To: Intake  

FAX TO: 303-487-7240

Date: 

Time: 

AM/PM

Total # of pages including cover:

The following sheet(s) contain CONFIDENTIAL information for the addressee and is meant for that person’s attention only. The authorized recipient of this information is prohibited from disclosing this information to any other party.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in relation to these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

From: 

Department:

Direct phone no.

Re:

Special instructions (language, interpreter, etc.):

Who to contact and their contact number:

☐ Completed Intake Paperwork Attached (All intake paperwork must be completed and signed before a scheduled intake appointment can be offered.)

Notes:

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Operator’s Initials 

J:

Everyone\Reach logos name form\fax format\Mary Ciancio Building.doc
**Community Reach Center ADMISSION FORM**

<table>
<thead>
<tr>
<th>TIER #</th>
<th>Admit Date: / /</th>
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<table>
<thead>
<tr>
<th>Client’s Last Name</th>
<th>Legal First Name</th>
<th>M.I.</th>
<th>Preferred Name</th>
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<tr>
<th>Home Phone Number</th>
<th>Cell Phone Number</th>
<th>Email Address</th>
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<tr>
<th>Street Address</th>
<th>Apt or Lot #</th>
<th>County</th>
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<th>State</th>
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<tr>
<th>Birth Date</th>
<th>Social Security Number</th>
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<tr>
<th>Employer/School Address</th>
<th>Work Phone</th>
<th>Occupation (or grade in school)</th>
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### Are You

- Spanish/Hispanic/Latino:
  - ☐ Hispanic – Mexican
  - ☐ Hispanic – Cuban
  - ☐ Hispanic – Puerto Rico
  - ☐ Hispanic – other
  - ☐ Not Hispanic or Latino
  - ☐ Declined

- Ethnicity:
  - ☐ American Indian/Alaskan Native
  - ☐ Asian
  - ☐ Black/African American
  - ☐ Native Hawaiian/Pacific Islander
  - ☐ White
  - ☐ Declined

### Are You Pregnant?

- ☐ Yes
- ☐ No

### Problem Existed One Year or Longer:

- ☐ Yes
- ☐ No

### Are you a Veteran or Active Military?

- ☐ Yes
- ☐ No

### Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Married Separated
- ☐ Widowed
- ☐ Divorced

### Employment Status:

- ☐ Full Time
- ☐ Part Time
- ☐ Disabled
- ☐ Unemployed
- ☐ Student

### Previous Mental Health Services:

- ☐ Inpatient Care
- ☐ Other 24-hour Care
- ☐ Partial Care
- ☐ Outpatient Care

### Living Arrangement (Check all that apply):

- ☐ Alone
- ☐ Guardian
- ☐ Foster Parent
- ☐ Mother
- ☐ Father
- ☐ Partner/Significant Other
- ☐ Spouse
- ☐ Sibling(s)
- ☐ Child/Children
- ☐ Relative(s)
- ☐ Unrelated Person(s)

### Years of Education:

- _______ (High School Diploma = 12 years)

### Years of Education:

- _______ (High School Diploma = 12 years)

### Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: ________________

Other Family Members in the Home:

<table>
<thead>
<tr>
<th>Name(s):</th>
<th>DOB or Age:</th>
<th>Sex (M or F):</th>
<th>Relationship:</th>
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In Case of Emergency, Call:

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<tr>
<th>Name:</th>
<th>Phone Number:</th>
<th>Relationship:</th>
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<tbody>
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<td>(____) ____-</td>
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</table>
I have reviewed the Consumer Financial Form above and the Fee Billing Policies and Financial Agreement for the Center. I have completed the requested information completely and to the best of my knowledge. I have received a copy of this form and as well as the fee policy agreement and agree to its terms. I agree to assume responsibility and pay the Center the assigned fee.

RELEASE OF INFORMATION
I authorize Community Reach Center to release information for insurance purposes as may be required by the insurance company.

Signature of Consumer/Parent or Guardian Date

Signature of Insured Date

FOR OFFICE PURPOSES ONLY – TO BE COMPLETED BY COMMUNITY REACH CENTER STAFF
Gross Annual Household Income: $ No. of Dependents: Fee Per Session:
No. of Child Dependents:
Community Reach Center, Inc.
Fee Policy and Financial Agreement

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

Community Reach Center, Inc. (CRC) is a non-governmental, not for profit organization that relies on fees and insurance payments for a major portion of its operating expenses. You are ultimately financially responsible for all services you or members of your household receive from the Center.

If you have insurance, Medicare or Medicaid, we require you to:

- Provide a copy of your CURRENT Medicaid card (front and back) at the time of each visit or at least once a month thereafter. Failure to provide a copy of your current card could result in being charged full rate for services. Services are available to you as long as you continue to reside in Adams County and remain eligible for Medicaid services. If you reside outside of Adams County, CRC is responsible to provide emergency services only until we receive a prior authorization from your primary provider. Your primary care physician (PCP) will be notified you are receiving mental health services.

- Provide CRC with any insurance claim form(s) from your employer, insurance agent or company with required information filled in and/or a copy of your insurance card (front and back). Verification of insurance benefits is not a guarantee of payment. The contract for your insurance is between you and your insurance carrier. We will assist you in every way possible to receive payment from them. However, you are ultimately responsible for payment. You are responsible for any/all deductibles and copays.

