EPIC Behavioral Healthcare
Registration Information

First Name ____________ Middle Name ____________ Last Name ____________

Suffix ________ SSN ____________ DOB ____________

GENDER	RACE	ETHNICITY	MARITAL STATUS
☐ Male	☐ American Indian	☐ Cuban	☐ Never Married
☐ Female (Given on ID)	☐ Asian	☐ Haitian	☐ Married
	☐ Black	☐ Mexican	☐ Widowed
Preferred Gender	☐ Alaskan Native	☐ Mexican American	☐ Divorced
	☐ Hawaiian/Pacific Islander	☐ Puerto Rican	☐ Separated
	☐ Multi-Racial	☐ Spanish/Latino	☐ Legally Separated
	☐ White	☐ Other Hispanic	☐ Unreported
	☐ Other	☐ None of the Above	☐ Registered Domestic Partner

Do you need accomodations? ☐ Yes ☐ No

Interpreter? ☐ Yes ☐ No If yes, what language dialect? ____________

Sign Language? ☐ Yes ☐ No Reading Assistance? ☐ Yes ☐ No

Assistance Filling Out Forms? ☐ Yes ☐ No

IDENTIFY ANY KNOWN DISABILITIES OF THE CLIENT		
☐ Developmentally Disabled	☐ Physically Disabled	☐ Non-Ambulatory
☐ Visually Impaired	☐ Hearing Impaired	☐ Severely Impaired English Language

Address Homeless ☐ Yes ☐ No

Mailing Address ____________ ____________

City ____________ State ____________ Zip ____________

Is the above also the billing address? ☐ Yes ☐ No

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Message Phone ____________

Email Address ____________ @ ____________

Emergency Contact Person ____________

Business Phone ____________ Home Phone ____________

Relation to client ____________

Is this person the Client's guardian? ☐Yes ☐No

Is this person Financially Responsible for the client's care? ☐Yes ☐No

What is the highest grade level you completed? ____________ (Or estimate # years of schooling)

☐ No School ☐ HS Diploma/GED ☐ Some College ☐ AA ☐ BS/BA ☐ Master's ☐ Doctorate ☐ Vocational ☐ Special School

Employment Status		
	☐ Full Time	☐ Leave of Absence
☐ Active Military, Overseas	☐ Part Time	☐ Terminated/Unemployed
☐ Active Military, USA	☐ Homemaker	☐ Not Authorized to Work
☐ Disabled	☐ Student	☐ Criminal Inmate
☐ Retired	☐ Unpaid Family Workers	☐ Inmate Other

Has the client ever or are you currently serving in the military? ☐Yes ☐No
Current Tobacco Use? ☐Never used ☐Have Used/Not Current ☐Regular User ☐Use Smokeless Tobacco
Do you have Advanced Directives? ☐Yes ☐No
Are you receiving any Psychiatric Social Security Disability Income?

☐ Determined to be ineligible ☐ Eligibility determination pending ☐ Eligibility status unknown
☐ Eligible, not receiving payments ☐ Eligibile, receiving payments ☐ Potentially eligible, has not applied

CLIENT RESIDENTIAL STATUS			
☐ Independent Alone	☐ Assisted Living Facility	☐ Nursing Home	☐ Children's Residential Treatment
☐ Independent Relatives	☐ Foster Care/Home	☐ Supported Housing	☐ MH Licensed ALF
☐ Independent Non-Relatives	☐ Group Home	☐ Correctional Facility	☐ Other
☐ Dependent Relatives	☐ Homeless	☐ DJJ Facility	☐ Unknown
☐ Dependent Non-Relatives	☐ Hospital	☐ Crisis Residence	

Have you been diagnosed in past with Co-Occurring Mental Health/Substance Use Disorder? ☐ Yes ☐ No ☐ Unknown
Name of Primary Care Physician/Practice ____________________ Phone ____________________
☐ No Client does not have a Primary Care Physician
Previous Mental Health services: ☐ Yes ☐ No ☐ Unknown
If yes, where? ____________________
Previous Substance Treatment Services: ☐ Yes ☐ No ☐ Unknown
If yes, where? ____________________
Have you recently been Baker Acted to a Treatment Facility? ☐ Yes ☐ No ☐ Unknown
If yes, where? ____________________

