capped at $N/A | |

**Deductible is applicable to**

| | |
|---|---|
| [ ] Damages Only | [X] Damages and Defense Costs |

**PROFESSIONAL SERVICES:** Outpatient mental health/substance abuse counseling services

---

## Endorsements

Click any link below to view a PDF specimen

1. Drop Down Endorsement (AAH015)
2. Specified Professional Services Exclusion Endorsement (AAH021)
3. Schedule Of Locations Endorsement (AAH022)
4. Allied Alphahealth Accession Coverage Endorsement (AAH032)
5. Minimum Earned Premium Endorsement (AAH045)
6. Service of Suit Endorsement - Wyoming (SS-WY)

## Terms

1. Consent to settle is afforded to the First Named Insured.
2. Defense costs are within the limit of insurance.
3. The extended reporting period endorsement, if elected, will not reinstate the limit of insurance provided under this policy. The same limit provided in the policy period to which this endorsement attaches would apply to any claims brought under this endorsement.

## Conditions

**THIS BINDER IS SUBJECT TO OUR RECEIPT, REVIEW AND WRITTEN ACCEPTANCE OF THE FOLLOWING INFORMATION PRIOR TO POLICY ISSUANCE:**

1. Completed Surplus Lines Filing Confirmation, prior to binding coverage.

---

## Named Insured And Mailing Address

Specialty Counseling & Consulting, LLC
4025 Rawlins Street
Cheyenne, WY 82001

## Policy Period

April 27, 2024 to March 26, 2025

## Payment Terms

Premium is payable on an annual basis

## Important Notice - Please Read Carefully

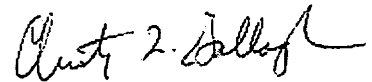
This coverage confirmation note is subject to all terms and conditions of the policy being issued.

EXHIBIT 1-D

Conditions precedent to coverage afforded by this coverage confirmation are: (1) receipt, review and acceptance of the information required herein within the stated timeframe and (2) that no material change in the risk occurs and no submission is made to the Insurer of a claim or circumstances that might give rise to a claim between the date of this coverage confirmation indicated above and the effective date. If between the date of this renewal binder and the effective date of the policy or date of binding, whichever is later, there is any material change in underwriting information, then the applicant must notify us as a condition prior to binding. We reserve the right to premium adjustment, coverage revision or withdrawing our renewal binder or proposal entirely.

This renewal binder is subject to and conditional upon the submitting broker or agent being validly licensed to enter into this transaction in the Company's domicile and on the broker or agents compliance with all applicable laws and regulations of the applicable jurisdiction governing this transaction.

We need to agree in writing to any changes made to any underlying quote(s) or binder(s) made subsequent to issuing our original quote or renewal binder. Any changes to our own terms must be agreed to in writing.



Authorized Signature

## ATTACHMENTS and FORMS

- Attachment A, *List of Licenses and Certificates for Current Staff designated for Project*
  - Gary King, LPC -- Therapist and Supervisor
  - Tyler Bartow, LPC – Therapist and Program Manager
  - Stephanie Keller, CSW – Case Coordinator/Support Services Program Manager
  - Amy Mavy, LCSW – Therapist and Clinical Intake Coordinator
  - Joee Speicher, -- Case Manager and Peer Specialist
  - Rachel Ball PPC -- Therapist and Case Manager
  - Brian Blake – Case Manager
  - Ashley Nowlin-Hakala – Case Manager
  - Robert Logan, LPC – Therapist and Supervisor/Agency Owner and Operator
- Attachment B, CARF Accreditation Letter
- Attachment C, State of Wyoming Accreditation Letter
- Attachment D, Program Operations/Staff Training
- Attachment E, Community Partnerships, Contracts, MOU's
- Attachment F, Program Operations/Curriculum
- Attachment G, Program Operations/On-site Drug Testing
- Attachment H, Program Operations/Formal Grievance Procedures
- Attachment I, Program Operations/After Hours and Emergency Services Protocol
- Attachment J, Program Operations/MAT Provider Contract
- Attachment K, Forms
  - Complete Intake Packet
  - Client Rights
  - Quality Assurance Review Form
  - Release of Information/Confidentiality/HIPAA
  - Clinical Intake Assessment Form
  - Treatment Plan Form
  - Discharge Form

- Attachment L, Cost Proposal and Verification Form
- Exhibit 1, Agency Insurance Coverage and Requirements

## ATTACHMENTS and FORMS

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  - Treatment Plan Form
  - Discharge Form

- Attachment L, Cost Proposal and Verification Form
- Exhibit 1, Agency Insurance Coverage and Requirements

ATTACHMENT A 1-1

# WYOMING MENTAL HEALTH PROFESSIONS LICENSING BOARD

2001 Capitol Ave RM 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508

Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov

August 22, 2023

Gary R. King
2368 Rd 217
Cheyenne WY 82009

Via email: gking@specialtycounseling.com

RE: License #LPC-1227

Gary R. King,

Your license has been renewed through September 2, 2025. Attached you will find two (2) new pocket cards. One card is to carry with you and the other is placed inside your certificate frame covering the previous expiration date. **This letter will also serve as receipt of your check number 1001451441 in the amount of $168.00.**

For your next renewal, the Board will only consider continuing education acquired during the period of September 3, 2023 through September 2, 2025. Approximately two (2) months prior to the expiration date a renewal notice will be mailed to you at your last address of record, as reflected above. To ensure that you will receive the renewal notice and other correspondence, it is vital that you inform the Board, in writing, of any changes in your name, business address and residential address.

Sincerely,

Greg Searls
Executive Director

STATE OF WYOMING

MENTAL HEALTH PROFESSIONS LICENSING BOARD

*Certifies that subject to the conditions prescribed by law,*

**GARY R. KING**

*is authorized to practice in the state of Wyoming as a*

**LICENSED PROFESSIONAL COUNSELOR**

LICENSE #: LPC-1227 EXPIRING: September 2, 2025

STATE OF WYOMING

MENTAL HEALTH PROFESSIONS LICENSING BOARD

*Certifies that subject to the conditions prescribed by law,*

**GARY R. KING**

*is authorized to practice in the state of Wyoming as a*

**LICENSED PROFESSIONAL COUNSELOR**

LICENSE #: LPC-1227 EXPIRING: September 2, 2025

A 1-2

# *Wyoming Mental Health Professions Licensing Board*

2001 Capitol Ave, Room 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508
Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov

May 1, 2024

Tyler R. Bartow
2524 E. 15th St.
Cheyenne WY 82001

RE: License #LPC-2290 issued April 29, 2024

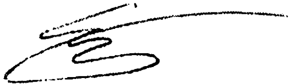
Tyler R. Bartow,

The Mental Health Professions Licensing Board is pleased to present your license as a Professional Counselor. Your license will expire on August 22, 2026. The Board will only consider continuing education acquired during the period of April 29, 2024 through August 22, 2026 for your first renewal.

Approximately two (2) months prior to the expiration date a renewal notice will be mailed to you at your last address of record, as reflected above. To ensure that you will receive future notices and other correspondence, it is vital that you inform the Board, in writing, of any changes in your name, business address, residential address, and email address.

Take a few moments to familiarize yourself with the renewal requirements and ethical standards in the current rules and regulations. If I can be of further assistance, please contact me at wyomhplb@wyo.gov.

Sincerely,



Carlos Gomez
Executive Director

Enclosure: Wall Certificate

STATE OF WYOMING

MENTAL HEALTH PROFESSIONS LICENSING BOARD

*Certifies that subject to the conditions prescribed by law,*

**TYLER R. BARTOW**

*is authorized to practice in the state of Wyoming as a*

**LICENSED PROFESSIONAL COUNSELOR**

LICENSE #: LPC-2290 EXPIRING: August 22, 2026

A I-3

# WYOMING MENTAL HEALTH PROFESSIONS LICENSING BOARD

2001 Capitol Ave RM 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508
Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov

November 22, 2023

Stephanie L. Keller
PO Box 1557
Wellington CO 80549

Via email: skeller@specialtycounseling.com

RE: Certificate #CSW-099

Stephanie L. Keller,

Your certificate has been renewed through November 18, 2025. Attached you will find two (2) new pocket cards. One card is to carry with you and the other is placed inside your certificate frame covering the previous expiration date. **This letter will also serve as receipt of your check number 34842 in the amount of $143.**

For your next renewal the Board will only consider continuing education acquired during the period of November 19, 2023 through November 18, 2025. Approximately two (2) months prior to the expiration date a renewal notice will be mailed to you at your last address of record, as reflected above. To ensure that you will receive the renewal notice and other correspondence, it is vital that you inform the Board, in writing, of any changes in your name, business address and residential address.

Sincerely,

Greg Searls
Executive Director

| STATE OF WYOMING | STATE OF WYOMING |
| --- | --- |
| MENTAL HEALTH PROFESSIONS LICENSING BOARD | MENTAL HEALTH PROFESSIONS LICENSING BOARD |
| *Certifies that subject to the conditions prescribed by law,* | *Certifies that subject to the conditions prescribed by law,* |
| **STEPHANIE L. KELLER** | **STEPHANIE L. KELLER** |
| *is authorized to practice in the state of Wyoming as a* | *is authorized to practice in the state of Wyoming as a* |
| CERTIFIED SOCIAL WORKER | CERTIFIED SOCIAL WORKER |
| CERTIFICATE #: CSW-099 EXPIRING: November 18, 2025 | CERTIFICATE #: CSW-099 EXPIRING: November 18, 2025 |

A 1-4

# WYOMING MENTAL HEALTH PROFESSIONS LICENSING BOARD

2001 Capitol Ave RM 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508
Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov

June 29, 2023

Amy M. Mavy
3923 Hayes Ave
Cheyenne WY 82001

Via email: amyflaim@gmail.com

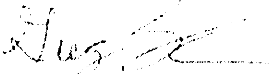
RE: License #LCSW-1321

Amy M. Mavy,

Your license has been renewed through June 25, 2025. Attached you will find two (2) new pocket cards. One card is to carry with you and the other is placed inside your certificate frame covering the previous expiration date. **This letter will also serve as receipt of your check number 583 in the amount of $168.00.**

For your next renewal, the Board will only consider continuing education acquired during the period of June 26, 2023 through June 25, 2025. Approximately two (2) months prior to the expiration date a renewal notice will be mailed to you at your last address of record, as reflected above. To ensure that you will receive the renewal notice and other correspondence, it is vital that you inform the Board, in writing, of any changes in your name, business address and residential address.

Sincerely,



Greg Searls
Executive Director

STATE OF WYOMING
MENTAL HEALTH PROFESSIONS LICENSING BOARD
*Certifies that subject to the conditions prescribed by law,*
**AMY M. MAVY**
*is authorized to practice in the state of Wyoming as a*
**LICENSED CLINICAL SOCIAL WORKER**
LICENSE #: LCSW-1321 EXPIRING: June 25, 2025

STATE OF WYOMING
MENTAL HEALTH PROFESSIONS LICENSING BOARD
*Certifies that subject to the conditions prescribed by law,*
**AMY M. MAVY**
*is authorized to practice in the state of Wyoming as a*
**LICENSED CLINICAL SOCIAL WORKER**
LICENSE #: LCSW-1321 EXPIRING: June 25, 2025

# Certified Advanced Grief Counseling Specialist

THIS IS TO CERTIFY THAT

## Amy Mavy

*has successfully completed all requirements established by Evergreen Certifications and gained the status of Certified Advanced Grief Counseling Specialist.*

02/06/2025
EXPIRATION DATE

EVERGREEN® CERTIFICATIONS
Certification granted by Evergreen Certifications
www.evergreencertifications.com
Certification Number: 666723

DEPUTY DIRECTOR

A-5

A 1-6

RECOVER WYOMING

September 9, 2023

Jolene Speicher
4025 Rawlins St.
Cheyenne, WY 82001
Certification #071

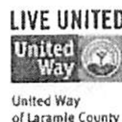
Dear Jolene Speicher,

Enclosed is your renewal certificate from the International Certification & Reciprocity Consortium (IC&RC) for the Internationally Certified Peer Recovery (ICPR) certification affirming that you meet the qualifications and standards set for Wyoming Peer Specialists. By meeting the qualifications, services provided by you as a Peer Specialist may be billed to Wyoming Medicaid by qualified organizations within the specifications set by Wyoming Medicaid. The certificate also recognizes that you have met the training requirements and criteria to obtain the Forensic Endorsement.

The certificate is valid through September 9, 2025. Additional information about Wyoming Peer Specialist qualifications and training opportunities is available on our website at https://recoverwyoming.org/peer-specialist-training-certification/.

Lana Mahoney

Lana Mahoney, BA, CPS
Executive Director
Recover Wyoming
IC&RC Member Board- Wyoming
1017 East Lincolnway
Cheyenne, WY 82001
(307) 421-7261



A 1-7

# INTERNATIONAL CERTIFICATION & RECIPROCITY CONSORTIUM

*certifies that*

# Jolene Speicher

*has demonstrated the knowledge, skills and professional competencies for an*

## Internationally Certified Peer Recovery (ICPR)

Forensic Endorsement

*as attested to by*

## Recover Wyoming

| | |
|---|---|
| IC&RC President | September 9, 2023<br>Date of Issue |
| 071<br>Certificate Number | September 9, 2025<br>Valid Through |

A 18

# WYOMING MENTAL HEALTH PROFESSIONS LICENSING BOARD

2001 Capitol Avenue, Room 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508
Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov/

September 8, 2023

Rachel A. Ball
1427 Ave C Lot #9
Cheyenne WY 82007

RE: License #PPC-1418 issued September 6, 2023

Rachel A. Ball,

The Board has issued your provisional license as a Professional Counselor in the State of Wyoming. Your provisional license will expire on September 5, 2026 or when you have been issued the LPC, whichever occurs first. During the term of your provisional license you may practice under the clinical supervision provided by Gary King.

Anytime during the term of your provisional license you may sit for your examination. The Board accepts the National Board for Certified Counselor's (NBCC) National Counselor Examination (NCE) or the National Clinical Mental Health Examination (NCMHE) or the CRCC examination. Specific information on acceptable exams can be found in Chapter 11 of the Rules and Regulations.

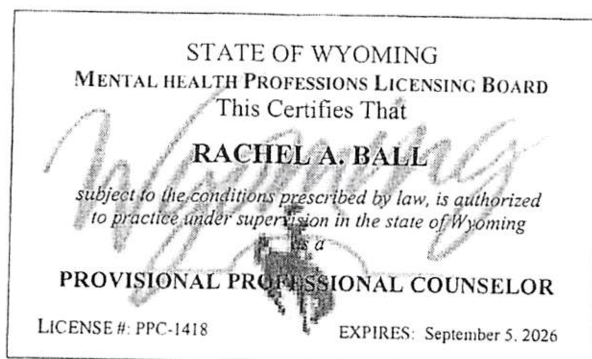
Register online at https://my.cce-global.org/ and on the "Application" tab select "State Licensure Exam". NBCC will correspond with you directly regarding specific exam details. You may access the exam information and order study materials through NBCC's web site at http://www.nbcc.org/Exams. To register for the CRCC exam go to CRCC's website at https://www.crccertification.com/.

**NBCC REQUIRES THAT YOU PROVIDE A COPY OF THIS PAGE WHEN YOU REGISTER FOR YOUR EXAM. DO NOT LOSE THIS SHEET, IT IS THE ONLY COPY YOU WILL RECEIVE!!!**

Unless this office is otherwise notified in writing all future correspondence from the Board will be addressed to you as it appears above. If I can be of further assistance, please do not hesitate to contact me at (307) 777-3628.

Sincerely,

Greg Searls
Executive Director



STATE OF WYOMING
MENTAL HEALTH PROFESSIONS LICENSING BOARD
This Certifies That

**RACHEL A. BALL**

*subject to the conditions prescribed by law, is authorized to practice under supervision in the state of Wyoming as a*

**PROVISIONAL PROFESSIONAL COUNSELOR**

LICENSE #: PPC-1418 EXPIRES: September 5, 2026

A 1-9

# WYOMING MENTAL HEALTH PROFESSIONS LICENSING BOARD

2001 Capitol Ave RM 127 ◆ Cheyenne WY 82002 ◆ (307) 777-3628 ◆ Fax: (307) 777-3508
Email: WyoMHPLB@wyo.gov ◆ Web: http://mentalhealth.wyo.gov

October 7, 2022

Robert A. Logan
2301 Champion Drive
Cheyenne WY 82001

Via email: blogan@specialtycounseling.com

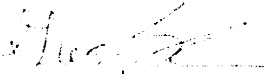
RE: License #LPC-455

Robert A. Logan,

Your license has been renewed through September 18, 2024. Attached you will find two (2) new pocket cards. One card is to carry with you and the other is placed inside your certificate frame covering the previous expiration date. **This letter will also serve as receipt of your check number 2438 in the amount of $168.00.**

For your next renewal, the Board will only consider continuing education acquired during the period of September 19, 2022 through September 18, 2024. Approximately two (2) months prior to the expiration date a renewal notice will be mailed to you at your last address of record, as reflected above. To ensure that you will receive the renewal notice and other correspondence, it is vital that you inform the Board, in writing, of any changes in your name, business address and residential address.

Sincerely,



Greg Searls
Executive Director

| STATE OF WYOMING<br>MENTAL HEALTH PROFESSIONS LICENSING BOARD<br>*Certifies that subject to the conditions prescribed by law,*<br>**ROBERT A. LOGAN**<br>*is authorized to practice in the state of Wyoming as a*<br>**LICENSED PROFESSIONAL COUNSELOR**<br>LICENSE #: LPC-455 EXPIRING: September 18, 2024 | | STATE OF WYOMING<br>MENTAL HEALTH PROFESSIONS LICENSING BOARD<br>*Certifies that subject to the conditions prescribed by law,*<br>**ROBERT A. LOGAN**<br>*is authorized to practice in the state of Wyoming as a*<br>**LICENSED PROFESSIONAL COUNSELOR**<br>LICENSE #: LPC-455 EXPIRING: September 18, 2024 |
|---|---|---|

carf INTERNATIONAL

ATTACHMENT
B H

October 20, 2021

Robert Logan, LPC
Specialty Counseling & Consulting, LLC
4025 Rawlins Street
Cheyenne, WY 82001

Dear Mr. Logan:

It is my pleasure to inform you that Specialty Counseling & Consulting, LLC has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s)/service(s):

Case Management/Services Coordination: Family Services (Children and Adolescents)
Intensive Outpatient Treatment: Substance Use Disorders/Addictions (Adults)
Intensive Outpatient Treatment: Substance Use Disorders/Addictions (Children and Adolescents)
Outpatient Treatment: Integrated: SUD/Mental Health (Adults)
Outpatient Treatment: Integrated: SUD/Mental Health (Children and Adolescents)

This accreditation will extend through February 29, 2024. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The accreditation report is intended to support a continuation of the quality improvement of your organization's program(s)/service(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A Quality Improvement Plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (*customerconnect.carf.org*), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Vidal Ramirez by email at vramirez@carf.org or telephone at (888) 281-6531, extension 7131.

**CARF International Headquarters**
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

Bob Logan <blogan@specialtycounseling.com>

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# Fwd: CARF Survey Timeframe Change 178783

2 messages

**Randi Losalu** <rlosalu@specialtycounseling.com> Wed, Feb 14, 2024 at 12:03 PM
To: Bob Logan <blogan@specialtycounseling.com>

Hi Bob,

This is an email stating the extended expiration date.

Kind Regards,
Randi

--

**Randi Losalu, MSW, LCSW**
Executive Director
Clinical Therapist
Specialty Counseling & Consulting
4025 Rawlins St. Cheyenne, Wyoming 82001
307-426-4797 ext. 120
www.specialtycounseling.com

Please note that Specialty Counseling & Consulting, LLC (SCC) uses a fully HIPAA compliant email service. Additionally, this message is intended only for the addressee and may contain confidential, privileged information. If you are not the intended recipient, you may not use, copy or disclose any information contained in the message. If you have received this message in error, please notify the sender by reply e-mail and delete the message.

