CFCC
AND ASSOCIATES

A compassionate ministry of hope and healing

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WELCOME

Welcome to CFCC & Associates, Inc. (hereafter, "CFCC"). We realize how hard it is to take the first step of starting a counseling process and we want you to know that we are here for you. CFCC's mission is to be a compassionate ministry of hope and healing for all people. This informational brochure outlines various CFCC policies and procedures. We request that you read this brochure and bring any questions you have to your first counseling session or call our office. CFCC currently has four locations in Topeka, one in Emporia, one in Atchison, one in Manhattan, and one in Shawnee. We are blessed to have numerous community partners in addition to these partner locations. We also have 2 Equine locations, one in Topeka and one in Atchison.

CONFIDENTIALITY

We at CFCC value your information and your story. We are committed to maintaining the highest standards of confidentiality, which means that we must have your written permission to discuss or share any of your information outside of our agency. The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. A full explanation of HIPAA requirements is available at our main office. Some key concepts of confidentiality are:

1. If you request that your information be shared with an outside source (such as a school, physician, family member, lawyer, employer, etc.), you must complete and sign an Authorization for the Use and Disclosure of Protected Health Information form. This form instructs us where to send the information and any restrictions you have on what is released. This form is valid for up to one year from your signature date.

2. Your records at CFCC are kept in electronic form within an Electronic Medical Record format. This is a cloud-based platform that maintains rigorous cybersecurity standards. Our therapists and office staff are committed to the highest standards of safeguarding your Protected Health Information (PHI).

3. If you use your private health insurance, they often request detailed information about your treatment to determine if medical necessity criteria are met. We do not notify you of these requests and comply in order to receive reimbursement. You may opt to not use your insurance and pay privately, but your rate will be the insurance rate per insurance contractual requirements.

4. Insurance payers may conduct inspections and review documents which may include PHI in the normal performance of their duties.

5. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services. CFCC uses a number of outside venders to conduct business. These vendors may have access to your PHI but must agree to abide by the confidentiality rules of HIPAA.

6. CFCC will provide you with access to your records in accordance with CFCC policies, and state and federal laws.

7. You have the right to request restrictions on the use of your PHI in accordance with state and federal laws, and to request changes in certain procedures used within the office concerning your PHI. However, we are not obligated to conform to restriction requests that are not explicitly stated in state or federal law.

8. There are two major exceptions to client confidentiality:

a. We are mandated reporters of child and/or adult abuse and neglect. We are required to report any suspicion of child abuse (which includes child-on-child abuse), and/or neglect (including medical, educational, physical, or financial exploitation). This also includes children who are witnesses to domestic violence, substance abuse, or endangerment in any way. Any form of abuse or neglect toward elderly or disabled adults will be reported to the appropriate authorities.

b. When we are concerned that you are a risk of grave harm to yourself or someone else. This may mean that we notify your identified emergency contact of our concern for your safety. We may also warn potential victims that we determine are at risk from you. In the absence of a viable emergency contact, we will utilize local law enforcement to assess your wellbeing.

9. We must respond to a subpoena, but we cannot reveal information without your written permission or an order from the court. Your records may be subpoenaed by court order and CFCC has no choice but to comply.

10. When we see one person for therapy services, an individual file is opened under that person's name. When that person brings additional people to the session, the focus remains on the individual. Information gathered in an individual file is only available to the individual, even if collateral contacts attended. If, however, the focus of therapy is a couple or family issue, then a relational file will be opened with sessions billed under that file. Information gathered in a relational file is available to all the individuals attending the sessions. Please talk with your therapist about your options and rules of confidentiality in relational counseling.

11. Parents have a legal right to information shared by their child during a therapy session. However, for children and adolescents to feel safe with their therapist, we ask that parents do not request specific information. A child's therapist may encourage them to share information and help them do this, but the therapist will not share detailed information unless they believe it is necessary to protect the life and wellbeing of the child or the safety of someone else. In the case of divorce, both parents are equally entitled to information shared by their child during a therapy session, unless there are legal documents stating otherwise. Please bring custody documents, guardianship paperwork, or protection from abuse orders to your initial Intake session.

