Hello and thank you for applying for services from the Montrose Center. In order to best serve you, please read these instructions carefully as they will tell you which of the following forms you need to complete. While there is quite a bit of questions to respond to, they are necessary in order to ensure that you are receiving the highest level of care possible.

Instructions on Forms to be completed

- ✓ **3.1.3.1 Eligibility Screening & Consent for Services:** All persons applying for Counseling and/or Case Management need to complete this form.
- ✓ **11.2.9 Consent for Emergency Medical Care:** All persons applying for Counseling and/or Case Management need to complete this form.
- ✓ **3.1.3.2.1 Consent for Services Form Sliding Scale/Grant:** Persons who are applying for Counseling and/or Case Management and want to be considered for sliding scale or grant funded services should complete this form. If you have insurance, you are still able to complete this form, as you may be eligible for copay assistance under our sliding scale or grant coverage.
- ✓ **3.1.3.2 Consent for Services Form full Fee:** Persons who are applying for Counseling and do not want to be screened for sliding scale or grant funded services, or do not wish to provide proof of income should complete this form.
- ✓ **3.1.3.1.1 Substance Use Screening:** Only persons applying for our Intensive Outpatient Program or Relapse Prevention Group Services should complete this form.
- ✓ **3.1.3.8 Parental/Guardian Consent Checklist:** If you are a parent/guardian and are applying for services for a minor, please complete this form. If the child's parents are divorced, each parent who has custody must complete this form. If the child's parents are married, only one parent needs to complete this form.

Documentation to Provide

In addition to the paperwork packet and forms detailed in the section above, you will also need to submit the following documentation (*please note that all requests for services will be pending until all documents needed to complete eligibility have been received*).

- Proof of Address
- Proof of Income (if applicable)
  - Proof of spouses income if legally married
- ID (Form of Identification)
- Insurance, back and front of card (if applicable)
- Proof of HIV status (if applying for HIV Counseling and/or Case Management)
- Proof of Veteran status (if applying for Veteran's Counseling and/or Case Management)
- Proof of Joint Custody, Sole Custody, or Guardianship (if applying for a minor in instances where the child's parents have joint or sole custody, or a guardian has been appointed)

Instructions on Submitting Documents

To submit your completed paperwork you may either **1)** email your completed forms to clientsupport@montrosecenter.org, **2)** fax the forms to 713.526.4367, or **3)** drop off the forms in person at 401 Branard Street, 2nd Floor, Houston, TX 77006.

Questions/Concerns

If at any time you have questions or concerns please reach out to our Eligibility Department Monday thru Fridays, from 8:00 am to 5:00 pm at 713-529-0037 (press 0 to speak to an Eligibility Specialist). Alternatively, questions may be emailed to an Eligibility Specialist at clientsupport@montrosecenter.org.

3.1.3.1 ELIGIBILITY SCREENING & CONSENT FOR SERVICES

I. PROFILE

Please Block Print Today's Date: __ / __ / ____

Legal Name: ____________________
First MI Last

Chosen/Preferred Name: ____________________

Home Address: ____________________ Apt/Unit# ____

City: ____________________ State: __ Zip: _____

County: ☐ Harris ☐ Other: ____________________

May we send you mail to this address? ☐ yes ☐ no

Home Ph: (___) ___-____

Work Ph: (___) ___-____ Ext: _____

Cell Phone: (___) ___-____ May we text reminders about appts? ☐ yes ☐ no

The Montrose Center staff will only leave their name and phone number (713.529.0037). If we can leave a more detailed message, it may expedite your assignment to a Therapist. May we leave a private/confidential message? ☐ Home ☐ Cell

Email: ____________________

@ ____________________ . ___

May we email you about appointments? ☐ yes ☐ no May we add you to our e-newsletter list? ☐ yes ☐ no

Social Security #: ___-__-____

Indentification #: __________ State: __ Country ________

Type of ID: ☐ Drivers License ☐ State ID ☐ Passport ☐ School ID ☐ Consolate ID

Your Income $ ___,___ [1] **Other Resources: $** ________

How often are you paid? ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other: ____________

