CCH Request For Services

☐ **Original** ☐ **Change or Correction, effective date:** _____

Client Name: (First, Middle, Last) _____ **Client ID#:** _____

Preferred Name/Pronoun: _____

Date of Birth: _____ **Age:** _____ **SSN:** _____

Gender:
☐ (1) Female ☐ (2) Male ☐ (4) Transgender ☐ (5) Intersex: Person born with characteristics of both ☐ (6) Other ☐ (7) Refuse

Physical/Residential Address (required):

Address: _____ **City:** _____ State: _____ County: _____

Mailing Address (required/Unless Confidential):

Address: _____ **City:** _____ State: _____ County: _____

Confidential Address

Address: _____ **City:** _____ State: _____ County: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Communication Preference (select one): ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ US Mail ☐ Do not Contact

Reminder Notification (select one): ☐ Text ☐ Email ☐ Text and Email

Living Situation:
☐ (A) Homeless
☐ (B) Homeless With Housing
☐ (C) Foster Home/Foster Care
☐ (D) Residential Care
☐ (E) Crisis Residence
☐ (F) Institutional Setting
☐ (G) Jail/Correctional
☐ (H) Private Residence Adult
☐ (I) Independent Living
☐ (J) Dependent Living
☐ (K) Private Residence Child
☐ (L) Other Residence Status
☐ (Z) Unknown

Primary Language:
☐ (15) American Sign Language
☐ (23) Amharic
☐ (33) Arabic
☐ (06) Cambodian
☐ (16) Cantonese
☐ (26) Czech
☐ (35) Dutch
☐ (13) English
☐ (25) Farsi
☐ (24) Finnish
☐ (12) French
☐ (14) German
☐ (21) Greek
☐ (36) Gujarati
☐ (32) Hindi
☐ (08) Hmong
☐ (17) Hungarian
☐ (10) Ilocano
☐ (37) Indian
☐ (38) Italian
☐ (01) Japanese
☐ (02) Korean
☐ (39) Lakota Sioux
☐ (05) Laotian
☐ (07) Mandarin
☐ (40) Malay
☐ (41) Marathi
☐ (27) Mien
☐ (42) Norwegian
☐ (34) Other Chinese (not Mandarin or Cantonese)
☐ (99) Other Language
☐ (20) Polish
☐ (30) Puyallup
☐ (19) Romanian
☐ (18) Russian
☐ (29) Salish
☐ (09) Samoan
☐ (03) Spanish
☐ (11) Tagalog
☐ (31) Thai
☐ (22) Tigrigna
☐ (43) Ukrainian
☐ (04) Vietnamese
☐ (28) Yakama

Hispanic Origin:
☐ (709) Cuban
☐ (000) General Hispanic
☐ (722) Mexican/Mexican-American/Chicano
☐ (727) Puerto Rican
☐ (998) Not Spanish/Hispanic
☐ (799) Other Spanish/Hispanic
☐ (999) Unknown

Ethnicity (to report multiple ethnicities, enter in order of prominence):
☐ (21) American Indian or Alaska Native
☐ (31) Asian Indian
☐ (40) Black or African American
☐ (604) Cambodian
☐ (605) Chinese
☐ (608) Filipino
☐ (660) Guamanian or Chamorro
☐ (611) Japanese
☐ (612) Korean
☐ (613) Laotian
☐ (801) Middle Eastern
☐ (32) Native Hawaiian
☐ (999) Not Reported/Unknown
☐ (34) Other Asian
☐ (33) Other Pacific Islander
☐ (50) Some Other Race
☐ (10) White

Smoking Status:
☐ (1) Current smoker
☐ (4) Refuse To Answer
☐ (2) Former smoker
☐ (5) Unknown
☐ (3) Never smoker

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Marital Status:

☐ (A) Single or Never Married
☐ (B) Now Married or Committed Relationship
☐ (C) Separated
☐ (D) Divorced
☐ (E) Widowed
☐ (F) Unknown

Grade Level (highest completed):

