

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information"(PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The confidentiality of alcohol and drug abuse Client records is specifically protected by Federal law and regulations. The confidentiality of mental health client records is specifically protected by state law. Nicasa is required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend the program or disclosing any information that identifies you as an alcohol or drug abuser. The violation of these laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations or applicable law.

How We May Use and Disclose Health Information About You

- **For Services.** We may use medical and clinical information about you to provide you with services.
- **For Payment.** With your authorization, we may use and disclose medical information about you so that we can receive payment for the services provided to you. If you are receiving substance abuse treatment services, this will only be done with your authorization.
- **For Health Care Operations.** We may use and disclose your protected health information ("PHI") for certain purposes in connection with the operation of our program.
- **Without Authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained on the following pages.
- **With Authorization.** We must obtain written authorization from you for other uses and disclosures of your PHI.

Your Rights Regarding Your PHI. You have the following rights regarding PHI we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **Complaints.** You have the right to file a complaint in writing to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filing a complaint.*

**If you have any questions about this Notice of Privacy Practices,
please contact Nicasa's Privacy Officer at
Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450**

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by posting a copy on our website NICASA.ORG, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

Listed below are examples of the uses and disclosures that Nicasa may make of your protected health information ("PHI"). These examples are not meant to be exhaustive. Rather, they describe types of uses and disclosures that may be made.

Uses and Disclosures of PHI for Services, Payment and Health Care Operations

Services. Your PHI may be used and disclosed by your physician, counselor, program staff and others outside of our program that are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and any related services. This includes coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care treatment. For example, your protected health information may be provided to the state agency that referred you to our program to ensure that you are participating in treatment. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the program, becomes involved in your care. Except for emergency services, we will not send your PHI to an outside health care provider who is caring for you unless you give us written authorization to do so.

Payment. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If you are in a substance abuse treatment program, we will not use your PHI to obtain payment for your health care services without your written authorization. If you are in a mental health program, we may use your PHI to obtain payment for your health care services without your written authorization.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our program including, but not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or counselor. We may also call you by name in the waiting room when it is time to be seen. We may share your PHI with third parties that perform various business activities (e.g., billing or typing services) for Nicasa, provided we have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI.

We may contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you concerning Nicasa's fundraising activities.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Clients. We may disclose PHI regarding deceased Clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Nicasa.

Criminal Activity on Program Premises/Against Program Personnel. We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel.

Court Order. We may disclose your PHI if the court issues an appropriate order and follows required procedures.

Interagency Disclosures. Limited PHI may be disclosed for the purpose of coordinating services among government programs that provide mental health services where those programs have entered into an interagency agreement.

Public Safety. If you are in a mental health treatment program only, we may disclose PHI to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Uses and Disclosures of PHI With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization at any time, unless the program or its staff has taken an action in reliance on the authorization of the use or disclosure you permitted.

Your Rights Regarding your Protected Health Information

Your rights with respect to your protected health information are explained below. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

You have the right to inspect and copy your Protected Health Information

You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the record. A "designated record set" contains medical and billing records and any other records that the program uses for making decisions about you. Your request must be in writing. We may charge you a reasonable cost-based fee for the copies. We can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right to appeal the denial of access. Please contact our Privacy Officer if you have questions about access to your medical record.

You may have the right to amend your Protected Health Information

You may request, in writing, that we amend your PHI that has been included in a designated record set. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of it. Please contact the Nicasa Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of some types of Protected Health Information disclosures.

You may request an accounting of disclosures for a period of up to six years, excluding disclosures made to you, made for treatment purposes or made as a result of your authorization. We may charge you a reasonable fee if you request more than one accounting in any 12 month period. Please contact our Privacy Officer if you have questions about accounting of disclosures.

You have a right to receive a paper copy of this notice.

You have the right to obtain a copy of this notice from us. Any questions should be directed to our Privacy Officer.

You have the right to request added restrictions on disclosures and uses of your Protected Health Information.

You have the right to ask us not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for restrictions must be in writing and we are not required to agree to such restrictions. Please contact our Associate Director if you would like to request restrictions on the disclosure of your PHI.

You have a right to request confidential communications.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable, written requests. We may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. We will not ask you why you are making the request. Please contact the Client Services Department if you would like to make this request.