This figure is a set annual salary ☐ yes ☐ no

Number of people in the household: _________ How many of these are dependent children? _____

Marital status (for insurance purposes): ☐ single ☐ legally married ☐ domestic partnership
☐ married but separated ☐ widowed

If legally married, **spouse's income $** ___,___ (provide proof of both yours and spouse's income to request reduced fees or grant subsidies)

How often are they paid? ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other: ____________

This figure is a set annual salary ☐ yes ☐ no

What are your **sources** of that income: (check all that apply) ☐ job ☐ private disability ☐ retirement ☐ SSI[1] ☐ SSD[1]
☐ workers comp ☐ parents ☐ unemployment ☐ food stamps ☐ TANF ☐ other: ________________

Date of Birth: __ / __ / ____ **Sex assigned at birth:** ☐ Male ☐ Female ☐ X

Intersex Condition ☐ Yes ☐ No ☐ Don't Know ☐ Declined

Gender: ☐ cis-Male/Masculine ☐ cis-Female/Feminine ☐ Transgender Female/Feminine
☐ Transgender Male/Masculine ☐ Non-Binary Agender ☐ Non-Binary Genderfluid
☐ Non-Binary Demigender ☐ Third Gender ☐ Other: ________________

Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ None/Use my name
☐ Other/Neopronouns: _____________

Orientation: ☐ Asexual ☐ Bisexual ☐ Gay/Lesbian ☐ Heterosexual/Straight ☐ Pansexual ☐ Queer
☐ Questioning ☐ Don't Know ☐ Other: ________________

Ethnicity (optional - for statistical information only):
Are you of Spanish/Latino(a) origin? ☐ yes ☐ no ☐ Decline to Answer

Race (optional - for statistical information only):
☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/PI
☐ White ☐ Other, explain: _____ ☐ Decline to Answer
If Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other/Multi Asian

Mother's First Name & Maiden Last Name: _____ Your City of Birth: _____
Are you a **U.S. citizen**? ☐ yes ☐ no
If no, do you have an ID? ☐ yes ☐ no Permanent Resident card? ☐ yes ☐ no Visa? ☐ yes ☐ no

Did you serve in the **military**[2]? ☐ no ☐ active duty ☐ honorable discharge ☐ other than honorable discharge

Are you a spouse/partner, child, or dependent of a someone who did or doesserve in the military? ☐ yes ☐ no

Are you currently a student? ☐ yes ☐ no Are you under your parent's insurance? ☐ yes ☐ no

Do you have[3] (check all that apply): ☐ no **health insurance** ☐ Medicaid[4] ☐ Tricare/Champus/VA
☐ private w/o substance abuse coverage ☐ Medicare ☐ HHS Discount (formerly Gold Card) ☐ TCHIP
☐ private with substance abuse coverage ☐ TANF ☐ DARS ☐ TCHIP perinatal
☐ Texas Healthy Women ☐ EAP[5] benefits through work, if yes, EAP authorization # _____
If none, will you be eligible in the next 6 months for: ☐ health insurance ☐ Medicaid ☐ Medicare

Have you applied for: ☐ SSI ☐ SSDI ☐ disability insurance Explain: _____

Would you like assistance in applying for:

☐ Healthcare Marketplace https://www.healthcare.gov/

☐ Medicaid/CHIP https://www.hhs.texas.gov/services/health/medicaid-chip

☐ Medicare https://www.medicare.gov/

Do you have multiple insurances? ☐ yes ☐ no If yes, please give both cards to the Eligibility Staff
Have you alerted each carrier about the other so that they may coordinate your benefits? ☐ yes ☐ no

Comments: _____

[3] complete the top portion §19.3.4 and submit to Program Secretary for insurance verification [4] Please double check for secondary insurance
[5] client must request benefits from employer and receive an authorization before we can bill.

