**CLOUD PEAK COUNSELING CENTER**
401 South 23rd Street, Worland, WY 82401
Phone (307) 347-6165 Fax (307) 347-6166
www.cloudpeakcc.org

# APPLICATION FOR SERVICES

Welcome to Cloud Peak Counseling Center (CPCC). Our agency exists for the benefit of the public and is staffed by well-trained professionals. We offer a variety of services and will do our best to provide the services you require. All information is confidential.

Today's Date: _____

## CLIENT INFORMATION

Client Name: First_____ M.I._____ Last_____ Maiden Name :_____

Date of Birth: _____ Age: _____ Social Security Number: _____ Gender: _____

Place of Birth: _____ Mother's First Name: _____

Residence Address: _____Apt #_____

City: _____ State: _____ Zip: _____

Mailing Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Message Phone: _____

Employer:_____Employer/Work Phone_____

Email:_____ May we contact you/ leave a message at: Home? Yes / No Mobile? Yes / No Work? Yes / No

May we send correspondence to your mailing address? Yes / No If no, what is your alternative:_____

Spouse's Name: First_____M.I.____Last_____Spouse's Date of Birth:_____

Spouse's Social Security Number:_____ Spouse's Employer:_____

In Case of Emergency Contact: _____Relationship:_____Phone:_____

Address: _____City: _____ State: _____ Zip:_____

How would you prefer to get reminder notifications for your appointments? Phone:____ Text:_____ Email:_____

## DEMOGRAPHICS

SOURCE OF REFERRAL:
___ Self
___ Family/ Friends
___ Police/ Law Enforcement
___ Court
___ Private Psychiatrist
___ Other Physician
___ Other Private Mental Health Practitioner
___ Clergy
___ Wyoming State Hospital
___ Other Inpatient Psychiatric Services
___ Drug/ Alcohol Abuse Treatment Facility
___ Shelter
___ Community Mental Health Center
___ Schools
___ Employer
___ Department of Family Services (DFS)
___ Division of Vocational Rehabilitation (DVR)
___ Nursing Home
___ Medical Hospital
___ Development Disability
___ Drug Court
___ Adult Probation and Parole
___ Juvenile Probation
___ Early Childhood Setting
___ Attorney
___ Veteran Affairs (VA)
___ Department of Corrections (DOC)
___ Other

RACE:
___ Caucasian
___ African American
___ Native American/ Alaskan
___ Asian
___ Other/ Unknown
___ Native Hawaiian/ Other Pacific Islander
___ More than One Race

HISPANIC ORIGIN:
___ Not Hispanic
___ Cuban
___ Puerto Rican
___ Mexican
___ Other Hispanic
___ Unknown

EMPLOYMENT STATUS:
___ Unemployed
___ Part-Time
___ Full-Time
___ Homemaker
___ Retired
___ Disabled
___ Child Under 15
___ Student Over 15
___ Inmate of Institution

Name of School_____

Highest Grade Completed:_____

MARITAL STATUS:
___ Never Married
___ Now Married
___ Separated
___ Divorced
___ Widowed
___ Minor Child

VETERAN STATUS: Y / N
Combat: Y / N
Non-combat: Y / N

Do you have an Advance Directive or Living Will? Yes / No

## FAMILY MEMBERS

**Please List All Family Members Residing In The Home:**

| Name | Sex | Age | Birth Date | Grade Completed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

**Family's Total Annual Income Before Taxes** $_____

## PRESENTING PROBLEM

Describe the problems that bring you to Cloud Peak Counseling Center (CPCC):_____

_____

_____

_____

Have you been seen at CPCC or WMHS before? YES / NO If yes, under what name?_____

Please list other agencies in which you are involved: _____

## HEALTH HISTORY

Family Physician: _____

Are you currently being treated for a medical problem? YES / NO If yes, please explain: _____

_____

Are you taking medications? YES / NO If yes, please list below:

| Physician | Medication | Dosage | How Long? | Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you had any serious medical problems in the past? YES / NO If yes, please explain: _____