- Provide a copy of your Medicare card at the time of each visit or at least once a month which reflects whether you are eligible for services under your Medicare Part B insurance. Services provided by Physicians, Licensed Psychologist or Licensed Therapist who are supervised by a physician or psychologist present and available on the premises at the time services are rendered. You are responsible for any/all deductibles and copays not covered by Medicare.

- If at any time your coverage changes, it is your responsibility to notify CRC. Failure to do so could result in the fees billed to you instead of Medicaid, Medicare, your insurance company, special grant or other third party payor.

- In the event additional services are requested or required that are not covered under your insurance or payor plan, you will be solely responsible for those services.

Fee/Billing Policies:

- It is your responsibility to notify CRC of any changes in your financial situation during the term of this agreement. Failure to do so may result in the termination of this agreement and/or changes in your fee.
- At the time of intake, you will be asked to complete a financial statement, if requesting a reduced fee. This reduced fee will be in effect as long as the account remains current. This fee agreement will remain in effect for 1 year unless otherwise noted. An annual review is required on each consumer’s account.
- CRC policy states that consumers who fail to pay for three (3) sessions are at risk of termination of services. The decision to terminate services will be based on both clinical and financial information.
- A NO SHOW fee of $15.00 will be charged if you fail to notify CRC, at least 24 hours prior to your scheduled appointment. This fee will be due at your next appointment.
- Payment is expected prior to any psychological or interactional evaluation for all self-pay consumers.

Delinquent Accounts:

- In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.
Income Attestation Form

Client name: ____________________________  Client ID#__________

I understand that I must provide proof of income in order to set my fee for services received at Community Reach Center. This is according to the State of Colorado Department of Human Services, Division of Mental Health Ability to Pay schedule.

I will provide Community Reach Center with such evidence for each member of my family who contributes to the household income. Income includes wages earned, retirement, child support, maintenance/alimony, investment income, money received from public assistance, and cash received as a gift to aid in the support of the family.

_____ I currently receive Social Security Income in the amount of $________ per month
_____ I currently receive Social Security Disability Income in the amount of $________ per month

I do attest that my total household income is $______________ ( ) per year ( ) per month

This income supports_____ adults (including myself) and _____ children under age 18.

_____ Consumer is Minor consenting to treatment

I understand that this information needs to be updated yearly and I may be asked to sign this form at such time.

_______________________________  __________________
Client’s signature  Date

_______________________________  __________________
Witness (CRC Staff)  Date

4/10/2013
In the last twelve months:

**c** Have you ever felt you should **cut down** on your drinking or drug use?  

**A** Have people **annoyed** you by criticizing your drinking or drug use?  

**g** Have you ever felt bad or **guilty** about your drinking or drug use?  

**E** **Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?
For Clients under the age of 15 or adults who are not their own legal guardians:

<table>
<thead>
<tr>
<th>What type of custody does the parent/guardian have?</th>
<th>Full</th>
<th>Joint</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>Other (temporary, power of attorney, healthcare proxy):</td>
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<td>For divorced/separated parents with joint decision making, consent from both parents is required.</td>
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Parent/Guardian 1: ___________________ Phone #: _____________ Parent/Guardian 2: ___________________ Phone #: _____________

Do you have supporting custody/court documentation with you today? Yes____ No____

Please briefly describe why you are here today: ________________________________________________

Have you used any alcohol or drugs in the last 24 hours (including marijuana)? Yes____ No____

If yes, please write what substance(s) and time it was last used: __________________________________________

Check if you are experiencing the following:

- Active thoughts about killing yourself
- Active thoughts about killing someone else

Check the reason(s) why you are seeking services:

- Individual therapy
- Group therapy
- Drug/Alcohol Treatment
- Medications
- Resources for housing, shelter, food
- Recent Mental Health Hospitalization
- Probation Evaluation
- Other: __________________
- Other: __________________

Do you currently have a therapist or counselor? Yes_____ No_____

If yes, please write their name and what they are treating you for: __________________________________________

Medications will not be prescribed today during your intake. Appointments for medication can be as far out as 30 days. If you need medications sooner, please contact your PCP.

Clinical staff does not monitor this form. It is not intended for crisis intervention.

If you are experiencing a mental health crisis, call Colorado Crisis Services for 24-Hour assistance: (844) 493-8255 (TALK) or dial 911 for emergency assistance.
Consumer ID # ____________________  
Medical Record # ____________________

Name: _______________________________________

Date of Birth: __________________

Primary Care Doctor: ____________________  
PCP Office/Clinic: ____________________

Address: ____________________________________  
City, State, Zip: ____________________

Phone Number: (_______)________________  
Fax Number: (_______)________________

Date of last physical: ____________________

<table>
<thead>
<tr>
<th>Physical Conditions (example: Diabetes, High Blood Pressure, surgeries, etc.)</th>
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<tr>
<td>☐ No known physical conditions</td>
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<tr>
<th>Medication name</th>
<th>Strength (example: 50mg)</th>
<th>Frequency (example: at bedtime, 2x/day, etc.)</th>
<th>Prescribing Physician</th>
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<thead>
<tr>
<th>Medication Allergies</th>
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<tbody>
<tr>
<td>☐ No known medication allergies</td>
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<thead>
<tr>
<th>Medication</th>
<th>Reaction (example: hives, rash, etc.)</th>
<th>Medication</th>
<th>Reaction (example: hives, anaphylaxis, etc.)</th>
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Dental: Please list any dental problems: ______________________________________

☐ No known dental problems