Center for Mental Health

For Office Use Only

Client Case Number: _____

Date Received: _____

APPLICATION FOR SERVICES

This application is a part of your C4MH record, and the information provided will be treated as confidential. This information is required in order for us to provide you services and bill you and/or your insurance company. Please complete the questions as thoroughly as possible. The C4MH provides services and benefits to its clients without regard to race, color, religion, gender, national origin, age, handicap, or economic status.

PLEASE COMPLETE THIS APPLICATION SPECIFIC TO THE PERSON SEEKING SERVICES

Name: _____ **Date of Birth:** _____ **Age:** _____

(First) (Mi) (Last)

Gender: ☐ Male ☐ Female ☐ Transgender

☐ Other: _____

Social Security #: _____

Maiden/Previous Names Used: _____

Address: _____

(Street or P O Box) (City) (State) (Zip Code)

Home #: _____ **Work #:** _____ **Cell #:** _____

Other/Message Phone #: _____ **Email Address:** _____

☐ _____ **I consent to be contacted by C4MH via any of the above listed phone number(s) and/or email address(es).**

Legal Status: ☐ Voluntary ☐ Court Order ☐ Civil Involuntary ☐ Criminal Involuntary ☐ Unknown

Probation and/or Parole: ☐ No ☐ Yes

Legal Custody: ☐ Self ☐ Parent/Grandparent ☐ Guardian ☐ Dept of Family Services ☐ Dept of Corrections/Juvenile Justice

☐ Bureau of Indian Affairs/Tribal Court ☐ Other Family ☐ Other, please specify: _____

Complete only if applicant is under the age of 18 OR if the client has a Legal Guardian:

Parent/Guardian Name: _____ **Home #:** _____

Address, if different than above: _____ **Cell #:** _____

Relationship/Agency: _____ **Work #:** _____

Appointment Reminders: **Okay to leave a voice message?** ☐ Yes ☐ No **Okay to send a text reminder?** ☐ Yes ☐ No

Appointment reminder calls/texts may be made to (person): _____

Relation: _____ **Phone #:** _____

SOURCE OF REFERRAL

Reason for seeking services: _____

_____

Referred by: _____

CONTACT INFORMATION: IN CASE OF AN EMERGENCY

In case of an emergency and/or scheduling changes, I give consent for the C4MH to contact:

Name: _____ **Relation:** _____

(First) (Mi) (Last)

Address: _____

(Street or P O Box) (City) (State) (Zip Code)

Home #: _____ **Work #:** _____ **Cell #:** _____

DEMOGRAPHIC INFORMATION

Race/Ethnicity:

- ☐ Caucasian
- ☐ Asian
- ☐ American Indian, Alaskan Native
- ☐ African American
- ☐ Native Hawaiian, Other Pacific
- ☐ Hispanic/Latino
- ☐ Unknown
- ☐ More than one race

Marital Status:

- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Single, Never Married

Veteran Status:

- ☐ Yes
- ☐ No

Employment Status:

- ☐ Full-time
- ☐ Part-time
- ☐ Retired
- ☐ Disabled
- ☐ Student
- ☐ Homemaker
- ☐ Supported/Sheltered Employment
- ☐ Unemployed, but desiring work
- ☐ No interest in work
- ☐ Other:

Education Status:

- ☐ No formal education
- ☐ Adult Education (GED)
- ☐ Vocational School
- ☐ College part-time
- ☐ College full-time
- ☐ Home School
- ☐ Public School K-12
- ☐ Private School
- ☐ Other:

Last grade completed: _____

Living Arrangements:

Homeless: ☐ Yes ☐ No

- ☐ Transient/Hotel
- ☐ Mission/Shelter
- ☐ Independently Alone
- ☐ Independently with Others
- ☐ Living with Others (in their care)
- ☐ Supported Independent Living
- ☐ Mental Health Group Home
- ☐ Non-MH Group Home
- ☐ Personal Care Home
- ☐ Nursing Home
- ☐ Jail/Pre-Release
- ☐ Hospitalization (Medical)
- ☐ Hospitalization (Psychiatric)
- ☐ Foster Care
- ☐ Therapeutic Foster Care
- ☐ Other:

FAMILY HOUSEHOLD INFORMATION

Number of dependents (for whom you have legal responsibility—including client): _____

	NAME OF HOUSEHOLD MEMBER (Include Middle Initial)	RELATIONSHIP (To Head of Household)	DATE OF BIRTH (MM/DD/YYYY)	EMPLOYER/SCHOOL
1				
2				
3				
4				
5				
6				
7				
	DEPENDENTS LIVING ELSEWHERE (Include Middle Initial)	**RELATIONSHIP (To Head of Household)**	**DATE OF BIRTH (MM/DD/YYYY)**	**EMPLOYER/SCHOOL**
8				
9				
10				
11				

FAMILY INCOME

List all gross monthly income and benefits you, your spouse, dependents, or other family members receive from <u>any</u> source (including employment, Social Security, SSI, SSDI, Pensions, VA, Child Support, BIA, etc...).