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us by notifying Nicasa's Privacy Officer at Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450. We will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services as follows:

200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257

The effective date of this Notice is April 14, 2003.

**Nicasa's Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received a copy of Nicasa's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nicasa's Privacy Officer at 847-546-6450.

Signature of Client **Date**

Signature or Parent, Guardian or Personal Representative * **Date**

* If you are signing as a personal representative of a client, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt:

Signature of Staff Member **Date**

Nicasa Behavioral Health Services
CONSENT FOR GAMBLING EVALUATION SERVICES

I authorize and consent that I, _____,
receive evaluation as a result of _____.

The nature and purpose of the service will be to explore my relationship with gambling, concerns I have about my gambling, concerns others may have about my gambling, identify other substance use or mental health conditions that may be related to my gambling, and to develop recommendations to address these. I understand that, the findings of this evaluation, or other information will be shared with 3rd parties for whom I have given written permission. Confidentiality is maintained per applicable laws, and the exceptions to this have been explained to me. Alternatives to these services have also been explained to me by _____.

I understand that no guarantee or assurance has been given me, by anyone, as to the results of the service.

I also have been informed that my records and disclosures will be kept absolutely confidential except only as the law may otherwise require such disclosures.

This consent for services is revocable by either party through written notice. In such instances, the case will be closed and maintained for possible future use. After closing the case, the same standards of confidentiality and accessibility to records will be upheld.

Signature of Client

Signature of Witness

Signature of Parent or Guardian

Client ID #

Date

Emergency Notification

I _____, hereby authorize Nicasa staff to contact the following persons in the case of an emergency.

Primary Contact:

Name

Phone
Secondary Contact: (to be contact if primary contact cannot be reached)

Name

Phone

If you have a medical emergency and cannot communicate with First Responders, the following will be shared with emergency personnel:

- Name
- Address
- Date of Birth

Please initial and complete the following if you wish this information to be released to emergency personnel:

___ All medications that you have disclosed at Nicasa that you are taking

Initials

___ The following allergies and/or medical condition(s): _____

Initials

Client Signature

Date

If you are able to communicate, Nicasa will release no private health information to First Responders.

Nicasa Request for Confidential Means of Communications

ORIGINAL CHANGE

Today's Date: _____	
Client's Name: _____	Client # _____
Client's Birth Date _____	Social Security Number _____
Client's Address: _____	
Daytime Telephone _____	Evening Telephone _____

Nicasa may contact you by mail, phone or fax. This communication may include your protected health information. If you do not wish to be contacted by one or more of these methods please specify below:

DO NOT CONTACT ME AS FOLLOWS: _____

If you wish to be contacted at an address other than the one stated above, please specify below:

PLEASE CONTACT ME AT: _____

If the restrictions affect my payment arrangements, payment will be made as follows:

I understand that Nicasa will agree to all reasonable requests, but may deny a request if I do not clearly provide an alternative means of contact, or if I do not provide information as to how payment, if applicable, will be made. Nicasa will notify me in writing of its response to my request.

Signature of Client

Date

Signature of Client's Personal Representative

Date

<u>THIS SECTION TO BE COMPLETED FOR CHANGE IN CONFIDENTIAL MEANS OF COMMUNICATION ONLY</u>	
<u>For Organization Use Only:</u>	
Date Request Received: _____	
Date of Written Response: _____	
Action taken (CHECK ONE): _____ Approved _____ Denied	
Staff person signature _____	Date _____



Positive Choices. Lifelong Solutions.

I, _____ (Client's Name), whose Date of Birth is _____, authorize Nicasa to disclose to and/or obtain from: _____

(Name of Person/Title of Person or Organization) the following information:

Description of Information to be Disclosed (Client needs to initial each item to be disclosed)

- Assessment/Evaluation, Diagnosis, Psychological Evaluation, Psychiatric Evaluation, Treatment Plan/Summary, Current Treatment Update/Status, Medication Management Information, Presence/Participation in Treatment, Nursing/Medical Information, Toxicological Reports/Drug Screens, Risk Reduction Education Information, Discharge/Transfer Summary, Continuing Recovery Plan, Progress in Treatment, Demographic Information, SOS Documentation (Updates, Tx Verification), Status/Completion Letters, Other

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to services and when appropriate, coordinate services. If other purpose, please specify: _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Nicasa, at 31979 Fish Lake Road, Round Lake, IL, 60073. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires one year from the date of my discharge.