☐ (A) No formal schooling
☐ (B) Nursery school, pre-school, head start
☐ (C) Kindergarten, less than one school grade
☐ (D) Grade 1
☐ (E) Grade 2
☐ (F) Grade 3
☐ (G) Grade 4
☐ (H) Grade 5
☐ (I) Grade 6
☐ (J) Grade 7
☐ (K) Grade 8
☐ (L) Grade 9
☐ (M) Grade 10
☐ (N) Grade 11
☐ (O) Grade 12
☐ (P) High School diploma or GED
☐ (Q) 1st year of College/University (Freshman)
☐ (R) 2nd year of College/University (Sophomore or Associates Degree)
☐ (S) 3rd year of College/University (Junior)
☐ (T) 4th year of College/University (Senior)
☐ (U) Bachelor's Degree
☐ (V) Graduate or professional school- includes Master's and Doctoral degrees, medical school, law school, etc.
☐ (W) Vocation school- includes business, technical, secretarial, trade, or correspondence courses which provide specialized training for skilled employment
☐ (X) Unknown

Education:

☐ (1) Full-time education/training
☐ (2) Part-time education/training
☐ (8) Not in education/training
☐ (9) Unknown

Employment:

☐ (A) Full-time (35+ hours per week)
☐ (B) Part-time (less than 35 hours per week)
☐ (C) Unemployed
☐ (D) Employed Full or Part time (which cannot be ascertained)
☐ (E) Homemaker
☐ (F) Student
☐ (G) Retired
☐ (H) Disabled
☐ (I) Other reported classification (e.g. volunteer)
☐ (J) Sheltered/Non-Competitive Employment
☐ (K) Not Applicable/Not in the workforce
☐ (L) Unknown

Sexual Orientation (13 years of age and older):

☐ (1) Heterosexual
☐ (3) Gay/Lesbian/Homosexual
☐ (4) Bisexual
☐ (5) Undecided
☐ (9) Choosing not to disclose

Impairment Kind (check all that apply):

☐ Alcohol or Drug ☐ Development or Intelligence ☐ Hearing Impairments ☐ None/No disability
☐ Other communication difficulties ☐ Physical ☐ Vision impairments ☐ Unknown
☐ Other medical or physical disabilities

Military Service: ☐ Yes ☐ No ☐ Refuse ☐ Unknown

Tribe Name (if 21 selected above): _____

School Attendance (within the last 3 months): ☐ Yes ☐ No

Female Only: Are you currently pregnant? ☐ Yes ☐ No **Due Date:** _____

Self-Help (Participation in Substance Use Disorder Self-Help group in the past 30 day (e.g. AA, NA)):

☐ (1) No Attendance
☐ (2) Less than once a week
☐ (3) About once per week
☐ (4) 2-3 times per week
☐ (5) At least 4 times per week
☐ (6) Not collected
☐ (97) Unknown

Needle Use Ever (IV Drug use only):

☐ (1) Continuous ☐ (2) Intermittently ☐ (3) Rarely ☐ (4) Never
☐ (5) Refuse To Answer ☐ (6) Unknown

Used needle recently (last 30 days): ☐ Yes ☐ No

Are you parenting any child(ren) under the age of 18? ☐ Yes ☐ No

03/09/2023

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Dr. Name & Office_____ **Referred by PCP** ☐

☐Power of Attorney for health care ☐ Guardianship ☐ Documentation requested?

Funding Source, check all that apply: ☐ Apple Health ☐ Medicare Plan ☐ Commercial Insurance ☐ Other_____

P1# _____ P1 benefit plan _____ Notes: _____

Insurance & ID# _____ Insurance & ID# _____

Special Accommodations: ☐Intake out of office ☐Evening appointments ☐Interpreter ☐Other_____

Intake is: ☐ Routine ☐ Urgent ☐ Emergent ☐ Post Hospitalization

1st Offered Apt: _____ **1st Accepted Apt:** _____ **Staff name & ID** _____

Notes:_____

☐ Client requests extension ☐ Provider requests extension ☐ Letter Sent Rescheduled _____

Nature of the problem/services being requested: ☐ Health & Safety ☐ other

_____

_____

_____

How did you hear about us?

☐ Facebook
☐ Twitter
☐ Company website
☐ Community Event
☐ Radio
☐ Phone Book
☐ Referred by family/friend
☐ Referred by other agency
☐ Other_____

☐ Episode admission data entered
☐ F99 entered
☐ RFS entered
☐ Intake scheduled

Client ID _____

Cascade Community Healthcare
Financial Agreement

New _____
Update _____

Client Information:

Legal Name: _____ Date of Birth: _____

Social Security Number: _____

Financial Responsible Party Information:

Legal Name: _____ Date of Birth: _____

Social Security Number: _____ Relationship to Client: _____

Mailing Address: _____
Street/PO Box City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Spouse Name: _____ Date of Birth: _____

Spouse Employer: _____ Employer Phone: _____

Insurance Information:

Primary Insurance Name: _____ ID Number: _____

Group Number: _____ Subscriber Name: _____ DOB: _____

Secondary Insurance Name: _____ ID Number: _____

Group Number: _____ Subscriber Name: _____ DOB: _____

Medicare Information:

ID Number: _____ Primary? Yes / No

Medicare Supplement Coverage:

Insurance Name: _____ ID Number: _____

Please present insurance card(s) to receptionist.