Other Benefits: ☐ free/reduced lunches ☐ housing assistance ☐ SNAP (Lone Star Card) ☐ WIC
☐ Comprehensive Energy Assistance Program

Where do you **live**: ☐ 1 private residence/independent (own) ☐ 1 private residence/independent (lease)
☐ 2 dependent in family home ☐ 3 homeless/street ☐ 4 shelter ☐ 5 jail/correctional facility
☐ 6 halfway house ☐ 7 supportive housing ☐ 8 group home ☐ 9 crisis residence ☐ 10 foster home
☐ 11 hospital ☐ 12 children's residential treatment facility ☐ 13 residential care/nursing home/assisted living
☐ 14 institutional setting (psychiatric/medical) ☐ 15 intermediate care ☐ 16 treatment/rehab center
☐ 17 other, explain _____ How long have you live there? _____
Have you been in a "**controlled environment**" in the past 3 years? ☐ yes ☐ no If yes, what type: ☐ jail
☐ alcohol/drug treatment ☐ medical treatment ☐ psychiatric treatment ☐ other: _____

Employment status[1]: ☐ unemployed, not sought in past 30 days ☐ unemployed, sought in past 30 days
☐ unemployed, secured a position ☐ PT (<35 hrs/wk) ☐ FT (>35 hrs/wk) ☐ disabled
☐ not in labor force

Nicotine use status: ☐ 0 Never smoker ☐ 1 Former smoker ☐ 2 Light tobacco smoker ☐ 3 Current, some days smoker
☐ 4 Current, every day smoker ☐ 5 Heavy tobacco smoker ☐ 6 Unknown if ever smoked
☐ 7 Smoker, current status unknown

Have you been tested for **HIV**? ☐ yes ☐ no Have you been diagnosed with HIV? ☐ yes ☐ no
Is the reason you are seeking services related to HIV? ☐ yes ☐ no

Have you had a history of: Alcohol issues ☐ Y ☐ N Drug issues ☐ Y ☐ N

When was the last time you used? _____

Are you court mandated for substance use treatment? ☐ yes ☐ no

Is this a suicidal crisis? ☐ Yes ☐ No If you check yes, please explain the nature of your crisis:

_____

_____

Are you currently having thoughts of suicide? ☐ Yes ☐ No If yes, please talk to the Eligibility Staff immediately.

Suicidal Ideation Attributes Scale (SIDAS)

1. In the past month, how often have you had thoughts about suicide?
   0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
   Never — Always
2. In the past month, how much control have you had over these thoughts?
   0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
   No control/ do not control — Full control
3. In the past month, how close have you come to making a suicide attempt?
   0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
   Not at all close — Have made an attempt
4. In the past month, to what extent have you felt tormented by thoughts about suicide?
   0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
   Not at all — Extremely
5. In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?
   0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
   Not at all — Extremely

Have you decided on a method to kill yourself? ☐ YES ☐ NO

AUDIT

Spijker, B. A., Batterham, P. J., Calear, A. L., Farrer, L., Christensen, H., Reynolds, J., & Kerkhof, A. J. (2014). The Suicidal Ideation Attributes Scale (SIDAS): Community-Based Validation Study of a New Scale for the Measurement of Suicidal Ideation. Suicide and Life-Threatening Behavior,44(4), 408-419. doi:10.1111/sltb.1208

How did you hear about the Montrose Center? ☐ 211/United Way ☐ Friends/Family ☐ Website ☐ Social Media ☐ Flyer/Card ☐ TV/Radio ☐ Another Agency ☐ Other _____

Primary Spoken Language: ☐ English ☐ Spanish ☐ ASL ☐ Other: _____

Primary Reading/Written Language: ☐ English ☐ Spanish ☐ ASL ☐ none ☐ Other: _____

Do you have any **physical challenges or special needs**? (check all that apply)
☐ mobility ☐ hearing ☐ sight ☐ speech ☐ reading ☐ learning ☐ other: _____

Do you have any physical challenges for which **personal care assistance** is needed while here? ☐ yes ☐ no
If yes, what assistance is needed? _____

Community resources: Are you receiving services from any other agencies? ☐ yes ☐ no
If yes, where: _____

Is the situation for which you seek help related to a **crime**? ☐ yes ☐ no If yes, how long ago was the crime? _____
If yes, did you report the crime to the police? ☐ yes ☐ no If yes, within 72 hours? ☐ yes ☐ no
If yes, you may be eligible for Crime Victim's Compensation to pay for counseling services if: you do not have insurance, the crime was against you within the last year & you reported it within 72 hours. The Center can help you process your forms & receive direct payment from them.