---------- Forwarded message ---------
From: **Melinda Hudson** <mhudson@carf.org>
Date: Mon, Feb 5, 2024 at 3:02 PM
Subject: CARF Survey Timeframe Change 178783
To: rlosalu@specialtycounseling.com <rlosalu@specialtycounseling.com>

Specialty Counseling & Consulting, LLC, WY, Cheyenne

CARF Survey 178783

Hello Randi Losalu,

CARF has been working to schedule your organization's survey in the February/March 2024 timeframe. However, high survey volumes have saturated surveyor availability and we are not able to confirm February or March dates for your survey.

We are now planning to schedule your survey to occur in April 2024. Please provide us with any specific dates that you need us to AVOID in April, keeping as many dates open as possible.

Your current accreditation expires April 30, 2024 and will remain in effect until the delivery of your outcome after the survey.

CARF truly appreciates your flexibility and apologizes for any inconvenience. Thank you for your dedication to enhancing the lives of persons served.

Best Regards,

*Melinda*

Melinda Hudson

Team Lead, Scheduling | Survey Services

Extension: 7191 | **Direct Phone:** (520) 495-7191

ATTACHMENT C

# CERTIFICATION

*Specialty Counseling and Consulting, LLC*

Has been certified by the

**Wyoming Department of Health, Behavioral Health Division**

as meeting the requirements for service delivery of the following services:

Substance Use Disorder Services

For a full listing of services provided by location, please see the Wyoming Certified Substance Use Services Providers public listing at:
**https://wyoimprov.com/MHSAPublicProviderSearch.aspx**

**Certification Expires: July 31, 2025**

Ben Kifer
Mental Health and Substance Abuse Administrator

July 18, 2022
Date

SA SPECIFIC TRAINING

Therapists, Case Managers, Peer Support Staff, and Treatment Coordinators attend NADCP training annually in conjunction with Rocky Mountain Prevention and Traffic Safety Summit's. The Treatment Coordinator and also attends NADCP National training's. Our Treatment Court staff participates with any training's as directed by Laramie County Treatment Court Team.

ATTACHMENT D 1-1

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| Last name, First name | 1st Aid/CPR - Completed | Client Abuse and Neglect Training - Completed | CSSRS Training - Completed | De-escalation Training - Completed |
|---|---|---|---|---|
| Ball, Rachel | 01/20/2023 | 01/11/2024 | 11/27/2023 | 02/12/2024 |
| | 01/16/2021 | 02/22/2023 | N/A | 02/21/2023 |
| Bartow, Tyler | 02/27/2023 | 01/02/2024 | 01/02/2024 | 01/02/2024 |
| | 09/30/2021 | 01/04/2023 | N/A | 01/04/2023 |
| Blake, Brian | | | | |
| | | | | |
| Keller, Stephanie | 08/23/2022 | 01/25/2024 | 12/11/2023 | 01/25/2024 |
| | | 02/03/2023 | N/A | 02/03/2023 |
| King, Gary | 01/05/2023 | 03/18/2024 | 12/03/2023 | 03/19/2024 |
| | 11/07/2022 | 02/26/2023 | N/A | 02/26/2023 |
| Logan, Robert | 08/23/2022 | 04/17/2024 | 01/09/2024 | 04/17/2024 |
| | 10/07/2020 | 04/17/2023 | N/A | 04/15/2023 |
| Mavy, Amy | 04/11/2024 | 03/27/2024 | 12/04/2023 | 03/27/2024 |
| | 12/31/2021 | 03/01/2023 | N/A | 03/02/2023 |
| Padilla, Raul | N/A | N/A | N/A | N/A |
| | | | | |
| Speicher, Jolene | 01/05/2023 | 03/22/2024 | 02/12/2024 | 03/21/2024 |
| | 10/17/2020 | 3/24/2023 | N/A | 3/24/2023 |

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| Driver's Safety / Defensive Driving Training - Completed | Health Safety Quiz - Completed | HIPAA Training - Completed | SAMHSA TIP 59 Improving Cultural Competence - Completed |
|---|---|---|---|
| 02/12/2024 | 02/12/2024 | 02/12/2024 | 02/12/2024 |
| 02/21/2023 | 03/03/2023 | 02/28/2023 | 06/16/2023 |
| 01/02/2024 | 01/02/2024 | 01/02/2024 | 01/02/2024 |
| 01/04/2023 | 01/04/2023 | 01/042023 | 05/22/2023 |
| | | | |
| | | | |
| 01/25/2024 | 01/25/2024 | 01/19/2024 | 06/01/2023 |
| 02/03/2023 | 02/03/2023 | 02/03/2023 | 02/06/2023 |
| 03/18/2024 | 03/19/2024 | 04/04/2024 | 06/15/2023 |
| 02/26/2023 | 02/26/2023 | 02/26/2023 | 02/27/2022 |
| 04/17/2024 | 04/17/2024 | 04/17/2024 | 04/17/2024 |
| 04/17/2023 | 04/15/2023 | 04/15/2023 | 06/14/2023 |
| 03/27/2024 | 03/27/2024 | 03/27/2024 | 06/01/2023 |
| 03/01/2023 | 03/02/2023 | 03/02/2023 | 01/25/2022 |
| N/A | N/A | N/A | N/A |
| | | | |
| 03/21/2024 | 03/21/2024 | 03/21/2024 | 06/14/2023 |
| 3/24/2023 | 2/24/2023 | 3/24/2023 | 3/25/2022 |

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| SAMHSA TIP 59 Improving Cultural Competence Part 2 of 3: \| Counselor Toolbox - Completed | SAMHSA TIP 59 Improving Cultural Competence Part 3 of 3: \| Counselor Toolbox - Completed | SCC Emergency Drills - Completed | Seclusion and Restraint Training - Completed |
|---|---|---|---|
| 02/12/2024 | 02/12/2024 | 01/11/2024 | 02/12/2024 |
| 06/16/2023 | 06/16/2023 | 02/22/2023 | 02/21/2023 |
| 01/02/2024 | 01/02/2024 | 01/02/2024 | 01/02/2024 |
| 05/22/2023 | 05/22/2023 | 01/08/2023 | 01/04/2023 |
| | | | |
| | | | |
| 06/01/2023 | 06/01/2023 | 01/25/2024 | 01/25/2024 |
| N/A | N/A | 02/06/2023 | 02/03/2023 |
| 06/13/2023 | 06/14/2023 | 03/14/2024 | 03/18/2024 |
| N/A | N/A | 02/26/2023 | 02/27/2023 |
| 06/14/2023 | 06/14/2023 | 04/17/2024 | 04/17/2024 |
| N/A | N/A | 04/17/2023 | 04/15/2023 |
| 06/01/2023 | 06/01/2023 | 01/15/2024 | 03/27/2024 |
| N/A | N/A | 03/03/2023 | 03/01/2023 |
| N/A | N/A | N/A | N/A |
| | | | |
| 06/14/2023 | 06/14/2023 | 03/22/2024 | 03/21/2024 |
| N/A | N/A | 3/27/2023 | 3/24/2023 |

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| Universal Precautions for Communicable Diseases & Bloodborne Pathogens Training - Completed | Social Media and Internet Training - Completed |
|---|---|
| 02/12/2024 | 02/12/2024 |
| 02/21/2023 | 02/21/2023 |
| 01/02/2024 | 01/02/2024 |
| 01/04/2023 | 01/04/2023 |
| | |
| | |
| 01/25/2024 | 01/25/2024 |
| 02/03/2023 | 02/03/2023 |
| 03/18/2024 | 03/18/2024 |
| 02/27/2022 | 02/27/2022 |
| 04/17/2024 | 04/17/2024 |
| 04/15/2023 | 04/15/2023 |
| 03/27/2024 | 03/27/2024 |
| 03/01/2023 | 03/01/2023 |
| N/A | N/A |
| | |
| 03/21/2024 | 03/21/2024 |
| 3/27/2023 | 3/24/2023 |

ATTACHMENT E 1-1

Corporate Office: 4025 Rawlins St, Cheyenne, WY 82001
Phone: 307-426-4797 Fax: 307-426-4799
www.specialtycounseling.com

| Name of Entity/Agency - WYOMING | Name of Entity/Agency - COLORADO |
|---|---|
| Wyoming Child & Family Development, Inc | Colorado Youth Detention Continuum |
| Platte County School District | Larimer County DHS |
| Headstart - Wheatland | Weld County DHS |
| Federal Contract District of Wyoming | Department of Youth Services |
| Converse County Sheriff's Department | Child and Youth Mental Health Treatment Act |
| Laramie County Drug Court | Harvest Farm Sober Living Program |
| Albany County Drug Court - Adult Diversion | |
| Cooperative Education Agreement (University of Wyoming) | |

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www.specialtycounseling.com

**APP – A.31**

**Business Associate Contract**

**This Agreement** is entered into on this , between Specialty Counseling & Consulting, LLC ("COVERED ENTITY") and ("BUSINESS ASSOCIATE").

**Whereas** COVERED ENTITTY will make available and/or transfer to BUSINESS ASSOCIATE Protected Health Information (PHI), in conjunction with goods or services that are being provided by BUSINESS ASSOCIATED to COVERED ENTITY, that is confidential and must be afforded special treatment and protections.

**Whereas** BUSINESS ASSOCIATE will have access to and/or receive from COVERED ENTITY Protected Health Information that can be used or disclosed only in accordance with this Agreement and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Parts 160 and 164).

**Whereas** COVERED ENTITY must have a valid business associate contract/agreement in effect to comply with the HIPAA Privacy Rule when providing BUSINESS ASSOCIATED access to PHI.

**NOW THEREFORE,** COVERED ENTITY and BUSINESS ASSOCIATE agree as follows:

1. **Definitions**
   a) *Business Associate.* "BUSINESS ASSOCIATE" shall mean .
   b) Covered Entity. "COVERED ENTITY" shall mean Specialty Counseling & Consulting, LLC
   c) *Individual.* "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
   d) *HIPPA Privacy Rule.* "HIPAA Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
   e) *Protected Health Information.* "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by BUSINESS ASSOCIATE from or on behalf of COVERED ENTITY.

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f) *Required by Law.* "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.
g) *Secretary.* "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Other terms used in this Agreement, but not defined above shall be defined as they are defined in the HIPAA Privacy Rule.

**2. Obligations and Activities of BUSINESS ASSOCIATE**

BUSINESS ASSOCIATE agrees to:

a) Not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.
b) Use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c) Mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of a use or disclosure of Protected Health Information by BUSINESS ASSOCIATE in violation of the requirements of the Agreement.
d) Report to COVERED ENTITY any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
e) Ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by BUSINESS ASSOCIATE on behalf of COVERED ENTITY, agrees to the same restrictions and conditions that apply through this Agreement to BUSINESS ASSCOIATE with respect to such information.
f) Provide access, at the request of COVERED ENTITY, and in the time and manner **([Insert negotiated terms] or [designated by COVERED ENTITY]**), to Protected Health Information in a Designated Record Set, to COVERED ENTITIY or, as directed by COVERED ENTITY, to an Individual to meet the requirements under 45 CFR § 164.524.
g) Make any amendment(s) to Protected Health Information in a Designated Record Set that the COVERED ENTITY directs or agrees to pursuant to 45 CFR § 164.526 at the request of COVERED ENTITY or an individual, and in the time and manner **([Insert negotiated terms] or [designated by COVERED ENTITY]). [Not necessary if BUSINESS ASSOCIATE does not have PHI in a designated record set.]**
h) Make internal practices and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by BUSINESS ASSOCIATE on behalf of COVERED ENTITY available **to the COVERED ENTITY, or to the Secretary, in a timely manner ([Insert negotiated terms]) or [requested by COVERED ENTITY]**) or designated by the Secretary, for purposes of the Secretary determining COVERED ENTITY's compliance with the HIPAA Privacy Rule.
i) Document such disclosures of Protected Health Information and information related to such disclosures as would be required for COVERED ENTITY to respond to a request by

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an Individual for an accounting of disclosures of Protected Health Information with 45 CFR § 164.528.

j) Provided to COVERED ENITITY or an Individual, in timely manner **([Insert negotiated terms] or [designated by COVERED ENTITY]),** information collected in accordance with Section [Insert Section Number in Agreement Where Provision (i) Appears] of this Agreement, to permit COVERED ENTITY to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

**3. *Permitted Uses and Disclosure by BUSINESS ASSOCIATE***

a) General Use and Disclosure Provisions **[Select an alternative.]**

i. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use or disclose Protected Health Information on behalf of: or to provide services to, COVERED ENTITY for the following purposes, if such use or disclosure of Protected Health Information would not violate the HIPAA Privacy Rule if done by COVERED ENTITY: [**List Purposes.]**

ii. Refer to underlying services agreement/contract Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, COVERED ENTITY as specified in [Insert Name of Services Agreement/Contract], provided that such use or disclosure would not violate the HIPAA Privacy Rule if done by COVERED ENTITY or the minimum necessary policies and procedures of the COVERED ENTITY.

b) Specific Use of Disclosure Provisions [only necessary if parties wish to allow BUSEINSS ASSOCIATE to engage in such activities.]

i. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.

ii. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE, provided that disclosures are Required by Law, or BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it disclosed to the person, and the person notifies the BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of the information is breached.

iii. Except as otherwise limited in this Agreement, BUSINESS ASSOICATE may use Protected Health Information to provide Data Aggregation services to COVERED ENTITY as permitted by 42 CFR § 164.504€(2)(i)(B).

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4. **Obligations of COVERED ENTITY**
   a) Provisions for COVERED ENTITY to inform BUSINESS ASSOCIATE of Privacy Practices and Restrictions **[provisions dependent on business arrangement]**

**COVERED ENTITY shall:**

i. Notify BUSINESS ASSOCIATE of any limitation(s) in its notice of Privacy practices of COVERED ENTITY in accordance with 45 CFR § 164.520, to the extent that such limitation may affect BUSINESS ASSOICATE's use or disclosure of Protected Health Information.
ii. Notify BUSINESS ASSOCIATE of any changes in, or revocation of permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect BUSINESS ASSOCIATE's use or disclosure of Protected Health Information.
iii. Notify BUSINESS ASSOCIATE of any restriction to the use or disclosure of Protected Health Information that COVERED ENTITY has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect BUSINESS ASSOCIATE's use or disclosure of Protected Health Information.

   b) Permissible Requests by COVERED ENTITY: COVERED ENTITY shall not request BUSINESS ASSOCIATE to use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Privacy Rule if done by COVERED ENTITY. [Include an exception if the BUSINESS ASSOCIATE will use or disclose protected health information for, and the contract/agreement includes provisions for, data aggregation or management and administrative activities of BUSINESS ASSOCIATE].

5. **Term and Termination**
   a) Term: The Term of this Agreement shall be effective as of                , and shall terminate when all of the Protected Health Information provided by COVERED ENTITY to BUSINESS ASSOICATE, or created or received by BUSINESS ASSOCIATE on behalf of COVERED ENTITY, is destroyed or returned to COVERED ENTITY, or, if it is infeasible to return or destroy Protected Health Information, in accordance with the termination provisions in this Section. [Term may differ.]
   b) Termination for Cause: Upon COVERED ENTITY's knowledge of a material breach by BUSINESS ASSOCIATE, COVERED ENTITY shall either:
      i. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation and terminate this Agreement **[and the Agreement/sections of the            Agreement]** if BUSINESS ASSOCIATE

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does not cure the breach or end the violation within the time specified by COVERED ENTITY.

ii. Immediately terminate this Agreement **[and the Agreement/Sections of the Agreement]** if BUSINESS ASSOCIATE has breached a material term of this Agreement and cure is not possible; or

iii. If neither termination nor cure is feasible, COVERED ENTITY shall report the violation to the Secretary.

**[The "bracketed language' in this provision may be necessary if there is an underlying service agreement/contract. Also, opportunity to cure is permitted, but not required by the Privacy Rule.]**

c) Effect of Termination:

i. Except as provided in paragraph ("ii") of this section, upon termination of this Agreement, for any reason, BUSINESS ASSOCIATE shall return or destroy all Protected Health Information received from COVERED ENTITY, or created or received from COVERED ENTITY, or created or received by BUSINESS ASSOICATE on behalf of COVERED ENTITY. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall retain no copies of the Protected Health Information.

ii. If BUSINESS ASSOCIATE determines that returning or destroying the Protected Health Information is infeasible, BUSINESS ASSOICATE shall provide COVERED ENTITY notification of the conditions that make return or destruction infeasible. Upon **([Insert negotiated terms] or [mutual agreement of the Parties])** that return, or destruction of Protected Health Information is infeasible, BUSINESS ASSOCIATE shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as BUSINESS ASSOCIATE maintains such Protected Health Information.

**6. Governing Law**

a) This Agreement shall be governed by the laws of the State of Wyoming and Colorado.

**7. Injunctive Relief**

a) Notwithstanding any rights or remedies provided for in this Agreement, COVERED ENTITY retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of Protected Health Information by BUSINESS ASSOCIATE or any agent, subcontractor, or third party that received Protected Health Information from BUSINESS ASSOCIATE.

**8. Binding Nature and Assignment**

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a) This Agreement shall be binding on the Parties hereto and their successors and assigns, but neither Party may assign this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

**9. Notices**

a) Whenever under this Agreement one party is required to give notice to the other, such notice shall be deemed given if mailed by First Class United States mail and postage prepaid, and addressed as follows:

Specialty Counseling & Consulting, LLC
4025 Rawlins St.
Cheyenne, WY 82001
**[BUSINESS ASSOCIATE ADDRESS]**
Either Party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

**10. Entire Agreement**

a) This Agreement consists of this document and constitutes the entire agreement between the Parties. There are no understanding or agreements relating to this Agreement which is not fully expressed in this Agreement and no change, waiver, or discharge of obligations arising under this Agreement shall be valid unless, in writing and executed by the Party against whom such change, waiver, or discharge is sought to be enforced.

**11. Miscellaneous**

a) Regulatory References: A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended.
b) Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for COVERED ENTITY to comply with the requirements of the HIPAA Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law 104-19I.
c) Survival: The respective rights and obligations of BUSINESS ASSOCIATE under Section 5 of this Agreement shall survive the termination of this Agreement.
d) Interpretation: Any ambiguity in this Agreement shall be resolved to permit COVERED ENTITY to comply with the Privacy Rule.

**In Witness Whereof,** BUSINESS ASSOICATE and COVERED ENTITY have caused this Agreement to be signed and delivered by their dually authorized representatives, as of the date set forth above.

| BUSINESS ASSOCIATE: | COVERED ENTITY: |
| --- | --- |
| ______________________ | ______________________ |
| Signature | Signature |

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Print Name and Title

Print Name and Title

## Specialty Counseling and Consulting, LLC

ATTACHMENT G

### DRUG TESTING OF CLIENTS

**POLICY: OPS-D.20**

Specialty Counseling and Consulting, LLC may engage in drug testing of clients. Such testing will always be in full compliance with Federal and State laws and regulations.

**PROCEDURES:**

1. Upon admission, all clients receiving services are advised that they may be subject to a request for drug testing. Documentation of such notification will be placed in their clinical file.
2. If a client is suspected of being intoxicated by a drug (including alcohol), he/she may be requested to submit to a drug test.
3. All outpatient substance abuse clients may be tested with a screening UA drug test at time of admission as part of their written treatment plan and in accordance with probation or other stakeholder plan.
4. Clients considered to be high risk for drug use will be randomly tested in accordance with their treatment plan.
5. Results of any testing will be released to outside agencies/persons only with a properly signed release or as required by law.

## Specialty Counseling and Consulting, LLC

ATTACHMENT H-1

### CLIENT GRIEVANCES

**POLICY: OPS-D.19**

As part of the intake procedure, Specialty Counseling and Consulting, LLC will provide to every person requesting its services a written statement that the person make take grievances, complaints, or suggestions to the Executive Director or Owner/Operator. This information is contained in the intake paperwork and forms. Filing a complaint shall not result in retaliation or be a barrier to services.

