Eastern Montana Community Mental Health Center
Financial Application

Please complete this form with information specific to the applicant seeking services.

Full Name of Applicant: _____ SSN/Client ID: _____
Last *First* *MI*

Other Names used in past:: _____

Mailing/Residence Address: _____ Education Level: _____

City, State, Zip: _____ Current County of Residence: _____

Home Phone #: _____ Work Phone #: _____ Message Phone #: _____

Date of Birth:	Marital Status:	Gender:	Race:	Ethnicity: *Of Hispanic or Latino Origin* Yes No	Tribal Affiliation:

Has the applicant ever served on active duty in the Armed Forces? . . . . . Yes No
(Not counted are those whose only service was in the Reserves, National Guard or Merchant Marines)

Who is legally responsible for the applicant? *(circle one to specify)* Self Guardian Limited Guardianship

Other *(specify)* _____

LIST EVERYONE WHO LIVES WITH APPLICANT. (Attach additional sheet if more than five people live with applicant.)

Last Name, First, Middle Initial	How is this person related to applicant?	Sex	Birth Date	Education Level	Social Security Number
1.					
2.					
3.					
4.					
5.					

INCOME: **SUBMIT VERIFICATION OF *ALL* INCOME FOR ALL HOUSEHOLD MEMBERS**
List all income and benefits you, your spouse, dependents, or other household members receive from any source (i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.) **2 months** of paystubs

Name	Source	Gross Amount of Income	How Often Received

If Zero income, what is your source of support? _____

Do you anticipate this income to change in the next two months? . . . . . Yes No

If yes, what is the expected change: _____

Number of Family Members Dependent on Family Income? _____

PLEASE LIST THE MENTAL HEALTH CARE PROVIDER(S) AUTHORIZED TO RECEIVE COPIES OF MHSP CORRESPONDENCE

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

DO YOU HAVE HEALTH INSURANCE COVERAGE? ..... Yes ☐ No ☐
(If yes, please complete the following for all insurance coverage including Medicare. ***ATTACH COPY OF CARDS***)

Name of Insured: _____ Relationship to Applicant: _____

Insured's SSN: _____ Policy # _____ Group # _____

Insurance Carrier Name: _____ Start Date: _____

Insurance Carrier Address: _____ End Date: _____

ARE YOU RECEIVING MEDICARE: ..... Yes ☐ No ☐

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they shall form a part of the insurance contract for which I am applying. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, organization, institution or person that has any records or knowledge of my health to disclose to Eastern Montana Community Mental Health Center (EMCMHC) or its designee any such information. A photographic copy of this authorization shall be as valid as the original. I may revoke this authorization at any time except to the extent that the person or entity making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from the date that I sign.

I agree to notify EMCMHC of any changes of income, family size or other insurance coverage within 30 days of the change.

Signature of Applicant: _____ **Date:** _____

This application is considered complete only when income documentation has been attached.

Please Mail to:
EMCMHC
PO Box 1530
Miles City, MT 59301

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
ADMISSION FORM

Name: _____ **Social Security Number:** _____

(Last) *(First)*

SOURCE OF REFERRAL
_____1. Self
_____2. Private MH Professional
_____3. Courts
_____4. Schools
_____5. Social/Community Agency
_____6. Other
_____7. Clergy
_____8. Non-psychiatric Physician
_____9. Montana State Hospital
_____10. Residential Facility
_____11. Other Mental Health Center
_____12. Law Enforcement
_____13. Crisis Center
_____14. Hospital Emergency Room
_____15. Native American Agency
_____16. Homeless Shelter
_____17. Alcohol/Drug Treatment Center
_____18. Agency of the Elderly
_____19. Agency for Children
_____20. Developmental Disabilities
_____21. Veteran=s Administration
_____22. EAP