********Obtain Releases of Information on any facilities listed above********

Number of Dependents ____________ Total Number in Household ____________
Client Monthly Income ____________ Client Annual Income ____________
Household/Family Annual Income ____________

********Income primarily needed for anyone with insurance********

PRIMARY SOURCE OF INCOME (Must be completed)		
☐ Salary	☐ Retirement/Pension/SSI	
☐ Wages/TANF	☐ Other	
☐ Disability	☐ Unknown	☐ None

Do you have Florida Medicaid? ☐ Yes ☐ No If Yes, Medicaid # ____________
Medicare Part B? ☐ Yes ☐ No If Yes, Medicare # ____________
Do you have Commercial Insurance? ☐ Yes ☐ No
Name of Insurance
Insurance ID # ____________________ Group # ____________
Is the client the subscriber of policy? ☐ Yes ☐ No
If No, Name of Subscriber ____________________
DOB of Subscriber ____________ SSN of Subscriber ____________
Address of Subscriber ____________________

REFERRAL SOURCE (Check as many as apply)			
☐ Individual (Self Referral)	☐ Other Community Referral	☐ MHSA: DCF/Family Svcs	☐ Physician/Doctor
☐ Subtance Use Provider	☐ TASC/Assessment Ctr	☐ CINS (Children in Need Svc)	☐ Law Enforcement
☐ Mental Health Provider	☐ Probation/Parole	☐ Addiction Receiving Fclty	☐ Family Safety Foster Care
☐ Juvenile Justice	☐ DUI/DWI	☐ Outreach Program	☐ Family Safety Protective Svcs
☐ County Public Health Unit	☐ Pretrail	☐ DCF/ADM	☐ None of the Above
☐ School (Educational)	☐ Prison/Jail	☐ Community Hospital	☐ Other:
☐ Employee/EAP	☐ Oher Court Order	☐ State Hospital	☐ Other:

Referring Agency or Physician/Hospital ______________________________

Reason for Referral ______________________________

Phone Number ____________________ Contact Person ____________________

Address of Referring Person/Agency ______________________________

City ____________________ State ____________ Zip ____________

Would you like to register to vote while you are here today? ☐ Yes ☐ No

(For any Florida resident not already registered)

STAFF CHECKLIST

- ☐ Insurance subscriber added as a contact in order to be linked to the coverage plan
- ☐ Creat coverage plan
- ☐ Apply coverage plan w/start date
- ☐ Complete Financial Worksheet
- ☐ Complete Financial Attestation if applicable
- ☐ Client Account check box Financial Information Complete
- ☐ Client information Billing address checkbox selected to billing address
- ☐ Informed Consent completed
- ☐ Registration FL document completed
- ☐ Online Therapy Consent (if applicable) completed
- ☐ HIV/TB Risk Assessment completed
- ☐ Picture of patient added to account
- ☐ Insurance cards scanned and uploaded
- ☐ Program Enrollment requested
- ☐ Release of Information to Primary Care Physician
- ☐ Release of information to any past MH, Substance Treatment or Baker Act Facilities
- ☐ Release of Information to Referral Sources
- ☐ Release of Informantion to any family members

Next should be Medical History Questionnaire
Communicable Disease Questionnaire

HIV/AIDS/TB Risk Assessment

Please check your response to the following questions:

Shared needles/syringes? ☐ Yes ☐ No

Have you had unprotected sex within the last year? ☐ Yes ☐ No

Have you been a sex or needle sharing partner of a person with HIV/AIDS? ☐ Yes ☐ No