**PROCEDURE:**

1. An informal grievance, complaint, or suggestion from any source will be referred to the Executive Director or Owner/Operator for action. If the person expressing the grievance, complaint, or suggestion is not satisfied with the Executive Director's or Owner/Operator's action of decision, the person may choose to follow a formal grievance procedure. The Executive Director or Owner/Operator will inform the person of the procedure stated below and provide the person with a written copy.
2. A person wishing to submit a formal grievance must do so in writing to the Executive Director or Owner/Operator. The Executive Director or Owner/Operator will acknowledge receipt of the grievance in writing and act within ten working days from the receipt of said grievance. The Executive Director or Owner/Operator will inform the persons submitting the grievance of the decision in writing.
3. If the person submitting the grievance wishes a review of the Executive Director or Owner/Operator's action, the person may refer the grievance to the Administrative Team and request a hearing.
4. When the Administrative Team receives the written request for a grievance hearing, the team will set a time and place for a hearing no later than thirty (30) days from the date the request was for a hearing. The person requesting a hearing will receive a notice by certified mail telling him/her of the time and place of the hearing no less than ten (10) days before the date set for the hearing.
5. The person requesting a hearing will have the right to bring other people to the hearing to assist in presenting the grievance. The Administrative Team will inform the person submitting the grievance of its decision by certified mail no later than twenty (20) days after the hearing. The decision of the Administrative Team is final.
6. The Quality Assurance (QA) committee will review all client grievances and submit a written annual report identifying trends, performance improvement and actions to be taken for Team analysis.

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**Revocation of Consent:**
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. If you revoke this consent, it is office policy to treat you as a cash client with payment due at the time of service.

**Confidentiality:**
In general, all material discussed during counseling sessions is legally confidential. Your records are protected and cannot be disclosed without your written consent. However, your therapist may consult with a supervisor or clinical team regarding your therapy progress in general. Federal Law (42CFR, Part 2) prohibits making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of information is not sufficient for this purpose. Per Substance Abuse Requirements Federal Law (45CFR, 160 & 164) also applies which provides the first comprehensive federal protection for the privacy of health information and standards for privacy of individually identifiable health information.

**Security:**
All files are in the care of The Company in a locked file cabinet in The Company's building. We take your privacy very seriously and make every effort to keep your material confidential. Any person with access to records for treatment or billing purposes will sign a confidentiality agreement prior to access being granted. **There are certain situations in which your therapist is required by law to reveal information obtained during therapy without your permission. These situations are:**

- If you threaten bodily harm or death to yourself or another person.
- If a court of law issues a legitimate subpoena.
- If you reveal information relative to physical abuse, sexual abuse, or neglect of a child, elderly person, or person with a disability (in the past as well as in the present).
- If you are in therapy by order of a court of law.
- If you are involved in a criminal or delinquency proceeding.

**Special Note:**
Because of the nature of our business providing outpatient services at the office and extensively in the community, preserving full confidentiality may be limited at times. Such locations where exposure of the counseling relationship may be seen include schools, client's home, local businesses, parks, recreational sites, and other similar social locations.

- In addition, office staff may call to remind you about your upcoming appointment or call about missed appointments and may leave a voicemail as to the therapist's name, who is being called, and the nature of the call.
- Moreover, if the use of email and/or text is a part of the counseling process between therapist and client, The Company cannot preserve the full extent of confidentiality if someone else views our emails or texts.
- Finally, a discharge letter may be emailed to you with the address provided on the Intake Client Form.

**Complaints:**
If you have questions regarding services you receive, please discuss them with your therapist. If you do not receive a satisfactory response, contact the State of Wyoming's Mental Health Professions Licensing Board at (307) 778-7788. You can also reference their website at http://plboards.state.wy.us/mentalhealth. Complaints can also be filed with the Wyoming Department of Health Behavioral Health Division at (307)777-6494. There are no repercussions for complaints.

**Reservation of Right to Change Privacy Practices:**

ATTACHMENT I H

www.specialtycounseling.com

APP – A.30

**Staff Crisis Call Procedure**

If the front desk receives a call from a client in crisis, it is important to address the situation as quickly and efficiently as possible. The following is a procedure to follow for such calls:

- Ask for a phone number and address. This gives us a means to contact them later, and may serve to shift the caller's focus from their immediate distress.
- If the caller is an SCC client, attempt to contact their therapists or case coordinator.
- If the caller is not an SCC client, attempt to contact any available therapist in the office.
- If no therapists are available, attempt to contact the clinical director.
- If the clincial director is not available, attempt to contact the Executive Director and/or Owner.
- If no clinical staff are available, ask the caller if they are okay to wait on a return call from a therapist. If so, confirm the phone number and pass it to a therpaist as soon as possible. If not, encourage caller to consider calling 911 or go to the Emergency Room at the hospital.
- If the caller continues to be in distress and refuses to go to the hospital or seek immediate available services, a call to law enforcement for a "wellness check" may be appropriate.
- Complete an incident report documenting the contact and any actions taken.

I 1-2

**No-Show**
A no-show is failing to arrive for an appointment at the scheduled time without contacting SCC to cancel the appointment.

**SCC Procedure**

First Late Cancellation/No-Show: There will be no charge. No show policy signature form presented for signature by provider.

Second Late Cancellation/No-Show: May result in a $50 fee may be collected by the provider.

Third Late Cancellation/No-Show or more: May result in a $50 fee may be collected by the provider. Discuss possible discharge.

***I have read and understand SCC's Cancellation, Missed Appointment & No-Show Procedure.***

Client Printed Name: ______________________________ Birthdate____________

Parent/Guardian Printed Name (if applicable): ______________________________

Client or Parent/Guardian Signature: ______________________ Today's Date: ________

Specialty Counseling & Consulting values you as a client and strives to provide you with excellent mental health services! Thank you for your support in this process.

**Health Insurance Claims:**
We bill your insurance (if accepted by The Company) as a courtesy. However, you are ultimately responsible for the balance due. If your insurance has not paid within 90 days, we require that you pay the balance due and talk to your insurance company about reimbursing you.

**Emergencies:**
Your therapist cannot always guarantee availability during a crisis. If an emergency arises outside of normal business hours and/or your therapist is not available by phone during an emergency, you should call 911 or go to the nearest hospital emergency room for assistance.

**Your Rights as a Client:**

1. You are entitled to be treated with respect and dignity.
2. You are entitled to impartial access to treatment, regardless of race, religion, gender, sexual orientation, gender expression, ethnicity, age or ability.
3. You are entitled to information about any procedures, methods of therapy, techniques, possible duration of therapy, and costs of treatment.
4. You have the right to choose a treatment provider and modality that suits your individual needs. If you desire, your therapist will provide you with the names of other qualified professionals whose services you might prefer.
5. You have the right to seek a second opinion from another therapist at any time, which may or may not be covered by your benefit plan.
6. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued, unless prevented by law.
7. You have the right to expect confidentiality within the limits described in the Privacy Policy herein.

**Your Responsibilities as a Client:**

1. You are expected to respect the rights and property of other clients, staff, the building, and vehicles.



INTAKE PW —

ATTACH J 1-1

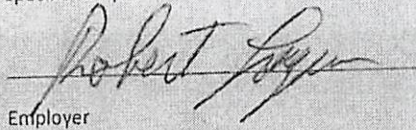
4025 Rawlins St • Cheyenne, WY 82001 • Phone: 307-426-4797 • Fax: 307-426-4799

# EMPLOYMENT AGREEMENT ADDENDUM

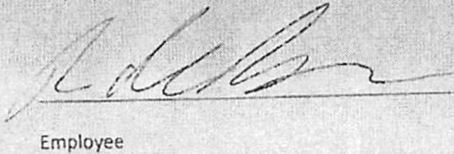
This addendum to the current Employment Agreement between Specialty Counseling & Consulting, LLC and Raul (Alex) Padilla shall be added to the existing Employment Agreement and become effective as of today's date: 1/4/2022.

The parties, for good consideration, hereby agree as follows:

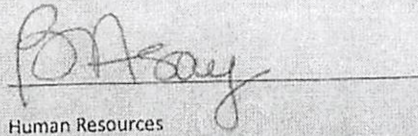
As a subcontractor, Raul (Alex) Padilla meets all of the rules, regulations and policies of SCC. This is in specific compliance for CARF standards documentation.



Employer — Date: 1-10-22



Employee — Date: 1/7/22



Human Resources — Date: 1/11/2022

J 1-2

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| MP5943902 | 03-31-2026 | $888 |

| SCHEDULES | BUSINESS ACTIVITY | ISSUE DATE |
|---|---|---|
| 2,2N,3, 3N,4,5 | MLP-NURSE PRACTITIONER | 03-24-2023 |

PADILLA, RAUL ALEXANDER (NP)
4025 RAWLINS ST
CHEYENNE, WY 820011900

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

REGISTERED ACTIVITY WITHIN SCHEDULE IS RESTRICTED BY YOUR STATE.

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

**THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.**


**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| MP5943902 | 03-31-2026 | $888 |

| SCHEDULES | BUSINESS ACTIVITY | ISSUE DATE |
|---|---|---|
| 2,2N,3, 3N,4,5 | MLP-NURSE PRACTITIONER | 03-24-2023 |

REGISTERED ACTIVITY WITHIN SCHEDULE IS RESTRICTED BY YOUR STATE.

PADILLA, RAUL ALEXANDER (NP)
4025 RAWLINS ST
CHEYENNE, WY 820011900

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.


Form DEA-223 (9/2016)

J 1-3

| DEA REGISTRATION NUMBER | THIS REGISTRATION EXPIRES | FEE PAID |
|---|---|---|
| MP5943902 | 03-31-2026 | $888 |

| SCHEDULES | BUSINESS ACTIVITY | ISSUE DATE |
|---|---|---|
| 2,2N,3, 3N,4,5 | MLP-NURSE PRACTITIONER | 03-24-2023 |

PADILLA, RAUL ALEXANDER (NP)
4025 RAWLINS ST
CHEYENNE, WY 820011900

CONTROLLED SUBSTANCE/REGULATED CHEMICAL
REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

REGISTERED ACTIVITY WITHIN SCHEDULE IS RESTRICTED BY YOUR STATE.

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

**THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.**

Form DEA-223/511 (9/2016)

**REPORT**

**CHANGES**

**PROMPTLY**

REQUESTING MODIFICATIONS TO YOUR
REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at **deadiversion.usdoj.gov** - or
2. call our customer Service Center at **1-(800) 882-9539** - or
3. submit your change(s) in writing to:
   **Drug Enforcement Administration**
   **P.O. Box 2639**
   **Springfield, VA 22152-2639**

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

## Specialty Counseling and Consulting, LLC

J 1-4

### MEDICATION MANAGEMENT

**POLICY: MED-G.1**
Specialty Counseling and Consulting, LLC provides Medication Management for clients after medication evaluation and authorization by a licensed prescriber to ensure routines related to the management and documentation of medications are consistent and are as directed.

SCC staff do not provide medication monitoring. Medication monitoring is defined as observing a client self-administer his/her medication(s). Licensed physicians, licensed nurse practitioners, or licensed physician's assistants are the only personnel authorized to prescribe medication. All clients and/or parents/guardians must consent to the use of each medication. The agency medical coordinator or contracted designee will provide information on side effects and risks of the medication being prescribed. The Support Services Program Manager must be kept current with medication protocols and guidelines through ongoing license training and other requirements to ensure client safety.

**PROCEDURES:**

1. Medications will be prescribed by a contracted licensed psychiatrist, nurse practitioner, or physician's assistant and/or community physician group. A complete list of the clients' medications is available to the clinical team and therapist to provide continuity of care.
2. To the extent possible, the use of treatment guidelines and protocols shall promote state-of-the-art pharmacotherapy and ensure client safety.
3. The written prescriptions, once consents are complete, are then faxed or E-prescribed to the pharmacy. When pick up or delivery occurs, the written prescription is then given to the pharmacy of record.
4. Upon prescription of any new medication, special dietary needs and restrictions associated with the medication use will be documented by the prescribing party in the medical notes. Education to clients of special dietary needs and restrictions shall be provided by the medical coordinator or approved designee.
5. Prescribing:
    a. Prescribing authorities shall comply with all applicable local, State and Federal laws and regulations pertaining to medications and controlled substances. Prescribing authorities shall be available for consultation 24 hours a day 7 days per week. Medications may be prescribed or ordered after a medication evaluation by the licensed physician or medical professional. Upon initial assessment, the prescriber will screen for common medical comorbidities using evidence (or consensus) based protocols, review the client's past medication use including effectiveness, side effects, allergies and adverse reactions, pregnancy risks, co-existing medical conditions, substance abuse history, and the use of over-the-counter medications/herbs/supplements.
    b. This is followed by routine and regular checks by the physician or medical professional. These checks are conducted at a minimum of every 120 days. Routine and regular checks include reviewing and evaluating the appropriateness and effectiveness of each medication, the need for continued us of each medication, the presence of side effects, unusual effects, adverse reactions and contraindications, the use of multiple medications (prescription or over-the-

counter), drug interactions, pregnancy, risks of alcohol or street drug us in conjunction with the prescribed medication(s), driving or hazardous occupations, special dietary requirements/restrictions, necessary laboratory studied or tests, existence of co-occurring medical conditions, and the satisfaction of the client. All medications prescribed will be documented in the client's medical record with the name of the person, the dosage, the frequency, instructions for use, and the prescriber's name. The prescriber will coordinate care with the client's other physicians (i.e. family practice) as appropriate.

  c. The prescribing authority shall document or have confirmation of signed informed consent for each medication prescribed, when possible. When a medication is prescribed, informed consent shall be obtained from the client, parent, and legal guardian when possible. Informed consent may be obtained verbally, electronically, or in person.

6. Administering:
   a. SCC does not provide or participate in the administering of medications.
7. Dispensing:
   a. SCC will not provide pharmaceutical services for its clients. Medications shall not be dispensed at SCC. A written prescription from the client's physician can be filled by the client on an outpatient basis at a pharmacy of their choosing.
8. Storage:
   a. SCC does not store client medication.
9. Monitoring:
   a. SCC does not provide medication monitoring.
10. Emergencies:
    a. Referral to the local hospital is made in emergency situations. Consultation regarding medical issues is also available through the local hospital. Clients will be instructed to call the hospital or visit their family practice physician for consultation if there is an emergency.
11. Medication Errors:
    a. All medication errors will be reported to the Clinical Director, Executive Director, or Owner/Operator and appropriate follow-up or referral to the local hospital will be provided to the client. Medication errors will be reported on a Critical Incident Report Form. Refer to the Critical Incident Reporting Policy.
12. Drug Reactions:
    a. SCC is not equipped to handle serious drug reactions. If a serious reaction occurs, the local Emergency Medical System is accessed by dialing 911. If mild side effects occur, the available licensed medical personnel will provide assessment and treatment as appropriate and refer to the local hospital, if necessary. A list of medication allergies will be kept in each client's file that sees a psychiatric provider. If a client experiences a drug reaction, staff will complete a Critical Incident Report. Serious reactions would include any difficulty breathing, hives, and decrease consciousness.
13. Treatment Plans:
    a. Medication management services are documented in the client's treatment plan. They are reviewed a minimum of every 90 days. The client is encouraged to and expected to be an active participant in treatment. Family members *and/or*

J 1-6

significant others are encouraged to also participate in the client's treatment unless clinically contraindicated. The use of medication is intended to assist and enhance other treatment services.

14. Poison Control:
    a. Access to information about Poison Control is available to all personnel and clients.
15. Education:
    a. Licensed personnel will provide clients, client's family members, and agency personnel with medication information and education as requested. Information given to clients about medication will be noted next to the medication in the medical notes. Education will include: how medication works, risks, benefits, side effects, contraindications, adverse interactions with other medications and food, pregnancy risks, compliance, alternatives, early signs of relapse, signs of noncompliance, potential drug reaction when combining medication with other prescriptions, over the counter or illicit drugs, self-administration instructions, wellness management and recovery planning, and availability for financial supports to assist with prescriptive costs.

# Specialty Counseling and Consulting, LLC

J 1-7

## PHYSICIAN OF RECORD

**POLICY: MED-G.2**
To ensure continuity of care, a primary care physician/practitioner (PCP) is identified for caring for the medical needs of each client at Specialty Counseling and Consulting, LLC.

**PROCEDURES:**

1. Upon admission to SCC outpatient programs, the staff worker responsible for the client's intake should determine whether the client has a primary physician. This information should be recorded on the medical history intake in the intake packet.
2. If specialized care is needed while on premises, consent for these services should be designated at intake and a release signed. Later, if it becomes apparent that a client needs additional services, the client's legal guardian should be consulted and give consent.
3. General primary care may be provided by licensed SCC contracted medical staff.

# Specialty Counseling and Consulting, LLC

J 1-8

## HISTORY AND PHYSICAL EXAMINATION

**POLICY: MED-G.3**
All clients admitted to Specialty Counseling and Consulting, LLC are screened for health needs.

**PROCEDURES:**

1. A personal health overview including an assessment of medications, medical history, including allergies or adverse reactions, over the counter medications used by women of childbearing age (including pregnancy risk), biohazard management, and past physical examination will be completed at time of intake.
2. The intake form must be taken to the licensed medical practitioner for evaluation and review at the time for the medical appointment.
3. A complete health assessment may only be completed by authorized medical staff.
4. When problems are identified, immediate intervention will be pursued.
5. Procedures for providing necessary care to pregnant clients:
    a. Clients with known pregnancy will be identified at the time of intake. This information will be documented in the medical notes.
    b. Medical staff will be notified as needed.
    c. New and continuing OB care will be discussed with medical staff.
6. Procedure for the providing of care to client with special needs secondary to both temporary and long-term disabilities.
    a. Medical and physical special needs shall be identified at the time of intake. Medical staff will be notified at the time of intake if applicable.
    b. Information will be written in the medical notes.
7. Procedure for identifying clients with allergies:
    a. Allergies are identified and documented at the time of intake on the client chart.

## Specialty Counseling and Consulting, LLC

J 1-9

### MEDICAL ORDERS

**POLICY: MED-G.4**
To obtain medical orders as needed for clients in a manner that is consistent and safe.

**PROCEDURES:**

1. A licensed medical staff visit-appointment record will be kept for all clients who receive medication services through SCC.
2. Documentation of each licensed medical staff visit will be completed. A copy must be maintained in the client's permanent file, and a copy given to the physician.
3. When a visit is made with contracted medical staff, the provider will write orders, record on the SCC EHR system, and provide prescriptions.
4. If the medication being ordered is a scheduled medication (e.g. Ritalin), the provider must provide a written prescription for the medication in addition to documenting the order in the client's chart.
5. If the provider is not on-site, a written prescription or telephoned order to the pharmacist may be generated.
6. Any changes in medication need to be noted in the client's file.

## Specialty Counseling and Consulting, LLC

J 1-10

### MEDICAL EMERGENCIES

**POLICY: MED-G.5**
The safety and continued health of all clients will be provided for in times of emergency situations.

Definition: A medical emergency is any sudden event that can cause the loss of life or limb or that can affect the quality of life. Such emergencies include, but are not limited to: a client who; is not breathing or who is taking very shallow breaths or who is gasping for breath; has no pulse; has a head injury that involves a loss of consciousness; has taken an overdose of medications or chemicals; exhibits profuse bleeding, eye injury, compound fracture (bones sticking through the skin), severe allergic reactions, deep wounds, burns, or some seizures; has suffered electrocution, drowning, back or neck injury, or impaled objects.

**PROCEDURES:**

1. If life threatening, immediately call 911 for ambulance and emergency responders.
2. Maintain an open airway.
3. Check for pulse and breathing.
4. Begin CPR, if necessary.
5. If there is profuse bleeding, apply pressure to bleeding areas, using gloves and a sterile gauze pad, for five minutes and then check bleeding again.
6. If the client is able to move and walk and is breathing without difficulty, transport the client to the nearest emergency room (i.e. high fever, lacerations, objects in skin, etc.).
7. If the client cannot move, an ambulance will be called (i.e. back or neck injury, unconsciousness, severe eye injury, burns, etc.).
8. The Medical staff, Executive Director, or Owner/Operator will be notified by involved staff.
9. The Department of Family Services and parents/guardians will be notified by a member of the treatment team, if applicable.
10. A Critical Incident Report will be completed by the involved staff and forwarded as per procedure.