Cascade Community Healthcare does not guarantee that the cost of services is covered by third party insurance. Eligible services will be billed to third party insurance provided accurate billing information is received. By signing this agreement, you understand that you are financially responsible for the services provided by the staff at Cascade Community Healthcare and for services not covered by reported insurance. Please sign that you have this document in its entirety (including the reverse side) and the information provided is accurate and true.

_____ _____
Signature of Financially Responsible Party Date

_____
Witness of Cascade Community Healthcare

Client ID _____

Cascade Community Healthcare - Fee Policies
Please Read Carefully

- I understand my **Insurance Identification Card must be present at each service**. Apple Health and all other insurance eligibility and benefits must be verified at each visit.
- I understand my third party insurance plan(s) must be billed primary to Apple Health. I am required to provide the necessary information for Cascade to bill for eligible services.
- I authorize cascade to release any and all medical records necessary for the completion of claims and coordination of treatment and treatment planning. **I assign any insurance benefit for services rendered to Cascade.**
- I authorize payment from any third-party insurance and/or Medicare benefits be made to Cascade Community Healthcare for any services furnished.
- I understand payments for services sent to the insurance subscriber for services provided by Cascade will be billed to the Financial Responsible Party.
- I understand **the following services will not be billed to third party insurance** and will be billed directly to the Financially Responsible Party as reported on this document:
  · Case Management Services · Collateral Contact Services ·Missed visit/leave early fees
  · Services provided outside of this facility · Supported Employment Services
- I understand I will be billed fee for service if my insurance coverage is inactive on the dates the services were rendered, or if the insurance benefit plan does not include mental health services, or if I am not authorized for services
- I understand **Cascade Community Healthcare does not guarantee payment** from my Medicaid, third-party insurance, or Medicare plans. Any services not covered by these benefit plans will be billed to the Financial Responsible Party as reported on this document unless: the client is covered by Apple Health, has met Access to Care Standards, and is authorized for services by the Managed Care Organization.
- I understand not all services are eligible to be billed to third party insurance and will be billed directly to the Financially Responsible Party as reported on this document.
- **Medicare beneficiaries and Medicare alternative plan beneficiaries:** Cascade Community Healthcare has limited Medicare providers. This client's Medicare plan will be billed only for services provided by a Medicare covered provider. All other services provided will be billed directly to the Financially Responsible Party as reported on this document.
- **Labor and Industries Disability claims:** Cascade Community Healthcare is not currently a labor and industries provider. All services must be preauthorized by Labor and Industries. Any unauthorized services provided will be billed directly to the Financially Responsible Party as reported on this document.
- I understand that if, during my course of treatment, I become eligible and obtain DSHS medical benefits that would cover behavior health services; I must notify the assigned clinician immediately. The Mental Health Division requires an evaluation and authorization to be in place to determine eligibility for services. I will remain fee for service until it has been determined that I meet the Mental Health Divisions minimum criteria for Medicaid covered Mental Health Services.
- I understand that **co-payments and fees for services are due at the time services are rendered.** If I have insurance, the insurance will be billed according to the policies listed on this document. Accounts that are determined delinquent will be sent to a collections agency. I understand that if I do not pay for services at the time services are rendered and I am provided services, I will not be provided services until I have paid for prior appointments.
- All clients seeking mental health services at Cascade are assured that they will have access to services regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**
- Accounts are considered delinquent sixty days after this agency has billed the Financially Responsible Party as reported on this document. Fees for services will be mailed to the last address reported to our agency. Delinquent accounts will be referred to a collection agency.

Should the account be referred for collection the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. In the event of court action venue and jurisdiction shall be Lewis County in the State of Washington.

A missed visit fee will be billed to the Financially Responsible Party as reported on this document if the client:

- **does not show for scheduled appointment**
- does not cancel/reschedule appointment within 24 hours
- is late for scheduled appointment and it results in cancellation of the appointment due to time constraints

Missed visit fees do not apply to clients with Medicaid coverage.

Billing procedures and policies are subject to change. Notification of changes will be posted in the waiting area, provided at time of service and/or mailed to the mailing address as last reported.