Are you looking for Batterers' Intervention & Prevention Program (BIPP)? ☐ yes ☐ no

Have you ever been convicted of a domestic violence charge? ☐ yes ☐ no
Have you ever been convicted of a sexual offense? ☐ yes ☐ no Are you looking for court ordered sex offender treatment? ☐ yes ☐ no

I am seeking assistance with the following services (check all that apply)**:**

☐ individual therapy counseling ☐ couples/family therapy ☐ group therapy ☐ case management
☐ substance use disorder treatment ☐ CPCDMS registration ☐ HOPWA
☐ domestic violence ☐ sexual assault ☐ hate crime ☐ human trafficking

Reason for seeking services: _____

_____

Do you have any family members or close friends you want to include in your treatment? If you are seeking Couples/Family Therapy, please include name(s) of all partner(s) and/or family member(s) that will be included in therapy. List all name here.

_____

Do you have a preference for specific characteristics in a Therapist/Case Manager? ☐ yes ☐ no

If yes, please explain: _____

Please indicate the day(s) and time(s) you are available for appointments.

	Mon	Tue	Wed	Thu	Fri	Sat*
8:00 to 11:00 am	☐	☐	☐	☐	☐	☐
11:00 am to 1:00 pm	☐	☐	☐	☐	☐	☐
1:00 pm to 3:00 pm	☐	☐	☐	☐	☐	☐
3:00 pm to 5:00 pm	☐	☐	☐	☐	☐	☐
5:00 pm to 7:00 pm*	☐	☐	☐	☐	☐	

*____ (initial) I understand evening and Saturday appointments are extremely limited and may experience an extended wait time or require assignment to see an out-of-network therapist at the full fee.

*____ (initial) I understand if my availability is limited to evening/weekend I will be assigned to next available therapist without regard to any specific characteristics listed above.

*____ (initial) In the event that there is a wait list for entrance into Individual or Couples counseling, I agree to forego the use of my insurance and be assigned to the next available therapist for a rate of $50/individual therapy session / $30/couples therapy session [per person] **or** my sliding scale fee (found on form 3.1.3.2 or 3.1.3.2.1) whichever is higher.

____ (initial) In the event that there is a wait list for entrance into Individual or Couples/Family counseling, I agree to: forego the use of my insurance and be assigned to a student intern for up to 12 sessions of Solution-Focused Brief Therapy at a discounted student intern sliding scale rate (available upon request). After 12 sessions, my rate will be $50/session **or** my sliding scale fee (found on form §3.1.3.2 or §3.1.3.2.1), whichever is higher. I understand I may close my file or return to the general wait list.

Would you prefer to:☐ be assigned the next available Therapist/Case Manager or ☐ wait for your preference

I am willing to wait _____ day(s) for my demographic characteristic preferences before being assigned to the next available Therapist.

3.1.3.2.1 CONSENT FOR SERVICES FORM SLIDING SCALE/GRANT

I have read the statement of client rights and responsibilities and have answered all questions to the best of my ability. I am requesting services from the Montrose Center. I understand the Montrose Center strives to make mental health care affordable and accessible and will explore insurance and grant options if I am willing to provide the necessary eligibility paperwork including ID, insurance card, proof of income, proof of residence and proof of HIV status (if applicable). I further understand that if I do not provide proof of income, I will not be screened for a grant subsidy or be eligible for the sliding fee scale.

Optional Telehealth:

_____ initial I understand that my therapist/psychiatrist/case manager (provider) may offer a telehealth session for therapy, case management or medication management using a HIPAA compliant telehealth platform as long as my insurance (or applicable grant funding) allows. My provider has explained to me how the video conferencing technology will be used and that I will not be in the same room as my provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation. I understand that if a staff member other than my provider is present during the session, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and I will have the right to request the following: 1) omit specific details of my psychosocial and medical history that are personally sensitive to me; (2) ask the other person to leave the telehealth room: and/or (3) terminate the session at any time. I have had the alternatives to telehealth explained to me, and I am choosing to participate in telehealth. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify: 1) That I have read or had this form read and/or had this form explained to me, 2) That I fully understand its contents including the risks and benefits of the session(s), 3) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction, and 4) I consent to services provided by telehealth.