RESIDENTIAL ARRANGEMENT
_____1. Homeless
_____2. Jail
_____3. Hospitalization
_____4. Nursing Home
_____5. Single Room Occupancy (Transient Hotel)
_____6. Shelter/Mission
_____7. Personal Care Home
_____8. Mental Health Group Home
_____9. Non-Mental Health Group Home
_____10. Foster Home
_____11. Living with others (in their care)
_____12. Supported Independent Living
_____13. Living Independently With Others
_____14. Living Independently
_____15. Other (Please Specify in File)
_____16. Therapeutic Foster Care
_____17. Residential Treatment Facility

RECENT MH SERVICES
_____1. MT State Hospital
_____2. Other Inpatient Care
_____3. Partial Hospitalization
_____4. Outpatient
_____5. No Prior Services
_____6. Unknown
_____7. This Facility
_____8. Psychiatric or Other Residential

EMPLOYMENT AT ADMISSION
_____1. No Interest in Work
_____2. Unemployed but desiring & able to Work
_____3. Involved in Day Treatment
_____4. Job Corps
_____5. Being Evaluated by Voc Rehab Services
_____6. Employed in Ongoing Volunteer Work
_____7. Employed in Sheltered Workshop
_____8. Transitional Employment Program
_____9. Supported Employment
_____10. Part-time Gainful Employment
_____11. Full-time Gainful Employment
_____12. Homemaker
_____13. Retired: Age 55 or Over
_____14. Other
_____15. Student/Preschool
_____16. Disabled

YEARS OF EDUCATION:_____Years

EDUCATIONAL STATUS
_____1. No Formal Education Activity
_____2. Adult Education Classes/GED
_____3. Attends Vocational School
_____4. Attends College Part-time
_____5. Attends College Full-time
_____6. Other
_____7. Public School
_____8. Home School
_____9. Private School For General Population

DEVELOPMENTAL DISABILITY
_____1. Yes
_____2. No
_____3. Unknown

MOST SEVERE PRESENTING PROBLEM AT TIME OF ADMISSION
_____1. Martial/Family Problems
_____2. Social/Interpersonal (not family)
_____3. Problems Coping with Daily Activities
_____4. Medical/Somatic
_____5. Depression or Mood Disorder
_____6. Attempt, Threat, or Danger of Suicide
_____7. Alcohol
_____8. Drug
_____9. Involved w/Criminal Justice System
_____10. Eating Disorder
_____11. Thought Disorder
_____12. Abuse/Assault/Rape Victim
_____13. Runaway Behavior

HOMELESS IN THE LAST 6 MONTH
_____1. Yes
_____2. No
_____3. Unknown

ON PROBATION OR PAROLE DURING LAST
_____1. Yes
_____2. No

CHRONICAL MEDICAL PROBLEMS IN THE LAST YEAR
_____1. Yes
_____2. No

MEDICAL EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

DENTAL EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

VISION EXAM IN LAST 3 MONTHS
_____1. Yes
_____2. No

NEW GENERATION MEDS
_____1. Yes
_____2. No

NEW GENERATION MEDS ARE
Clozaril (clozapine)
Zyprexa (olanzapine)
Fumarate Seroquel (quetiapine)
Risperdal (risperidone)
Geodon (ziprasidone)

SMOKING STATUS
_____1. Current Every Day Smoker
_____2. Current Some Day Smoker
_____3. Former Smoker
_____4. Never Smoker

ELIGIBILITY DETERMINATION
_____1. SSI Due to Mental Illness
_____2. SSI Not Due to Mental Illness
_____3. SSDI Due to Mental Illness
_____4. SSDI Not Due to Mental Illness
_____5. Does Not Apply

SNAP BENEFITS
_____1. Yes
_____2. No

TANF BENEFITS
_____1. Yes
_____2. No

Eastern Montana Community Mental Health Center

CONTRACT FOR PAYMENT OF SERVICES

CLIENT NAME: _____

The Eastern Montana Community Mental Health Center is a private, non-profit corporation financed largely by the collection of client fees.

