DISC VILLAGE

Outpatient Services Intake Packet

To be completed by DISC Staff:

Today's Date:		Appointment Date:	
Appointment Time:		Counselor Name:	
MIS#:		Date Received:	

GENERAL INFORMATION – *client complete*

Client Name: _____ Date of Birth: _____

Home/Cell Phone: _____ Work Phone: _____

Age: _____ Race: _____ ☐ Male ☐ Female

Social Security Number: _____ Medicaid #: _____

Address: _____ City / State / Zip: _____

Phone: _____ Email: _____

Driver's License #: _____

Check One: ☐ Adult ☐ Juvenile *(If juvenile, answer the following four questions)*

School Name & Location: _____

Parent/Legal Guardian Name: _____

Parent Phone: *(if different from above)* _____

Was the parent notified that this referral was made? ☐ Yes ☐ No

By providing the above contact information, I hereby consent to receiving communication from DISC Village, Inc.

CLIENT EMERGENCY CONTACT INFORMATION: (*Must also sign PHI with info to be released*)

Contact Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

CLIENT QUESTIONNAIRE:

1. Why are you seeking services today?
   ☐ Want Help ☐ Information Only ☐ Required ☐ Vivitrol/Medication Assisted Treatment

2. Do you have any immediate needs such as food, shelter, employment or education?
   ☐ Yes ☐ No *If yes, what are they:* _____

3. Do you have any immediate needs regarding physical health (including prenatal care), mental health, vision and/or dental?
   ☐ Yes ☐ No *If yes, what are they:* _____

4. Do you have any medical symptoms or conditions for which you feel you need treatment?
   ☐ Yes ☐ No *If yes, what are they:* _____

5. Do you have any currently prescribed medications? *(Provide list of prescriptions)* ☐ Yes ☐ No

_____

6. Do you have any drug allergies? ☐ Yes ☐ No

If yes, what are they: _____

7. What is the name of your current doctor? _____

Phone Number: _____

8. May we contact them in the event of an emergency? ☐ Yes ☐ No

9. Are you interested in receiving services via the internet? ☐ Yes ☐ No

PERSONS WITH DEPENDENT CHILDREN:

The following questions only apply to persons with dependent children. If you do not have children, check this box: ☐ N/A – I do not have children

1. Do you have any immediate needs for your children? (vision, dental, medical, immunizations, mental health, etc.)

☐ Yes ☐ No *If yes, please describe:*

_____

2. Do you believe that your child has been affected negatively by maternal substance abuse?

If yes, please describe:

_____

3. Do you need assistance obtaining childcare? ☐ Yes ☐ No

If yes, indicate when:

☐ While I attend treatment services

☐ While I work or attend other non-treatment activities

☐ Both

4. Do you need help with parenting skills? (*Parenting skills includes training about the risks associated with substance use, the developmental needs of children, community resources, appropriate discipline, and health and safety issues)*

☐ Yes ☐ No

5. Do you need help accessing community resources such as Medicaid, Head Start, free/reduced price lunch programs, etc.?

☐ Yes ☐ No

For New Moms Only:

6. Are you breastfeeding? ☐ Yes ☐ No

If 'Yes', do you need lactation assistance or nutritional information? ☐ Yes ☐ No

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FINANCIAL & INSURANCE INFORMATION (*CLIENT COMPLETE*)

HOUSEHOLD INCOME INFORMATION:

Income can come from many sources including employment, social security, disability, unemployment, retirement, grants, TANF Cash Assistance, Trust Payments, Annuities, etc.	**ATTENTION STUDENTS:** Did your parents claim you on their taxes? If the answer is YES, you will need THEIR tax information.

How many people did you claim on your taxes last year? (Family Size; *Be sure to include yourself*) _____

Your (Client) Gross Income:	$ _____	**INCOME VERIFICATION:** **[Documentation Must Be Attached]**
Parent/Guardian #1 Gross Income:	$ _____	☐ Previous Year Tax Return
Parent/Guardian #2 Gross Income:	$ _____	☐ Current Payroll Stub
Spouse/Significant Other Gross Income:	$ _____	☐ W2
Adult Child Living at Home Gross Income:	$ _____	☐ Signed Letter from Current Employer
Other Gross Income:	$ _____	☐ Other
TOTAL HOUSEHOLD INCOME:	**$** _____	☐ Date Financial Info. Reviewed: _____

Full Rate: _____ (*Initial if you prefer not to provide income and/or insurance information).* I prefer not to provide DISC Village with documentation of my income or insurance coverage. I understand that I will be charged the full rate for all services. I also understand that payment in full is expected at the time-of-service delivery.	**Medicaid Coverage:** _____ *(Initial if you have active Medicaid coverage at the time of admission).* I understand that if during treatment my Medicaid coverage stops, I will be required to bring in proof of income in order to have my copay determined. I also understand that should I fail to provide income documentation. I will be required to pay the full rate for services.	**Foster/Group Home:** _____ *(Initial if you currently live in a foster or group home).* I acknowledge that DISC Village has asked me for documentation of my parents' income. However, because of my living situation I do not have access to my parents' financial information.

