



GRUPOS DE APOYO FAMILIAR

¿Tiene un familiar o ser querido que viva con una enfermedad mental?

Nuestros grupos de apoyo familiar están aquí para USTED. Esta es una oportunidad para conocer a otros que enfrentan desafíos similares a los suyos. Una oportunidad para compartir y conectarse en un ambiente seguro y abierto. Nuestro objetivo es brindarle apoyo emocional y práctico y ofrecerle recursos útiles y consejos para enfrentarlo. Los grupos de apoyo familiar son GRATUITOS y están abiertos a TODOS. Para su comodidad, puede completar los siguientes formularios antes de asistir a su primera reunión. También estarán disponibles en la sesión.



Authorization to Exchange Information
Via Electronic Means between Provider and Client

Transitions-Mental Health Association

Inspiring hope, growth, recovery and wellness in our communities.

Client Name _____ Date of Birth _____

If communication is with Guardian or legal representative (name and relationship) _____

Client's Cell Phone Number and/or Email _____ Call Phone Carrier (so we can text from computer) _____

The following providers may exchange health related information with me via text message and email:

Shawn Ison, Fernando Vasquez, Vivian Soul, Maria Perez, Zandra Alfaro-Olea, Laura Gaisie, Linda Quesenberry, Elissa Feld

Provider names and roles (Clinician, Case manager, Nurse, etc.) _____

NOTE: Signing this document authorizes the exchange of health information between client and provider via text messaging and via e-mail.

Please read all of the cautions below:

- Communication by text and/or e-mail may not be secure and private. Understanding this risk, you are voluntarily requesting this form of communication.
- If your situation is important or time-sensitive and needs immediate attention, do not rely on text message or e-mail. Electronic communications will only be returned during business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. (excluding holidays). If you have sent an electronic message to your provider and have not had a response within 48 hours, please contact your provider by phone.
- Communication by text will be limited to scheduling and logistics only. If communication is initiated, which includes clinical information, TMHA Staff is responsible for switching to in-person or phone (voice) discussion.
- Electronic communication will not be used for crisis services or to communicate clinical information. **If you are having a crisis, call 911 or call TMHA hotline at 800-783-4607.**
- If you change your phone number or e-mail address, you must notify the Health Agency.

I request and authorize the San Luis Obispo County Health Agency to exchange limited information with me about my healthcare via text messaging and e-mail. I have read and understand this Request and Authorization to Share Information via Electronic Means between Provider and Client.

Client or Legal Representative Signature _____ Date _____

Print Client or Legal Representative's Name _____

For Staff Use Only:

Client ID#: _____ Date Received: _____

784 High Street
San Luis Obispo, California 93401
805-540-6500 ♦ FAX 805-540-6501



Family Services Client Intake Form

Date of Contact (Today's Date) MM / DD / YYYY _____
Your Information: _____

First _____ Middle _____ Last _____ Home Address _____

City _____ County _____

State _____ Zip Code _____

Email #1 _____ Email #2 _____

Home Phone _____ Cell Phone _____

Work Phone _____ Referring Agency _____

Your Age (Fill in the circle) Children (0-15) Female
 TAY (16-25) Male
 Adult (26-59) Other
 Older Adult (60+)

Ethnicity - Are you of Hispanic descent? No Yes
 No English
 Mesteco Spanish
 Other None
 Other

Primary Language English Mesteco Spanish Other
 English None Other

Do you attend the Family Support Group? Yes No

Referred By _____ Consumer Name (Family Member/Loved One) _____

First _____ Middle _____ Last _____

CAN WE PUT YOU ON OUR MAILING LIST (Newsletters, Solicitations, Etc.) YES NO
CAN EMAIL YOU? YES NO
CAN WE TEXT YOUR CELL PHONE? YES NO

Your Relationship to the Consumer _____

Under-served Population
Homeless Yes No Veteran Yes No LGBTQIA Yes No Spanish Language Yes No Rural Yes No Hearing Impaired Yes No Vision Impaired Yes No Other Disability Yes No

I understand that the services I receive through TMHA programs are completely confidential and provided free of cost through Mental Health Services Act funding and private donations.

Signature _____

Grupo de Apoyo Familiar Para familias y seres queridos que tienen personas con problemas mentales; visite el grupo sin hacer cita, no hay costo y no es necesario llamar para asistir. Llame 805-540-6573

San Luis Obispo

Martes 12–3 pm

784 High Street

Para información llame al (805) 540-6571

Atascadero

Jueves 11-12 pm

5575 Hospital Dr

Para información llame al (805) 540-6574

Cambría

Primer y tercer viernes de cada mes 12: 30-2: 30 pm

1069 Main St.

Para información llame al (805) 503-0009

Santa Maria

Jueves 12-2 pm

500 Foster Road

Viernes 12-1: 30 pm (Se habla español)

Para información llame al (805) 441-3325

Lompoc

Miércoles 12-2 pm

401 East Cypress St. (Sala de conferencias del primer piso)

Para información llame al (805) 458-5487

Si tienes alguna pregunta, llame a Shawn Ison,

Director del programa de servicios familiares

al **(805) 540-6571**