_____

How much alcohol do you drink? _____ How often? _____

Do you use street drugs? YES / NO If yes, which ones? _____

What problems have you and your family had with alcohol/ drugs? _____

_____

What problems have you and your family had with mental illnesses? _____

_____

## BILLING INFORMATION

**How do you plan to pay for services?**

___ Self Pay: *Person Responsible for Payment*_____

___ Equality Care (Medicaid): *Equality Care Number*_____

___ Kid Care CHIP: *Kid Care Number*_____

___ Department of Family Services: *Name of Caseworker*_____

*Phone of Caseworker*_____

___ Department of Vocational Rehabilitation *DVR Case Number*_____

___ Other Contract: *Agency Name*_____ *Contact Person*_____

*Address*_____ *Phone*_____

___ Veteran Affairs

___ EAP: *Employer*_____ *Phone*_____

*Authorization Number*_____ *How many sessions?*_____

___ Health Insurance (Please fill out the following information)

## PRIMARY INSURANCE

**Policy Holder Information:**

Name of Policy Holder: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Phone: _____

Name of Insurance Company: _____ Phone: _____

Identification Number: _____ Group Number: _____ Relationship to Client: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

## SECONDARY INSURANCE

**Policy Holder Information:**

Name of Policy Holder: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Phone: _____

Name of Insurance Company: _____ Phone: _____

Identification Number: _____ Group Number: _____ Relationship to Client: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

For Questions About Billing Please Contact:

Amanda Kretz/Billing Clerk
James Donahue/Corporate Compliance Officer
(307) 347-6165
(307) 347-6166 Fax

**Have you considered whether or not you are eligible for Equality Care/ Kid Care CHIP health benefits? If you are interested in the eligibility requirements or would like to apply for these benefits please ask our front office staff for an application. Completed applications must be returned to Department of Family Services (DFS) for a final determination.**

# FINANCIAL AGREEMENT

Name: _____ Social Security Number: _____

1. Cloud Peak Counseling Center (CPCC) is a private, non-profit organization, established to help people with emotional and/or behavioral problems and to provide consultation and education to community organizations. CPCC receives some public funding, but that funding provides only a part of the financial support needed to operate CPCC. The balance must come from the individuals who receive services. Fees for services are assessed on an "ability to pay" basis, as shown on the Fee Schedule.

2. If you have health insurance, we will bill your insurance company CPCC's full provision of services rate. The current rates of service are posted. However, the client is always responsible for payment for services assessed at his or her adjusted income rate, unless the adjusted income rate plus the insurance payment exceeds current rates. In that case, the client is responsible only for the difference between the insurance payment rate and CPCC's full provision of services rate.

3. If you have Equality Care (Medicaid), we will bill the charges directly to Equality Care for services covered. If you receive services from CPCC not covered by Medicaid, you will be charged according to your adjusted income rate.

4. A No-Show Fee will be charged if you fail to show up for a scheduled appointment. The No-Show Fee is $10.00 for all services EXCEPT medication management and telehealth services. Medication management and telehealth services will be assessed a $25.00 No-Show fee.

5. **The recipient of services is required to make full payment at the time services are provided, unless other arrangements have been made with the business office in advance. All statements of account are due and payable in full upon receipt.**

6. I understand and agree that I am responsible to pay for all services provided to me by Cloud Peak Counseling Center and its staff. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all attorney fees-should legal action need to be taken.

## FEE SCHEDULE

Gross Annual Family Income $_____. Number of dependent persons in family _____ x $4,320 deductions _____

Adjusted Gross Income $_____.

| ADJUSTED INCOME | PERCENT OF FULL FEE |
|---|---|
| At or Below 100% FPL | $10.00 Flat Rate |
| $12,490 - $19,999 | 10% |
| $20,000 - $29,999 | 20% |
| $30,000 - $39,999 | 30% |
| $40,000 - $49,999 | 40% |
| $50,000 - $59,999 | 50% |
| $60,000 - $69,999 | 60% |
| $70,000 - $79,000 | 70% |
| $80,000 - $89,000 | 80% |
| $90,000 - $99,999 | 90% |
| $100,000 and Above | 100% |

**2019 Poverty Guidelines**

| Persons in family/household | Poverty guideline |
|---|---|
| 1 | $12,490 |
| 2 | $16,910 |
| 3 | $21,330 |
| 4 | $25,750 |
| 5 | $30,170 |
| 6 | $34,590 |
| 7 | $39,010 |
| 8 | $43,430 |

For each additional person, add $4,320

Your adjusted income rate is _____ percent of the full fee. Charges for other services, such as books, testing materials and fees, evaluations, and some workshops or classes may not be adjusted to our sliding fee scale. If you believe that the fee set by the sliding scale is unreasonably inconvenient, discuss this with your therapist or the business office.