Have you traded sex for drugs or money? ☐ Yes ☐ No

Have you had a sexually transmitted disease? ☐ Yes ☐ No

Have you ever had an HIV test? ☐ Yes ☐ No

If yes, Date: ____________ Results: ____________

Are you a hemophiliac or blood transfusion recipient? ☐ Yes ☐ No

Are you a victim of sexual assault? ☐ Yes ☐ No

An injection drug user? ☐ Yes ☐ No

A person with other/HIV/AIDS risks? ☐ Yes ☐ No

Unexplained fevers? ☐ Yes ☐ No

Recent unexplained weight changes? ☐ Yes ☐ No

Client was referred to the Public Health Department for follow up? ☐ Yes ☐ No

Date of positive Tuberculosis (TB) test ____________

Date of last X-ray for Tuberculosis ____________

Have you ever taken medication for Tuberculosis? ☐ Yes ☐ No

Name of Medication ____________

Check if you have had any of the following symptoms for 3-4 weeks

Productive Cough ☐ Yes ☐ No

Persistent weight loss without dieting ☐ Yes ☐ No

Loss of appetite ☐ Yes ☐ No

Persistent fever above 100.0 F ☐ Yes ☐ No

Night sweats ☐ Yes ☐ No

Swollen glands in the neck or elsewhere ☐ Yes ☐ No

Coughing up blood (hemoptysis) ☐ Yes ☐ No

Shortness of breath ☐ Yes ☐ No

Chest pains ☐ Yes ☐ No

Fatigue or weakness ☐ Yes ☐ No

Frequent or Recurring chills ☐ Yes ☐ No

Medical Questionnaire Page 1

Patient Name: ______________________________

Medical History

Have you had any of the following (please check box and explain if needed):

Condition			
Sexually transmitted Disease(s) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Asthma Attacks Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Tuberculosis(TB) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Heart Trouble Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Condition Needing Surgery Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Diabetes Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Difficulty Hearing Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Kidney/Urination Problems Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Physical Handicap Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Rheumatic Fever Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Poor Eyesight Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Speech Defect Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Ulcer(stomach/intestine) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Serious Dental Problems Explain-Being Treated:	☐ Never	☐ Past	☐ Now
In Hospital in Last 4 Years Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Anemia Explain-Being Treated:	☐ Never	☐ Past	☐ Now

Medical Questionnaire Page 2

Medical History Continued

Have you had any of the following (please check box and explain if needed):

Suicidal in Last 3 Months Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Allergic to drugs/foods Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Pregnant (Females Only) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Immunizations up to date Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Sickle cell Explain-Being Treated:	☐ Never	☐ Past	☐ Now

Any other conditions: ______________________________

____

FOR ANSWERS MARKED IN THE NOW COLUMN, IT IS RECOMMENDED YOU SEEK A DOCTOR'S CARE

List all medications you are taking: ______________________________

____

Primary Care Physician Name: ______________________________

Primary Care Physician Phone Number: (____) ________-__________

I have no Primary Care ☐

Patient Signature: ______________________ Signature Date: ______________

SNAP Assessment

Strengths, Needs, Abilities, Preferences

Client Name:______________________________ Date: ______________

Client ID: ______________________________ Program: ______________

Check all that apply and list what is not shown.

STRENGTHS (What will help you in treatment)

		COMMENTS
☐	Support from family	
☐	Support from spouse or significant other	
☐	Connection to self-help group (AA, NA, NAMI)	
☐	Connection to a church group of minister	
☐	Supportive friends	
☐	Stable finances or benefits	
☐	Stable housing or shelter	
☐	Stable transportation or access to transportation	
☐	Established primary care (doctor) services	
☐	Distance from unsupportive social network	
☐	Others:	
☐		
☐		
☐		

NEEDS (What you want to learn in treatment)

		COMMENTS
☐	Education about my diagnosis	
☐	Education about addiction	
☐	Education about the impact of trauma	
☐	Improvement in my communication skills	
☐	Improvement in my interpersonal skills	
☐	Contact with supportive others	
☐	Emotion management skills	
☐	Anger management skills	
☐	Anxiety management skills	
☐	Personal safety and recovery plan	
☐	Parenting skills	
☐	Education about improving my health	
☐	Day to day self-management (structure, goals)	
☐	Others:	
☐		
☐		
☐		