J 1-11

## INJURIES AND ACCIDENTS

**POLICY: MED-G.6**
Immediate and effective first aid treatment shall be given to clients who are injured on SCC property.

**PROCEDURES:**

1. Any time a client is injured, the area of the injury will be assessed for bleeding, swelling, bruising, movement, and pain. All SCC staff shall receive first aid training.
2. SCC staff will only apply first aid as deemed necessary, and only until the client can be seen by authorized medical staff or emergency responders, if applicable
3. Notification:
    a. Any time there is a client injury, the Owner/Operator or Executive Director will be notified.
    b. The Executive Director or designee will then be responsible for notifying the client's family, if applicable.
    c. A Critical Incident Report will be completed by the person who witnessed the injury and cared for the child/client.

ATTACHMENT K 1-1

www.specialtycounseling.com

APP-A.3

**Wyoming Client Intake Information Form**

Full Name: ______________________ DOB: ______________

Physical Address: ______________________

City: ______________ State: ________ Zip: ______________

Client Mailing Address: ______________________

City: ______________ State: ________ Zip: ______________

Home Phone #: ______________ Cell Phone #: ______________

Email Address: ______________________

Social Security #: ______________

Emergency Contact: ______________ Relationship: ______________

Emergency Contact Phone #: ______________

Relationship Status of Client: □ Single □ Partnership □ Married □ Divorced □ Widowed □ Minor.

Gender of Client: □ Male □ Female □ Other

**Responsible Party:**

(If client is a minor, please fill out parent information.)

Please understand that the Parent/Guardian of a minor is financially responsible for services received.

Responsible Party's Name: ______________________ DOB: ______________

Address: ______________________

City: ______________ State: ________ Zip: ______________

Home Phone #: ______________ Cell Phone #: ______________

Social Security #: ______________Driver's License # and State: ______________

Employer: ______________ Work Phone #: ______________

**Insurance Information and Authorization:**

Primary Insurance: ______________ Policy #: ______________ Group #: ________

Policy Holder's Name: ______________ SS #: ______________ DOB: ________

Secondary Insurance: ______________ Policy #: ______________ Group #: ________

Policy Holder's Name: ______________ SS #: ______________ DOB: ________

Last updated: 03/2024

K 1-2

*I attest that the information I have given above is true and correct to the best of my knowledge.
*By signing below, I authorize treatment of the Client listed above.
*I request that payment of medical benefits be made to Specialty Counseling & Consulting, LLC.

Signature of Client or Person Acting on Client's Behalf Date

**Agreement and Signature**

*I have reviewed the Disclosure/Privacy Policy and give my permission to Specialty Counseling & Consulting, LLC ("SCC") to use and disclose my health information in accordance with this policy.
*I agree to meet the financial obligation agreed upon.
SCC is responsible for invoicing only for treatment services provided by its staff in the office or directly related to such treatment. Any additional services provided to a client that are outside the usual and customary treatment regimen must be arranged between the therapist and client and paid for as directly as agreed. Such additional services include, without limitation, deposition testimony, court appearances, client employer meetings and consultation, etc.

Client Name (Please Print) Client or Representative Signature Date

**Insurance Authorization**

*I authorize the release of my medical or any other information necessary to process my insurance claim.
*I request that payment of medical benefits be made to Specialty Counseling & Consulting, LLC
*I am responsible for my bill. I understand and acknowledge that any costs incurred and not covered under my insurance benefits will be my responsibility.
*I understand that billing my insurance company is a courtesy on my behalf.

Client or Representative Signature Date

K 1-3

## Office Procedures, Notice of Privacy Practices and Consent for Treatment

Client Name: ___________________________________

### Office Procedures

Welcome! Your decision to enter counseling is an opportunity for you, with the assistance of your therapist, to find new insight, direction, and solutions to life's challenges. This document has been prepared to inform you about what you can expect from the counseling relationship. The following outlines office policies and clarifies your rights and responsibilities as a client. Please read this document carefully and express any concerns or questions you may have. Please let your therapist know if you would like a copy of this document for your records.

**General Information:**
Please understand that the practice of psychotherapy is not an exact science and treatment outcomes cannot be guaranteed. Psychotherapy can have associated benefits and risks as follows: Psychotherapy often leads to increased self-awareness and confidence, improved relationships, solutions to specific problems, and significant reductions in feelings of distress and other symptoms. Your therapist will be there to support you as you make the choices and changes that are required to achieve your desired goals. Since psychotherapy often involves discussing unpleasant aspects of your life, you may feel uncomfortable feelings. You may discover, come to understand, or realize aspects of yourself or others that may bring up difficult emotions. You may make decisions or changes that other people in your life dislike. There is also the risk that therapy may not resolve your issues or that therapy alone may not be sufficient. Should this be the case, your therapist will explore along with you ways to either supplement added support or find other resources that may better serve you.

**Therapy Sessions and Fees:**
Specialty Counseling and Consulting, LLC ("The Company") tries to meet the needs of you and your family while considering your own financial obligations. A reduced cash rate may be available for private-paying clients.

### Cancellation, Missed Appointment & No-Show

**Procedure**
Dear Valued Client, our goal is to provide quality therapy and support services. No-shows and late cancellations inconvenience those who need access to our services in a timely manner. This policy enables us to better utilize available appointments for all our clients.

**Cancellation of Appointment**
To be respectful of the needs of other clients, please be courteous and call the Specialty Counseling & Consulting (SCC) office promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely services.

**How to Cancel your Appointment**
To cancel an appointment, please contact the front desk or your provider. If you do not reach the receptionist, you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to schedule or confirm your next appointment.

**Late cancellation**
A late cancellation is an appointment canceled in less than 24 hours of the scheduled appointment time.

K 1-4

**No-Show**
A no-show is failing to arrive for an appointment at the scheduled time without contacting SCC to cancel the appointment.

**SCC Procedure**

First Late Cancellation/No-Show: There will be no charge. No show policy signature form presented for signature by provider.

Second Late Cancellation/No-Show: May result in a $50 fee may be collected by the provider.

Third Late Cancellation/No-Show or more: May result in a $50 fee may be collected by the provider. Discuss possible discharge.

***I have read and understand SCC's Cancellation, Missed Appointment & No-Show Procedure.***

Client Printed Name: ________________________________________ Birthdate______________

Parent/Guardian Printed Name (if applicable): ________________________________________

Client or Parent/Guardian Signature: ____________________________ Today's Date: _________

Specialty Counseling & Consulting values you as a client and strives to provide you with excellent mental health services! Thank you for your support in this process.

**Health Insurance Claims:**
We bill your insurance (if accepted by The Company) as a courtesy. However, you are ultimately responsible for the balance due. If your insurance has not paid within 90 days, we require that you pay the balance due and talk to your insurance company about reimbursing you.

**Emergencies:**
Your therapist cannot always guarantee availability during a crisis. If an emergency arises outside of normal business hours and/or your therapist is not available by phone during an emergency, you should call 911 or go to the nearest hospital emergency room for assistance.

**Your Rights as a Client:**

1. You are entitled to be treated with respect and dignity.
2. You are entitled to impartial access to treatment, regardless of race, religion, gender, sexual orientation, gender expression, ethnicity, age or ability.
3. You are entitled to information about any procedures, methods of therapy, techniques, possible duration of therapy, and costs of treatment.
4. You have the right to choose a treatment provider and modality that suits your individual needs. If you desire, your therapist will provide you with the names of other qualified professionals whose services you might prefer.
5. You have the right to seek a second opinion from another therapist at any time, which may or may not be covered by your benefit plan.
6. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued, unless prevented by law.
7. You have the right to expect confidentiality within the limits described in the Privacy Policy herein.

**Your Responsibilities as a Client:**

1. You are expected to respect the rights and property of other clients, staff, the building, and vehicles.

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2. It is your responsibility to be on time for appointments and to make any cancellations in accordance with the policy listed above.
3. You and your therapist will create a service plan together to guide your treatment. It is your responsibility to let your therapist know if you are unhappy with the treatment plan or wish to adjust it. Your therapist is here to help you reach your goals in therapy. However, it is your responsibility to follow the agreed-upon service plan. If at any time you refuse to follow the service plan, this may be cause for termination of services, as it is unethical to maintain a therapeutic relationship that is non-beneficial to the client.

***The following notice describes how medical information about you may be used and disclosed and how you can get access to this information.***

**Notice of Privacy Practices Acknowledgement**

Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

You have the right to obtain a paper copy of Specialty Counseling and Consulting, LLC's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of your health information (SCC P&P Policy). This organization has the right to change its *Notice of Privacy Practices* from time to time and you may contact this facility at any time to obtain a current copy of the *Notice of Privacy Practices.* You may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, or behavioral health services. You are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Use and Disclosure of Your Protected Health Information:**

Your protected health information will be used by Specialty Counseling & Consulting, LLC for the purpose of treatment, operations, and billing to support the day-to-day operations of the practice without written consent required from the Client.

**Your Rights under HIPAA:**

1. Access and right to copy medical records, this does not include psychotherapy notes.
2. Request for amendment to designated record set.
3. Request for accounting of disclosures.
4. Request to be contacted at an alternate location.
5. Request for further restrictions on who has access.
6. Right to file a complaint.

**Your authorization must be received to release your PHI (Private Health Information) for the following reasons:**

- Authorization of disclosure of session notes.
- Revocation of consent to use and disclose of PHI.
- Standard authorization of use and disclosure of PHI.
- Authorization of internal use without decoding.
- Authorization release for investigational treatment.
- Revocation of authorization release for investigational treatment

**Requesting a Restriction (Opt Out):**

You may request a restriction on the use or disclosure of your protected health information.

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**Revocation of Consent:**
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. If you revoke this consent, it is office policy to treat you as a cash client with payment due at the time of service.

**Confidentiality:**
In general, all material discussed during counseling sessions is legally confidential. Your records are protected and cannot be disclosed without your written consent. However, your therapist may consult with a supervisor or clinical team regarding your therapy progress in general. Federal Law (42CFR, Part 2) prohibits making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of information is not sufficient for this purpose. Per Substance Abuse Requirements Federal Law (45CFR, 160 & 164) also applies which provides the first comprehensive federal protection for the privacy of health information and standards for privacy of individually identifiable health information.

**Security:**
All files are in the care of The Company in a locked file cabinet in The Company's building. We take your privacy very seriously and make every effort to keep your material confidential. Any person with access to records for treatment or billing purposes will sign a confidentiality agreement prior to access being granted. **There are certain situations in which your therapist is required by law to reveal information obtained during therapy without your permission. These situations are:**

- If you threaten bodily harm or death to yourself or another person.
- If a court of law issues a legitimate subpoena.
- If you reveal information relative to physical abuse, sexual abuse, or neglect of a child, elderly person, or person with a disability (in the past as well as in the present).
- If you are in therapy by order of a court of law.
- If you are involved in a criminal or delinquency proceeding.

**Special Note:**
Because of the nature of our business providing outpatient services at the office and extensively in the community, preserving full confidentiality may be limited at times. Such locations where exposure of the counseling relationship may be seen include schools, client's home, local businesses, parks, recreational sites, and other similar social locations.

- In addition, office staff may call to remind you about your upcoming appointment or call about missed appointments and may leave a voicemail as to the therapist's name, who is being called, and the nature of the call.
- Moreover, if the use of email and/or text is a part of the counseling process between therapist and client, The Company cannot preserve the full extent of confidentiality if someone else views our emails or texts.
- Finally, a discharge letter may be emailed to you with the address provided on the Intake Client Form.

**Complaints:**
If you have questions regarding services you receive, please discuss them with your therapist. If you do not receive a satisfactory response, contact the State of Wyoming's Mental Health Professions Licensing Board at (307) 778-7788. You can also reference their website at http://plboards.state.wy.us/mentalhealth. Complaints can also be filed with the Wyoming Department of Health Behavioral Health Division at (307)777-6494. There are no repercussions for complaints.

**Reservation of Right to Change Privacy Practices:**

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The company reserves the right to modify the privacy practices outlined in the notice. As revisions are completed and new forms issued to clients, all current clients will be given a new Notice of Privacy Practices and be asked to sign that they received a revised copy.

**Acknowledgement of Office Procedures and Privacy Practices:**
Your signature below indicates that you have read, understood, and agreed to all the terms of this document. You acknowledge that you have received a copy for your records (if requested), are aware of your client rights & responsibilities, and that any questions have been answered to your satisfaction.

**Consent for Treatment**

By signing this document, you consent to treatment for yourself and/or your minor child with Specialty Counseling & Consulting, LLC. Said treatment may include any or all the following: individual therapy, family therapy, group therapy, drug & alcohol counseling, therapeutic mentoring, assessments and evaluations, family/group treatment coordination, case management, and other services deemed appropriate and necessary.

_______________________________________________ ______________________

Client or Representative Signature Date

**Insurance Notification**

As a courtesy, Specialty Counseling & Consulting will file your insurance claim on your behalf. We require that any co-payments be made at the time that services are rendered. If you are not medically insured, we request that all charges be paid after each visit. At any time if payments are not being made on your account, services can be suspended by management, and it will be at their discretion if services can be scheduled. Our office will make every attempt to provide you with a payment plan that is conducive to your financial situation. However, if after 3 attempts to collect your balance via collection notices or phone contacts the status of your account remains the same, your account may be transferred to a collection agency.

Please understand that the reimbursement rates that insurance companies choose to pay are usually less than most provider fees. Each insurance company and different plans underwritten by each insurance company may reimburse at different rates. We do not and cannot allow a third party to determine the amount that we charge for services. Should you wish to determine the benefits wo which you are entitled under the provisions of your contract, we recommend that you contact your insurance company to obtain precise information about your coverage.

I hereby authorize Specialty Counseling & Consulting, LLC to furnish to the relevant insurance company(ies) all information which the insurance company(ies) may request. I hereby assign all benefits to which I am entitled for medical expenses related to services rendered, but not to exceed my indebtedness to said provider. It is understood that any money received from the insurance company(ies) over and above my indebtedness will be refunded when the bill is paid in full. I understand that I am financially responsible to Specialty Counseling & Consulting, LLC for charges not covered by this assignment. I further agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable fee should this be required.

**I have read and understand Specialty Counseling & Consulting, LLC's insurance notification.**

Client / Legal Guardian Signature: ______________________________________________

Relation to Client: ______________________________ Date: ____________________

**Self-Pay Fees Notification**

Self-Pay Fees for all of Specialty Counseling & Consulting locations are:

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| | |
|---|---|
| Initial Intake | $200.00 |
| Individual Session 60 minutes | $100.00 |
| Individual Session 45 minutes | $ 75.00 |
| Individual Session 30 minutes | $ 50.00 |

**I have read and understand Specialty Counseling & Consulting, LLC's self-pay fee notification.**

Client / Legal Guardian Signature: ___________________________________________

Relation to Client: ____________________________ Date: ________________

**Special Accommodations Request:**
Clients may request reasonable accommodations necessary to engage in, and benefit from services. In most cases, SCC staff will recognize and address needs for accommodation prior to the individual's request. Requests can be made by the person served or someone acting on their behalf. SCC will provide reasonable accommodations for recognized or reported barriers. This will be done as soon as reasonably possible following recognition or request. Please list below anything that we can do to assist you in fully participating in your program(s):

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

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**A Bill of Rights for Clients**

Title V, Section 501 of the Mental Health Systems Act, 42 U.S.C. 9501, defines in United States law a Bill of Rights for mental health Clients. A person seeking treatment from Specialty Counseling & Consulting, LLC for the purpose of receiving mental health services shall be accorded the following:

- The right to treatment and services under conditions that support the person's personal liberty and restrict such liberty only as necessary to comply with treatment needs, law and judicial orders.
- The right to an individualized, written treatment or service plan (to be developed promptly after admission) regardless of type of mental health or substance abuse disorder, treatment based on the plan, periodic review and assessment of needs, and appropriate revisions of the plan, including a description of services that may be needed after discharge.
- The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the treatment plan, and the right to be provided with a reasonable explanation of all aspects of one's own condition and treatment.
- The right to refuse treatment, except during an emergency, or as permitted under law in the case of a person committed by a court for treatment.
- The right not to participate in experimentation in the absence of the Client's informed, voluntary, written consent; the right to appropriated protections associated with such participation; the right and opportunity to revoke such consent. The right to freedom from restraint or seclusion other than opportunity to revoke such consent. The right to freedom from restraint or seclusion, other than during an emergency.
- The right to a humane environment that affords reasonable protection from harm and appropriate privacy.
- The right to confidentiality of records.
- The right to access, upon request, one's own mental health case records.
- The right (in residential care) to converse with others privately and to have access to the telephone and emails unless denial of access is documented and necessary for treatment.
- The right to be informed promptly, in appropriate language and terms of the rights described in this section.
- The right to assert grievances with respect to infringement of the Bill of Rights, including the right to have such grievances considered in a fair, timely and impartial procedure.
- The right to access protection service and a qualified advocate in order to understand, exercise and protect one's rights.
- The right to exercise the rights described in this section without reprisal, including reprisal in the form of denial of any appropriate, available treatment.
- The right to referral, as appropriate, to other providers of mental health services upon discharge.

**Liability Release Form**

Client Name: ______________________________ DOB: ______________________

I (We) release **Specialty Counseling & Consulting, LLC** from all liability for the above name while client is participating in company approved services including therapy, groups, activities and programs. Such activities may include but are not limited to pro-social activities, participation in sports, going on community outings, and transportation from the client's home, school, office, or other community setting. The client will be accompanied by Specialty Counseling & Consulting staff. If the client has any conditions that require special attention or limits client's participation in such activities (i.e., medical conditions, allergies, food allergies, physical restrictions, etc.), please list those conditions in detail below:

______________________________________________________________________

______________________________________________________________________

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______________________________________________________________________

______________________________________________________________________

**In Case of Emergency Contact:**
Name: ________________________________Relationship: ________________________

Phone #: ________________________________

I (We) understand this Liability Release Form is effective until the client has completed or is discharged from therapy services while under the care of Specialty Counseling & Consulting, LLC.

______________________________________________ ______________________

Client or Representative Signature Date

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## Health History Form

The information requested below will assist us in treating you safely. Please ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless required by law or your written permission is given.