HH MBR # means Household Member Number from above.

HH MBR #	EMPLOYMENT/WAGES	SOCIAL SECURITY /PENSIONS	PUBLIC ASSISTANCE	OTHER INCOME
TOTALS	$	$	$	$
			Add totals from (A) through (D) above for Total Family Income	$

Family stated monthly income is $ _____ but does not have or will not bring in any documentation verification.

<u>ZERO INCOME:</u> **<u>Check this box</u>** if your total household income is **<u>ZERO</u>:** ☐

INSURANCE INFORMATION		
Do you have Medicaid? ☐ Yes ☐ No	**ID#:**	**Effective Date:**
Do you have Medicare? ☐ Yes ☐ No	**ID#:**	**Effective Date:**
Do you have private insurance? ☐ Yes ☐ No	**ID#:**	**Effective Date:**
Insurance Company Name:		
****Please bring the appropriate insurance card(s) with you when returning this packet.****		

A. PERSON RESPONSIBLE FOR PAYMENT: ☐ Self ☐ Spouse ☐ Parent/Guardian

Name: _____

Cell #: _____ **Home #** _____ **Work #:** _____

Address: _____ Montana
(Street or P O Box) (City) (State) (Zip Code)

Sponsor Name, if Military: _____

Branch of Military Service: _____ **Rank:** _____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**

Employer: _____ **Address:** _____

Contact Person: _____ **Phone #:** _____

B. PRIMARY HEALTH INSURANCE INFORMATION:

Insured / Policyholder's Name: _____

Insured's SSN: _____ **Insured's Date of Birth:** _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Insurance Company: _____

Address: _____
(Street or P O Box) (City) (State) (Zip Code)

Group / Policy #: _____ **ID#:** _____

Client's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

C. ADDITIONAL HEALTH INSURANCE INFORMATION: (*if applicable)*

Insured / Policyholder's Name: _____

Insured's SSN: _____ **Insured's Date of Birth:** _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Insurance Company: _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Group / Policy #: _____ **ID#:** _____

Client's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

D. Social Security Designation: (SELECT ONE)

- ☐ SSI due to Mental Illness
- ☐ SSI not due to Mental Illness
- ☐ SSDI due to Mental Illness
- ☐ SSDI not due to Mental Illness
- ☐ Does not apply

COST OF CARE PAYMENT AGREEMENT

I hereby give authority to the C4MH to furnish all information in which the Social Security Administration, Veteran's Administration, my insurance provider, its intermediaries or carriers may request and need in connection with my mental health condition; at the same time, I give authority to the insurance company to make payable to the C4MH any benefits which may be due to me under this policy as a result of my mental health condition.

I understand that the C4MH does not accept responsibility for collection of my insurance benefits or negotiating the settlement of a disputed claim. I am responsible for payment of all C4MH charges regardless of anticipated insurance coverage, unless pre-arranged through my employer or a third-party payee.

I understand the C4MH's policy is to bill my primary insurance carrier for covered services before billing me for the balance due. In fact, before billing Medicaid or HELP, as a final payer, my primary insurance carrier must be billed. If there is another agency responsible for payment of my services, I will ensure that information is given at the time of application.

If it is determined I do not qualify for the above services, and/or there is a balance due after my insurance carrier has been billed for covered services, I will be billed the C4MH's regular, full-fee rate for services. I may qualify for the sliding fee scale which is based on the total family income and the number of individuals in the household, with a personal fee rate determined when I provide the proof of income documentation. Other assistance may be offered based on my individual case, such as maximum amount billed for services and/or financial plan based on what I can afford to pay monthly on my SELF-pay balance. I will receive a monthly billing statement indicating my balance due and if I am unable to make full payment, I will contact the C4MH's billing department at (406)771-8648. **No one will be denied access to services due to inability to pay. There is a discount/sliding fee schedule available.**

I understand that any unpaid charges may be turned over to collections.

I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to the C4MH.

