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:

Operator's Initials

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

TIER # ___________________________  Admit Date: _______ / _______ / _______

Client’s Last Name ___________________________  Legal First Name ___________________________  M.I. _______  Preferred Name ___________________________

(____) _______ - _______  (____) _______ - _______  Email Address ___________________________

Home Phone Number  Cell Phone Number

Street Address

_________  ___________  ________________

City State Zip

Birth Date _______ / _______ / _______  Social Security Number

Employer/School Address  Work Phone  Occupation (or grade in school)

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

Gender:
☐ Female
☐ Male

Sexual Orientation:
☐ Heterosexual
☐ Gay/Lesbian
☐ Bisexual
☐ Decline to answer
☐ Other: __________________

Have you ever been diagnosed with the following:

☐ Developmental Disability
☐ Blind / Severe Vision Loss
☐ Traumatic Brain Injury (TBI)
☐ Deaf / Severe Hearing Loss
☐ Learning Disability
☐ None

Marital Status:
☐ Never Married
☐ Married
☐ Married Separated
☐ Widowed
☐ Divorced

Preferred language:
☐ English
☐ Spanish
☐ Other: __________________

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)

Other Family Members in the Home:

Name(s):

DOB or Age: _______  Sex (M or F): _______  Relationship: __________________

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

In Case of Emergency, Call:

Name: ___________________________  Phone Number: _______  Relationship: __________________

(____) _______ - _______  ___________________________
### COMMUNITY REACH CENTER
#### CONSUMER FINANCIAL FORM

**FEE AGREEMENT**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Consumer Account Number:</th>
</tr>
</thead>
</table>

**CONSUMER INFORMATION**

- **Consumer's Last Name:**
- **First Name:**
- **M.I.:**
- **Consumer's Soc. Sec. Number:**
- **Consumer's Date of Birth:**

**PERSON FINANCIALLY RESPONSIBLE**

<table>
<thead>
<tr>
<th>( ) Self</th>
<th>( ) Spouse</th>
<th>( ) Dependent</th>
<th>( ) Parent/Guardian</th>
<th>( ) Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>First Name M.I.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>Apartment/Space Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Head of Household (Check One)</td>
<td>( ) YES</td>
</tr>
<tr>
<td>Home Phone Number:</td>
<td>Work Phone Number and Ext:</td>
<td>Employer:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRIMARY INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>( ) Self</th>
<th>( ) Spouse</th>
<th>( ) Dependent</th>
<th>( ) Parent/Guardian</th>
<th>( ) Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number:</td>
<td>Medicaid Number:</td>
<td>County</td>
<td>CORE Household Number:</td>
<td>Other:</td>
</tr>
<tr>
<td>Insured’s Soc. Sec. Number</td>
<td>Insured’s Last Name</td>
<td>First Name</td>
<td>M.I.</td>
<td></td>
</tr>
<tr>
<td>Insurance Co. Name</td>
<td>Insurance Phone Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing/Street Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Group Number</td>
<td>Authorization Number (If required)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECONDARY INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>( ) Self</th>
<th>( ) Spouse</th>
<th>( ) Dependent</th>
<th>( ) Parent/Guardian</th>
<th>( ) Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number:</td>
<td>Medicaid Number:</td>
<td>County</td>
<td>CORE Household #:</td>
<td>Other:</td>
</tr>
<tr>
<td>Insured’s Soc. Sec. Number:</td>
<td>Insured’s Last Name</td>
<td>First Name</td>
<td>M.I.</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing/Street Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Group Number</td>
<td>Authorization Number (If required)</td>
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</tbody>
</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.

**AUTHORIZATION OF BENEFITS**

I authorize payment to be made directly to Community Reach Center.

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**FOR OFFICE PURPOSES ONLY – TO BE COMPLETED BY COMMUNITY REACH CENTER STAFF**

- **Gross Annual Household Income:** $
- **No. of Dependents:**
- **No. of Child Dependents:**
- **Fee Per Session:**
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
Name: ____________________________________  Today’s Date: ____________________________

How did you hear about us? ________________________________________________________________

For Clients under the age of 15 or adults who are not their own legal guardians:

What type of custody does the parent/guardian have?  Full______ Joint_______ Unsure_____

Other (temporary, power of attorney, healthcare proxy): ________________________________

For divorced/separated parents with joint decision making, consent from both parents is required.

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  ☐ Medications  ☐ Probation Evaluation
☐ Group therapy  ☐ Resources for housing, shelter, food
☐ Drug/Alcohol Treatment  ☐ Recent Mental Health Hospitalization
☐ 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.
Name: ______________________________________ Date of Birth: __________________

Primary Care Doctor: ______________________ PCP Office/Clinic: ______________________

Address: __________________________ City, State, Zip: __________________________

Phone Number: (____)________________ Fax Number: (____)________________

Date of last physical: __________________________

**Physical Conditions (example: Diabetes, High Blood Pressure, surgeries, etc.)**

<table>
<thead>
<tr>
<th>No known physical conditions</th>
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**Current Medications**

<table>
<thead>
<tr>
<th>No current medication</th>
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<table>
<thead>
<tr>
<th>Medication name</th>
<th>Strength (example: 50mg)</th>
<th>Frequency (example: at bedtime, 2x/day, etc.)</th>
<th>Prescribing Physician</th>
</tr>
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**Medication Allergies**

<table>
<thead>
<tr>
<th>No known medication allergies</th>
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<table>
<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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<tbody>
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**Dental:** Please list any dental problems: ____________________________________________________________

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<thead>
<tr>
<th>No known dental problems</th>
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