_____ initial I understand that if my insurance does not cover telehealth services at the Montrose Center and I still want to receive telehealth services at the Center, I will pay the insurance contracted rate for an in office visit with the therapist out-of-pocket.

_____ initial **I am interested in paying a sliding fee based on my income below 725%[6] of the Federal Poverty Level and/or being assessed for grant subsidies for which I may be eligible.** [6]$109,185 for a household of 1- FY24

Please initial all statements below

_____ initial I give the Montrose Center permission to verify if I am enrolled under Medicaid and if so, precertify my sessions.

_____ initial I recognize grants are payers of last resort and that I must provide my Medicare, Medicaid and third party insurance information to be billed first.

_____ initial The Montrose Center's fee for intake is $150.00. However, if I am providing an insurance card, proof of income less than 725% of the poverty level or eligible for a grant subsidy ***then I understand my portion of the intake fee is the insurance contracted rate/copay***. Certain grant subsidies may cover the cost of intake in its entirety.

_____ initial If I provide an insurance card and proof of income less than 725% of the poverty level or request a grant subsidy then I understand my portion of the individual, family, group or IOP fee may be covered by a grant.

_____ initial **I understand that the full fee (before sliding scale, grant subsidies or insurance company contracted rates are assessed) is:** individual session fee - $120.00; 90 minute session fee - $180; crisis phone call

outside of regular appointments fee - $25/15 minutes; couple/family session fee - $60.00 per person, maximum - $120.00; group fee - $60.00; Intensive Outpatient (IOP) Substance Use Disorder Treatment - $200/day; psychiatric intake fee - $250 and psychiatric follow-up fee - $125. The fee contracted by my insurance company may be discounted from these rates which will be explained in the Explanation of Benefits (EOB) I receive from my insurance company.

_____ initial **I understand I am responsible for the following fees:** intake/crisis stabilization - $150.00; individual session fee - $120.00; 90 minute session fee - $180; couple/family session - $60.00 per person, maximum - $120.00; group fee - $60.00; crisis phone call outside of regular appointments fee - $25/15 minutes, Intensive Outpatient Substance Use Disorder Treatment - $200/day; psychiatric* intake fee - $250 and psychiatric* follow-up fee - $125. The fee contracted by my insurance company may be discounted from these rates which will be explained in the Explanation of Benefits (EOB) I receive from my insurance company.

_____ initial I understand that if I want 90 minute sessions and my insurance carrier does not cover this service, I agree to pay out-of-pocket $180 for the 90 minute session and can submit to my insurance carrier for partial reimbursement. (This service is covered if a client is on a grant)

_____ initial I understand that if I want to receive psychiatric services, the Center is not in-network with most insurance carriers for this service, therefore I agree to pay out of pocket and submit for reimbursement from my insurance carrier. (N/A for clients with Medicare and/or Medicaid)

_____ initial If my insurance is out of network, I understand I will be required to pay the full fee and Montrose Center will submit claims to my insurance carrier as a courtesy to me. I am responsible for understanding my out-of-network coverage **and how my insurance will reimburse me**.

If I do not want the Center to bill my insurance:

_____ initial I have insurance but am requesting that the Center not bill it. I understand that I will be charged the full fee of $150 for intake/crisis stabilization session, $120 for individual sessions, $180 for 90 minute individual sessions, $60.00 for my part of a family session, $60.00 for my part of a group session, $200/day for Intensive Outpatient Substance Use Disorder Treatment, $250 for a psychiatric intake, $125 for a psychiatric follow-up and $25/15 minute increments for crisis calls outside of a regular appointment.

Reason(s) I do not want to use my insurance (optional): _____

_____

_____ initial If I use insurance benefits, I understand I may have a deductible to meet before I am eligible to pay my copay and will be charged the full allowable rate for services until the Explanation of Benefits is received informing our Benefits Specialist that the deductible have been met.