ABILITIES (Your qualities/skills that will help in treatment) **COMMENTS**

☐	I am motivated for treatment	
☐	I have insight in to my mental health or substance use concerns	
☐	I am willing to accept feedback and guidance	
☐	I am willing to take responsibility for my actions	
☐	I am able to ask for help from others	
☐	I am willing to work to grow and change	
☐	I am able to express my concerns and needs	
☐	I have some positive plans and goals for my future	
☐	I have a good relationship with a higher power	
☐	I am capable of offering support to others	
☐	I believe recovery is possible	
☐	I am able to fulfill my treatment obligations	
☐	Others:	
☐		
☐		
☐		

PREFERENCES (What you hope to get out of treatment) **COMMENTS**

☐	I will have a better understanding of my diagnosis	
☐	I will have a better understanding of trauma and its effects	
☐	I will learn the skill to stay mentally stable	
☐	I will learn the skill to stay clean and sober	
☐	I will be able to communicate more effectively	
☐	My interpersonal skills/relationships will improve	
☐	I will be able to manage my emotions	
☐	I will be able to manage my anxiety	
☐	I will be able to manage my anger	
☐	I will be able to resolve grief and loss concerns	
☐	I will develop a positive support network	
☐	My health will improve	
☐	I will have developed a recovery/relapse plan	
☐	I will improve my day to day functioning	
☐	Others:	
☐		
☐		
☐		

Client Signature: ______________________________ Date: ______________

Staff Signature: ______________________________ Date: ______________

EPIC Behavioral Healthcare

<u>Informed Consent for Treatment and Participant Agreement</u>

By my signature, I understand and agree to the following:

- ✓ I have read, understand, and have been offered a copy of this Informed Consent for Treatment and Participant Agreement, which includes but is not limited to an explanation of my rights and responsibilities, complaint/grievance procedure, and confidentiality of my patient record.
- ✓ I agree to participate in the intake and assessment process, and to receive services, which could include assessment, stabilization, detoxification, medication treatment, clinical and medical services, drug screens, discharge planning, and Care Coordination services.
- ✓ I agree to follow the Program Rules as discussed.
- ✓ I understand and agree to the exchange of confidential information through Release of Information process
- ✓ I agree to participate in programmatic data collection as needed for this program
- ✓ I was informed that this consent could be revoked by me verbally or in writing, before or during the period in which I receive services, except to the extent that action has been taken on reliance on it.
- ✓ I acknowledge that there have been no guarantees or assurances made to me as the results of services rendered by EPIC, or its employees.
- ✓ I give permission to contact me for the purposes of obtaining follow up information concerning my progress after completing services.

____

Signature of Person Served Date

____

Guardian or Legal Custodian Signature, if applicable Date

____

Staff Signature and Title/Credential Date

☐ Participant Agreement provided to patient.

☐ Signature Page placed in patient record.

EPIC Behavioral Healthcare
Online Therapy Consent Form

Online Therapy and Limitations

I understand that online therapy includes the practice of health care delivery, diagnosis, consultation, treatment, and education using interactive audio and video communication. I understand that discussing my presenting concerns may cause discomfort as difficult issues are addressed and worked through. This is often a common experience of psychotherapy in general and I acknowledge no guarantees have been made to me as to the effect of treatment on my condition. I understand that phone and online sessions have limitations compared to in-person sessions, among those being the lack of "personal" face-to-face interaction, the lack of visual and audio cues in the therapy process, and the fact that most insurance companies will not cover this type of therapy. I understand online therapy is not appropriate if I am experiencing crisis or having suicidal or homicidal thoughts. Should crisis occur, I agree to call 911, go to the nearest emergency room, or contact a crisis hotline (e.g. 800-273-8255).

Procedures for technical difficulties or Internet disruptions

As a client of EPIC Behavioral Healthcare, I understand that online therapy is technical in nature and that problems with the Internet may occur. If something beyond our control disrupts the connectivity of our session I will immediately try to video call the therapist again. If video call is repeatedly unsuccessful for 10 minutes, sessions will be:

1) completed via phone call to the therapist at **(904) 829-2273** or
2) refunded based on length of session prior to disruption (e.g. less than 10 minutes the session will be rescheduled at no cost, 15-30 minutes will result in half of the fee being refunded).

