Hernando County Mental Health Center, Inc.

Post Office Box 6239 • Spring Hill, Florida 34606-6239
Tel. (904) 688-0700 • 688-0701

Day late and a dollar short for this call here.
Had they done right it would be a different
story.

June 3, 1992

Dear Mr. Jones,

I have attempted to speak with you by telephone on at least three separate occasions, but have been unsuccessful in reaching you.

If you are still interested in receiving services from Hernando County Mental Health Center, please telephone me to schedule a time for an appointment or to discuss the services you are seeking.

If I do not hear from you in the next 10 days, I will assume you are no longer interested in services.

Please feel free to contact Hernando County Mental Health in the future, however.

Sincerely,

Robert Chmiko, LCSW

Robert Chmiko, M.S.W.
Supervisor, Emergency Services

RC:kww

April 10 1992

799 1579

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This is the second cry for help!

HERNANDO COUNTY MENTAL HEALTH CENTER, INC.

INTAKE INQUIRY

[X] PHONE [ ] WALK-IN INTAKE #: ~~B 04403~~

STATUS: [X] Routine (within 5 days) [ ] Urgent (within 24 hours)

DATE: 4-9 1992 TIME: 1:45 m INTAKE RECORDER'S NAME: Sauck

CLIENT'S NAME: Dewey Jones AGE: 36 SEX: M

ADDRESS: 6258 Kurt St CITY: B'ville ZIP: 34609

PHONE #'S: Home: ( ) n/A Work: ( ) Other: ( )

INSURANCE: [ ] Medicare [ ] Medicaid [ ] Private [ ] None "on hold" for insurance

CALLER'S NAME: Sandra Jones PHONE #: ( )

RELATION TO CLIENT: wife REFERRAL SOURCE: HRS told him to call

CALLER'S DESCRIPTION OF PROBLEM/BEHAVIOR:

cant walk - crisis / cannot work @ all

wants to talk to a psychiatrist @ home AS PP

sad & depressed - doesn't know which way to go. spelling?

needs to talk to someone

MEDICATION: [X] YES [ ] NO If yes, indicate type: Tylox, Hydrodon, Darvaset

Prescribed by:

PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT/HISTORY: [ ] YES [X] NO

If yes, indicate where/whom and date(s):

Diagnosis:

TYPE OF SERVICE REQUESTED: [X] MH [ ] SUBSTANCE ABUSE [ ] CHILDREN'S SERVICES [ ] OTHER

ASSIGNMENT:

Therapist assigned to follow-up:

Therapist assigned to complete evaluation:

CALL BACK LOG: (indicate date, time and response of each call back; at least three attempts at contact must be made)

1. 4-9-92 1:45pm — 2:00pm
2.
3.

FOLLOW-UP LETTER SENT: [ ] YES [ ] NO Date: Response:

DISPOSITION (check applicable box):

[ ] Evaluation appt.: Date: Time: m [ ] SHOW [ ] NO SHOW
Time: m

Date: Time: m [ ] SHOW [ ] NO SHOW
Time: m

[ ] Referred out: Where: Why:

THERAPIST'S COMMENTS: Explained to caller that we could not go out to visit with husband as she stated he was requesting. Offered alternatives especially should this be an emergency case such as calling 911 or asking a minister to do a home visit. Did recommend she find help in getting husband to a phone in order that he call. She denied any suicidal or homicidal intent on client's behalf.

David Britt MA LI

THERAPIST'S SIGNATURE/CREDENTIALS

HCMHC - 3/90 (Rev.)

Four days after DV I was made as hell with these people for not helping me when I needed it.
Then they changed their name to Professional Therapy Center.

Duplicate

HERNANDO COUNTY MENTAL HEALTH CENTER, INC.

INTAKE INQUIRY

[X] PHONE [ ] WALK-IN

INTAKE #: R05090

DATE: 5-26 1992 TIME: 3:00 pm

STATUS: [X] Routine (within 5 days) [ ] Urgent (within 24 hours)

INTAKE RECORDER'S NAME: Jane Kaylion

CLIENT'S NAME: Dewey Jones AGE: 37 SEX: M

ADDRESS: 6258 Kent St CITY: Brooksville ZIP: 3609.

PHONE #'S: Home: (904) 754-1426 Work: ( ) Other: ( )

INSURANCE: [ ] Medicare [X] Medicaid [ ] Private [ ] None SSI

CALLER'S NAME: self PHONE #: ( )

RELATION TO CLIENT: REFERRAL SOURCE:

CALLER'S DESCRIPTION OF PROBLEM/BEHAVIOR: domestic problems - 2 sm children total disability; punched wife in face on weekend after she scalded him @ 120° - spinal injury - wife in Missouri - needs surgery. police called. ES was called on weekend. - Clint disabled, wife now in Missouri with his children. - not interested in services at this time.

MEDICATION: [ ] YES [X] NO If yes, indicate type: [redacted]

Prescribed by:

PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT/HISTORY: [ ] YES [X] NO

If yes, indicate where/whom and date(s):

Diagnosis:

TYPE OF SERVICE REQUESTED: [ ] MH [ ] SUBSTANCE ABUSE [ ] CHILDREN'S SERVICES [X] OTHER ES.

ASSIGNMENT:

Therapist assigned to follow-up: Rol Chinko

Therapist assigned to complete evaluation:

CALL BACK LOG: (indicate date, time and response of each call back; at least three attempts at contact must be made)

1. 5-26-92 - 5:15 PM - No Answer
2. 5-27-92 10:15 AM No Answer, 10:30 N.A. 12 noon No Answer
3. 6-3-92 2:45 pm No Answer.

6-5-92 3:00 pm - 3:15 PM - Client contacted

FOLLOW-UP LETTER SENT: [X] YES [ ] NO Date: 6-2-92 Response:

6-17-92

DISPOSITION (check applicable box):

[ ] Evaluation appt.: Date: [redacted] Time: [redacted] m [ ] SHOW [ ] NO SHOW

Time: m

Date: Time: m [ ] SHOW [ ] NO SHOW

Time: m

[X] Referred out: Where: None Why: Client not interested in services at this time

THERAPIST'S COMMENTS: Client denied suicidal / homicidal ideation plans, intentions. Cl. denied substance abuse problems.

HCMHC - 3/90 (Rev.)

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Robert Smith, LCSW

THERAPIST'S SIGNATURE/CREDENTIALS

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