_____ initial I understand fees can be paid by cash, check, MasterCard/VISA. They cannot be paid with Discover, AMEX or any other credit card unless done through the Center's website and Paypal https://www.montrosecenter.org/forms/payment-form/. Fees may be subsidized by grant funds if eligibility criteria are met. I understand that payment is due at the time services are rendered.

_____ initial I understand a $25.00 fee will be assessed on each returned check and VISA/MasterCard charge.

Please initial all of the next 7 items

_____ initial I will update my insurance information prior to receiving any additional services after a change and recognize failure to do so may result in lapse in coverage during which I am solely responsible for the full cost of any services provided.

_____ initial **Unless I have Medicaid, I agree to pay the sliding scale rate for an individual or family session not cancelled at least 24 hours ahead of time. This may be higher than the rate contracted by my insurance company since no shows are not allowed to be billed to insurance.**

Please initial 1 of the next 2 items

____ initial If there is a credit card on file, I agree that the Center may automatically charge the full rate for no showed appointments regardless of circumstance.

____ initial If there is not a credit card on file, I will remit payment for my no show appointment prior to any additional service being provided - I may do so over the phone with a credit card or pay in person with cash, credit card or check.

____ initial Before beginning services, I will talk with an eligibility staff person, review my fees for service and provided the necessary eligibility documents to determine my sliding fees based on my household income less than 725% poverty. (Fees to be completed by eligibility staff at time of consultation with client)
Intake $____, Individual $____, Family (per person) $____, Group $____,
Psychiatry Intake $____, Psychiatric Follow-up $____,
IOP Substance use disorder treatment group $____, Crisis Stabilization $____, Crisis Call $25/15 min.

____ initial I understand if my income, grant eligibility or insurance changes my fees may change too.

____ initial I have had the fees specified above explained to me and I agree to accept services at this fee.

____ initial I authorize the release of any medical or other information necessary to process any grant, insurance, Medicaid or Medicare claims. I assign payment of insurance and government benefits (Medicaid or Medicare) to be paid to the Montrose Center for behavioral health services provided by the Montrose Center staff.

____ initial I understand that the Montrose Center was founded to serve the Lesbian, Gay, Bisexual, and Transgender community.

In the interest of providing quality care, the Montrose Center uses a team approach in treatment/case management including consultation among staff members, departments and volunteers. Please be aware that this can include reports of substance use. If you are aware of a conflict of interest based on a prior or current relationship with any Montrose Center staff member or volunteer, please report it to your intake or individual Therapist. Conflicts will be resolved on a case-by-case basis with the primary goal of the resolution being the best interest of you and the therapeutic relationship. Options for resolution include setting boundaries, reassignment to a different Therapist or Case Manager, or referral to another agency or private practitioner. I understand that there are limits to confidentiality and that they are outlined in the Client Handbook.

I certify that all of the information provided above is correct. I understand and have received an explanation of and copy of the Client Handbook containing the program rules, description of services, treatment process, regulations, client rights, HIPAA Privacy Act Notice, CM1500 claim form disclosure and grievance procedures, HIV, Hepatitis, sexually transmitted diseases, tobacco and TB education. After being fully informed of all of the above, I voluntarily consent to receive treatment and/or case management services from the Center. I further agree to give the Center staff permission to verify my Medicaid/Medicare enrollment monthly. I further agree that if I bring someone into my counseling or case management session that I am consenting to them having information that is discussed in that session. I understand that this consent does not extend outside of the session unless I have signed an additional specific release allowing them to do so.

X_____ ____/____/____ _____

Client's Signature Date Parent, Guardian, or Authorized Representative's Signature [7]

[7] Therapist/Case Manager, obtain proof of guardianship for the client record

11.2.9 CONSENT FOR EMERGENCY MEDICAL CARE

Client Name: _____
Medical Conditions: _____

_____

Drug Allergies: _____

_____

Physician's Name: _____
Physician's Address: _____
Physician's Phone Number(s): (_____)_____-_____ (_____)_____-_____

MEDICAL FACILITY DESIGNATED BY CLIENT TO PROVIDE EMERGENCY CARE:

Facility: _____
Phone Number(s): (_____)_____-_____ (_____)_____-_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Address: _____

Relationship: _____
Phone Number(s): (_____)_____-_____ (_____)_____-_____

I, _____, authorize the Montrose Center staff to notify my physician and/or emergency contact listed above in case of a medical emergency. In the event of an emergency, I hereby authorize and direct the Center to take emergency action on my behalf.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, § 42 CFR, Part 2, § 33 of Public Law 91-616 as amended by Public Law 93-282, HIPAA Privacy Act §45 CFR 160 – 164, and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as valid as the original.