12. Telehealth sessions are available. They can be utilized by therapists to prevent an interruption of services due to weather, sickness, or for the convenience of all involved. Telehealth considerations include:

a. You have the right to confidentiality regarding your treatment and related communications via telehealth under HIPAA. The same mandatory and permission exceptions to confidentiality outlined above apply to telehealth sessions.

b. You may withdraw consent for telehealth services at any time without affecting your right to future care or treatment, and without risking the loss of any program benefits to which you are entitled.

c. There are potential risks and consequences of telehealth services including, but not limited to the possibility, despite reasonable efforts and safeguards on the part of your therapist, that transmissions can be disrupted or distorted by technical failures. If there has been a disruption, your therapist will contact you to reinitiate the connection or otherwise reach out at the contact number provided. Please call our office to let your therapist know if you have resolved any technical issues on your end.

d. CFCC uses HIPAA compliant telehealth platforms, but it is possible that the therapy session could be accessed by unauthorized persons.

e. When participating in therapy via telehealth, there is the possibility that you may be overheard by people near you. You are responsible for choosing a location that is private and free from distractions and intrusions. If you have enabled Personal Assistance Devices (e.g., Siri, Alexa, Google Home, etc.) and they are live during your telehealth session, you accept responsibility for those devices listening in on the session.

f. Some telehealth platforms allow for video and/or audio recordings. It is the policy of CFCC that therapy sessions must not be recorded, except for a clinical intern or a CFCC therapist under supervision. There will be a separate consent form notifying you that your intern or therapist will be recording the session in order to obtain clinical supervision. All supervisors or dyadic group members are bound by professional ethics to treat all information as strictly confidential with exceptions defined by State Law.

g. At the beginning of your telehealth session, your therapist will ask for your location if it is different than your home address or usual session location. This is to protect you in case you need emergency interventions during the session.

h. Your therapist will make reasonable efforts to ascertain and provide you with emergency resources in your geographic area when necessary, but your therapist may not be able to directly assist you in an emergency situation. If you require emergency care, you may call 988 or 911, or go to your local emergency room for assistance.

13. Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist. Covert recording is a direct violation of trust and good faith to all in the therapy room. CFCC has a strict policy of not allowing any form of audio or video recording of any interactions with a CFCC therapist. This includes but is not limited to: a) in-person conversations; b) conversations via phone; c) conversations via live audio or video link or App; d) therapy sessions; or e) conversations involving a third party. Please see the Supervision Exception explained above. Any covert recording will lead to termination of therapy services.

14. Under the provisions of KSA 65-6404(b), my therapist is required to notify my Primary Care Physician or Psychiatrist to inform them a mental health diagnosis has been given. In the Informed Consent Contract, you will be asked to either waive your right for CFCC to notify your Provider or allow us to contact your Provider indicating you have presented for treatment. If you allow us to contact your Provider, please complete the section with their contact information. If an ongoing discussion is needed with your medical treatment team beyond initial notification, you will be asked to complete a separate Authorization for the Use and Disclosure of Protected Health Information form.

15. Any concerns or complaints that you have regarding privacy and confidentiality should be brought to the attention of the Office Manager.

What to Expect in Therapy

1. Your first therapy session is called an Intake Assessment. In this session you will start to establish a therapeutic relationship with your therapist as they gather information about you and your concerns. While your story is important, this session will mostly focus on your symptoms and how they impact your daily life. Subsequent sessions will build on what you share during the Intake Assessment and appropriate interventions will be utilized. Typically, an Intake Assessment lasts 60-90 minutes

2. During your second session, a Treatment Plan will be developed based on your goals for therapy. Your treatment plan will be updated every 90 days.

3. Therapy sessions typically last 30-53 minutes. Therapy sessions usually take place weekly or every other week, depending on your needs and the schedules of both you and your therapist. Therapy sessions lasting more than one hour will be billed accordingly in a private pay fashion as insurance rarely pays for extended sessions. Your therapist will be respectful of your time by ending your session on time. Please be respectful of your therapist's schedule by doing the same. Present topics you want to address in your therapy session at the beginning of your session so there is adequate time to address them.

