COMMUNITY REACH CENTER

FAX: 303-487-7240

To: **Intake:** **EMAIL:**

Intake@CommunityReachCenter.org

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

Community Reach Center ADMISSION FORM

Credible # _____ Admit Date: ____/____/____

Client's Last Name _____ Legal First Name _____ M.I. _____ Preferred Name _____

(____)____--____ Home Phone Number

(____)____--____ Cell Phone Number

Email Address _____

Street Address _____ Apt or Lot # _____ County _____

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 Rican
- ☐ Hispanic – other
- ☐ Not Hispanic or Latino
- ☐ Declined

Ethnicity:

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

Years of Education:

_____(High School Diploma = 12 years)

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
- ☐ Separated
- ☐ Widowed
- ☐ Divorced

Gender:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Prefer not to answer

Sexual Orientation:

- ☐ Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Decline to answer
- ☐ Fill in: _____

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

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

In Case of Emergency, Call (First/Last Name): _____

Phone Number: (____)____--____

Relationship: _____

COMMUNITY REACH CENTER
CONSUMER FINANCIAL FORM

FEE AGREEMENT **ASSIGNMENT OF BENEFITS** **RELEASE OF INFORMATION**

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

PERSON FINANCIALLY RESPONSIBLE

○ Self	○ Spouse	○ Dependent	○ Parent/Guardian	○ Other:
Last Name	First Name			M.I.
Street Address			Apartment/Space Number	
City	State	Zip Code	Head of Household (Check One) ○ YES ○ NO	
Home Phone Number:	Work Phone Number and Ext:		Employer:	

PRIMARY INSURANCE INFORMATION

Copy of insurance card (front & back) attached

Insurer's Relationship to Consumer: (Check One)

○ Self	◉ Spouse	○ Dependent	○ Parent/Guardian	○ Other:
Medicare Number:	Medicaid Number:	County	CORE Household Number:	Other:
Insured's Soc.Sec. Number	Insured's Last Name	First Name		M.I.
Insurance Co. Name	Insurance Phone Number:			
Mailing/Street Address	City	State		Zip Code
Policy Number:	Group Number	Authorization Number *(If required)*		

SECONDARY INSURANCE INFORMATION

Copy of insurance card (front & back) attached

Insurer's Relationship to Consumer: (Check One)

○ Self	○ Spouse	○ Dependent	○ Parent/Guardian	○ Other:
Medicare Number:	Medicaid Number:	County	CORE Household #:	Other:
Insured's Soc. Sec. Number:	Insured's Last Name	First Name		M.I.
Insurance Co. Name	Insurance Phone Number:			
Mailing/Street Address	City	State		Zip Code
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 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 to directly to Community Reach Center.

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:** **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.
- 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 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

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.

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:

- Clients 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.

_____ _____
Client's signature Date

_____ _____
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

Name you go by:_____ Today's Date:_____

Pronouns you use: ☐ she/her ☐ they/them ☐ he/him ☐ Other (please specify):_____

How did you hear about us? _____

If younger than age 15 or an adult with legal guardian:

Parent/Guardian1: _____ Phone #:_____ Relationship:_____

Parent/Guardian 2: _____ Phone #:_____ Relationship:_____

What type of **decision-making rights** does the parent/guardian have? Full ☐ Joint ☐ Unsure ☐

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

Is there a custody plan/court documentation? Yes ☐ No ☐

Do you have supporting custody/court documentation **with you today**? Yes ☐ No ☐

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

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:

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 reason(s) 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 and are only scheduled for those clients meeting regularly with an individual therapist at CRC.**

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

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 or mental health crisis, please call Colorado Crisis & Support Line at 1-844-493-8255 that number again is 1-844-493-8255. You may also go to one of the Denver metro crisis centers – the closest ones are at 2206 Victor Street in Aurora and 4643 Wadsworth Blvd in Wheat Ridge. If you are experiencing a life-threatening emergency, please hang up and dial 911 or proceed to your nearest Emergency Room.

COMMUNITY REACH CENTER

Consumer ID # _____

Medical Record # _____

Medical History

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 medication			
Medication name	Strength (example: 50mg)	Frequency (example: at bedtime, 2x/day, etc.)	Prescribing Physician

Medication Allergies			
☐ No known medication allergies			
Medication	Reaction (example: hives, rash, etc.)	Medication	Reaction (example: hives, anaphylaxis, etc.)

Dental: Please list any dental problems: _____

☐ No known dental problem