_____

Please initial for acknowledgement

INFORMED CONSENT TO MENTAL HEALTH TREATMENT

I understand that I may receive services from a variety of C4MH employees in order to meet my specific mental health needs. I also understand that their participation in my care will be within the scope of their respective professional education, training, experience, and licensure/certification. I understand that with my consent, my treatment may change based on my needs and preferences as well as following the guidelines of the Mental Health Administrative Rules of Montana.

I understand that the practice of mental health treatment is not an exact science and that no guarantees have been or can be made about the likelihood of success or outcome of any treatment. I understand there are risks and benefits in mental health treatment and am agreeing to treatment, including mental health assessment, screenings, and an individual treatment plan.

I understand that my mental health information will only be shared as appropriate under HIPAA Privacy and Confidentiality Laws and Regulations 42 CFR Part 2. I understand there are allowable circumstances under HIPAA covering treatment, operations, and payment in which a signed consent release is not required. I also understand information may be released in an emergency, as subpoenaed by a court of law or as required by law for mandatory reporting of abuse and neglect.

I hereby voluntarily consent to the treatment provided by the C4MH and its employees or designees. I authorize the services deemed necessary or advisable by my providers to address my needs.

I understand that if this application is being completed on behalf of another individual (i.e. – a minor or client with a legal guardian), I am voluntarily consenting to mental health treatment on their behalf as stated above.

_____

Please initial for acknowledgement

CLIENT AGREEMENT

SERVICES POLICY. I have been informed about the programs and services available at the C4MH. I understand that not all services are covered by all funding sources. Additionally, I understand that my mental health treatment may not include all services offered. I will receive care based upon my individual needs. As the Center offers a variety of services along with therapeutic modality types that may change over time, I will have an opportunity to review with a C4MH employee and/or my treatment team the different types of available services, therapeutic interventions within those services and my treatment plan upon initiation into services and at regular treatment plan updates.

CANCELLATION POLICY. I understand that it is my responsibility to keep my scheduled appointments with my C4MH providers. I will call at minimum 24 hours in advance to reschedule any conflicting appointments. C4MH employees may provide support with appointment reminders through phone calls, texts and/or mail correspondence; however, if upon review of my attendance history, I "no-show" or "cancel" on a consistent basis or my C4MH treatment team believes there is a high level concern with my commitment to treatment, they will review my attendance history and there is a possibility for termination of services at the C4MH. If services are terminated, the C4MH will make attempt to notify me in writing.

AGGRESSION POLICY. I understand that the C4MH is designed to be a safe place. Aggressive behavior is not acceptable. Aggressive behavior is defined as: physical fighting, pushing, throwing objects, yelling, swearing, or threatening harm.

First Violation: Leave C4MH property immediately for 24 hours. May keep all scheduled appointments. Meet with case manager and/or treatment team to resume services.

Second Violation: Leave C4MH property immediately for 48 hours. May keep all scheduled appointments. Meet with program supervisor/manager to resume services.

Third Violation: Leave C4MH property immediately and not return until meeting with Area Director or designee to discuss whether I am benefitting from C4MH services.

Severe/Significant Violation: Leave C4MH property immediately and may not be allowed to return to services due to the severe and significant nature of the aggressive act(s).

I understand that any time the C4MH deem appropriate, law enforcement or other emergency responders may be contacted in order to maintain the safety of all parties. If services are terminated, the C4MH will make attempt to notify me in writing.

GRIEVANCE POLICY. I understand that that the C4MH has a Grievance Policy. I may discuss a complaint with any C4MH employee to determine whether the complaint can be resolved without filing a formal grievance. Informal discussion does not preclude the filing of a formal grievance. The C4MH employee may assist me at any time during the process but may also channel the grievance to the appropriate C4MH employee for resolution. There is no statute of limitations on filing a grievance.

NOTICE OF PRIVACY PRACTICES. I understand that as a part of my health care, the C4MH receives, originates, maintains, discloses and uses individually identifiable health information including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment plans, and billing and health insurance information. **I acknowledge I have been provided the C4MH "Notice of Privacy Practices"** brochure. My rights including the right to see and get a copy of my record, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Practices. I understand that I may revoke in writing my consent for release of my health care information, except to that extent the C4MH has already made disclosures with my prior consent. As a standard, the Center maintains health records for a length of 10 years.

MENTAL HEALTH RIGHTS IN MONTANA. I understand that I have mental health rights. **I acknowledge I have been provided the C4MH "My Mental Health Rights"** brochure. I understand that this brochure also includes Advocacy Resources through the State of Montana.