4. Fees:

a. Intake Assessment fees are $220.00

b. Therapy session fees are $180.00

c. Reduced fee arrangements may be made on a case-by-case basis. A Reduced Fee Agreement (RFA) form will be provided to you upon your request to determine eligibility for a reduced fee and, if eligible, what your reduced fee will be. A reduced fee is not available for the sole reason of having a high deductible insurance plan or high patient co-pay. RFAs will be reviewed for renewal at least annually (January).

d. Court appearance fees are $350.00 (private pay) and must be paid in advance of the court appearance. This fee will not be billed to insurance. If more than 2 hours are required, the additional time is billed at $150.00 per hour. Travel time will also be billed separately at the current IRS reimbursement rate.

e. Psychological Testing fees are $450.00 plus the test price (private pay) and must be paid in advance of the first testing session. This fee will not be billed to insurance. This two-session fee includes testing, review of the findings with the Psychologist or Psychology Intern, and a written report.

f. Additional fees may be charged but will not be submitted to your insurance. These additional fees may include phone conversations that are longer than 10 minutes, preparation of letters, special forms, or reports, attending outside meetings on your behalf, or sending behavioral health records on your behalf.

5. Payment is required at each time of service. You will be notified before your Intake Assessment what your expected co-pays or fees will be for each session. If you do not make your regular expected payment or your balance reaches a certain limit, your therapy services will be suspended until you pay your account balance.

6. Your appointment times are set aside especially for you. If you need to miss an Intake Assessment or therapy session, it is expected that you provide at least 24 hours' notice that you will miss the session. If you do not provide 24 hours' notice or miss the session without any contact, you will be charged half of your session fee. Leaving a voicemail or email message the night before your scheduled session does not constitute 24 hours' notice and you will be charged half of your session fee. After three total (not consecutive) late canceled (within 24 hours of the appointment time) or no-

call/no-show therapy sessions, you will be discharged from therapy services for 90 days. After 90 days you may again call CFCC to request another Intake Assessment.

7. CFCC is not a crisis agency. If you are experiencing a mental health crisis, please go to the nearest emergency room and request a mental health crisis assessment. You may also call 988 or 911 if immediate assistance is needed. CFCC does offer non-emergency and non-life-threatening contact with your therapist. You may email your therapist (see the CFCC website for contact information) or use your patient portal to make contact. You may also contact the office during business hours and request your therapist to contact you.

8. Your therapist does not prescribe medications. If it is determined that medication may be beneficial in your situation our therapist will discuss this recommendation with you and refer you to either your Primary Care Physician or a provider that specializes in psychiatric medications.

9. As a courtesy, our Electronic Medical Record program will send a text, voicemail, or email reminder of your upcoming appointment. Upon request you may opt out of these notifications. As text and voicemail messages are unencrypted forms of communication, there is risk that unauthorized disclosure exists and it is possible that text and/or voicemail messages may be intercepted in transit or may be extracted from a mobile device or your mobile carrier's servers by unauthorized and unintended recipients.

10. When telehealth services are utilized, there are some requirements that your therapist will address with you at each session.

a. At the beginning of the session, your therapist will ask your location at the time of the session. This is for your protection so that if there are any emergency Interventions needed during the session, your therapist knows your location and can get you the necessary assistance.

b. With telehealth, there is a possibility that miscommunication may occur due to technical issues. Your therapist will do their best to address and resolve any miscommunications that occur during a session.

c. It is expected that you will do your therapy session in a private setting where you will not be overheard by others. These settings work best if they are quiet and are without background noise. It is expected that you will be appropriately dressed and remain focused for the entire session.

d. Even when most of your sessions are done in an in-person office setting, there are times (inclement weather, travel within the State, illness, etc.) when a telehealth session may be suggested. In any of these circumstances, you may decline the telehealth option and ask to be seen at a later date.

e. Conducting telehealth with children or adolescents presents unique challenges. It is expected that those telehealth sessions will be conducted with privacy so that your child will feel free to discuss any concerns. Telehealth with children and adolescents is best done with clients that are motivated and able to engage for an entire therapy session. Your therapist may suggest that in-office appointments are better suited for your child to accomplish the therapy goals.

11. While you may provide information to your therapist via email, therapy services cannot be conducted via email. Do not rely on email for crisis management. Your therapist will check their email periodically but will not monitor their email constantly. Your therapist will not provide lengthy email responses.

12. As part of the No Surprises Act of 2022, a Good Faith Estimate will be developed for those who are not using their insurance or do not have insurance and are private pay. This GFE is an explanation of expected charges based on your fee agreement and is just that, an estimate. Any additional charges for additional services will require a separate GFE. A GFE is available upon request for any client.