1. State Funded Coverage/Self Pay:

_____ I am Medicaid eligible. I agree to notify EMCMHC regarding any changes in my eligibility.

_____ I am Medicaid eligible. I agree to pay **$120.00** for PFL Group.

_____ I am eligible for the Chemical Dependency Service Plan. I agree to provide monthly income verification.

_____ I qualify for a reduced monthly rate based on the Sliding Fee Scale.

_____ I am applying for HELP Medicaid or HELP TPA thru HealthCare.gov.

☐ I am FULL FEE ☐ $410/PFL ☐ $150/MIP ☐$295/CD EVAL ☐OTHER $_____

2. Insurance/Medicare Coverage:

- I understand that I am responsible for payment of all services received at the Center. After I complete and sign an insurance information form, the Center will submit a claim to my insurance company for services rendered. Payment from the insurance or Medicare will be sent directly to the Center. If I receive payment and do not remit the payment to the Center in a timely manner, I understand that I will be billed for the full amount of services.

_____ I agree to pay the full difference between what my insurance/Medicare pays.

3. No Third Party Coverage Payment Plan:

_____ I agree to pay full fee for all Center services according to my monthly payment plan:

☐ $25 per mo. $☐ 50 per mo. ☐ $75 per mo. ☐ $100 per mo. ☐ Payment in Full

(The above monthly payment plan is based on poverty guideline)

4. Cancellations / Broken Appointments

- I agree to be responsible for notifying the Center at least 24 hours in advance if I am unable to keep my appointment. I understand that I will be charged $100.00 ($150.00 for nurse practitioners) for every broken appointment without the 24 hour notification. If I break two appointments without advance notice the Center may not schedule a third appointment.

- I understand that should my circumstances change, I am responsible to inform Eastern Montana Community Mental Health Center. I understand that I will be billed full fee until the updated financial information has been received by the Center. I also understand that should I fail to make the above agreed upon payments, Eastern Montana Community Mental Health Center can pursue legal action to collect the outstanding balance in my account, and I will be responsible for court costs and attorney fees.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS, AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE AND CORRECT, AND I AGREE TO THIS PAYMENT CONTRACT AND ITS TERMS.

Signature of client or responsible party: _____ Date: _____

Address of client or responsible party: _____

Signature of Staff: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/19

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Eastern Montana Community Mental Health Center

ZERO INCOME VERIFICATION

Applicant's Name: _____

Present Living Arrangement:

- ○ Homeless
- ○ Alone
- ○ With family
- ○ With friends
- ○ Other (please explain)_____

I hereby certify that I do not individually receive income from any of the following sources:

- Wages from employment (including commissions, tips, bonuses, fees, etc.),
- Income from operation of a business;
- Rental income from real or personal property;
- Interest or dividends from assets;
- Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
- Unemployment or disability payments;
- Public assistance payments;
- Periodic allowances such as alimony, child support, or gifts received from persons living in my household;
- Sales from self-employed resources (Avon, Mary Kay,etc.);
- Any other source not named above.

Please explain how you are paying for your housing, food, and other necessities: _____

_____

_____

_____

I hereby declare that all information provided by me on this form is complete and true to the best of my knowledge and belief. I agree to notify EMCMHC of any changes in the above information as soon as possible, but within 30 days of my knowledge of the change.

Applicant's Signature:_____

Date:_____

Applicant's Address:_____

Applicant's Social Security Number:_____

Employee/Witness Signature:_____

Date:_____

CONSUMER RIGHTS

The purpose of this document is to ensure you know your rights and privileges while you are a consumer of Eastern Montana Community Mental Health Center.

YOU HAVE THE RIGHT:

* To receive prompt service with due consideration given to current case load and scheduling vacancies.
* To receive emergency services without undue delay.
* To know what to expect when you come in for assistance.
* To expect any information about you to be kept confidential, except in situations the law or legal precedence mandates disclosure of information.
* To ask about our assessment of your problems, our plan for your treatment, and the outcome we foresee.
* To participate in reviewing your treatment plan and making improvements upon it as your treatment progresses.
* To ask questions about anything you do not understand, or is worrying you.
* To be treated in privacy with dignity and respect.
* To receive treatment in the least restricted environment.
* To receive adequate care and treatment so you may again regain your health as soon as possible.
* To secure a lawyer to help you with legal problems, and he/she has the right to talk to your therapist about your condition with your consent.
* To receive 24 hour emergency treatment services by calling your local Center crisis line.
* To receive interpretations if English is not your spoken language.
* To read and make changes on all printed forms you are asked to sign.