Conditions: I further understand that Nicasa will not condition my services on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: client responsible for obtaining all information in person.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format or electronically.

Redisclosure: State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

Signature of Client

Date

Signature of Parent, Guardian or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Check here if Client refuses to sign authorization

Signature of Staff Witness Attesting to Identity & Authority

Date

Nicasa Criminal Justice System Referral

Client# _____

I, _____, whose social security number is _____, hereby consent to communication between Nicasa and:

- _____ Circuit or District Court of _____ County ordering me to treatment (including the Judge and District Attorney)
- _____ Illinois Department of Corrections and Parole
- _____ _____ County Department of Corrections
- _____ _____ County Department of Probation
- _____ City of _____ Police Department
- _____ _____ County Sheriff's Department
- _____ Treatment Alternatives for Safe Communities ("TASC")
- _____ Defense Attorney (name): _____

Information will be disclosed for the purpose of informing the criminal justice agencies listed above of my participation and progress in Nicasa programs, including any of the following information: Assessment, Completion Letters, Diagnosis, Treatment Plan or Summary, Current Treatment Update, Medication Management Information, Toxicological Reports/Drug Screens, Educational Information, Discharge/Transfer Summary, Legal History, Other: _____.

I understand that Nicasa is providing treatment to me in reliance on this authorization permitting disclosure to criminal justice agencies. Therefore, I understand that this authorization will remain in effect and cannot be revoked by me until final disposition of the proceeding that gave rise to the criminal justice system referral. At that time, I may revoke this authorization as follows: in writing mailed to Nicasa at 31979 Fish Lake Road, Round Lake, IL 60073. If not revoked, this authorization will terminate one year after the date of discharge or final disposition of the proceeding giving rise to the criminal justice system referral, whichever is later.

A person who receives confidential information may redisclose and use it only to carry out that person's official duties.

Signature of client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Nicasa Behavioral Health CLIENT RIGHTS

Nicasa provides treatment for individuals and families. Your rights are protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Although each of Nicasa's individual programs vary in the type of care offered, the following policies and procedures are made to improve the dignity of all clients and to protect their rights as human beings. These rights will be given to you in all cases.

You have the right:

1. To personalized treatment that is fair, with no unfairness shown because of your race, religion, gender, age, ethnicity, sexual orientation, sexual identity, HIV status, or disability.
2. To have your disabilities accommodated as required by the Americans with Disabilities Act section 504 of the Rehabilitation Act and the Human Rights Act.
3. To be treated at all times with dignity and respect in a setting that is free from the following: physical punishment or abuse; sexual abuse or harassment; psychological abuse including humiliating, threatening and exploitive actions; verbal abuse; neglect; and exploitation for financial gain.
4. To treatment in a setting that is the least interfering to your personal freedom and that provides privacy within the limits of the agency's capabilities.
5. To know that any testing you have regarding HIV/AIDS will be anonymous and that your HIV/AIDS status and testing will remain completely confidential.
6. To know the clinical staff responsible for your care, their credentials, qualifications, and professional experience.
7. To participate in your treatment and discharge planning, including periodic review of your treatment plan.
8. To confidentiality and privacy governed by the Confidentiality Act and the Health Insurance Portability and Accountability of 1996.
9. To confidentiality and privacy and to know that confidentiality is limited by law in cases such as medical emergencies, suspected child abuse, court order, suspected abuse of adults who cannot protect themselves, threats to the lives of others, and any other instances specified by law when disclosure may be made without client's consent.
10. To know that identifiable photographs, video tape, films, etc., will not be made or used without your written consent, nor will you be required to make public statements which acknowledge gratitude to Nicasa, NFP for its services.
11. To complain, initiate a grievance, or report any inappropriate activity without fear of reprisal or retaliation.

For clients receiving mental health services, clients have the right to:

- a) Contact the Guardianship and Advocacy Commission and Equip for Equality, Inc.
- b) Assistance in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality,

Inc.: GUARDIANSHIP AND ADVOCACY COMMISSION 160 N. LaSalle Street,
Suite S500 Chicago, IL 60601 Voice: (312) 793-5900 or (866) 274-8023 Fax: (312)
793-4311 Website: www.gac.state.il.us.