13. When a child/adolescent begins therapy services, it is expected that one or both parent(s)/guardian(s) participate in the Intake Assessment. Parent(s)/guardian(s) will be asked to provide necessary information and then may be asked by the therapist to wait in the waiting room while they continue the Intake interview with the child/adolescent. During the second session, a treatment plan will be developed with input from the child/adolescent and their parent(s)/guardian(s). Treatment planning for a child/adolescent must include family therapy because the input of the parent(s)/guardian(s) is necessary. Thus, parent(s)/guardian(s) may be asked to attend subsequent therapy sessions at the therapist's discretion.

14. When a child/adolescent begins therapy services in the case of a family transition (e.g., parental divorce or remarriage), some necessary information for the Intake Assessment may be sensitive or previously unknown to the child/adolescent. In such cases, please make this known to your child's/adolescent's therapist either before or during the initial portion of the Intake Assessment so they can decide regarding the appropriateness of beginning the Intake Assessment without the child present. While such family transitions can be difficult, parental cooperation and participation in the therapy process is expected in accordance with the best interests of the child/adolescent. Be advised that CFCC therapists are not mediators and therefore do not make recommendations regarding custody, visitation arrangements, vacation schedules, or other determinations related to legal proceedings.

15. If you have questions and/or if you have information about which you want to ensure your therapist is aware, please email the therapist before the next scheduled session. The therapist may respond to confirm receipt but please do not expect a lengthy email exchange. Please see the Confidentiality section about rights to records.

Informed Consent Contract

Please carefully read the Welcome Document in which detailed explanations for each area of informed consent are provided.

Please initial your agreement:

___ I agree for myself and/or my child(ren) to enter therapy services at CFCC & Associates, Inc. (hereafter, "CFCC"). I understand that, as guarantor, I am responsible for the entire session fee of $220.00 for the Intake Assessment and $180.00 for each subsequent session. I understand that payment is due at the time of service. My insurance may assist with these fees based on the provisions of my health insurance policy. If I am utilizing a Reduced Fee Agreement, I understand that I am responsible for the agreed upon amount for each session.

___ I hereby consent and authorize CFCC and Associates, Inc. to make any and all claims on my/our behalf to my insurance company (if applicable). If for any reason my health insurance policy does not cover the cost of CFCC and Associates, Inc. services, I understand that, as guarantor, I am responsible for the total balance owed.

___ I understand that my information will be treated with the highest measure of confidentiality by CFCC. There may be times my insurance company requests additional information to determine payment for services. See the Confidentiality section of the Welcome Document for detailed explanations and limitations of confidentiality.

___ I understand that I may discontinue therapy services at any time and that I have no moral, legal, or financial obligation to complete a maximum or minimum number of therapy sessions. If I discontinue therapy services I agree to pay my total remaining balance due, and I understand that I must do so before I resume therapy services later.

___ I agree to notify CFCC as soon as possible when I need to cancel a therapy session. If I neglect to cancel a session, or if I do so within 24 hours of the scheduled appointment time, I will be responsible for half of the regular session fee. I understand that after three instances of neglecting to cancel a session or doing so within 24 hours of the scheduled appointment time, I will be discharged from therapy services. CFCC provides the option to notify me via my preferred contact method to remind me of upcoming appointments.

___ I understand that telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (i.e., Internet or Phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management in my behavioral health care. I understand that telehealth may be utilized by my therapist. I have read the telehealth section of the Welcome Document and acknowledge I understand and accept the expectations, limitations, and complications that may arise using telehealth services.

___ I agree that I will not record any of my sessions by any means. My therapist will not record my sessions unless they are an Intern or a therapist under supervision working to obtain their clinical license. These exceptions are explained in the Welcome Document and I will sign a separate document about the scope and use of those recordings.

___ I agree to the customary procedures utilized by CFCC for the handling of patient records, documents containing Protected Health Information (PHI), and other documents. I understand that if I want more specific information about the Health Care Portability and Accountability Act (HIPAA), it will be provided upon my request.