_____

Please initial for acknowledgement

APPLICATION AUTHORIZATION

CLIENT PHOTO IMAGE RELEASE. The C4MH requests the irrevocable and unrestricted right to take a client photograph as there exists a clinical need to obtain a photo image of C4MH clients and place in the client's clinical record for purposes of: treatment, care coordination amongst C4MH employees and to improve quality measures of both the client's treatment services and their electronic medical record, while ensuring that the client's rights to privacy and confidentiality are respected.

☐ **Yes, I approve to have my photo taken.**

☐ **No, I decline to have my photo taken.**

SOCIAL MEDIA. C4MH takes very seriously dual relationships and professional boundary conduct. Our policy is to not friend/follow our clients on any social media platform. We request the right to keep C4MH services in a professional status.

EMERGENCY SERVICES. I understand that C4MH provides emergency services 24 hours a day, and if I have a mental health emergency when the C4MH is closed, I can receive after-hours emergency services by calling the Voices of Hope Crisis Hotline number at 1-800-273-TALK.

TERMS OF AGREEMENT. I voluntarily agree to the terms and conditions contained herein. I acknowledge that all the information provided is true and correct. Further, I understand that I am required to pay my assigned fee at each visit and that services may be terminated due to non-payment of assigned fees. Under penalties of perjury, I certify that the information presented in this Application for Services is true and accurate to the best of my knowledge and belief. I further understand that providing false representations herein constitutes an act of fraud. False, misleading, or incomplete information may result in the termination of the services.

I agree that during the time that I am a client at the C4MH, I will keep the C4MH informed of my current address, phone number, employment status and all information pertinent to my mental health progress.

If at any time I decide to stop treatment at the C4MH, I will inform my treatment team.

I understand that I may revoke consent to treatment at any time.

_____ _____

Client's signature **Date**

_____ _____

Parent/Legal Guardian (for children 17 and under) **Date**

_____ _____

Witness **Date**

For office use only	
The client was provided the Notice of Privacy Practices and Mental Health Rights & Advocacy brochures. _____ _____ C4MH Employee Signature Date	**Sliding Fee Applications** ☐ Approved ☐ Not Approved Reason: _____

MIDAS

(Mental Illness, Drug and Alcohol Screening)

Please answer as related to the last 6 months only.	
☐ Yes ☐ No	1. Do you feel that you have a problem with your use of drugs and/or alcohol and/or gambling?
☐ Yes ☐ No	2. Do you use drugs, alcohol, or gambling even though your doctor or other providers recommend that you do not?
☐ Yes ☐ No	3. Is your family concerned about your drugs and/or alcohol or gambling?
☐ Yes ☐ No	4. Are your providers concerned about your drugs and/or alcohol or gambling?
☐ Yes ☐ No	5. Have you had legal problems or engaged in illegal activity (other than using drugs) due to drugs and/or alcohol or gambling?
☐ Yes ☐ No	6. Have you had medical problems related to, or worsened by, drugs and/or alcohol or gambling?
☐ Yes ☐ No	7. Do you use drugs and alcohol or gambling to relieve mental health symptoms?
☐ Yes ☐ No	8. Do you find that using drugs and/or alcohol or gambling worsens your mental health symptoms?
☐ Yes ☐ No	9. Do you have problems taking your psychiatric medication as prescribed because of drugs and/or alcohol use or gambling?
☐ Yes ☐ No	10. Have you gotten in trouble, including getting in trouble at a mental health treatment program, because of drugs and/or alcohol or gambling?
☐ Yes ☐ No	11. Have you had ER visits or psychiatrics hospitalizations that were connected to drugs and/or alcohol use or gambling?
☐ Yes ☐ No	12. Do you every feel guilty about your drugs and/or alcohol use or gambling?
☐ Yes ☐ No	13. Have you experienced withdrawal symptoms or intense cravings to use drugs or alcohol or to gamble?
☐ Yes ☐ No	14. Have you attend self-help (e.g., 12 Step) meetings relating to drugs and/or alcohol use or gambling?
☐ Yes ☐ No	15. Have you received any addiction treatment, including detoxification?
☐ Yes ☐ No	16. Have you felt unable to control your use of any drug or alcohol or gambling?
☐ Yes ☐ No	17. Do you consider yourself to be an alcoholic or drug addict or gambling addict?
☐ Yes ☐ No	18. Do you engage in the use of alcohol, drugs, or gambling activity three times a week or more?
*Adapted with expressed permission for use from Dr. Ken Minkoff, MD developer of the MIDAS Screening Tool.	
*Client self-reported form is located in electronic Clinical Record with Application documents.	
*See Intake Assessment under Substance Abuse section for full clinical assessment.	