COMMUNITY REACH CENTER

Community Reach Center Admission Form

NextGen MRN: _____

Consumer Last Name	Legal First Name	M.I.	Preferred Name

( ) Home Phone #	( ) Cell Phone #	Email Address

Street Address	Apt or Lot #	County

City	State	Zip

/ / Birth Date	- - Social Security

Employer/School	Street Address	( ) Work Phone #

Occupation or Grade Level

ETHNICITY

- ☐ Hispanic - Mexican
- ☐ Hispanic - Cuban
- ☐ Hispanic - Puerto Rican
- ☐ Hispanic - Other
- ☐ Not Hispanic or Latino
- ☐ Declined

RACE

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

MARITAL STATUS

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

ARE YOU A VETERAN OR ACTIVE MILITARY?

- ☐ Yes
- ☐ No

BIRTH SEX

- ☐ Male
- ☐ Female

PRONOUNS

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/Them/Theirs
- ☐ Ze/Zir/Zem
- ☐ Declined
- ☐ Fill In: _____

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Fill In: _____

DO YOU NEED ANY ACCOMODATIONS?

- ☐ Blind
- ☐ Deaf
- ☐ Mobility
- ☐ Transportation
- ☐ None
- ☐ Fill In: _____

In Case of Emergency, Call (First/Last Name)	( ) Phone #	Relationship

COMMUNITY REACH CENTER

Community Reach Center
Reason for Services Form

NextGen MRN: _____

Preferred Name _____ Today's Date _____ How did you hear about us? _____

If younger than the age of 15 or adult with legal guardian:

Parent/Guardian 1 _____ Phone # _____ Relationship _____

Parent/Guardian 2 _____ Phone # _____ Relationship _____

What type of decision making rights does the parent/guardian have?

- ☐ Full
- ☐ Joint
- ☐ Unsure
- ☐ Fill in: _____

Is there a custody plan/court documentation?

- ☐ Yes
- ☐ No

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)? If yes, please list what substance(s) and last use. _____

Check if you are experiencing:

Thoughts about ending your life:	☐ Today	☐ In the past month	☐ In the past year
Thoughts about killing other people:	☐ Today	☐ In the past month	☐ In the past year

Check the reasons why you are seeking services. Please note: Medications are not prescribed during your intake. Appointments for medication can be as far out as 30 days.

- ☐ Individual therapy
- ☐ Group therapy
- ☐ Family therapy
- ☐ Medications
- ☐ Resources for housing, shelter, food, etc.
- ☐ Recent mental health hospitalization
- ☐ Probation evaluation
- ☐ Drug/alcohol treatment
- ☐ Fill in: _____

Do you currently have a therapist or counselor? ☐ Yes ☐ No

If yes, please write their name and what they are treating you for. _____

If you are experiencing a behavioral health crisis please call The Suicide and Crisis Lifeline at 988.
If you are experiencing a life threatening emergency, please call 911 or go to the nearest emergency room.

COMMUNITY REACH CENTER

Community Reach Center Consumer Financial Form

NextGen MRN: _____ Today's Date _____

Consumer Last Name _____ Consumer First Name _____

Birth Date ___/___/___ Social Security ___-___-___

Person Financially Responsible

☐ Self ☐ Spouse ☐ Dependent ☐ Parent or Guardian ☐ Fill in: _____

Last Name _____ First Name _____ M.I. _____ Date of Birth _____

Street Address _____ Apartment # _____ City _____ State _____ Zip Code _____

Head of Household? ☐ Yes ☐ No

Home Number _____ Work Number _____ Employer _____

Primary Insurance Information

Copy of Insurance Card (front and back)

☐ Self ☐ Spouse ☐ Dependent ☐ Parent or Guardian ☐ Fill in: _____

Medicare Number _____ Medicaid Number _____ County _____ CORE Household # _____ Other _____

Insured's Social Security # _____ Insured's Last Name _____ Insured's First Name _____ M.I. _____

Insurance Company Name _____ Insurance Phone Number _____

Insurance Address _____

Policy Number _____ Group Number _____ Authorization number (if required) _____

Secondary Insurance Information

Copy of Insurance Card (front and back)

☐ Self ☐ Spouse ☐ Dependent ☐ Parent or Guardian ☐ Fill in: _____

Medicare Number _____ Medicaid Number _____ County _____ CORE Household # _____ Other _____

Insured's Social Security # _____ Insured's Last Name _____ Insured's First Name _____ M.I. _____

Insurance Company Name _____ Insurance Phone Number _____

Insurance Address _____

Policy Number _____ Group Number _____ Authorization number (if required) _____

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 CRC 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.

Release of Information
I authorize payment to be made directly to Community Reach Center.

Signature of Consumer or Parent/Guardian _____ Date _____ Signature of Insured _____ Date _____

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

Gross Annual Household Income _____ Number of Dependents _____ Fee Per Session _____

COMMUNITY REACH CENTER

Community Reach Center Fee Policy and Financial Agreement

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.
- 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 orpayor 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 may 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.

COMMUNITY REACH CENTER

Community Reach Center Income Attestation Form

Income Attestation Form

Consumer Name: _____ **NextGen MRN:** _____

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 attest that my total household income is $_____ ☐ per year ☐ per month.

This income supports____ adults (including myself) and ____ children under age 18.

I understand that this information needs to be updated according to the following events and I may be asked to sign this form at such time:

- Consumers must provide documentation annually (at least once every state fiscal year);
- Family income has changed significantly;
- The number of dependents in the family has changed; or
- Information provided was not accurate.

_____ _____ _____ _____

Signature of Consumer | Date | Signature of Witness (CRC Staff) | Date

Acceptable Forms of Proof of Income

Income Type	Supporting Documentation Required
Wages/Tips/Salary	Paystubs
Unemployment Compensation	Award letter or statement
Self-Employment Income	Prior year income tax return
Worker's Compensation	Award or determination of benefits letter
SSDI or SSI	Benefit letter, statement of benefits received, notice of award
Alimony	Court Decree
Rental Income	Copy of lease
Trust Fund	Letter from trustee

If Paystub will be used please complete the following:

Average number of hours worked per week: _____ Hourly Rate: _____

COMMUNITY REACH CENTER

Community Reach Center Medical History

NextGen MRN: _____

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.)

☐ No Known Physical Conditions

Current Medications

☐ No Current Medications

Medication Name	Strength (ex: 50mg)	Frequency (ex: at bed time)	Prescribing Physician

Medication Allergies

☐ No Known Medication Allergies

Medication Name	Reaction (ex: hives etc.)		

Dental (please list dental problems): _____

☐ No Known Dental Problem