Appointment Payment

I agree to pay the agreed upon fee at the time of service through the EPIC Mental Health Outpatient Office in person or by phone. (e.g. through credit card or insurance on file, which will be charged the day of the appointment).

Appointment Cancellations

If cancellation is needed, I understand that notice of at least 24 hours via phone call to the office staff is necessary in order to avoid any associated fees. Cancellations with less than 24 hours notice will be billed at $25 per occurrence.

Missing an appointment without prior notice will be billed at $25 per occurrence. In addition, I understand that the accumulation of 3 late cancellations or missed appointments in any combination will result in discharge from the program.

Termination of Services

During the intake and first few sessions, the therapist will assess if online therapy is of benefit to me and my needs. The therapist will use his/her best judgment to determine if online therapy is the best medium for providing me counseling services. If online therapy is deemed inappropriate, the therapist will provide me with a number of referrals in my area so face-to-face counseling can be pursued.

Confidentiality:

Because online therapy utilizes the Internet for the transmission of personal information I understand the therapist cannot guarantee confidentiality of the personal information I provide via this form of communication. However, any information that I provide to the therapist will subsequently remain confidential and will not be given to a third party unless I give specific permission to release the information, or the therapist is required to do so by law. The issue of confidentiality is further governed by both law and ethics. I understand that the therapist follows the law and professional regulations of

the State of Florida and the counseling treatment provided will be considered to take place in the State of Florida.

By law I hold the privilege of confidentiality and the therapist will not release any information to anyone without my written permission, or a court order. There are some exceptions to my rights under the law. Examples include, but are not limited to, when the therapist has reasonable cause to believe that I am a danger to myself or another person. The therapist is also required by law to report any information about or reasonable suspicion of sexual, physical or emotional abuse of minors or elders to Child Protective Services or Adult Protective Services. I understand that if I have any concerns regarding confidentiality issues, I should speak with my therapist about these and other exceptions to the confidentiality privilege and her responsibility concerning them.

I understand EPIC Behavioral Healthcare has not given consent or release for the recording of this session outside the electronic platform used to deliver the service.

Harm to Self or Others

If there is an emergency during our work together where the therapist is concerned about my personal safety, the possibility of me injuring someone else or about my receiving proper psychiatric care, I understand the therapist will do whatever she can within the limits of the law to prevent me from injuring myself or others and to ensure that I receive the proper medical care. For this purpose, the therapist may also contact law enforcement, hospital or an emergency contact whose name I have provided.

By signing this form I agree with the above.

Signature of Client	Date
Signature of Client	Date

EPIC BEHAVIORAL HEALTHCARE
Sliding Fee Scale/ Financial Attestation
Effective March 1, 2023-February 28, 2024