This consent expires one (1) year after my last date of service (individual, family, or group session) at the Montrose Center, or ____ other _____unless I revoke it as provided for above.

_____ ____/____/____ _____
Client's Signature Date Parent, Guardian, or Authorized Representative's Signature

3.1.3.2 CONSENT FOR SERVICES FORM FULL FEE

I have read the statement of client rights and responsibilities and have answered all questions to the best of my ability. I am requesting services from the Montrose Center. I understand the Montrose Center strives to make mental health care affordable and accessible and will explore insurance and grant options if I am willing to provide the necessary eligibility paperwork including ID, insurance card, proof of income, proof of residence and proof of HIV status (if applicable). I further understand that if I do not provide proof of income, I will not be screened for a grant subsidy or be eligible for the sliding fee scale.

Optional Telehealth:

_____ initial I understand that my therapist/psychiatrist/case manager (provider) may offer a telehealth session for therapy, case management or medication management using a HIPAA compliant telehealth platform as long as my insurance (or applicable grant funding) allows. My provider has explained to me how the video conferencing technology will be used and that I will not be in the same room as my provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation. I understand that if a staff member other than my provider is present during the session, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and I will have the right to request the following: 1) omit specific details of my psychosocial and medical history that are personally sensitive to me; (2) ask the other person to leave the telehealth room: and/or (3) terminate the session at any time. I have had the alternatives to telehealth explained to me, and I am choosing to participate in telehealth. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. I understand that my copay should be the same for telehealth as an in-person session as long as my insurance covers the sessions. If my insurance does not cover the session, I understand that I will be charged the sliding scale. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify: 1) That I have read or had this form read and/or had this form explained to me, 2) That I fully understand its contents including the risks and benefits of the session(s), 3) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction, and I consent to services provided via telehealth.

_____ initial I understand that if my insurance does not cover telehealth services at the Montrose Center and I still want to receive telehealth services at the Center, I will pay the insurance contracted rate for an in office visit with the therapist out-of-pocket.

_____ initial **I plan to use Medicare or third party insurance and I am unable or unwilling to provide proof of income less than 725% [6] to demonstrate financial hardship.** [6]$109,185 for a household of 1- FY24

Please initial all statements below

_____ initial **I understand that the full fee (before sliding scale, grant subsidies or insurance company contracted rates are assessed) is:** individual session fee - $120.00; 90 minute session fee - $180; crisis phone call outside of regular appointments fee - $25/15 minutes; couple/family session fee - $60.00 per person, maximum - $120.00; group fee - $60.00; and Intensive Outpatient (IOP) Substance Use Disorder Treatment - $200/day. The fee contracted by my insurance company may be discounted from these rates which will be explained in the Explanation of Benefits (EOB) I receive from my insurance company.

_____ initial **I understand I am responsible for the following fees:** intake - $150.00; individual session fee - $120.00; 90 minute session fee - $180; couple/family session - $60.00 per person, maximum - $120.00; group fee - $60.00; crisis phone call outside of regular appointments fee - $25/15 minutes, Intensive Outpatient Substance Use Disorder Treatment - $200/day; psychiatric* intake fee - $250 and psychiatric* follow-up

fee - $125. The fee contracted by my insurance company may be discounted from these rates which will be explained in the Explanation of Benefits (EOB) I receive from my insurance company.

_____ initial I understand that if I want 90 minute sessions and my insurance carrier does not cover this service, I agree to pay out-of-pocket $180 for the 90 minute session and can submit to my insurance carrier for partial reimbursement.