Cancellation Policy: DISC Village will schedule your appointment more than 24 hours in advance and will reserve this session time for you. If you will be unable to attend your session, you must notify our agency at least 24 hours before the scheduled appointment so that we may use this spot for another client. All cancellations with less than 24-hour notice, other than due to illness or emergency as evidenced by appropriate documentation, will result in a **failure to cancel fee of $25.00**. This fee must be paid in full before any further services are received.

_____ (Initial) I have read and agree with the **Cancellation Policy.**

_____ (Initial) **I agree that I am responsible for part, or all of the costs associated with my treatment**. I understand that fees are based on the financial and insurance information that I provided, and I attest to the accuracy of the provided information.

_____ (Initial) **Sliding Scale Acceptance**: DISC Village utilizes a Sliding Fee Scale based on Florida Administrative Code 65E-14.018. DISC Village Sliding Fee Scale is calculated on the Federal Poverty Income Guidelines, the number of people in a household and annual income. **Urinalysis testing is not subject to Sliding Fee Scale. We cannot notify your referring agency of your completion of treatment until all assessed fees have been collected.**

Client Signature	Date	Staff Signature	Date
[Parent/Guardian Signature if client is under 18 years of age]			

Counselor Signature	Date

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FINANCIAL & INSURANCE INFORMATION (*STAFF COMPLETE*)

MEDICAID INFORMATION:

Medicaid Number: _____

Medicaid Eligibility as of today: ☐ Eligible ☐ Ineligible

Type of Medicaid

☐ **Managed Care** (*Staywell, Simply Healthcare, Sunshine Health, Magellan Complete Care, Concordia Behavioral Health, Clear Choice Alliance, Aetna Better Health, Humana, Vivida Health, Freedom Health, Optimum Healthcare, Ultimate Health Plans*)

List Managed Care Plan: _____

☐ **Fee for Service** (Full Medicaid) [Managed Care section does not list any Managed Care information.]
Medicaid Co-Pay Amount: $ **2.00 per day***
*(*Does Not Apply to Managed Care Clients.)*

Check Reason If Not Eligible:

- ☐ Client Not Enrolled in Medicaid
- ☐ Not Eligible on Date of Service
- ☐ Family Planning Medicaid
- ☐ Limited to Medicare Premiums
- ☐ Limited to Transportation

NOTE: ATTACH A COPY OF THE PERSON'S MEDICAID CARD AND THE PRINTOUT FROM AVAILITY

INSURANCE INFORMATION:

Instructions for Intake Staff: *Make a copy of the front & back of insurance card. Ensure that the copy is large and clear enough to read. Write your initials/date at the bottom of the copy.*

Policy Holder's Name: _____ Policy Holder's DOB:_____

Policy Holder's SSN: _____ Relationship to Client: _____

1. Type of Insurance:

☐ Copay Amount: $ _____

☐ Co-Insurance Amount: $ _____

☐ 70/30 ☐ 80/20 ☐ Other:_____

2. Annual Deductible Amount: _____

3. How much of the deductible has been paid?

_____

4. How much is left on the deductible: _____

5. What billing protocol is accepted by the insurance company?

☐ Per Visit Amount: $ _____

☐ Based on Procedure Codes for services

6. Does the client's insurance plan cover substance abuse treatment?

☐ Yes ☐ No

If yes, indicate level of care covered:

- ☐ *Non-Residential (Outpatient)*
- ☐ *Residential*
- ☐ *Both*

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INSURANCE INFORMATION CONTINUED:

Full Pay Service Rates:		Non-Insurance Sliding Fee Co-Pay Amounts:	
Assessment (Per Exam):	**$ 150.00**	***Assessment (Per Exam):***	**$**
Individual (Per Session):	**$ 96.00**	***Individual (Per Session):***	**$**
Group/Family (Per Session):	**$ 24.00**	***Group/Family (Per Session):***	**$**
Residential (Per Day):	**$ 206.00**	***Residential (Per Day):***	**$**
Youth Drug Court Program Fee:	**$ 60.00**	***UA Fee:***	**$**

Youth Drug Court Program Fees:

See the Youth Drug Court Sliding Fee Scale

- ☐ **Level 6 $ 1,500.00**
- ☐ **Level 5 $ 1,250.00**
- ☐ **Level 4 $ 340.00**
- ☐ **Level 3 $ 320.00**
- ☐ **Level 2 $ 160.00**
- ☐ **Level 1 $ 80.00**

Medicaid and insurance information verified by:

Staff Name *(printed)*

Staff Signature **Date**

This information has been reviewed with the client and confirmed correct by:

Counselor Signature **Date**