Client Name ____________________ Client ID # ____________________

Federal Poverty Level Family Annual Income		ELEGIBLE FAMILY ANNUAL INCOME		HOUSEHOLD NUMBER							
Minimum Income	Maximum Income	150% Minimum Income	150% Maximum Income	1	2	3	4	5	6	7	8
				The percentage represents the clients responsibility for each chargeable service. 0% will be assessed a minimum fee of $3.00 per chargeable service. Any consumer that falls into the yellow is eligible for LSFHS funding, all others will fall under the sliding fee scale of your organization.							
$0.00	$ 14,580.00	$0.00	$ 21,870.00	0%	0%	0%	0%	0%	0%	0%	0%
$ 14,581.00	$ 19,720.00	$ 21,870.01	$ 29,580.00	5%	0%	0%	0%	0%	0%	0%	0%
$ 19,721.00	$ 24,860.00	$ 29,580.01	$ 37,290.00	10%	5%	0%	0%	0%	0%	0%	0%
$ 24,861.00	$ 30,000.00	$ 37,290.01	$ 45,000.00	15%	10%	5%	0%	0%	0%	0%	0%
$ 30,001.00	$ 35,140.00	$ 45,000.01	$ 52,710.00	25%	15%	10%	5%	0%	0%	0%	0%
$ 35,141.00	$ 40,280.00	$ 52,710.01	$ 60,420.00	35%	25%	15%	10%	5%	0%	0%	0%
$ 40,281.00	$ 45,420.00	$ 60,420.01	$ 68,130.00	45%	35%	25%	15%	10%	5%	0%	0%
$ 45,421.00	$ 55,700.00	$ 68,130.01	$ 83,550.00	55%	45%	35%	25%	15%	10%	5%	0%
$ 55,701.00	$ 60,840.00	$ 83,550.01	$ 91,260.00	65%	55%	45%	35%	25%	15%	10%	5%
$ 60,841.00	$ 65,980.00	$ 91,260.01	$ 98,970.00	70%	65%	55%	45%	35%	25%	15%	10%
$ 65,981.00	$ 71,120.00	$ 98,970.01	$ 106,680.00	75%	70%	65%	55%	45%	35%	25%	15%
$ 71,121.00	$ 76,260.00	$ 106,680.01	$ 114,390.00	80%	75%	70%	65%	55%	45%	35%	25%
$ 76,261.00	$ 81,400.00	$ 114,390.01	$ 122,100.00	85%	80%	75%	70%	65%	55%	45%	35%
$ 81,401.00	$ 86,540.00	$ 122,100.01	$ 129,810.00	90%	85%	80%	75%	70%	65%	55%	45%
$ 86,541.00	$ 91,680.00	$ 129,810.01	$ 137,520.00	95%	90%	85%	80%	75%	70%	65%	55%
$ 91,681.00	$ 96,820.00	$ 137,520.01	$ 145,230.00	100%	95%	90%	85%	80%	75%	70%	65%
$ 96,821.00	$ 101,960.00	$ 145,230.01	$ 152,940.00	100%	100%	95%	90%	85%	80%	75%	70%
$ 101,961.00	$ 107,100.00	$ 152,940.01	$ 160,650.00	100%	100%	100%	95%	90%	85%	80%	75%
$ 107,101.00	$ 112,240.00	$ 160,650.01	$ 168,360.00	100%	100%	100%	100%	100%	100%	100%	100%

Insurance Company ____________ Policy Number ____________

Number of Household ____________

Household Annual Income ____________

I hereby attest that my Annual household income reported is correct.

____________ Date ____________ Client Signature

I hereby attest that I have perfomed due diligence in assessing financial eligibility for State funding.

____________ Date ____________ Employee Signature

EPIC Behavioral Healthcare
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize EPIC Behavioral Healthcare to (please check one):
☐ Obtain ☐ Release ☐ Exchange

the following ☐ ***written,*** ☐ ***verbal,*** ☐ ***electronic,*** ☐ ***video,*** ☐ ***audio information*** (check all that apply):

☐ Treatment goals and progress
☐ Physical exam
☐ Social history
☐ Psychological evaluation and test results
☐ Educational information
☐ Behavioral observation
☐ Information concerning AIDS/ HIV Infection
☐ Medical treatment
☐ Alcohol/drug treatment
☐ Psychiatric evaluation and treatment
☐ Other (specify) ______________________________

(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 42 CFR, Part 2.)

Information from the records of:

____
Client Name Client Code/Record #

____
Address

____
City, State, Zip

____
Date of Birth

Contact: ______________________________
Agency Contact Name

To/From (Circle one) ______________________________
Agency Name

____
Address

____
City, State, Zip

For information from ______________ to ______________
Date of Birth Date

For the purpose of (check one):
☐ to assist in the evaluation and treatment of the client.
☐ other (specify______________________

A signed revocation may be submitted at any time, but EPIC Behavioral Healthcare shall not be held liable for any information released prior to its receipt. This release form shall be valid for (check one)

☐ A single disclosure **OR**
☐ A continuing disclosure for **90 days** from signature date below.
☐ A continuing disclosure for **1 year** from signature date below

To Receiving Agency:
PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent or the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.
[In compliance with Federal Regulations 42 CFR, Part 2.]