Client Name: ______________________________ DOB: ______________________

Please indicate conditions the client is experiencing or have experienced:

| **Cardiovascular**<br>□ High Blood Pressure<br>□ Low Blood Pressure<br>□ Heart Disease<br>□ Stroke<br>□ Pacemaker/other device<br><br>Is there a family history of any of the above? □ Yes □ No<br><br>**Communicable Infections**<br>□ Hepatitis<br>□ Skin Conditions<br>□ TB<br>□ HIV/AIDS<br>□ Herpes<br>□ Other:<br>____________________ | **Other**<br>□ Migraines<br>□ Sleep Apnea<br>□ Digestive Problems<br>□ Bowel Troubles<br>□ Diabetes<br>□ Thyroid Problems<br>□ Cancer<br>□ Seizures/Epilepsy<br>□ Bone/ Joint Troubles<br>□ Miscarriage or termination of Pregnancy<br>□ Menstrual Problems<br>□ Allergies<br>□ Vision Problems<br>□ Hearing Problems<br>□ Arthritis<br>□ Other:<br>____________________<br>Is there a family history of any of the above? □ Yes □ No | Primary Care Physician:<br>____________________<br><br>Office Number:<br>____________________<br><br>Current Medications:<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ |
|---|---|---|
| **Office Use Only:** If communicable infection is present and client has no primary care physician, appropriate referral was made:<br>□ Yes<br>□ N/A | | |

I have read and understood the above is correct:

______________________________________ ____________________

Client or Representative Signature Date

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## Therapist Disclosure Statement

| Name | Degree | Educational Institution | License & Number | Counseling Orientation | Areas of Expertise |
|---|---|---|---|---|---|
| Robert Logan | Bachelor of Arts, Master of Science, Clinical Psychology | University of Minnesota-Morris<br>Emporia State University - Kansas | LPC-455<br>Licensed Professional Counselor | Cognitive Behavioral Therapy, Family Systems and Short-term Psychodynamic | Substance Abuse, Depression, Anxiety, Anger Management, Child and Adolescent Behavior, Blended Families & Parenting, Divorce & Marital Separation, Couples & Family Conflict, Trauma, Grief & Loss, Attachment & Bonding, Adoption & Foster Care Issues |
| Gary King | Bachelor of Arts, Psychology, Women's studies Master of Science, Counseling, Community Counseling | University of Wyoming | LPC-1227<br>Licensed Professional Counselor | CBT | Substance Abuse Issues |
| Stephanie Keller | Bachelor of Arts: Social Work | Chadron State College | CSW-099<br>Certified Social Worker<br>*Supervised by Robert Logan* | Counsel and support individuals, families, and groups | Child and Adolescent Individual, Family and Groups, Anger Management, Trauma, Attention Deficit Disorders, Sexual Abuse (victim), Foster Care, Depression, Anxiety. |
| Megan Bowman | Bachelor of Social Work<br>Master of Social Work | University of Wyoming<br>Metropolitan State University of Denver | LCSW-1344<br>Licensed Clinical Social Worker | CBT, DBT, solution focused, systems, mindfulness therapy | Children and Families, Adolescents |
| Clay Dokken | Bachelor of Science, Criminal Justice Master of Rehabilitation Counseling | Winona State University<br>Utah State University | LPC-2195<br>Licensed Professional Counselor | Cognitive, Cognitive-Behavioral, Person-Centered. | Youth and Family, Adolescent Development Issues, Anger Management. Anxiety/ADHD/PTSD, Emotional Processing, Developmental Disabilities & working with young folks with Autism |
| Randi Losalu | Bachelor of Arts Psychology<br>Criminal Justice Master of Social Work | University of Wyoming<br>University of North Dakota | WY: LCSW-1316<br>CO: CSW.09927334<br>Licensed Clinical Social Worker | EMDR Therapy, Trauma Play Therapy, Cognitive Behavioral Therapy, Theraplay Therapy, Solution Focused Therapy | Victims of Crime, Trauma, Anxiety, Self-esteem, Children, Youth, Adults, Families, Groups |
| Dawn Marchak | Bachelor of Science in Psychology<br>Master of Arts in Professional Counseling | Dallas Baptist University<br>Liberty University | WY: LPC-1423<br>CO: LPC.0018586<br>Licensed Professional Counselor | Client-Centered Therapy, CBT, Mindfulness | Depression and Anxiety in Teens, LGBTQ Clients, DV Victims. |
| Amy Mavy | Bachelor of Social Work<br>Master of Social Work | University of Wyoming<br>University of New England | LCSW-1321<br>Licensed Clinical Social Worker | Solution-Focused Grief Therapy, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Motivational | Substance Use, Grief, Aging, Anxiety and Depression, Child/Adolescent Issues |

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| | | | | | |
|---|---|---|---|---|---|
| | | | | Interviewing, and Narrative Therapy | |
| Faith McCrory | Bachelor of Social Work | University of Wyoming, Colorado State University, Western Dakota Technical Institute | CSW-297 Certified Social Worker *Supervised by Randi Losalu* | DBT, Motivational Interviewing, CBT, Solution Focused, and Trauma Informed Care | Empowerment, Strengths Based, Disabilities, Anxiety, Borderline Personality Disorder, Relationship Issues, Trauma, Depression, Coping Skills, Boundary Issues |
| Tyler Bartow | Bachelor of Arts, Criminal Justice<br>Master of Arts in Education, Clinical Mental Health Counseling | University of Wyoming<br>Chadron State University | PPC-1251 Provisional Professional Counselor *Supervised by Gary King* | CBT, Solution-Focused, Client Centered | Substance Abuse, Depression, Anxiety Anger Management |
| Douglas Geisner | Bachelor of Social Work | University of Wyoming | PCSW-1115 Provisional Clinical Social Worker *Supervised by Jonna Langston* | Cognitive Behavioral Counsel, Family Systems, Motivational Interviewing, Client-Centered, Trauma-Informed Care, Couples | Youth, Adults, Families, Couples |
| Jonna Langston | Bachelor of Sociology and Human Services<br>Master of Clinical Mental Health | Black Hills State University<br>South Dakota State University | WY: LPC-1756<br>CO: LPC.0017416<br>Licensed Professional Counselor | Trauma Focused-CBT, Cognitive Behavioral Therapy, Client-Centered, Adlerian Theory | Trauma Anxiety, Depression, Adults, PTSD, Veterans, EMDR |
| Kalyn Krotz | Bachelor of Science, Psychology<br>Master of Science, Community Counseling | Chadron State College | LPC-1120 Licensed Professional Counselor | Cognitive Behavioral, Client Centered, Motivational Interviewing, EMDR, Play Therapy, Art Therapy | Substance Abuse, Trauma Reduction, Grief Therapy, Depressions, Anxiety, Adolescent Behavior, Couples & Family Conflict, Anger Management, Group Therapy, Domestic Violence & Sexual Assault |
| Krista West | Bachelor of Social Work | University of Wyoming | CSW-354 Certified Social Worker *Supervised by Kalyn Krotz* | Cognitive Behavioral, Client Centered, Motivational Interviewing, Mindfulness, Group | Youth, Adult, Families, Substance Use, Victim of Abuse, Foster/Adoption, Depression, Anxiety |
| Sarah Washington | Master of Science, Professional Counseling | Grand Canyon University | PPC-1298 Provisional Professional Counselor *Supervised by Robert Logan* | Depression, Anxiety, Crisis, Trauma, Individual and Group Therapies, Children, Adolescents, Adults | Individual and Group Therapies, Children, Adolescents, Adults |
| Eric Williams | Bachelor of Science, Psychology<br>Master of Science, Counseling | Presentation College<br>Northern State University | LPC-2098 Licensed Professional Counselor | Individual Counseling – Children to Geriatrics, Relationship issues, Behavioral, Emotional Regulation, Grief, Loss, Parenting, Sexual Orientation, Trauma | Depression, Anxiety, Trauma, Dialectical Behavioral Therapy |
| Christina Frost | Master of Clinical Social Work<br>Bachelor of Clinical Social Work | Walden University<br>University of Wyoming | WY: PCSW-1021 Provisional Clinical Social Worker *Supervised by Kalyn Krotz* | Client Centered, Systems, Solution Focused, Mindfulness Therapy, CBT, DBT, ACT | Children, Adolescents, Adults, Geriatric, Individuals, Couples and Family |
| | | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| Felicia Dickerson | Bachelor of Social Work, Master of Social Work | University of Wyoming, Boise State University | PCSW-1053 Provisional Clinical Social Worker *Supervised by Jonna Langston* | Mindfulness, CBT, Solution Focused, Narrative Family Therapy | Children and Adolescent Behaviors, Blended and Family Approach, Systems, Trauma Focused |
| Rachel Taylor | Master of Social Work | Walla Walla University | LCSW-1575 Licensed Clinical Social Worker | Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution-Focused | Managing Anxiety, Anger, Depression, Trauma & Grief |
| Dorthea Clark | Master of Arts in Mental Health Counseling | Chadron State college | PPC-1416 Provisional Professional Counselor *Supervised by Gary King* | CBT, DBT, ACT, Solution Focused, Gestalt Therapy, Mindfulness Therapy, Child Directed Play Therapy | Trauma, Domestic Violence, Grief, Anxiety, Adjustment, Depression, Substance Disorder, and Child/Youth Behaviors |
| Rachel Ball | Bachelor of Science Criminal Justice, Master of Science in Mental Health Counseling | Walden University | PPC-1418 Provisional Professional Counselor *Supervised by Gary King* | Addiction, Forensic, Anxiety, Depression, conduct Disorder, Oppositional Defiant Disorder, Emotional Regulation, Behavior Issues | Addiction, Forensic, Anxiety, Depression, conduct Disorder, Oppositional Defiant Disorder, Emotional Regulation, Behavior Issues |
| Tracey Harris | Master of Social Work | University of Denver | LCSW-1608 Licensed Clinical Social Worker | CBT, DBT, Play Based Sand Tray, Animal Assisted Interventions, HARM Reduction | Client Centered, Equine Assisted Psychotherapy, Canine Assisted Therapy, Motivational Interviewing |
| Sierra Duncan | Master of Social Work | Boise State University | PCSW-1145 Provisional Clinical Social Worker *Supervised by Jonna Langston* | CBT and Solutions Focused Therapy | Trauma, Children, Teens, Adults and Families |

The practice of professional counselors, clinical social workers, marriage and family therapists, addictions therapists, social workers and mental health workers in Wyoming is regulated by the **Wyoming Mental Health Professions Licensing Board, Address: 2800 Central Avenue, Cheyenne, WY 82002, Telephone: (307)777-7788.** This disclosure statement is required by the Mental Health Professions Licensing Act. You are entitled to report complaints to the Board, and you cannot be retaliated against for making such complaints. Our therapists attest that they will adhere to the Code of Ethics of their relevant professional association: National Association of Social Workers, American Counseling Association, American Association for Marriage and Family Therapy, or National Association of Alcoholism and Drug Abuse Counselors. To maintain licensure, therapists are required to participate in annual continuing education, taking courses with content relevant to the counseling profession. Counseling relationships are professional in nature. The Board also requires that clients be informed that sexual intimacy between a client and therapist is illegal, unethical, and never appropriate and should be reported to the Board. Clients have the right to ask questions about a counselor's credentials and approach and may accept or reject any suggested counseling intervention. Clients may also request a different counselor. You have the right to confidentiality. Client conversations and records will be maintained in the strictest of confidence, according to all guidelines established by state statutes (W.S. 33-18-113). Confidential information may be disclosed in situations including, but not limited to, the following circumstances:

- Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected.
- The validity of the will of a former client is contested.

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- Information related to counseling is necessary to defend against a malpractice action brought by a client.
- An immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor.
- In the context of civil commitment proceedings, an immediate threat of self-inflicted harm is disclosed to the counselor.
- The client alleges mental or emotional damages in civil litigation or the client's mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation.
- The client is examined pursuant to a court order.
- In the context of investigations and hearings brought by the client and conducted by the Board, violations of this act are an issue.

Information that is deemed to be of a sensitive nature will be inspected by the Board and the Board shall determine whether the information will become part of the record and subject to public disclosure.

**I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.**

________________________________ ________________

Client or Legal Guardian Date

________________________________ ________________

Specialty Counseling & Consulting, LLC Staff Date

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# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING __0__ + ____ + ____ + ____

=Total Score: ____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

K 1-17

# GAD-7 Anxiety

| Over the last two weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid, as if something awful might happen | 0 | 1 | 2 | 3 |

Column totals ____ + ____ + ____ + ____ =

*Total score* ______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

# Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

# C-SSRS Self-Report - Recent

K 1-8

| Please place a check mark in the box for the appropriate answers | In the past Month | |
|---|---|---|
| | YES | NO |
| **Please answer questions 1 and 2** | | |
| **1) Have you wished you were dead or wished you could go to sleep and not wake up?** | | |
| **2) Have you actually had any thoughts of killing yourself?**<br>**If YES, answer all questions 3, 4, 5, and 6.**<br>**If NO, skip directly to question 6.** | | |
| **3) Have you thought about how you might do this?**<br>*(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")* | | |
| **4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them?**<br>*(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")* | | |
| **5) Have you started to work out, or worked out, the specific details of how to kill yourself and did you intend to carry out that plan?**<br>*(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")* | | |
| **6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?**<br>*(For example: took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.)* | | |
| **If YES, did this occur in the past 3 months?** | | |

*Only applies if any history of trauma

# PCL-5

K 149

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

| In the past month, how much were you bothered by: | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | 0 | 1 | 2 | 3 | 4 |
| 8. Trouble remembering important parts of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjoy? | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | 0 | 1 | 2 | 3 | 4 |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16. Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being "superalert" or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

## Specialty Counseling and Consulting, LLC

K 2-1

### CLIENT RIGHTS AND RESPONSIBILITIES

**POLICY: OPS-D.24**
Each client of Specialty Counseling and Consulting, LLC has the right to protection under the Mental Health Services Act 42 USC§9501. Clients must be made aware of their rights surrounding treatment prior to, or during, the first clinical session.

**PROCEDURES:**

1. A client Bill of Rights shall be made available to each client in the intake packet. The client will read and initial their acceptance of their rights. The clinician is responsible for reviewing these rights with the client during the first session. Intake staff are responsible for providing the client with a copy of their signed/dated rights.
2. Client Rights
    a. Clients have the right to impartial access to services, regardless of race, religion, sex, ethnicity, age, disability, or sources of financial support.
    b. Clients have the right to their personal dignity and privacy recognized and respected in the provision of all services.
    c. Clients have the right to receive services without worrying about abuse, financial or other exploitation, retaliation, humiliation, and neglect from staff.
    d. Clients have the right to an individualized plan for their treatment which provides for the least restrictive care that may be expected to benefit them.
    e. Written or verbal communications between clients and staff and the content of clinical records shall be held in confidence by all staff. Confidential information shall only be revealed or releases with the client's informed and written consent, instances of legally reportable child or adult abuse and neglect, client criminal activity on Specialty Counseling and Consulting, LLC premises or against Specialty Counseling and Consulting, LLC staff, and to qualified State and Federal personnel, and to authorized peer reviewers under written oath of confidentiality.
    f. Federal confidentiality rules (45 CFR & 42 CFR Part 2) prevent the use of any information we have obtained to criminally investigate or prosecute any alcohol or drug client. Disclosure of client identifying information is permitted if authorized by a court order, after application showing good cause.
    g. Clients have the right to initiate a grievance and obtain a mechanism for requesting a review of the grievance. Suggestions, complaints, or grievances should be taken to the Owner/Operator of SCC. In the event of a grievance, client will be provided with a copy of SCC Client Grievance and Hearing Policy.
    h. Clients have the right to have access to their own records, except when SCC feels it would not be in the client's best interest.
    i. Clients have the right to access or refer to legal entities for appropriate representation.
    j. Clients have the right to access self-help and advocacy support services.
    k. Clients have the right to be notified under what conditions these rights may be restricted, including criteria for resolution and return to treatment.
    l. Clients have the right to be notified of the purpose or benefit of any type of restriction of rights.

K 2-2

m. Client Responsibilities
   i. To provide true facts about their physical and mental illnesses, medications, and previous treatments.
   ii. To report any changes in their medications or symptoms to their therapist/case manager.
   iii. To ask questions about their care and treatment plan.
   iv. To follow the recommendations/instructions of their therapist/case manager.
   v. To realize that the problems caused by their failure to follow their treatment plan or therapist instructions are their responsibility.
   vi. To be considerate to other staff, visitors, and other clients by respecting their rights and confidentiality.
   vii. To notify their therapist or case manager if they are unable to attend a scheduled appointment as soon as they become aware that they will not be able to attend it.
   viii. To attend and participate in client/family/team planning and review meetings.

K 2-3

## A BILL OF RIGHTS FOR CLIENTS

**POLICY: OPS-D.25**

Federal law includes a Bill of Rights for persons receiving mental health treatment services. Title V, Section 501 of the Mental Health Systems Act, 42 USC§9501 defines in United States law a Bill of Rights for mentally ill clients. A person seeking treatment from SCC for the purposes of receiving mental health services shall be accorded the following:

1. The right to treatment and services under conditions that support the person's personal liberty, and to not restrict such liberty, only as necessary, to comply with treatment needs, law, and judicial orders.
2. The right to an individualized, written treatment or service plan (to be developed promptly after admission) regardless of the type of mental health or substance abuse disorder, treatment based on the plan, periodic review and assessment of needs, and appropriate revisions of the plan, including a description of services that may be needed after discharge.
3. The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the treatment plan, and the right to be provided with a reasonable explanation of all aspects of one's own condition and treatment.
4. The right to refuse treatment, except during an emergency, or as permitted under law in the case of a person committed by a court for treatment.
5. The right not to participate in experimentation in the absence of the client's informed, voluntary, written consent; the right to appropriated protection associated with such participation; and the right and opportunity to revoke such consent. The right to freedom from restraint or seclusion, other than during an emergency.
6. The right to a humane environment that affords reasonable protection from harm, and the right to appropriate privacy.
7. The right to appropriate confidentiality of records.
8. The right to access, upon written request, one's own mental health case records.
9. The right to be informed promptly, in appropriate language and terms, of the rights described in this section.
10. The right to assert grievances with respect to infringement of the Bill of Rights, including the right to have such grievances considered in a fair, timely and impartial procedure.
11. The right to access a protection service and a qualified advocate in order to understand and exercise and protect one's rights.
12. The right to exercise the rights described in this section without reprisal, including reprisal in the form of denial of any appropriate, available treatment.
13. The right of referral, as appropriate, to other providers of mental health services upon discharge.

K 3

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**APP – A.28**
**Discounted Fee/Rate Request**

Specialty Counseling & Consulting, LLC makes reasonable attempts to provide services for clients who are: uninsured, unable to pay regular fees or have a genuine financial hardship.

Please complete the short form below if you are interested in taking advantage of this policy.

| Name: | |
|---|---|
| Address: | |
| Phone Number: | |
| Date of Request: | |
| Type of insurance: | |
| Age of client seeking services: | |
| A brief explanation of the reason(s) for the reduced fee request: | |

Requestor's signature: ______________________________ Date: ________________

**Specialty Counseling and Consulting, LLC** K 4-1

## QUALITY ASSURANCE

**POLICY: OPS-D.14**
Specialty Counseling and Consulting, LLC shall have a Quality Assurance Committee responsible for peer review/utilization review (QA Peer Reviews), all incident reports, and safety procedures review.

**PROCEDURES:**

1. Committee Structure:
    a. The Quality Assurance Committee shall be composed of Specialty Counseling and Consulting, LLC staff and chaired by the Clinical Director and managed by the Executive Director. Committee members include the Leadership Team as well as any staff directed to participate in this committee
    b. The Quality Assurance Committee is under the direct supervision of the Clinical Director or Executive Director and is responsible for the coordination, monitoring, and reporting of committee activities and ensuring that requirements are met.
2. Committee responsibilities:
    a. The committee shall meet at least monthly and review selected client charts for completeness and accuracy.
    b. The committee shall also review all incident reports, emergency drills, and discuss and document all safety concerns.
    c. Newly hired clinical employees are encouraged to be part of the committee as soon as they begin work at SCC.
3. Communication of findings:
    a. For QA peer reviews, the committee members shall complete a Quality Assurance Chart Audit Tool form documenting the findings of each review.
    b. The committee members shall document findings and suggestions from all incident and safety reports on the Critical Incident Analysis sheet.
    c. Findings and statistics from all sessions are compiled by the Quality Assurance Chairperson in the minutes.
    d. Written records of all committee activities are kept, and a minimum include the following:
        i. Date of activity.
        ii. Committee members present and absent.
        iii. The case reviewed, re-reviewed.
        iv. Summary of overall findings.
        v. Recommendations for corrective actions.
    e. Corrective action must be taken by staff when requested by a QA committee representative within 10 days.
4. All quality assurance related documents are the property of SCC and are for internal purposes only. They do not become part of any client's clinical record. All quality assurance documents including incident reports and incident reviews are protected from discovery in civil and criminal investigations if they are turned over to the designated counsel.