- c) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position.
 - d) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights; and
 - e) The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
12. To give your informed consent, informed refusal, and/or expression of choice (and to be advised of the consequences of your decisions) in regard to service delivery, release of information, the availability of concurrent services, composition of your service delivery team, and your involvement in research projects.
 13. To know that Nicasa adheres to all federal and state-required research guidelines and ethics, and to refuse to participate in any research projects without compromising your access to services.
 14. To have access and/or referral to legal entities for appropriate representation, as well as access to self-help and advocacy support services.
 15. To have access to your record and other information pertinent to your treatment planning, and to have that information released in a timely and appropriate manner that will facilitate decision making. The only exception to this right being the restrictions permitted by federal law (HIPAA) which include psychotherapy notes and information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding.
 16. To a prompt investigation and resolution of alleged infringement of these rights.
 17. To know that all other legal rights to which you are entitled will be recognized and enforced while you are a client at Nicasa.
 18. To request an ethics review/investigation of any staff member without fear of reprisal.

For Residential Clients

19. (For residential clients) To visitation in a suitable area by all concerned persons who have been clinically determined to be of benefit to your treatment in accordance with agency policies.
20. To the receipt and sending of mail without censor and to know that your mail will not be read by staff members.
21. To conduct private telephone conversations in accordance with agency policy unless contraindicated by clinical considerations.

I understand the nature of treatment with Nicasa, and my signature indicates consent to treatment with Nicasa, NFP.

Client Signature: _____ Date: _____

Client's level of understanding: Satisfactory _____ Unsatisfactory _____

I have explained these rights to the individual (or guardian of the individual) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

Staff Signature: _____ Date: _____

Duplicate copy of Client Rights statement given to Client's:

Family _____ Significant Other _____ Guardian _____



Effective February 29, 2016

Service Fees

EVALUATIONS

DUI	\$150
Narrative Substance Abuse/Gambling	\$200
Mental Health Assessment	\$200
Locus Assessment	\$100
Secretary of State Part 1	\$100
Secretary of State Part 2	\$500

INDIVIDUAL SERVICES

Substance Abuse/Mental Health	1 hour @	\$100
Treatment Plan	1 hour @	\$100
AODA Intake	1/2 hour @	\$25
Moderate Intake	1 hour @	\$100
Significant/High Risk/IOP Intake	1 hour @	\$125
Youth Intake	1 hour @	\$100

Your costs

OUTPATIENT GROUP

Substance Abuse	1 hour @	\$28
Mental Health	1 hour @	\$28
AODA-TRACK	1 hour @	\$14
	1 hour @	\$10

Estimated hours*

Estimated costs

INTENSIVE OUTPATIENT GROUP

Substance Abuse/Mental Health	1 day @	\$250
	or 1 hour @	\$28

Estimated days/
hours*

Estimated costs

TOXICOLOGY

Urinalysis drug screen	\$60
Redi Strip alcohol screen	\$40

Estimated hours*

Estimated costs

OTHER

Parenting	1 hour @	\$28
GOALS	total program @	\$140

Estimated cost of your treatment

\$ _____

*Total number of hours/days is based on a client's individual treatment plan and progress and is subject to change.

Client Signature

Date

SOUTH OAKS GAMBLING SCREEN (SOGS)

1. Indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "not at all," "less than once a week," or "once a week or more."

Not at all	Less than once a week	Once a week or more	
			a. played cards for money
			b. bet on horses, dogs or other animals (In off-track betting, at the track or with a bookie)
			c. bet on sports (parley cards, with a bookie, or at jai alai)
			d. played dice games (including craps, over and under, or other dice games) for money
			e. went to casino (legal or otherwise)
			f. played the numbers or bet on lotteries
			g. played bingo
			h. played the stock and/or commodities market
			i. played slot machines, poker machines or other gambling machines
			j. bowled, shot pool, played golf or played some other game of skill for money

2. What is the largest amount of money you have ever gambled with any one day?

- never have gambled
- more than \$100 up to \$1000
- \$10 or less
- more than \$1000 up to \$10,000
- more than \$10 up to \$100
- more than \$10,000