I acknowledge that I have read this authorization and fully understand its contents.

______________________________ Date ___/___/___
Signature of Client

______________________________ Date ___/___/___
Signature of legal guardian (When applicable)

____
Relationship

______________________________ Date ___/___/___
Witness

PLEASE RETURN INFORMATION TO:
EPIC Behavioral Healthcare, Attn: ______________________, 1400 Old Dixie Hwy, St. Augustine, Florida, 32084.
(Name of staff)

EPIC Staff: When requesting information, send original to other Agency. When sending information, keep original in chart.
Originated 7/03

NATIONAL VOTER REGISTRATION ACT
Preference Form/Application

Client's preference (check the box only in 1. or 2.)

If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.

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

☐ Yes ☐ No, I decline.

2. If you are registered to vote where you live now, would you like to update your voter registration record?

☐ Yes ☐ No, I decline.

CLIENT: ______________________________
Name or identification number Date

OFFICIAL USE ONLY (check all that apply)

[Note: Only a client who is eligible can decline or accept an opportunity to register or update a record on his or her behalf]

1. Client applied for: ☐ New services/assistance ☐ Renewal of services/assistance ☐ Address change
2. How client applied: ☐ In person ☐ By phone ☐ At home ☐ Online/web service
3. Client: ☐ Submitted registration application. ☐ Was sent form/application on ___/___/___(date). ☐ Did not complete application/took form/application.

Preference form must be retained by agency for two years from dated form (DS-DE 77-ENG; rev. 11-2011)

=====================Notice of Rights=====================

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

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058, and 97.0585, F.S.]

To Register to Vote in Florida, You Must:

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 years old although you cannot vote until you are 18 years old)
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote.

If you do not meet these requirements, you are not eligible to register.

You Can Register to Vote at:

- Any Supervisor of Elections' office
- Any driver's license office or tax collector's office that issues driver's licenses
- Any voter registration agency (that is, any public assistance office, any office that provides services for persons with disabilities, any center for independent living, any armed forces recruitment office or any public library)
- The Division of Elections (Florida Department of State)

You Can Hand-in or Mail a Completed Application to Any of the Locations Listed Above

If mailing, mail with sufficient postage to:

Division of Elections
R.A. Gray Building
500 S. Bronough Street
Tallahassee, Florida 32399-0250

(contact information: 850-245-6200; http://election.dos.state.fl.us)

Your Supervisor of Elections will contact you if your application is incomplete, denied, or a duplicate. Once you are registered, you will receive a voter information card.

**************************Turn Page Over for Registration Application********************

Application to Register in Florida

Part 1 - Instructions

To Register In Florida, you must: Be a U.S. citizen, be a Florida resident and at least 18 years old (you may also pre-register if you are 16 or 17 years old but you cannot vote until you are 18).

If you have ever been convicted of a felony or if a court has ever found you to be mentally incapacitated as to your right to vote, your right to vote has to be restored before you can register.

If you do not meet any one of these requirements, you are not eligible to register.

Where to Register: You can register to vote in-person or by mailing or hand-delivering your application to any supervisor of elections' office, any office that issues driver's licenses, any voter registration agency (for example, any public assistance office, assisted living facility, office serving persons with disabilities, public library, or armed forces recruitment office) or the Division of Elections. *If mailing application, be sure to add sufficient postage.*

Deadline to Register: The deadline to register to vote is 29 days before an upcoming election. You can update your registration record at any time, but to change your political party for a primary election, you must make the change by the registration deadline. For a new application, you will be contacted if your application is incomplete, denied or a duplicate of an existing registration. If you receive a voter information card, that means you are registered to vote.

