Independent Management Services

Providing Human Services to Families in Southern Minnesota

101 21st St SE Suite 1 | Austin, MN, 55912 |Phone (507) 437-6389 | Fax (507) 437-0977 | info@imsofmn.com | imsofmn.com

TELEHEALTH ASSESSMENT FOR CLIENT FIT

Level of Risk:

- Have you been suicidal in the past 6 months, or are you at significant risk of becoming so? ☐ Yes ☐ No
- Have you been homicidal in the past 6 months or are you at significant risk of becoming so? ☐ Yes ☐ No
- Do you have delusions about technology/electronics, or have a significant risk of developing them? ☐ Yes ☐ No
- Are you willing to identify an appropriate Support Person who can be available during your Telehealth sessions? ☐ Yes ☐ No
- Are you willing to provide your own location, phone number and proof of your identity? The location of your Telehealth sessions will be your home. If this changes, will you let your therapist/mental health practitioner/CD counselor know your location? ☐ Yes ☐ No
- Are you a victim of domestic abuse? ☐ Yes ☐ No
  >> I understand there are risks of Telehealth services in domestic abuse situations. The option of in-person counseling is available to me. ☐ Yes ☐ No

Technology:

- Do you have a computer/device with internet access and that has the capability of using a HIPPA compliant webpage? ☐ Yes ☐ No
- Do you have an email address and are you comfortable using email? ☐ Yes ☐ No
- Are you comfortable with using video conferencing as a means of receiving counseling? ☐ Yes ☐ No
- Do you have a location to receive Telehealth services that allows for confidentiality? ☐ Yes ☐ No
  You will be asked to test the capability of your computer and video conferencing technology with either a staff or a friend prior to beginning Telehealth sessions. Are you willing to do this?
- I understand that my appointment time is valuable time with my therapist/mental health practitioner/CD counselor. I agree to be at my computer and ready for my staff to invite me to my Telehealth session within 5 minutes of my scheduled session. ☐ Yes ☐ No
- There is the potential for technology breakdowns and interruptions. Do you believe that the use of technology will cause you more distress than it will help you? ☐ Yes ☐ No

Region/Location:

- Will you be in the state of Minnesota when receiving Telehealth counseling? ☐ Yes ☐ No
- Are emergency services accessible? ☐ Yes ☐ No

  Name of local Hospital/Medical Clinic: _____

  Phone Number: _____

  Name of Support Person available during sessions: _____

  Phone Number: _____

  If your Support Person is not available, for your safety and well-being, do you agree to go to the local Emergency Room or access Crisis Services if your therapist/mental health practitioner/CD counselor make such a suggestion? ☐ Yes ☐ No

Independent Management Services

Providing Human Services to Families in Southern Minnesota

101 21st St SE Suite 1 | Austin, MN, 55912 |Phone (507) 437-6389 | Fax (507) 437-0977 | info@imsofmn.com | imsofmn.com

Insurance (if applicable):

- If your insurance does not cover Telehealth Counseling, are you willing to pay out of pocket for your sessions? ☐ Yes ☐ No

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

FOR STAFF USE ONLY:

Score: _____

A score of greater than **1** may indicate the client is not an appropriate fit for Telehealth services.

- Per Assessment, this client IS a fit for Telehealth, and it is appropriate to proceed at this time. ☐ Yes ☐ No
- This clinician is competent to address this client's needs/goals via Telehealth Services. ☐ Yes ☐ No
- This Client is NOT an appropriate fit for Telehealth Services at this time. Client should receive services in a face to face setting. ☐ Yes ☐ No

Staff Signature: _____ Date: _____