K 4-2

APP-A.3

# Specialty Counseling & Consulting Chart Audit Tool

| Name: | DOB: |
|---|---|
| Pay Source: | QA'd by & date: |
| Primary Provider: | |
| Additional Team Members: | |
| | |

| Intake Forms with all signatures | Yes | No | N/A | Comment (including dates) |
|---|---|---|---|---|
| Patient Information (demographics) | | | | |
| Procedures, Privacy Practices & Consent to Treat | | | | |
| Insurance Notification (Financial Policy - Medicare) | | | | |
| Therapist Disclosure Statement (to include therapist present at time) | | | | |
| Liability Release Form | | | | |
| Health History Form | | | | |
| Release(s) of Information | | | | |
| Is there a Telehealth Consent Form if med clinic is being provided? (Patient Forms) | | | | |
| Is there a Medication Management/Psychiatric Contract? (Agreement Med Management) | | | | |
| Intake follow-up; minor client turned 18 signed new paperwork | | | | |

| Intake Assessment | | | | |
|---|---|---|---|---|
| Assessment with clinician and supervisor signatures | | | | |
| Describes specific symptoms, behaviors and functional deficits of MH/SA disorder (Presenting Problem) | | | | |
| No Unspecified Dx as primary; No Spectrum Dx as sole Dx; No Intellecutal Dx as sole or primary. (If completed after 1/2023) | | | | |
| All sections of assessment adequately completed | | | | |
| DSM diagnosis supported (Clinical Summary) | | | | |
| SED/SPMI/LOC/OM data support level of services. | | | | |
| If Substance Abuse primary Dx, Cl referred for evaluation | | | | |
| Updated CDA completed if over a year (Medicaid) | | | | |

| Service Plans | | | | |
|---|---|---|---|---|
| Initial treatment plan within 14 days of the intake | | | | |
| Initial treatment plan signed by client/guardian | | | | |
| Treatment plan updated every 90 days and includes a completed summary. | | | | |
| Are summaries appropriate, not duplicated verbatim? | | | | |
| Subsequent plans signed by client/guardian | | | | |
| Goals & objectives are measurable | | | | |
| Goals & objectives less than a year old | | | | |
| Goals are related to presenting problem(s) and can be tied back to the assessment findings | | | | |
| All services provided have applicable G&O | | | | |

K 4-3

| | | | | |
|---|---|---|---|---|
| All services meet medical necessity criteria w/ appropriately identified LOC completed | | | | |
| Modalities/Interventions Included | | | | |
| Frequency, Time Period, Duration identified for all Modalities & Interventions | | | | |
| If substance dx, are there goals? If not, is it documented that Cl declined services? | | | | |
| Case Management Plan (if applicable) | | | | |
| ROIs indicated in CM Plan | | | | |
| Peer Support/IRS Tab is completed if service is being provided? | | | | |
| SED/SPMI Checklist | | | | |
| LOC Completed | | | | |
| OM Completed | | | | |
| Safety Plan completed if indicated/needed? | | | | |

| Substance Abuse Specific-for any client with any substance use disorder, primary | | | | |
|---|---|---|---|---|
| ASI completed, signed & dated by clinician and supervisor | | | | |
| If outside ASI being used for intake, ASAM documented for initial assessment | | | | |
| If outside ASI being used as intake, it is included in the file | | | | |
| If SA primary diagnosis, ASI/ASAM updated at least every 90 days thereafter | | | | |

| Progress Notes | | | | |
|---|---|---|---|---|
| Notes tie back to specific treatment plan goals | | | | |
| Notes include required DAP elements | | | | |
| Relative Goals and Objectives included | | | | |
| Services billed are billable | | | | |
| Notes are not duplicated | | | | |
| All progress notes written by provisionally licensed therpists and psychotherapy notes by WY CSW must be co-signed by licensed professional. | | | | |
| Dx matches on PNs, assessment & tx plan | | | | |
| If transfer, note completed | | | | |

| Discharge Paperwork | | | | |
|---|---|---|---|---|
| If no documented contact in past 90 days, and client has been seen a minium of 3 times, has client been discharged? | | | | |
| Discharge Summary Completed w/ Supervisor's Signature | | | | |

| Other Notes |
|---|
| |

| Signatures/Review | |
|---|---|
| Date Providers Notified | |
| Date Corrections Completed | |
| Corrections Reviewed by QA Reviewer | |

K5

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## Authorization for Release of Information

Client Name: ______________________________ Birthdate: ______________

Parent/Guardian (if applicable): ______________________________

I hereby authorize ***Specialty Counseling and Consulting*** to Release/Receive information

To/From: ______________________________

Address: ______________________________

Phone#: ______________ Fax #: ______________ Email Address: ______________

**Information to be:** **Released** ☐ **Received** ☐

***Please INITIAL the appropriate requested information below:**

_______ Drug & Alcohol Information and/or Assessment
_______ Psychological Evaluation and/or Testing
_______ Case Consultation/Treatment Progress/Discharge Summary
_______ School Grades/Behavior
_______ Medical Information
_______ Medication History
_______ Court Records/Probation Documents
_______ Other (Verbal exchange of information)

***The purpose of this release of information is to facilitate treatment and coordinate care between providers.***

**I/we understand that my or my child's records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my permission. I also understand that I may revoke my consent for disclosure in writing at any time, except that action has been in reliance on it and that in any event, this consent expires automatically as described below.**

I/we understand this Authorization of Release Form is effective for one year from the date of signature below, or is discharged from therapy services while under the care of the Therapist.

______________________________ ______________________________
Client/Responsible Party Date

______________________________ ______________________________
Specialty Counseling Representative Date

**FEDERAL LAW (42CFR, Part 2) prohibits making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose. Per Substance Abuse requirements Federal Law (45CFR), 160 & 164) also applies.**

**SCC (Cheyenne 1)**
4025 Rawlins Street
Cheyenne, WY 82001-1900
Phone: 307-426-4797 | Fax: 307-426-4799
Randi Losalu, LCSW

K 6-1

| Patient Details | Visit Details | Encounter Details |
|---|---|---|
| **Name:** Test Patient (Female)<br>**DOB:** 06/26/1997 **Age:** 26 Year(s)<br>**MRN:** 0000008639 **e-RIN:** | **Visit Date:** 05/08/2024 | **Encounter Type:** 90791 - Initial Intake (CDA) (60 min) |

## CDA Intro

**Comprehensive Diagnostic Assessment**

**Admission Date:**

**Supervisor:** Gary King

**Reason for Referral:** Diverson

**People Interviewed:** Client

Other here

**Records Reviewed:** Substance Abuse Eval

**Insurance Coverage/Pay Source:** Anthem BCBS of Colorado

**Collateral Contacts:** Diverson contact

**Preferred Gender and Pronouns** he/him

## Presenting Problem

- **Enter presenting problem here to include Why is the client here?**
  **What does the client report as chief complaints/difficulties?**
  **What brought them in now (immediate precipitant)?**
  **What symptoms does the client share (in their own words)?**
  **How are symptoms affecting current functioning?**
  **How long has this been a problem?**
  **What has client tried in the past to resolve these issues?**
  **Not a comprehensive history of issues; these details are spread throughout the CDA**
  **Summary shared by the client about why they are seeking services at this time**

## History

- **History**

### Social, Family & Developmental History

**Marital History:** Divorced

**Family of origin history and upbringing**

.

**Current family and social history**

.

**Living Situation:** Children

**Occupation:** . **Length of time at position:** 6 months

.

### Abuse/Trauma

**Add any information regarding past and present abuse including sexual, physical, verbal, emotional, and domestic violence**

.

**Have you experienced a recent significant loss?** No

.

### Medical and Psychiatric History

| | |
|---|---|
| **Current primary care provider:** | . |
| **Have you seen a doctor in the last year?** | Yes |
| **Have you seen a dentist in the past six months?** | No |
| **Does the client have any medical conditions?** | Yes |

.

| | |
|---|---|
| **Is there any major medical history (surgeries, head injuries, illnesses, diseases, other)?** | Yes |

.

| | |
|---|---|
| **Are you taking any medications?** | No |

.

| | |
|---|---|
| **Do you have a history of psychiatric treatment?** | Yes |

.

| | |
|---|---|
| **Does your family have a history of psychiatric treatment?** | Yes |

.

## Substance Abuse and Addiction History

| | |
|---|---|
| **Do you have a history of substance use?** | Yes |

.

## Legal History:

| | |
|---|---|
| **Do you have a history of legal issues?** | Yes |

.

## Academic History:

**Significant history, accommodations, highest level completed, certificates/special training, other**

.

## Military Service:

| | |
|---|---|
| **Do you have a history of military service?** | No |

.

## Religious or Spiritual Practices

| | |
|---|---|
| **Do you have religious or spiritual practices?** | No |

.

## Cultural and Ethnic History

**Include information regarding cultural and/or ethnic history and values; including gender identity and sexual orientation**

.

**Hobbies and interests**

.

**Coping styles and skills**

.

## Columbia-Suicide Severity Rating Scale

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | | Past month | |
|---|---|---|---|
| **Ask questions that are bolded and underlined.** | | **YES** | **NO** |
| **Ask Questions 1 and 2** | | | |
| **1.** | **Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | ☐ | ☑ |
| **2.** | **Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan.<br>***Have you actually had any thoughts of killing yourself?*** | ☐ | ☑ |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | | |
| **3.** | **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out.<br>*"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."*<br>***Have you been thinking about how you might kill yourself?*** | ☐ | ☐ |
| **4.** | **Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*<br>***Have you had these thoughts and had some intention of acting on them?*** | ☐ | ☐ |
| **5.** | **Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | ☐ | ☐ |
| **6.** | **Suicide Behavior Question:**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>**If YES, ask:** ***How long ago did you do any of these?***<br>☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months? | ☐ | ☐ |
| | | | **Total:** 0 |

| RISK STRATIFICATION | | |
|---|---|---|
| **High Suicide Risk** | **Moderate Suicide Risk** | **Low Suicide Risk** |
| ☐ Answered YES to #1 **and** #2 and any of: | ☐ Answered YES to #1 **or** #2 and any of: | |
| ☐ Answered YES to #3 | ☐ Answered YES to #3 | ☐ Answered No to #1 and |
| ☐ Answered YES to #4 | ☐ Answered YES to #4 | ☐ Answered No to #2 |
| ☐ Answered YES to #5 | ☐ Answered YES to #5 | |
| ☐ Answered YES to #6 | ☐ Answered YES to #6 | |

| RESPONSE | | |
|---|---|---|
| **High Suicide Risk** | **Moderate Suicide Risk** | **Low Suicide Risk** |
| ☐ Transfer to psychiatric facility<br>☐ Document all relevant information in chart<br>☐ Complete environmental factors below | ☐ Initiate Q15 minute observation<br>☐ Develop safety plan<br>☐ Complete environmental factors below<br>☐ Reassess Q12 hours until risk status is considered low or patient is transferred<br>☐ Document all relevant information in chart<br>☐ Schedule Psychiatric Consultation | ☐ Continue Q30 minute observations<br>☐ Reassess as needed<br>☐ Document all relevant information i chart |

Please identify triggers / factors which would increase your suicidal thoughts and / or behaviors.

Please share with us the factors or supports will help decrease your suicidal thoughts and / or behaviors?

| Signature of person completing assessment | Date | Patient Signature | Date |
|---|---|---|---|

**Patient Health Questionnaire (PHQ-9)**

**PHQ-9 Tool:** Adult Depression Screening, Positive Depression Screening

| | **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all (0)** | **Several days (1)** | **More than half the days (2)** | **Nearly every day (3)** |
|---|---|---|---|---|---|
| **1.** | Little interest or pleasure in doing things. | ☐ | ☐ | ☑ | ☐ |
| **2.** | Feeling down, depressed, or hopeless. | ☐ | ☐ | ☑ | ☐ |
| **3.** | Trouble falling/staying asleep, sleeping too much. | ☐ | ☐ | ☑ | ☐ |
| **4.** | Feeling tired or having little energy. | ☐ | ☐ | ☑ | ☐ |
| **5.** | Poor appetite or overeating. | ☐ | ☐ | ☑ | ☐ |
| **6.** | Feeling bad about yourself, or that you are a failure, or have let yourself or your family down. | ☐ | ☐ | ☑ | ☐ |
| **7.** | Trouble concentrating on things, such as reading the newspaper or watching TV. | ☐ | ☐ | ☑ | ☐ |

| | Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|---|
| 8. | Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual. | ☐ | ☐ | ☑ | ☐ |
| 9. | Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☐ | ☑ | ☐ |
| 10. | If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?<br>☐ Not difficult at all<br>☐ Somewhat difficult<br>☑ Very difficult<br>☐ Extremely difficult | | | | |
| | | | **Recorded By:** Losalu, Randi | | **Total: 18/27** |

| Score | Interpretation |
|---|---|
| 18 | Possibly indicates moderately severe risk of depression. Refer to DSM for diagnosis. |

**Generalized Anxiety Disorder 7-item (GAD-7) scale**

| | Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all (0) | Several days (1) | Over half the days (2) | Nearly every day (3) |
|---|---|---|---|---|---|
| 1. | Feeling nervous, anxious, or on edge | ☐ | ☐ | ☑ | ☐ |
| 2. | Not being able to stop or control worrying | ☐ | ☐ | ☑ | ☐ |
| 3. | Worrying too much about different things | ☐ | ☐ | ☑ | ☐ |
| 4. | Trouble relaxing | ☐ | ☐ | ☑ | ☐ |
| 5. | Being so restless that it's hard to sit still | ☐ | ☐ | ☑ | ☐ |
| 6. | Becoming easily annoyed or irritable | ☐ | ☐ | ☑ | ☐ |
| 7. | Feeling afraid as if something awful might happen | ☐ | ☐ | ☑ | ☐ |
| | **Add the score for each column** | **0** | **0** | **14** | **0** |
| | **Recorded By:** Losalu, Randi | | **Total Score (add your column scores) :** 14 | | |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☑ | ☐ |

| Score | Interpretation |
|---|---|
| 14 | Possibly indicates moderate risk of anxiety. Refer to DSM for diagnosis. |

**SPMI**

**Serious and Persistent Mental Illness (SPMI)**

| | | | |
|---|---|---|---|
| Yes | **1. Older than 18 years of age.** | DOB: 06/26/1997 | (If No, mark No on item 7) |
| Yes | **2. DSM-5 diagnosis is in one of the following categories:** | | (If No, mark No on item 7) |
| | Primary Diagnosis: | Secondary Diagnosis: | |
| No | **3. If primary diagnosis is one of the following: intellectual disability, substance abuse or dependence, or neurocognitive disorder, mark No.** | | (If No, mark No on item 7) |
| | **4. Receive SSI or SSDI based on disability for a diagnosed mental disorder.** | | (if yes, mark Yes on item 7) |

**5. Both criteria in 5.a and 5.b apply, or only criteria 5.c at the present time.**

Criteria 5a: Due to the mental Dx in item 2, client is disabled in one of the following ways:

**AND**

Criteria 5b: The disability had been present

**OR**

Criteria 5c

**6. Without treatment or other supports, both criteria 6.a and 6.b or only 6.c would apply.**

Criteria 6a: Due to the mental Dx in Item 2, client is disabled in one of the following ways:

**AND**

Criteria 6b: The disability had been present

**OR**

Criteria 6c

No **7. If the total number of YES responses is 5, client has a Serious and Persistent Mental Illness (SPMI)**

**LOC**

**Level of Care Guidelines**

**(Select all that apply from the drop down)**

**Level 1: Low Level of Care**

**Level II: Moderate Level of Care**

**Level III: High Level of Care**

Medium to High Intensity/Medium to High Chronicity (Over a Year),Moderate to Severe Diagnosis,Yes to SED/SPMI,Multiple Parties or Stakeholders Involved (DFS, Courts/Probation, etc.),Moderate to High Risk of Out-of-Home, School or Community Placement,History of Self-Harm or Violence,Multiple Services Recommended or Needed to for Stability/Safety,Psychiatric Medication(s) Required for Stability and Reduction of Symptoms,Definite Need for Case Management Services Weekly or More

**Level IV: Severe/Intense Level of Care**

**Level Of Care**

III

## MSE & Evaluations

- **Mental Status Exam:**
  - **Risk Assessment**: no suicidal thoughts; no homicidal thoughts
  - **Mood**: euthymic
  - **Appearance**: regular
  - **Presentation**: withdrawn; defensive
  - **Affect**: normal
  - **Attention**: fidgety
  - **Thought Process**: illogical
  - **Thought Content & Perceptions**: lucid
  - **Speech**: normal
  - **Orientation**: A&O times 3: date/time, person, place
  - **Judgment**: normal
  - **Insight**: good

## Clinical Summary

**Comprehensive Clinical Summary**

**Briefly summarize intake data**

Abridgement of the CDA.
A "pulling together" of all the information gathered in the assessment to form a clear rationale (medical necessity) for the diagnosis and course of treatment.
Not simply a list of DSM criteria.
Clinical picture of present functioning within an historical context.

**DSM symptoms and criterion referenced to justify diagnosis**

.

**Risk factors and protective factors**

.

**Client's motivation for change/desired outcomes**

.

**Services needed**

Individual Therapy, Group Therapy, Other

IOP

**Initial Prognosis:**

Guarded

## Diagnosis

- F41.1 - Generalized anxiety disorder (Illness Status: Therapeutically addressing)
- F33.1 - Major depressive disorder, recurrent, moderate (Illness Status: Therapeutically addressing)
- F10.20 - Alcohol use disorder, Moderate (Illness Status: Therapeutically addressing)

## Notes - Individual

**CDA Progress Note:**

**CDA Progress Note**

**Data**

Met with Client at the location: Cheyenne 1

Administered and completed a clinical comprehensive diagnostic assessment. Reviewed professional disclosure agreement and the attendance policy. Obtained biopsychosocial history through clinical interview questions. Reviewed presenting problem and reason for referral. Completed major domains of Medical, Psychiatric, Developmental, Social, Educational, Work, Substance Use, Legal, and Risk history. Conducted outcome measures and formulated diagnosis. Discussed clinically appropriate services, treatment process, and client expectations.

**Assessment/Engagement/Cooperation**

Progress is excellent, completion of Clinical Interview and CDA Report.

K 6-8

**Plan**

Assign therapist and other support staff/services as needed. Establish therapy direction, develop goals, and implement recommendations.

## Plan/Codes

- **Visit & Procedure Codes:**
  - 90791 - PSYCHIATRIC DIAGNOSTIC EVALUATION, Unit(s): 1.00

**SCC (Wheatland)**
975 Gilchrist Street
Wheatland, WY 82201-2931
Phone: 307-322-8122 | Fax: 307-426-4799
Kalyn Krotz, LPC

K 7-1

| Patient Details | Visit Details | Encounter Details |
|---|---|---|
| **Name:** Test Patient (Female)<br>**DOB:** 06/26/1997 **Age:** 26 Year(s)<br>**MRN:** 0000008639 **e-RIN:** | **Visit Date:** 05/03/2024<br>**Primary Payer:** Anthem BCBS of Colorado (1111111111111111) | **Encounter Type:** Service Plan<br>TX PLAN |

**Start Time:** 05/03/2024 11:00 AM **End Time:** 05/03/2024 12:00 PM **Total Time:** 1 hr 0 min

**Diagnosis**

- F41.1 - Generalized anxiety disorder (Illness Status: Therapeutically addressing)
- F33.1 - Major depressive disorder, recurrent, moderate (Illness Status: Therapeutically addressing)
- F10.20 - Alcohol use disorder, Moderate (Illness Status: Therapeutically addressing)
- F43.10 - Post-traumatic stress disorder, unspecified (Illness Status: Medically addressing)

**Client Summary**

**Client Information**

| Clinical Team Members | Role |
|---|---|
| Kalyn Krotz | Individual Therapist, Family Therapist, Case Manager |
| Krista West | Case Coordinator, IRS Social Skills |
| Dr. Alex Padilla | Medication Provider |
| Stephanie Keller | Case Manager |
| Gary King | Group Therapist, Peer Support Specialist, Adult AIOP group |

In the event that provider(s) listed above isn't available, an appropriate substitute will be provided.