If your financial or insurance situation changes while you are receiving services, it is your responsibility to report your new status to CPCC.

**CHECK APPROPRIATE BOX:**

( ) I hereby state that I do have third party coverage with _____ and that I will provide CPCC with all appropriate claim forms in order for direct payment to be made to CPCC. I authorize release of information necessary to process claims and authorize direct payment of benefits to CPCC. If payment is made directly to me, I hereby agree to promptly remit such payments to CPCC. I understand that I will be responsible for payment for any services not covered by my insurance.

( ) I hereby state that I do have third party coverage, but I do NOT want CPCC to bill my third party insurance. I understand, with this decision, I will be billed at the full fee for services.

( ) I hereby state that I do NOT have third party coverage. If I obtain such coverage in the future, I will immediately notify CPCC.

I acknowledge that I have read and understand the foregoing Financial Agreement and agree to abide by all of its terms and conditions.

_____ _____

Signature of client OR parent, guardian or person authorized to sign for client. Date

Relationship to client _____

Witness Date

Primary Income Source:

__ Self
__ Family (Parent/Guardian/Spouse/Adult Children)
__ SSI (Supplemental Security Income)
__ SSDI (Social Security Disability Income)
__ Other Disability
__ Retirement
__ DFS (Department of Family Services/Welfare)
__ Other/Unemployment

Tobacco Use:

__ Never Used
__ Yes (Traditional Cigarettes/Cigars/Pipes)
__ No
__ E-Cigarettes
__ Snuff/Chew
__ More than One Form of Tobacco
__ No Use Due to Recent Stay in Controlled Environment

Probation Client at Transaction Date:

__ Yes
__ No

Parole Client at Transaction Date:

__ Yes
__ No

Have you seen your Primary Care Doctor in the last year?

__ Yes
__ No

Arrest (last 90 days):

__ Yes (Arrested)
__ No (Not Arrested)

# YOUR RIGHTS & RESPONSIBILITIES

## RIGHTS

In accordance with Wyoming Statutes, clients served by mental health centers have the right to impartial access to services, regardless of race, religion, gender, sexual orientation, ethnicity, age, handicap, or sources of financial support.

You have the right to have your personal dignity and privacy recognized and respected in the provision of all services.

You have the right to receive services without worry about abuse, financial or other exploitation, retaliation, humiliation, and neglect from staff.

As a Cloud Peak Counseling Center (CPCC) client, you have a right to an individual plan for your treatment which provides for the least restrictive care that may be expected to benefit you.

Written and verbal communications between clients and staff and the content of clinical records shall be held in confidence by all staff. Confidential information shall be revealed or released only with the client's informed and written consent, instances of legally reportable child or adult abuse and neglect, criminal activity on CPCC premises or against CPCC staff, and to qualified State and Federal personnel, and to authorized peer reviewers under written oath of confidentiality.

Federal confidentiality rules (42 CFR Part 2 and 45 CFR Part 160 and 164) prevent use of any information we have obtained to criminally investigate or prosecute any alcohol or drug patient. Disclosure of client identifying information is permitted if authorized by a court order, after application showing good cause.

You have the right to initiate a grievance and obtain a mechanism for requesting a review of the grievance. You have the right to bring legal representation to the hearing to assist you in presenting the grievance. Suggestions, complaints, or grievances should be taken to the Director of Cloud Peak Counseling Center; in the event of a grievance, you will be provided a copy of our Client Grievance and Hearing Policy.

You have the right to have access to your own records, except when CPCC feels it would not be in your best interest.

You have the right to access legal entities for appropriate representation.

You have the right to access self-help and advocacy support service.

You have the right to be notified under what conditions these rights may be restricted including criteria for resolution and return to treatment.

## RESPONSIBILITIES

To provide true facts about your illnesses, medications and previous treatments.

To report any changes in your medications or symptoms to your therapist/ case manager.