___ I have read the expectations and limitations of confidentiality, record sharing, and outside venders' use of my protected health information (PHI) in the Welcome Document. I understand that I have the right to restrict use of my PHI, but that it may result in my insurance denying payment for sessions and, therefore, I will be responsible for all fees. I understand that my consent will remain in force from this time forward unless I submit written revocation of consent to the CFCC Office Manager.

I have read, understand, and agree to the terms listed in the Informed Consent Contract and explained in the Welcome Document.

Name of Client or Legal Guardian

_____

Signature of Client or Legal Guardian

_____

Date: _____

Name of Client's Partner who is presenting for services under a Relational File:

_____

Signature of Client's Partner who is presenting for services under a Relational File:

_____

Date: _____

Physician Notification

You have two options regarding CFCC's statutory obligation to notify your Primary Care Physician or Psychiatrist that you have initiated behavioral health services. You may either agree to allow this notification or you may waive your right to notify your physician. **Please choose only one**.

_____ I agree to allow my therapy provider to notify my Primary Care Physician or Psychiatrist/Medication Provider that I have initiated behavioral health services. If I choose this option, I will provide the necessary contact information below. If I do not provide this information, a letter will not be sent.

OR

_____ I waive my right for my therapy provider to notify my Primary Care Physician or Psychiatrist/Medication Provide that I have initiated behavioral health services.

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____

Psychiatrist/Medication Provider's Name: _____

Psychiatrist/Medication Provider's Address: _____

Psychiatrist/Medication Provider's Phone: _____

Appointment Notification

At CFCC, we will notify you of your appointment times via email, text, or phone call upon your request. Please indicate your preference:

I prefer to receive notifications via email at this email address:

_____

I prefer to receive notifications via text message at this number:

_____

I prefer to receive notifications via phone call at this number:

_____

CHILD INTAKE

Child Client:

Name:		Gender:
Date of birth:	Grade:	Referral Source:
Living Situation: □ Biological/Adoptive Mother and Father in Home □ Joint Custody with Shared Parenting – Name of Residential Parent: _____ □ Single Parent Home □ Foster Care _____ □ Other: _____		
Primary Care Physician:	Primary Care Physician Phone Number:	
Psychiatrist/Medication Provider:	Psychiatrist/Medication Provider Phone Number:	
Do you want your faith resource utilized in your child's therapy services? □ Yes □ No		

Caregiver #1:

Name:		Relationship:
Home Address:		
City:	State:	Zip:
Cell Phone: _____ Leave Message? □ Yes / □ No	Work Phone: _____ Leave Message? □ Yes / □ No	Home/Other Phone: _____ Leave Message? □ Yes / □ No
Employment Status: □ Full-Time □ Part Time □ Stay at Home Parent □ Unemployed □ Retired □ Disabled		

Caregiver #2:

Name:		Relationship:
Home Address (if different than #1):		
City:	State:	Zip:
Cell Phone: _____ Leave Message? □ Yes / □ No	Work Phone: _____ Leave Message? □ Yes / □ No	Home/Other Phone: _____ Leave Message? □ Yes / □ No
Employment Status: □ Full-Time □ Part Time □ Stay at Home Parent □ Unemployed □ Retired □ Disabled		

Foster Care Agency:

Name of Agency:	Name of Case Manager:	
Agency Phone Number:	Agency Fax Number:	Case Manager Phone Number:
Reintegration Plan at This Time:		

Emergency Contact Person:

Name:	Phone #:	Relationship:

Many of our clients allow family members or others to call and request therapeutic or billing or appointment time information. Under HIPAA, we are not allowed to give this information to anyone without the client's consent. If you wish to have this information released to family members or others, you may sign here. You have the right to revoke this consent in writing at any time.

I, _____ give my permission to CFCC & Associates, Inc. to disclose information to those listed below:

Name	Relationship

(check all that apply):

Information to be Disclosed (check all that apply):

- □ Therapeutic updates
- □ Information/changes to treatment planning
- □ Date and time of appointments
- □ Ability to cancel and reschedule appointments
- □ Billing information (check on balance, pay bill, etc.)
- □ Transportation Company _____

Signature: _____ **Date:** _____

Insurance Information: (Please provide support staff with your card to make copy.)

Insured's Name:		SSN:
Personal Identification #:	Group #:	Insured's Date of Birth:
Insurance Company:		Phone #:
Address:		
City:	State:	Zip:

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			