HOSPTIAL USE ONLY

hospitalnavigation@communityreachcenter.org

COMMUNITY REACH CENTER

FAX: 303-280-4002

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

Referring Hospital: Hospital Phone #: Contact Name:

Admit Date: Planned Discharge Date:

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

NextGen MRN: ____________________

Client 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
CONSUMER FINANCIAL FORM

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

Date:	NextGen MRN #	
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 hereafter. 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.

Income Attestation Form

Client 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 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: _______________