Client is at risk of hurting themselves or others Yes If clicked "Yes", complete a Safety Plan

**Review Date and Summary:**

**90 day update: Include date of service plan, types of service, frequency, progress shown/benefits from treatment, why treatment is still required for next 90 days:**

5/3/24
Over the last treatment period client has attended individually based sessions every other week, family sessions every other week, Parenting group weekly, IOP services and IRS social skills weekly. Client receives Peer Support as needed to help with substance use disorders. Case management is available upon request and has been utilized. Client was receiving individual therapy weekly, but this has been extended due to progress.
Client has had 1 cancelation due to illness for individual therapy this treatment period with no no-shows and client has canceled for parenting group 0 times with no no-shows. This is marked improvement for this client as attendance has been an issue HX. Client has improved with SI, however, we will continue to review Safety Planning. Client receives case management as needed. Client receives medication management from this agency and reports compliance with medications. Client reports sleeping better since starting medication but is having a hard time waking up in the morning. These issues are being addressed in medication management. No other SE noted. Client has improved with attendance in parenting group. When client is present she does participate well and is engaged. Client reports she has had no use of alcohol in the past 7 months which is progress for this client. With consistent attendance, client will graduate IOP next month.

Despite progress, client has had some difficulty finding motivation to attend work but reports improvement with attendance overall. Client reports improvement with anxiety in that anxiety episodes have reduced in frequency, duration and severity compared to when client first entered treatment. Client was reporting 2 anxiety episodes which she would rate moderate and would last 20 minutes every day she worked. Client now reports anxiety episodes at a mild to moderate level once a week lasting 5-10 minutes. Client reports improved relations with parents and they are now on speaking terms again. Client continues to work to be able to improve other interpersonal relationships. Client is now able to meet with her sister in person without resorting to verbal violence. We will continue to support this improvement in sessions and work to further reduce symptoms and increase ability to socialize without withdrawal or reactivity to daily stressors. Client is attending IOP and reports she is currently clean from alcohol and other drugs. Client is currently on probation and we are able to meet with her probation officer once a month. Release on file.

**Current diagnosis with symptoms justified by DSM criteria:**

In spite of client progress, there is continued struggle with depressive and anxiety symptoms.
Client has been experiencing both (A1) depressed mood and (A2) loss of interest or pleasure in activities she used to enjoy. This has been recurrent for more days than not for over a year. She continues to have weight fluctuations as she will sometimes lose appetite then feel like binging (A3). With medication, the client is now sleeping through the night and no longer meets criteria for A4 as long as medication is consistent. However, she still reports about once a month in which she will sleep excessively through the day. She also often reports she feels very fatigued (A6). Client reports she can feel restless but struggle to want to move at the same time and "uncomfortable in her own skin" (A5). Client struggles with underlying feelings of worthlessness (A7). Client will experience excessive guilt over her behaviors and determine she is a "terrible girlfriend" then try to leave her boyfriend even though he has worked to be understanding. Client will still express this thought pattern, however, she has not threatened to leave this planning

period. She reports loss of concentration (A8) to the point of struggle with getting DLA's done when she is in a depressive state then becomes overwhelmed with the state of the home. Client has a HX of suicidal ideation (A9) and is also working on trying to not consider this as an option. These symptoms cause the client significant distress and impairment in social, occupational, and other important areas of functioning (B). The symptoms are not the result of substance abuse or another medical condition (C). The symptoms are not better explained by another mental health disorder at this time (D). There has never been manic or hypomanic episode criteria met at this time (E). Client meets DSM5 criteria for Major Depressive Disorder. DX supported by OM's.

Client also reports feelings of worry and anxiety more often than not, almost every day for over a year (A). She relates she knows her worry is excessive but feels like, "I can't make it stop." She relates she becomes very paranoid in public and feels people judge her. She becomes very defensive with doctors or other professional peoples because, "They act like they're better than me and they're not." She reports intrusive thoughts which she struggles to control (B). Client reports feeling restless (C1) and will "move things around just to move them. I'm not actually accomplishing anything." She struggles with concentration at these times (C3) and will forget things she would normally remember or have less capacity for problem solving. Client reports becoming very irritable (C4) and needing less sleep at these times (C6). These symptoms cause the client significant distress and impairment in social, occupational, and other important areas of functioning (D). The symptoms are not the result of substance abuse or another medical condition (E). At this time, the disturbance is not better explained by another mental disorder (F). Client meets DSM5 criteria for Generalized Anxiety Disorder

Client also reports a problematic pattern in her use of alcohol leading to law enforcement involvement and is currently on probation for these charges (A). This has been her use pattern until treatment for over a year. Client reported she has recent HX of drinking more than she intended (A1) and not being able to cut down her drinking when she put efforts into stopping (A2). Client felt guilty about the amount of time she was either at the bar or working to "cover" her drinking (A3). Client continued to use despite having recurrent interpersonal disruptions caused by her drinking and almost lost her relationship with her boyfriend (A6). Client has only been able to maintain complete sobriety for a month. Client is not currently in a controlled environment. We will review at her next update for "early remission" status. Client meets DSM-5 criteria for Alcohol Use Disorder Moderate.

**Goals and objectives reviewed/updated:**

Client was involved in treatment planning and agreed to goals and objectives. Treatment planning was done over Google Meet and client agreed to a digital signature. Goals and objectives were updated to reflect progress and continued challenge. Goal added for improved sleep at last update. Client reports improvement with this goal and it has now been achieved.

**LOC and SED/SPMI reviewed/updated:**

Client meets criteria for SPMI at this time. Client engages well with LOC III services. SPMI and LOC have been reviewed and will be continued. When the client graduates from IOP, LOC II will be considered.

**Outcome measures and results:**

Client completed OM's. Client score on the PHQ-9 (10 improved from 14) indicates a moderate risk of depression. Client scores on the GAD-7 (Score : 11) Possibly indicates moderate risk of anxiety. Client scores on the C-SSRS indicate a high risk for suicide. Client has completed a safety plan.

**Recommended services for next 90 days:**

Client to engage in individually based therapy every other week, group therapy weekly, family therapy every other week, IRS services weekly, case management and Peer Support as needed and medication management as needed to achieve goals and reduce symptoms of depression and anxiety. Offer assistance as needed.

| **Last completed CDA Date:** | 08/01/2022 | **Is an annual CDA update needed (for Medicaid)?** | No |
|---|---|---|---|

**Statement of prognosis:** Good

I certify that the services outline in this treatment/services plan are therapeutically essential for the reduction of mental health and/or substance abuse/dependence disabilities.

## Presenting Problem

- **Anxiety- Client reports feelings of anxiety when she is in public as she feels she is being judged. She also becomes anxious at home and struggles with feelings of restlessness, irritability, rumination and sleep disturbances.** (reported by patient) Onset: more than 1 year, Onset when parents divorced at 16 Timing: chronic, episodic Context: occurs at work, after emotional trauma, occurs at home, marital problems, Client escalates when she sees her ex Alleviating factors: exercise, support person, relieved spontaneously, using prescription drugs, feel better at night, one-on-one counseling, activity Aggravating factors: conflict w/ family, being alone, stressors at home, stressors at work, social situations, Holidays Severity: moderate Pertinent Past Psychiatric History: depression, anxiety disorder, Client's mother was DX with Anxiety. Client was DX with Depression at 16. Associated Signs and Symptoms: Feeling Sad, Mood Swings, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Codependency, Depression, Suicidal Ideation, Sleep Disturbance, Low Energy/Fatigue, Loss of Appetite, Loss of Weight
- **Depression- Client reports excessive feelings of worthlessness and feels at times her loved ones would be**

**better off without her. She will struggle with fatigue and will want to sleep through the day.** (reported by patient) Onset: more than 1 year, Onset when parents divorced at 16 Timing: episodic Context: occurs at work, after emotional trauma, admits suicidal thoughts, occurs at home, marital problems Alleviating factors: exercise, support person, one-on-one counseling, relieved spontaneously, spring/summer season, using prescription drugs, activity Aggravating factors: conflict w/ family, being alone, being in enclosed spaces, stressors at home, stressors at work, social situations, winter season, Going to visit family Severity: mild, moderate Pertinent Past Psychiatric History: depression, anxiety disorder Associated Signs and Symptoms: Feeling Sad, Mood Swings, Angry all the Time, Irritability, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Memory Complaints, Codependency, Depression, Suicidal Ideation, Sleep Disturbance, Anxiousness/Stress, Low Energy/Fatigue, Stomachaches Have you experienced Fatigue or Loss of Energy: yes, Client will feel like she cannot get through her day without a nap.

- **Substance Use/Abuse- Client struggles with alcohol use and uses excessively. Client is on probation for DWUI.** (reported by patient's mother, self) Onset: more than 1 year Timing: intermittent, Client has been sober for a month. Context: alcohol use Aggravating factors: conflict w/ family Severity: Felt need to cut down on drinking/use?, Have people annoyed you by criticizing your drinking/use? Pertinent Past Psychiatric History: depression Associated Signs and Symptoms: Mood Swings
- **Trauma** (reported by patient)
- **PTSD** (reported by patient) Onset: 2 months ago, Auto Accident Timing: sudden onset Context: emergent situation, occurs at work, after emotional trauma, occurs at home, It was scary Alleviating factors: support person, avoiding confrontation, feel better in morning, one-on-one counseling, group therapy Aggravating factors: conflict w/ family, driving, stressors at home, stressors at work Severity: moderate Pertinent Past Psychiatric History: depression, anxiety disorder Associated Signs and Symptoms: Feeling Sad, Mood Swings, Irritability, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Trauma / Abuse, Chronic Pain, Depression, Panic Symptoms, Suicidal Ideation, Anxiousness / Stress, Loss of Appetite

## Goals & Objectives

- **Therapy**
  - **Goals & Objectives** (Next Review Date: 08/01/2024)
    - **Med Management** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
      - **Goals 1:** Maintain regular medication compliance to help control physical and/or psychological symptoms. [Date Started: 10/24/2023]
      - **Objectives 1:** Assess the effectiveness of medications and any side effects. [Date Started: 10/24/2023] [Progress: Added objective ]
      - **Objectives 2:** Client will administer medications as prescribed and will be encourage to make self-observations of the positive and negative effects of the medication. [Date Started: 10/24/2023] [Progress: Added objective ]
      - **Objectives 3:** Client will safely and appropriately use medications as well as understand potential side effects. [Date Started: 10/24/2023] [Progress: Added Objective]
      - **Objectives 4:** Maintain regular medication compliance to help control physical and/or psychological symptoms. [Date Started: 10/24/2023]
      - **Modalities & Interventions 1:**
        Medication Management [Frequency: Three times, Time Period: Per month, Duration: 3 months]
    - **Individual Rehabilitation Services IRS** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
      - **Goals 1:** Assist client in acquisition of social skills necessary for age appropriate social functioning. [Date Started: 01/22/2024] [Progress: Added goal ]
      - **Goals 2:** IRS to help client find sustainable empllyment [Date Started: 01/22/2024] [Progress: Added goal ]
      - **Objectives 1:** Individual Rehabilitation Services (IRS) plan to be completed with client/family and case coordinator for clarity clients individual needs to improve their age appropriate social functioning and skills to enhance success in all areas of daily activities. [Date Started: 01/22/2024] [Progress: Added objective ]
      - **Objectives 2:** Client to gain labor skills [Date Started: 01/22/2024] [Progress: Added objective ]
      - **Modalities & Interventions 1:**
        IRS Services [Frequency: Four times, Time Period: Per month, Duration: 3 months]
    - **Anxiety (mental health disorder - adult)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
      - **Goals 1:** Reduce overall frequency, intensity, and duration of the anxiety symptoms so that daily functioning is improved. [Date Started: 02/05/2024] [Progress: Added goal ]
      - **Objectives 1:** Demonstrate an increased understanding of anxious feelings and their causes. [Date Started: 02/05/2024] [Progress: Added objective ]
      - **Objectives 2:** Describe current and past experiences with specific fears, prominent worries, and anxiety symptoms including their impact on functioning and attempts to resolve it. [Date Started: 02/05/2024] [Progress: Added objective]
      - **Modalities & Interventions 1:**
        Individual Therapy, MI, CBT [Frequency: Three times, Time Period: Per month, Duration: 3 months]
      - **Patient Stated Goal(s) 1:** "I want to be able to go grocery shopping without leaving my cart." [Date Started: 05/03/2024]
    - **Blended Family Issues (relationship problem)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)

- **Goals 1:** Attain a level of peaceful coexistence whereby daily issues can be negotiated without becoming ongoing conflicts. [Date Started: 05/03/2024]
  - **Objectives 1:** Family members report the development of a bond between each member. [Date Started: 05/03/2024]
- **Objectives 1:** Work to establish new family roles and what that means for each member. [Date Started: 05/03/2024]
- **Modalities & Interventions 1:**
  Family Therapy [Frequency: Two times, Time Period: Per month, Duration: 3 months]

- **Depression (mental health disorder - adult)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Reduce frequency, intensity, and duration of the depression so that daily functioning is improved. [Date Started: 03/28/2024]
  - **Goals 2:** Resolve the underlying issues that contribute to the depression. [Date Started: 03/28/2024]
  - **Objectives 1:** Increased communicativeness [Date Started: 03/28/2024]
  - **Objectives 2:** Increased energy level [Date Started: 03/28/2024]
  - **Objectives 3:** Increase the frequency of assertive behaviors to express needs, desires, and expectations. [Date Started: 03/28/2024]
  - **Objectives 4:** Keep a daily journal of experiences, thoughts, and feelings to clarify instances of distorted negative thinking or perception that precipitate depressive emotions. [Date Started: 03/28/2024]
  - **Patient Stated Goal(s) 1:** I don't just want to survive the day. I want to feel like my old self. [Date Started: 03/28/2024]
- **Alcohol Use Disorder (substance abuse)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Client to graduate IOP [Date Started: 05/03/2024]
    - **Objectives 1:** Get an AA or NA sponsor. [Date Started: 05/03/2024]
  - **Modalities & Interventions 1:**
    Individual Therapy, Group Therapy, IOP [Frequency: Four times, Time Period: Per week, Duration: 3 months]
  - **Patient Stated Goal(s) 1:** I want to stop drinking. I want to feel like I've got my life under control. [Date Started: 08/18/2022] [Progress: Some improvement ]
- **Peer Support** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Assist client to improve recovery skills to reduce the risk and need for relapse and/or need for increased services. [Date Started: 11/16/2022] [Progress: Some improvement ]
  - **Objectives 1:** Peer support plan to be completed with client/family and case coordinator for clarity clients individual needs to improve their quality of life. [Date Started: 11/16/2022] [Progress: Some improvement ]
  - **Modalities & Interventions 1:**
    Peer Support [Frequency: Two times, Time Period: Per month, Duration: 3 months]
- **Med Management** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Maintain regular medication compliance to help control physical and/or psychological symptoms. [Date Started: 07/26/2023] [Progress: Some improvement ]
  - **Objectives 1:** Client will safely and appropriately use medications as well as understand potential side effects. [Date Started: 07/26/2023] [Progress: Some improvement ]
  - **Objectives 2:** Client will administer medications as prescribed and will be encourage to make self-observations of the positive and negative effects of the medication. [Date Started: 07/26/2023] [Progress: Some improvement ]
  - **Modalities & Interventions 1:**
    Med Management [Frequency: Two times, Time Period: Per month, Duration: 3 months]
- **Depression (mental health disorder - adult)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Appropriately grieve the loss in order to normalize mood and to return to previous adaptive level of functioning. [Date Started: 11/16/2022] [Progress: Added goal ]
  - **Objectives 1:** Keep a daily journal of experiences, thoughts, and feelings to clarify instances of distorted negative thinking or perception that precipitate depressive emotions. [Date Started: 11/16/2022] [Progress: Added Objective]
  - **Modalities & Interventions 1:**
    Individual Therapy, Family Threapy [Frequency: Four times, Time Period: Per month, Duration: 3 months]
- **Case Management** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Client will acquire and display the knowledge and skills required to effectively attend to DLAs. [Date Started: 11/16/2023]
  - **Objectives 1:** Complete a comprehensive case management plan supporting client's specific interpersonal needs. [Date Started: 11/16/2023]
  - **Objectives 2:** Providers will monitor with clients or families, link and advocate with outside team supports, and provide referrals and crisis intervention as necessary. [Date Started: 11/16/2023]
  - **Modalities & Interventions 1:**

Case Management [Frequency: Four times, Time Period: Per month, Duration: 3 months]

- **Anger Management (mental health disorder - adult)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
  - **Goals 1:** Client will eliminate physical and verbal aggression in public [Date Started: 11/16/2022] [Progress: Some improvement ]
  - **Objectives 1:** Client to gain empathy for grocery employees [Date Started: 11/16/2022] [Progress: Some improvement ]
  - **Modalities & Interventions 1:**
    Individual Therapy, Stress Management, Community Interaction [Frequency: Two times, Time Period: Per week, Duration: 3 months]

## Safety Plan

**Safety Plan**

Client struggles with suicidal ideation when she becomes overwhelmed and in a depressive state. Client does not currently have a plan and related she currently has no intentions of harming herself, however, she has admitted to thoughts of death and thinking that her loved ones would be better off without her.

**3 – 5 Triggers & Coping Skills I Can Utilize**

| Trigger (people, places, situations) | Coping skills and healthy distractions |
|---|---|
| Feeling worthless | journaling about the feelings and bringing it to therapy, call support if needed |
| Overwhelm with DLA's | looking at priority list and only doing what has to be done that day and allowing the rest to wait, call support if needed |

**Warning signs when things are starting to get out of control**

| | |
|---|---|
| Thoughts | My loved ones would be better off without me |
| Feelings | overwhelm, worthlessness, excessive anxiety, fatigue |
| Behaviors | yelling, wanting to leave, leaving the home upset, isolation |
| Symptoms | racing heart, tearfulness, headache, nausea |

**3 – 5 Personal Contacts I Can Ask For Help (friends, family, etc.)**

| Name: | Phone Number |
|---|---|
| Boyfriend- Exam Client | 3075555555 |
| Mother- Inventory Customer | 3074444444 |

**3 – 5 Professional References I Can Ask For Help**

| Name: | Phone Number |
|---|---|
| Therapist- Kalyn Krotz | 3073228122 |
| Case Coordinator- Krista West | 3073228122 |
| Suicide Hotline | 18002738255 |

| | |
|---|---|
| 988 Suicide & Crisis Lifeline - 24/7, free & confidential support; call, text, chat. | 988 |
| Crisis Text Line - 24/7 text connection with a volunteer crisis counselor | Text HOME to 741741 |

**The one thing that is most important to me and worth living for is:**

"Being here for my boys."

• In order to keep myself safe, I will remove or safely store things I could use to hurt myself (firearms, medications, household poisons, sharp or other dangerous objects).

• If I still feel suicidal and/or out of control, I will go to the nearest hospital emergency department or call 911.

## Case Management Plan

**Case Management Plan**

Family and Community Team Members

(Do not list SCC employees)

| Name: | Role or Agency: | ROI: |
|---|---|---|
| Samantha Twiford | Project Safe | Yes- 8/26/23 |
| Tanda Hicks | Medical Provider | Yes- 7/26/23 |
| Jenny Webb | Probation Officer | Yes- 10/24/23 |

| | | |
|---|---|---|
| Receiving SSI/SSDI? | No | |
| Receiving IEP Services? | No | |
| Psych Eval Needed? | No | |
| High Fidelity Wrap Services? | No | |
| Medication Provider? | Yes | Tanda Hicks, Dr. Alex Padilla |

**Staff will provide monitoring, linkage, advocacy, crisis intervention, and referral in the following area(s):**

Family/Parental Supports, Safety Issues , Daily Living Activities , Medical/Physical Issues , Housing , Transportation , Recreation , Social Development , Employment , Support Services , Peer Support

**CM Plan Details:**

Monitor, link, advocate, support and refer client for family, safety issues, daily living, medical/physical issues, housing and social development. Client struggles with interpersonal relationships and proper consistent boundaries. Client struggles with making phone calls without getting angry or upset. Client requires an advocate in scheduling medical appointments or requesting medications per the clinic. They have requested the ct not attend any appointment without someone else there to help her maintain.