3. Do (did) your parents have a gambling problem?

- both my father and mother gamble (or gambled) too much
- my father gambles (or gambled) too much
- my mother gambles (or gambled) too much
- neither gambles (or gambled) too much

4. When you gamble, how often do you go back another day to win back money you lost?

- never
- some of the time (less than half the time) I lost
- most of the time I lost
- every time I lost

5. Have you ever claimed to be winning money gambling but weren't really? In fact, you lost?

- never (or never gamble)
- yes, less than half the time I lost
- yes, most of the time

6. Do you feel you have ever had a problem with gambling?

- no
- yes, in the past, but not now
- yes

7. Did you ever gamble more than you intended?

Yes No

8. Have people criticized your gambling?

9. Have you ever felt guilty about the way you gamble or what happens when you gamble?

10. Have you ever felt like you would like to stop gambling but didn't think you could?

11. Have you ever hidden betting slips, lottery tickets, gambling money, or other signs of gambling from your spouse, children, or other important people in your life?

12. Have you ever argued with people you like over how you handle money?

13. (If you answered "yes" to question 12): Have money arguments ever centered on your gambling?

14. Have you ever borrowed from someone and not paid them back as a result of your gambling?

Yes No

15. Have you ever lost time from work (or school) due to gambling?

16. If you borrowed money to gamble or to pay gambling debts, where did you borrow from? (Check "yes" or "no" for each)

a. from household money		
b. from your spouse		
c. from other relatives or in-laws		
d. from banks, loan companies or credit unions		
e. from credit cards		
f. from loan sharks (Shylocks)		
g. your cashed in stocks, bonds or other securities		
h. you sold personal or family property		
i. you borrowed on your checking account (passed bad checks)		
j. you have (had) a credit line with a bookie		
k. you have (had) a credit line with a casino		

INTERVIEWER: For each question asked, circle YES or NO. When interview is complete, for questions for which R said YES, mark the corresponding box in the right-hand margin, ignoring items that do not have a corresponding box. Add up the number of checks from these boxes to determine R's score. A score of 0 indicates that results are not consistent with problematic levels of gambling. A score of 1 or 2 means that results are consistent with mild but subclinical risk for gambling problems. A score of 3 or 4 indicates results are consistent with moderate but subclinical gambling problems. A score of 5 or higher means that results are consistent with a likely diagnosis of pathological gambling. The highest score possible is 10.

1. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets?

YES SKIP TO ITEM 3
NO GO TO ITEM 2

1

2. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about ways of getting money to gamble with?

YES
NO

2

3. Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?

YES GO TO ITEM 4
NO SKIP TO ITEM 5

4. If so, has this happened three or more times?

YES
NO

4

5. Have you ever tried to stop, cut down, or control your gambling?

YES GO TO ITEM 6
NO IF RESPONDENT SAID YES TO ITEMS 1 or 3, CONTINUE TO ITEM 9 ON THE NEXT PAGE. OTHERWISE, THANK R AND CLOSE INTERVIEW.

6. On one or more of the times when you tried to stop, cut down, or control your gambling, were you restless or irritable?

YES
NO

6

7. Have you ever tried *but not succeeded* in stopping, cutting down, or controlling your gambling?

YES GO TO ITEM 8
NO SKIP TO ITEM 9

8. Has this happened three or more times?

YES
NO

8

The NORC Diagnostic Screen for Gambling Problems—Revised

9. Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement? 9
YES
NO
10. Have you ever gambled to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression? 10
YES SKIP TO ITEM 12
NO GO TO ITEM 11
11. Have you ever gambled as a way to escape from personal problems? 11
YES
NO
12. Has there ever been a period when, if you lost money gambling one day, you would often return another day to get even? 12
YES
NO
13. Have you ever written a bad check or taken money that didn't belong to you from family members or anyone else in order to pay for your gambling? 13
YES
NO
14. Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? 14
YES SKIP TO ITEM 17
NO GO TO ITEM 15
15. Has your gambling caused you any problems in school, such as missing classes or days of school or your grades dropping? 15
YES SKIP TO ITEM 17
NO GO TO ITEM 16
16. Has your gambling ever caused you to lose a job, have trouble with your job, or miss out on an important job or career opportunity? 16
YES
NO
17. Have you ever needed to ask family members or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling? 17
YES
NO