YOU CANNOT:

* Be given medication without written order by a physician.
* Be given medication or other treatments as punishment.
* Be given medication for staff convenience.
* Be subject to experimental research without written consent given by you, your guardian, or next of kin.

Your records are CONFIDENTIAL and CANNOT be released to anyone without written consent given by you, your guardian, or next of kin, unless there is a Court order.

You WILL be required to pay for care and services you receive unless you qualify for a reduced rate.

If you voluntarily work for the Center in a job that otherwise would be done by an employee of the Center, you must be paid for your work. You will not be paid for work activities performed as part of your treatment.

YOU DO HAVE THE RIGHT:

* To telephone or write to the Chairman of the Center's Board of Directors if you have a problem or complaint. The Board of directors is responsible for making sure all of your rights are protected.
* To receive information and referral services when the Center cannot provide appropriate treatment for your needs.

If any of the rights listed above are denied you, the specific reason for the denial of these rights must be justified in your individual treatment plan. If you feel your rights are being violated, write or call: Chairman, Board of Directors, Eastern Montana Community Mental Health Center, P.O. Box 1530, Miles City, MT 59301.
(406) 234-0234.

Client/Guardian: _____ Date: _____

Witness: _____

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The confidentiality of mental health, alcohol and drug abuse patient records maintained by Eastern Montana Community Mental Health Center is protected by Federal law and regulations. Generally, Eastern Montana Community Mental Health Center may not say to a person outside Eastern Montana Community Mental Health Center that a patient attends Eastern Montana Community Mental Health Center, or disclose any information identifying a patient as a mental health, alcohol or drug abuser *unless:*

(1) You authorize the disclosure in writing;
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

WHO WILL FOLLOW THIS NOTICE.

This notice describes Eastern Montana Community Mental Health Center's practices and that of:

- Any health care professional authorized to enter information into your treatment records.
- All departments and units of Eastern Montana Community Mental Health Center.
- All employees, staff and other Eastern Montana Community Mental Health Center personnel.
- All Eastern Montana Community Mental Health Center entities, sites and locations will follow the terms of this notice and may share health information with each other for treatment or operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We are committed to protecting health information about you. We create a record of the care and services you receive at Eastern Montana Community Mental Health Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Eastern Montana Community Mental Health Center. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, counselors, therapists, or other EMCMHC personnel who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment. For example, our counselors may share information about you with our psychiatrist if you have symptoms of depression or other mental disorder which may affect your recovery from chemical dependency. Likewise, our psychiatrist or medical doctor may share medical information about you with our staff in order to coordinate the different things you need, such as prescriptions or lab work.

For Health Care Operations. We may use and disclose health information about you for EMCMHC operations. These uses and disclosures are necessary to run EMCMHC and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many EMCMHC patients to evaluate trends in mental health and drug and alcohol use and to assess the effectiveness of our treatment services. We may also disclose information to doctors, nurses, technicians, therapists, and other EMCMHC personnel for review and learning purposes. We may also combine the health information we have with health information from other treatment centers to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove the information that identifies you from this set of health information so others may use it to study treatment services without learning who the specific patients are.

Medical Emergencies. Medical information may be disclosed to medical personnel who have a need for information about you for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

Food and Drug Administration. Medical information may be disclosed to medical personnel of the Food and Drug Administration who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

Audit and Evaluation. Health information may be disclosed for the purpose of audit or evaluation by any federal, state, or local government agency which provides financial assistance to EMCMHC or is authorized by law to regulate our activities. Health information may also be disclosed for audit and evaluation purposes to a third party payer which covers our patients, to a peer review organization performing utilization or quality control review, or is determined by our program director to be qualified to conduct the audit or evaluation activities.

Child abuse or Neglect. We may report any information about suspected child abuse or neglect to appropriate state or local authorities.