To ask questions about your care or treatment plan.

To follow the recommendations/ instructions of your therapist/ case manager.

To realize that the problems caused by your failure to follow your treatment plan or therapist instructions are your responsibility.

To pay your bills and work out financial arrangements for covering the cost of your treatment.

To be considerate to other staff, visitors and other clients by respecting their rights and confidentiality.

To notify CPCC if you are unable to attend a scheduled appointment as soon as you become aware that you will not be able to attend it.

**I acknowledge that I have read and understand my RIGHTS, including my rights to confidentiality and the financial agreement. I hereby give permission and consent to services by a representative of CPCC. If this application is for services for a child or ward, I authorize a representative of CPCC to interview and provide the recommended services to the child (may include transportation).**

_____ _____

Signature of client OR parent, guardian or person authorized to sign for client — Date

Relationship to client_____

_____ _____

Witness — Date

# Use and Disclosure Authorization
# Wyoming Department of Health
# Mental Health and Substance Abuse Division

In an effort to continually improve Wyoming treatment programs, we ask that you please read and sign the following form. By your signature, you are consenting to provide your Social Security Number for the purposes and under all the protections set forth in applicable state and federal laws. According to W.S. 9-2-125, records shall remain confidential except as required by law. You may revoke this at any time by signing and dating the revocation section of this form and returning it to the office.

- In order to improve treatment programs it is necessary for the State of Wyoming to conduct research, to audit programs and payments for services and to monitor treatment outcomes.
- By signing this form you are consenting to voluntarily disclose your Social Security Number (SSN) to the Wyoming Department of Health (WDH). Once received by the WDH, your SSN is kept Safe by using electronic encryption to alter your nine-digit SSN into a 25-digit number that will make is impossible to identify.
- The Department of Health is required by state and federal laws and regulations to protect your Social Security Number and all other personal health information obtained from you. If we fail to do so, there are penalties of law and you may be entitled to bring a law suit against the Department. In order to comply with these laws, the Department has implemented policies and procedures to protect your information from unlawful uses.

Please read the following statements prior to signing the document:

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties only in accordance with state and federal laws that will continue to protect your information.
- I understand this authorization will not expire pursuant to 45CFR 164.508(c) (v).
- Under the Privacy Act of 1974, I understand that my disclosure of this information to the Wyoming Department of Health is Voluntary, that the Department of Health has the authority to collect and maintain this information (pursuant to W.S. 9-2-125 et seq.) and that the uses of this information will include:
  - Research to include the creation and maintenance of research database and research repository pursuant to 45CFR Part 2, sec. 2.31 et seq., W.S.35-2-607 et seq., W.S. 9-2-126 et seq., and
  - To determine compliance with state and federal reporting requirements, management of financial audits, and programs monitoring and evaluation.
- I understand all information will be kept strictly confidential and database security will include encryption which meets or exceeds the highest.
- I understand my eligibility for treatment is not dependent on my signature and that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand I will be provided with an updated version of the WDH notice of privacy practice every three years.

I hereby authorize the use/disclosure/use and disclosure of my Social Security Number (please print):

| | |
|---|---|
| Client Name: | SSN: |
| Address: | Date of Birth: |
| Witness: | Date: |

I hereby authorize the following program to receive these disclosures:
Authorized program: Wyoming Department of Health, Mental Health and Substance Abuse Division
Research/Data Manager, 6101 Yellowstone Ave, Suite 220 Cheyenne, WY 82002 Telephone: (307) 777-7903

Client Signature: _____ Date: _____

Thank you for agreeing to help us improve services in Wyoming!

*Complete this section ONLY if the form is not signed by the client him/herself*

If not signed by the client please indicate the relationship:

__ Guardian or conservator of an incompetent client
__ Parent or guardian of minor client
__ Beneficiary or personal representative of deceased client
__ Other (specify) _____

Name of Client:

_____

For Office use only: Documentation or Relationship: __ Reviewed __ Attached

*Complete this section only if the client has chosen to revoke their prior authorization for release of private health information*

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Wyoming Department of Health program listed above. I further understand that such revocation does not apply to persons which have already acted in reliance on the authorization.

I hereby Revoke this authorization: _____ Date: _____