Identification (ID) Requirements: If you are a new applicant, state and federal law require you to provide a current and valid Florida driver's license number (FL DL#) or Florida identification card number (FL ID#). If you have not been issued a FL DL# or FL ID#, you must then provide the last four digits of your Social Security Number (SSN). If you have not been issued any of these ID numbers, check "None" on the application. If you do not provide any number or do not check "None," your registration may be denied. See s.303, HAVA and section 97.053(6), Fla. Stat.

Special ID requirements: If you are registering by mail, have never voted in Florida, and have never been issued one of the ID numbers above, you must include with your application, or at a later time before you vote, one of the following:

- A copy of an ID that shows your name and photo *(acceptable IDs)*--U.S. Passport, debit or credit card, military ID, student ID, retirement center ID, neighborhood association ID, or public assistance ID; or
- A copy of an ID that shows your name and current residence address *(acceptable documents)*--utility bill, bank statement, government check, paycheck, or other government document.

You do not have to provide the special ID to register if you are 65 or older, have a temporary or permanent physical disability, are a member of the active uniformed services or merchant marine who is absent from the county for active duty, or a family member thereof, or are currently living outside the U.S. but eligible to vote in Florida.

Political Party Affiliation: Florida is a closed primary election state. That means voters registered with a political party can only vote for that party's candidates in a partisan race on a primary election ballot. However, regardless of the political party with which you registered, you can still vote in the primary election on any issue, any nonpartisan race or any race where the candidate will face no opposition in the general election.

Indicate the political party with which you wish to be registered. If you leave the political party affiliation box blank or write "None," you will be registered without any party affiliation. For a list of political parties registered in Florida, go to the Division of Elections' website under the heading *For the Voters* at: http://election.dos.state.fl.us/

Race/Ethnicity: You are not required to list your race or ethnicity. However, if you choose to do so, please choose only one of the following: American Indian/Alaskan Native, Asian/Pacific Islander, Black (Not Hispanic) Hispanic, Multi-racial, White (Not Hispanic), or Other.

Public Record Notice: This application becomes a public record when filed. However, the following information is not available to the public and is used only for voter registration purposes: your FL DL#, FL ID# and SSN, where you registered to vote, and whether you declined to register or update your voter registration record when asked by a voter registration agency. Your signature can be viewed but not copied. (Section 97.0585, Fla. Stat.)

Criminal Offense: It is a 3rd degree felony to submit false information. Penalties include fines up to $5,000 and/or up to 5 years of prison.

Questions: For more information, contact your local supervisor of elections, or refer to the Division of Elections' website at: http://election.dos.state.fl.us.

Información en español: Sírvase llamar a la oficina del supervisor de elecciones de su condado si le interesa obtener este formulario en español.

Application To Register in Florida

Part 2 - Form (national mail-in application)

Are you a citizen of the United States of America? ☐ Yes ☐ No

Will you be 18 years old on or before election day? ☐ Yes ☐ No

If you checked "No" in response to either of these questions, do not complete form.

(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)

This space for office use only.

1	Last Name	First Name	Middle Name(s)		
2	Home Address	Apt. or Lot #	City/Town	State	Zip Code
3	Address Where You Get Your Mail If Different From Above		City/Town	State	Zip Code
4	Date of Birth (Month Day Year)	5	Telephone Number (optional)	6	ID Number - (See item 6 in the instructions for your state)
7	Choice of Party (see item 7 in the instructions for your State)	8	Race or Ethnic Group (see item 8 in the instructions for your State)		

9 I have reviewed my state's instructions and I swear/affirm that:

- I am a United States citizen
- I meet the eligibility requirements of my state and subscribe to any oath required.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States.

Please sign full name (or put mark)

Date: Month / Day / Year

If this application is for a change of name, what was your name before you changed it?

A	Last Name	First Name	Middle Name(s)

If you were registered before but this is the first time you are registering from the address in Box 2, what was your address where you were registered before?

B	Street (or route and box number)	Apt. or Lot #	City/Town/County	State	Zip Code

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.

C

- Write in the names of the crossroads (or streets) nearest to where you live.
- Draw an X to show where you live.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark.

Example: Route #2, Grocery Store, Woodchuck Road, Public School, X

NORTH

If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).

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