Law Enforcement. We may disclose information about you to law enforcement officers concerning a crime committed on EMCMHC premises or against any person who works for EMCMHC or a threat to commit such a crime.

Vital Statistics. We may disclose information about you relating to cause of death under laws requiring the collection of death or vital statistics or permitting inquiry into the cause of death.

Subpoena and Court Order. If we receive a subpoena to disclose information about you, we will not do so unless a court of competent jurisdiction enters an authorizing order. A court order may authorize disclosure only if the court finds that the disclosure is necessary:

(1) to protect against an existing threat to life or of serious bodily injury;
(2) to investigate or prosecute an extremely serious crime; or

(3) in connection with litigation or an administrative proceeding in which you offer testimony or other evidence relating to the information.

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include counselor's own notes (hand generated by the clinician).

To inspect a copy of health information that may be used to make decisions about you, you must submit your request in writing to EMCMHC, Administration, Box 1530, Miles City, Montana 59301. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by EMCMHC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

2. Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by EMCMHC. To request an amendment, your request must be made in writing and submitted to: EMCMHC, Administration, Box 1530, Miles City, Montana 59301. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by Eastern Montana Community Mental Health Center.
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

3. Right to an Accounting of Disclosures. You have the right to request an Accounting of Disclosures. This is a list of the disclosures we made of health information about you, other than disclosures to you or which you authorized.

To request an Accounting of Disclosures, you must submit your request in writing to: EMCMHC, Administration, Box 1530, Miles City, Montana 59301. Your request must state a time period which may not be longer than seven years and may not include dates before April 14, 2003.

The first Accounting of Disclosures you request within a 12 month period will be free. For additional requests, we may charge you for the costs of providing the Accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment or health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to EMCMHC, Administration, Box 1530, Miles City, Montana 59301. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail.

To request confidential communications, you must make your request in writing to EMCMHC, Administration, Box 1530, Miles City, Montana 59301. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact EMCMHC, Administration, Box 1530, Miles City, Montana 59301 or call 406-234-0234.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at the Reception Desk at Eastern Montana Community Mental Health Center. The notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you are admitted to Eastern Montana Community Mental Health Center for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with EMCMHC or with the Secretary of the Department of Health and Human Services. To file a complaint with EMCMHC, contact our Privacy Officer, Eastern Montana Community Mental Health Center, PO Box 1530, Miles City, Montana 59301, phone number: 406-234-0234. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.
Violation of the federal laws and regulations by EMCMHC is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

FEDERAL STATUTES AND REGULATIONS
This notice is issued pursuant to the following federal statutes and regulations:
Statutes: 42 U.S.C. 290dd-2
42 U.S.C. 1320d-1329d-8
42 U.S.C. 1320d-2
Regulations: 42 C.F.R. Part 2, 45 C.F.R. Subtitle A, Subchapter C, Part 160, Sections 160.101 – 164.534

If you have any questions about this notice, please contact the Eastern Montana Community Mental Health Center, Administration, PO Box 1530, Miles City, Montana 59301. Our phone number is (406) 234-0234.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Eastern Montana Community Mental Health Center's Notice of Privacy Practices and have been given the opportunity to review it.

Signed:

_____

Patient Name or Personal Representative

Date: _____

If you would like to request any restrictions on the use or disclosure of your protected health information, please complete the following:

1. State what information you want to restrict.

2. Does the restriction apply to our use, disclosure, or both?

3. To whom do you want the restrictions to apply?

To Staff: If the patient refuses to sign Acknowledgement of Receipt, please state the reason:

_____ _____

Employee Name Date

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby request and authorize

_____

Name of Individual/Organization Address Phone Fax

TO RELEASE TO: _____ **OBTAIN FROM:** _____ **EXCHANGE WITH:** _____

Client Initials Client Initials Client Initials

_____

Name of Individual/Organization Address Phone Fax

The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

_____Discharge Summary	_____Psychological/Mental Status Assess.	_____Social History
_____Progress Notes	_____Medical Assessment	_____Treatment Issues
_____Master Treatment Plan	_____Psychiatric Evaluation	_____Referral For Med
_____Educational Records	_____Medication Update	_____Hospital Records
_____Psychological Testing	_____Biopsychosocial Evaluations	
_____Medical Records/Reports	_____Billing and Insurance processes	

_____Other: _____

PLEASE NOTE: the client (and parent/personal representative, if applicable) must initial here _____ to authorize disclosure of records of alcohol/drug evaluation and treatment.