**Peer Support Plan**

**Peer Support Information Sheet**

| | | | |
|---|---|---|---|
| **Client Name** | Test Patient | **Case Coordinator** | Krista West |
| **Therapist(s)** | Kalyn Krotz | | |
| **Parent/Guardian** | Inventory Customer | **Phone Number** | 307-444-4444 |
| **Contact Info** | 3073333333 | **Email address** | test.patient@madeupurl.com |

**Peer Support needing to be worked on: (please select)**

- ☐ Alcohol Issues
- ☑ Mental Health
- ☑ Housing Issues
- ☑ Medical Issues
- ☐ School Issues
- ☑ Social Development
- ☐ Sexual Development
- ☑ Coping Skills
- ☐ Wellness Recovery Action Plan
- ☐ Dealing With Group/Peer Pressure
- ☑ Making A Decision
- ☑ Time Management
- ☑ Other
- ☐ Drug Issues
- ☐ Legal Issues
- ☑ Transportation Issues
- ☑ Physical Concerns
- ☑ Recreations
- ☑ Developmental Issues
- ☑ Employment
- ☑ Mental Health First Aid
- ☑ Wellness, Health Action Management
- ☐ Dealing With Wanting Something That Isn't Mine
- ☐ Being Honest
- ☐ Organization Skills

SI

**IRS Plan**

**Independent Rehabilitation Services**

| | | | |
|---|---|---|---|
| **Client Name** | Test Patient | **Case Coordinator** | Krista West |
| **Therapist(s)** | Kalyn Krotz | | |
| **Parent/Guardian** | Inventory Customer- mother | **Phone Number** | 307 4444444 |
| **Email address** | test.patient@madeupurl.com | | |

**Social Skills needing to be worked on: (please select)**

- ☐ Following Instructions
- ☑ Accepting "No" Answers
- ☑ Disagreeing With Others
- ☐ Asking Permission
- ☑ Apologizing
- ☑ Giving Compliments
- ☑ Listening To Others
- ☑ Introducing Yourself
- ☑ Saying Thank You
- ☑ Ignoring Distraction
- ☑ Setting and Maintaining Boundaries
- ☑ Expressing Your Feelings
- ☑ Expressing Concern For Another
- ☑ Dealing With Another's Anger
- ☑ Dealing With Fear
- ☐ Responding To Teasing
- ☐ Staying Out Of Fights
- ☑ Accepting Consequences
- ☐ Negotiating
- ☐ Showing Sportsmanship
- ☑ Dealing With Embarrassment
- ☐ Saying No
- ☑ Dealing With Group/Peer Pressure
- ☑ Making A Decision
- ☐ Time Management
- ☐ Other
- ☑ Accepting Criticism
- ☑ Staying Calm
- ☐ Asking For Help
- ☑ Getting Along With Others
- ☑ Conversation Skills
- ☐ Accepting Compliments
- ☑ Telling The Truth
- ☑ Showing Sensitivity To Others
- ☑ Asking A Question
- ☐ Sharing
- ☑ Knowing Your Feelings
- ☑ Recognizing Another's Feelings
- ☑ Dealing with Anger
- ☑ Expressing Affection
- ☑ Using Self-Control
- ☑ Avoiding Trouble
- ☑ Problem Solving
- ☑ Dealing With An Accusation
- ☐ Dealing With Losing
- ☐ Dealing With Feeling Left Out
- ☑ Reacting To Failure
- ☑ Relaxing
- ☐ Dealing With Wanting Something That Isn't Mine
- ☐ Being Honest
- ☑ Organization Skills

**SPMI**

**Severe and Persistent Mental Illness (SPMI)**

| | | | |
|---|---|---|---|
| Yes | **1. Older than 18 years of age.** | DOB: 06/26/1997 | (If No, mark No on item 7) |
| Yes | **2. DSM-5 diagnosis is in one of the following categories:** | | (If No, mark No on item 7) |
| | Primary Diagnosis: F33.1 | Secondary Diagnosis: | F41.1 |
| | b. Major Depressive or Bi-Polar Dx, c. Anxiety Dx, personality Dx, or a combination of personality disorders | | |
| Yes | **3. If primary diagnosis is one of the following: intellectual disability, substance abuse or dependence, or neurocognitive disorder, mark No.** | | (If No, mark No on item 7) |
| No | **4. Receive SSI or SSDI based on disability for a diagnosed mental disorder.** | | (if yes, mark Yes on item 7) |
| Yes | **5. Both criteria in 5.a and 5.b apply, or only criteria 5.c at the present time.** | | |

Criteria 5a: Due to the mental Dx in item 2, client is disabled in one of the following ways:

ii. Inability to perform activities of daily living

**AND**

Criteria 5b: The disability had been present

ii. Episodically at least a year

**OR**

Criteria 5c

Yes **6. Without treatment or other supports, both criteria 6.a and 6.b or only 6.c would apply.**

Criteria 6a: Due to the mental Dx in Item 2, client is disabled in one of the following ways:

ii. Inability to perform activities of daily living

**AND**

Criteria 6b: The disability had been present

ii. Episodically at least a year

**OR**

Criteria 6c

Yes **7. If the total number of YES responses is 5, client has a Serious and Persistent Mental Illness (SPMI)**

## LOC

**Level of Care Guidelines**

**(Select all that apply from the drop down)**

### Level 1: Low Level of Care

### Level II: Moderate Level of Care

Moderate Severity Diagnosis,Some Risk of Out-of-Home, School or Community Placement,Some Risk of Self-Harm or Recent Violence,Multiple Services Recommended or In Place,Need for Case Management Services at Least 1x per Week

### Level III: High Level of Care

Medium to High Intensity/Medium to High Chronicity (Over a Year),Yes to SED/SPMI,Psychiatric Medication(s) Required for Stability and Reduction of Symptoms

### Level IV: Severe/Intense Level of Care

**Level Of Care**

III

## Columbia-Suicide Severity Rating Scale

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | | Past month | |
|---|---|---|---|
| **Ask questions that are bolded and underlined.** | | **YES** | **NO** |
| **Ask Questions 1 and 2** | | | |
| **1.** | **Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | ☐ | ☑ |

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | | Past month | |
|---|---|---|---|
| **Ask questions that are bolded and underlined.** | | **YES** | **NO** |
| **2.** | **Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan.<br>***Have you actually had any thoughts of killing yourself?*** | ☐ | ☑ |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | | |
| **3.** | **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out.<br>*"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."*<br>***Have you been thinking about how you might kill yourself?*** | ☐ | ☑ |
| **4.** | **Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*<br>***Have you had these thoughts and had some intention of acting on them?*** | ☐ | ☑ |
| **5.** | **Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | ☐ | ☑ |
| **6.** | **Suicide Behavior Question:**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>**If YES, ask:** ***How long ago did you do any of these?***<br>☐ Over a year ago? ☐ Between three months and a year ago? ☑ Within the last three months? | ☑ | ☐ |
| | | | **Total:** 1 |

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | | Since Last Visit | |
|---|---|---|---|
| **Ask questions that are bold and underlined.** | | **YES** | **NO** |
| **Ask Questions 1 and 2** | | | |
| **1.** | **Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | ☐ | ☑ |
| **2.** | **Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan.<br>***Have you actually had any thoughts of killing yourself?*** | ☐ | ☑ |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | | |
| **3.** | **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out.<br>*"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."*<br>***Have you been thinking about how you might kill yourself?*** | ☐ | ☑ |

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | | Since Last Visit | |
|---|---|---|---|
| Ask questions that are bold and underlined. | | YES | NO |
| Ask Questions 1 and 2 | | | |
| 4. | **Suicidal Intent (without Specific Plan):** Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** | ☐ | ☑ |
| 5. | **Suicide Intent with Specific Plan:** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?*** | ☐ | ☑ |
| 6. | **Suicide Behavior** ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | ☑ | ☐ |
| | **Recorded By:** Krotz, Kalyn | | **Total:** 1 |

| RISK STRATIFICATION | | |
|---|---|---|
| **High Suicide Risk** | **Moderate Suicide Risk** | **Low Suicide Risk** |
| ☐ Answered YES to #1 **and** #2 and any of:<br>☐ Answered YES to #3<br>☐ Answered YES to #4<br>☐ Answered YES to #5<br>☐ Answered YES to #6 | ☐ Answered YES to #1 **or** #2 and any of:<br>☐Answered YES to #3<br>☐ Answered YES to #4<br>☐ Answered YES to #5<br>☑ Answered YES to #6 | ☑ Answered No to #1 and<br>☑Answered No to #2 |
| **RESPONSE** | | |
| **High Suicide Risk** | **Moderate Suicide Risk** | **Low Suicide Risk** |
| ☐ Transfer to psychiatric facility<br>☐ Document all relevant information in chart<br>☐ Complete environmental factors below | ☐Initiate Q15 minute observation<br>☑Develop safety plan<br>☐ Complete environmental factors below<br>☐ Reassess Q12 hours until risk status is considered low or patient is transferred<br>☐ Document all relevant information in chart<br>☐ Schedule Psychiatric Consultation | ☐ Continue Q30 minute observations<br>☑Reassess as needed<br>☑Document all relevant information in chart |

Please identify triggers / factors which would increase your suicidal thoughts and / or behaviors.
Please see Safety Plan.

Please share with us the factors or supports will help decrease your suicidal thoughts and / or behaviors?

| Signature of person completing assessment | Date | Patient Signature | Date |
|---|---|---|---|
| Kalyn Krotz | 05/07/2024 | Test | 05/07/2024 |

**Patient Health Questionnaire (PHQ-9)**

**PHQ-9 Tool:** Adult Depression Screening, Positive Depression Screening

| | Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|---|
| 1. | Little interest or pleasure in doing things. | ☐ | ☐ | ☑ | ☐ |
| 2. | Feeling down, depressed, or hopeless. | ☐ | ☑ | ☐ | ☐ |
| 3. | Trouble falling/staying asleep, sleeping too much. | ☐ | ☑ | ☐ | ☐ |
| 4. | Feeling tired or having little energy. | ☐ | ☑ | ☐ | ☐ |
| 5. | Poor appetite or overeating. | ☐ | ☑ | ☐ | ☐ |
| 6. | Feeling bad about yourself, or that you are a failure, or have let yourself or your family down. | ☐ | ☑ | ☐ | ☐ |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching TV. | ☐ | ☑ | ☐ | ☐ |
| 8. | Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual. | ☐ | ☑ | ☐ | ☐ |
| 9. | Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☑ | ☐ | ☐ |
| 10. | If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?<br>☐ Not difficult at all<br>☑ Somewhat difficult<br>☐ Very difficult<br>☐ Extremely difficult | | | | |

**Recorded By:** Krotz, Kalyn **Total: 10/27**

| Score | Interpretation |
|---|---|
| 10 | Possibly indicates moderate risk of depression. Refer to DSM for diagnosis. |

**Signature**

**Signature:**

Test P.

**Relation:** Self

Kalyn Krotz

Electronically Signed by Kalyn Krotz, LPC

**SCC (Cheyenne 1)**
4025 Rawlins Street
Cheyenne, WY 82001-1900
Phone: 307-426-4797 | Fax: 307-426-4799
Randi Losalu, LCSW

K-8-1

**Patient Details**

**Name:** Test Patient (Female)
**DOB:** 06/26/1997 **Age:** 26 Year(s)
**MRN:** 0000008639 **e-RIN:**

**Visit Details**

**Visit Date:** 05/08/2024
**Primary Payer:** Anthem BCBS of Colorado (1111111111111111)

**Encounter Details**

**Encounter Type:** Discharge Summary

## Diagnosis

- F41.1 - Generalized anxiety disorder (Illness Status: Therapeutically addressing)
- F33.1 - Major depressive disorder, recurrent, moderate (Illness Status: Therapeutically addressing)
- F10.20 - Alcohol use disorder, Moderate (Illness Status: Therapeutically addressing)

## Presenting Problem

- **Anxiety- Client reports feelings of anxiety when she is in public as she feels she is being judged. She also becomes anxious at home and struggles with feelings of restlessness, irritability, rumination and sleep disturbances.** (reported by patient) Onset: more than 1 year, Onset when parents divorced at 16 Timing: chronic, episodic Context: occurs at work, after emotional trauma, occurs at home, marital problems, Client escalates when she sees her ex Alleviating factors: exercise, support person, relieved spontaneously, using prescription drugs, feel better at night, one-on-one counseling, activity Aggravating factors: conflict w/ family, being alone, stressors at home, stressors at work, social situations, Holidays Severity: moderate Pertinent Past Psychiatric History: depression, anxiety disorder, Client's mother was DX with Anxiety. Client was DX with Depression at 16. Associated Signs and Symptoms: Feeling Sad, Mood Swings, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Codependency, Depression, Suicidal Ideation, Sleep Disturbance, Low Energy/Fatigue, Loss of Appetite, Loss of Weight
- **Depression- Client reports excessive feelings of worthlessness and feels at times her loved ones would be better off without her. She will struggle with fatigue and will want to sleep through the day.** (reported by patient) Onset: more than 1 year, Onset when parents divorced at 16 Timing: episodic Context: occurs at work, after emotional trauma, admits suicidal thoughts, occurs at home, marital problems Alleviating factors: exercise, support person, one-on-one counseling, relieved spontaneously, spring/summer season, using prescription drugs, activity Aggravating factors: conflict w/ family, being alone, being in enclosed spaces, stressors at home, stressors at work, social situations, winter season, Going to visit family Severity: mild, moderate Pertinent Past Psychiatric History: depression, anxiety disorder Associated Signs and Symptoms: Feeling Sad, Mood Swings, Angry all the Time, Irritability, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Memory Complaints, Codependency, Depression, Suicidal Ideation, Sleep Disturbance, Anxiousness/Stress, Low Energy/Fatigue, Stomachaches Have you experienced Fatigue or Loss of Energy: yes, Client will feel like she cannot get through her day without a nap.
- **Substance Use/Abuse- Client struggles with alcohol use and uses excessively. Client is on probation for DWUI.** (reported by patient's mother, self) Onset: more than 1 year Timing: intermittent, Client has been sober for a month. Context: alcohol use Aggravating factors: conflict w/ family Severity: Felt need to cut down on drinking/use?, Have people annoyed you by criticizing your drinking/use? Pertinent Past Psychiatric History: depression Associated Signs and Symptoms: Mood Swings
- **Trauma** (reported by patient)
- **PTSD** (reported by patient) Onset: 2 months ago, Auto Accident Timing: sudden onset Context: emergent situation, occurs at work, after emotional trauma, occurs at home, It was scary Alleviating factors: support person, avoiding confrontation, feel better in morning, one-on-one counseling, group therapy Aggravating factors: conflict w/ family, driving, stressors at home, stressors at work Severity: moderate Pertinent Past Psychiatric History: depression, anxiety disorder Associated Signs and Symptoms: Feeling Sad, Mood Swings, Irritability, Feeling Hopeless, Physical Complaints, Cognitive Complaints, Trauma / Abuse, Chronic Pain, Depression, Panic Symptoms, Suicidal Ideation, Anxiousness / Stress, Loss of Appetite

## Goals & Objectives

- **Goals & Objectives**
  - **Alcohol Use Disorder (substance abuse)** (Last Review Date: 05/03/2024, Next Review Date: 08/01/2024)
    - **Goals 1:** Client to graduate IOP [Date Started: 05/03/2024]
      - **Objectives 1:** Get an AA or NA sponsor. [Date Started: 05/03/2024]
    - **Modalities & Interventions 1:**
      Individual Therapy, Group Therapy, IOP [Frequency: Four times, Time Period: Per week, Duration: 3 months]
    - **Patient Stated Goal(s) 1:** I want to stop drinking. I want to feel like I've got my life under control. [Date Started: 08/18/2022] [Progress: Some improvement ]

## Discharge Summary

**Discharge Summary**

**Reason for Discharge:** Treatment goals reached

Client Notified of Discharge: Yes

Client Provided with Referral Sources and/or Instructions on Resuming Treatment: Yes

Team members and their roles throughout Client's service:

.

**Client Summary**

**Course of treatment - when did it start, frequency and type of services:**

.

**Significant clinical issues within treatment (advancements and barriers):**

.

**Motivation and engagement within treatment:**

.

**Ongoing services and recommendations (including meds) going forward:**

.

| | |
|---|---|
| **Overall Progress:** | Improved |
| **Prognosis:** | Good |
| **Strengths:** | Ability to ask for help |
| **Needs:** | Relapse prevention,social supports,Abuse/Trauma counseling |
| **Abilities:** | Time management,Computer literate,Good with people |
| **Preferences:** | PM Appointments,Male therapist |

GROUP RULES K 9-1

## SPECIALTY COUNSELING SERVICE AGREEMENT

I ________________________________________, am requesting treatment from the staff of Specialty Counseling and Consulting. As a condition of that treatment , I acknowledge the following items and agree to them. I understand the following:
***Please initial each item.***

_____ **The program:** The ASAM Level 2.1 Intensive Outpatient Treatment Program I am agreeing to participate in is based on the MRT Moral Reconation Therapy curriculum. The program staff believes that the treatment strategies employed provide a useful intervention for chemical dependency problems. No specific outcome can be guaranteed.

_____ Rules of Participation: Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violations of these rules can result in treatment termination. I agree to the following.

_____It is necessary to arrive on time for appointments. Late arrival will not be tolerated. If you arrive late you may not be eligible for participation at that group, it will be considered a missed group, and will be made up at the End of curriculum.

_____ ***Cell Phone Use Will Not Be Allowed during Group***

_____ Upon each visit I should be prepared to take urine, mouth swab, and/or breath drug/alcohol test. If I test positive for any substances or I appear under the influence I agree to obtain a drug/alcohol test from a certified laboratory within 24 hours. I further acknowledge that the court system or probation system will be notified.

_____ **Conditions of treatment require abstinence from all illicit drug and alcohol use for the entire treatment program.** If I am unable to make this commitment , I will discuss other treatment options with the program staff.

_____ I will discuss any drug or alcohol use with staff and group while in treatment.

_____ Treatment consists of group and individual sessions. Twenty four hours notice will be given to reschedule individual appointments if necessary.

K 9-2

_____ **Group appointments cannot be rescheduled, and attendance at them is extremely important.** The therapist will be notified of group absences in advance. Telephone notification will be made for last minute absence or lateness. I acknowledge that probation and the court will be notified of any missed groups/appointments and that it is my responsibility to notify probation and the court that I will miss group/appointment as well as Specialty Counseling. Each missed group will be made up at the end of curriculum based in number of missed groups/appointments.

_____ Treatment will be terminated if I attempt to sell drugs or encourage drug/alcohol use by other participants.

_____ I understand graphic stories of drug or alcohol use will not be allowed.

_____ **I will not become involved romantically or sexually with other patients or staff.**

_____ I understand it is not advisable to be involved in any business transactions with other patients.

_____ All matters discussed in group sessions and the identity of all group members is absolutely confidential and will not be shared with non members.

_____ All treatment is voluntary. If I decide to terminate treatment, I will discus this decision with the staff.

_____ **The Teaching Facility:** Services are provided by appropriately licensed therapists, appropriately supervised licensed provisional therapists, appropriately supervised licensed interns, case managers, and licensed Peer Support Specialists.

_____ **Confidentiality:** All information disclosed within these sessions is strictly confidential and may not be revealed to anyone outside of the clinic staff without the written permission of the patient or legal guardian (Release of Information). The only exceptions are when disclosure is permitted by law. Those situations typically involve substantial risk of harm to oneself or to others, or suspected abuse of children or the elderly.

_____ I understand the I am responsible to keep my billing payments up to date. I am responsible to ensure my insurance, Medicaid, Medicare, etc. is current and making my payments. Failure to make payments could result in discontinuing services.

K 9-3

_____ I understand that IOP consists of 3 three hour group sessions weekly and one individual and/or family session weekly or as needed for a minimum 4 months. Based on completion of treatment goal and objectives IOP then steps down to 1 group session weekly and one individual and/or family session weekly or as needed for 2 months. For a total of 6 months in the first phase of IOP. The second phase of IOP consists of movement into an ASAM Level 1 Aftercare group meeting 1x weekly for six months.

Agreement and consent. This agreement and consent covers the length of time the patient is involved in treatment activities with Specialty Counseling and Consulting.

Client signature                                        Date