I have the right to inspect and copy any information being disclosed.

I understand I may revoke this authorization in writing at any time except for the extent that action has already been taken on this authorization.

This authorization will expire on the following date or event: _____

Date Patient Initials

If I fail to specify a date or event, it will expire in six months.

I understand that I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

I have received a copy of this authorization.

_____ _____

Signature of Patient **Date** **Signature of Witness** **Date**

_____

Signature of Parent/Personal Representative **Date**

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: If this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2), the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name:_____ Date:_____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes	No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3. Does your wife, husband, a parent , or other near relative ever worry or complain about your drinking?	Yes	No
4. Can you stop drinking without a struggle after one or two drinks?	Yes	No
5. Do you ever feel guilty about your drinking?	Yes	No
6. Do friends or relatives think you are a normal drinker?	Yes	No
7. Are you able to stop drinking when you want to?	Yes	No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
9. Have you gotten into physical fights when drinking?	Yes	No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes	No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes	No
12. Have you ever lost friends because of drinking?	Yes	No
13. Have you ever gotten into trouble at work or school because of drinking?	Yes	No
14. Have you ever lost a job because of drinking?	Yes	No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
16. Do you drink before noon fairly often?	Yes	No
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
19. Have you ever gone to anyone for help about your drinking?	Yes	No
20. Have you ever been in a hospital because of drinking?	Yes	No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	Yes	No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times?_____)	Yes	No

Drug Use Questionnaire (DAST-20)

Name: _____

Case Number: _____

Charges: _____

Test Date: _____

Score: _____

Preliminary Comments

Adapted from language provided by Dr. Harvey Skinner (January 5, 2009)

The following questions concern your potential involvement with drugs other than alcohol. When you answer the questions, remember that the term "drug abuse" does not include alcohol. Instead, it refers to your use of prescribed or over the counter drugs in excess of the recommended dosage. For example, if you were given a prescription for pain killers, but took more than you were supposed to, that would be included. The phrase "drug abuse" also includes *any* non-medical drug use, including illegal drugs. This includes substances like marijuana, valium, cocaine, amphetamines, LSD, and heroin. Remember that the term "drug abuse" does not include alcohol. If you have difficulty with a statement, then choose the response that is mostly right.

Do you understand?

Questions

These questions refer to the past 12 months.	**Circle the Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7. Do you ever feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	Yes	No
19. Have you gone to anyone for help for a drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER

MEDICATION/ALLERGY LIST

Medication	Dosage	Frequency	Route Taken	Provider	Pharmacy

Allergy	Severity	Reaction

Behaviors and Symptoms

Reason for Seeking Treatment: *Please describe the situation or problem that led you to this Center*

_____

_____

_____

Life Stressors:

- ☐ Job Loss
- ☐ Relationship Breakup
- ☐ Military Deployment (combat or support)
- ☐ Sexual/Physical Assault Victim
- ☐ Court Ordered
- ☐ Substance Use Issues
- ☐ Other (Please explain)

_____

_____

Referred By:

Check all that apply to you **AT THE PRESENT TIME**

_____ Appetite Problem

_____ Sleep Problem

_____ Feel Stressed

_____ Depressed Mood

_____ Guilt Feelings

_____ Thinking About Harming Self Today _____ Within Last 2 Weeks _____

_____ Thinking About Harming Others Today _____ Within Last 2 Weeks _____

_____ Difficulty Maintaining Friendships

_____ Difficulty Making Decisions

_____ Experience Upsetting Thoughts That Will Not Go Away

_____ Sexual Problems

_____ Self-esteem Issues

_____ Difficulty Concentrating

_____ Frequent Temper Loss

_____ Bored Most of the Time

_____ Other