_____ initial I understand that if I want to receive psychiatric services, the Center is not in-network with most insurance carriers for this service, therefore I agree to pay out of pocket and submit for reimbursement from my insurance carrier. (N/A for clients with Medicare and/or Medicaid)

_____ initial If my insurance is out of network, I understand I will be required to pay the full fee and Montrose Center will submit claims to my insurance carrier as a courtesy to me. I am responsible for understanding my out-of-network coverage **and how my insurance will reimburse me**.

If I do not want the Center to bill my insurance:

_____ initial I have insurance but am requesting that the Center not bill it. I understand that I will be charged the full fee of $150 for intake session, $120 for individual sessions, $180 for 90 minute individual sessions, $60.00 for my part of a family session, $60.00 for my part of a group session, $200/day for Intensive Outpatient Substance Use Disorder Treatment, $250 for a psychiatric intake, $125 for a psychiatric follow-up and $25/15 minute increments for crisis calls outside of a regular appointment.

Reason(s) I do not want to use my insurance (optional): _____

_____

_____ initial I understand if my insurance changes my fees may change too.

_____ initial If I am using insurance benefits, I understand I may have a deductible to meet before I am eligible to pay my copay and will be charged the fee contracted (or out-of-network fee) by my insurance company for services until the Explanation of Benefits is received informing our Benefits Specialist that the deductibles have been met.

_____ initial I understand fees can be paid by cash, check, MasterCard or VISA. They cannot be paid with Discover, AMEX or any other credit card unless done through the Center's website and Paypal https://www.montrosecenter.org/forms/payment-form/.

_____ initial I understand that payment is due at the time services are rendered.

_____ initial I understand a $25.00 fee will be assessed on each returned check and VISA/MasterCard charge.

_____ initial **I agree to pay the full rate for an individual or family session not cancelled at least 24 hours ahead of time. This may be higher than the rate contracted by my insurance company since no shows are not allowed to be billed to insurance.**

_____ initial If there is a credit card on file, I agree that the Center may automatically charge the full rate for no showed appointments regardless of circumstance.

_____ initial If there is not a credit card on file, I will remit payment for my no show appointment prior to any additional service being provided - I may do so over the phone with a credit card or pay in person with cash, credit card or check.

Please initial all of the next 5 items

____ initial I will update my insurance information prior to receiving any additional services after a change and recognize failure to do so may result in lapse in coverage during which I am solely responsible for the full cost of any services provided and how my insurance will reimburse me.

____ initial I have had the fees specified above explained to me and I agree to accept services at this fee.

____ initial I authorize the release of any medical or other information necessary to process any grant, insurance, Medicaid or Medicare claims. I assign payment of insurance and government benefits (Medicaid or Medicare) to be paid to the Montrose Center for behavioral health services provided by the Montrose Center staff.

____ initial I understand that the Montrose Center was founded to serve the Lesbian, Gay, Bisexual, and Transgender community.

____ initial In the interest of providing quality care, the Montrose Center uses a team approach in treatment/case management including consultation among staff members, departments and volunteers. Please be aware that this can include reports of substance use. If you are aware of a conflict of interest based on a prior or current relationship with any Montrose Center staff member or volunteer, please report it to your intake or individual Therapist. Conflicts will be resolved on a case-by-case basis with the primary goal of the resolution being the best interest of you and the therapeutic relationship. Options for resolution include setting boundaries, reassignment to a different Therapist or Case Manager, or referral to another agency or private practitioner. I understand that there are limits to confidentiality and that they are outlined in the Client Handbook.

I certify that all of the information provided above is correct. I understand and have received an explanation of and copy of the Client Handbook containing the program rules, description of services, treatment process, regulations, client rights, HIPAA Privacy Act Notice, CM1500 claim form disclosure and grievance procedures, HIV, Hepatitis, sexually transmitted diseases, tobacco and TB education. After being fully informed of all of the above, I voluntarily consent to receive treatment and/or case management services from the Center. I further agree to give the Center staff permission to verify my Medicaid/Medicare enrollment monthly. I further agree that if I bring someone into my counseling or case management session that I am consenting to them having information that is discussed in that session. I understand that this consent does not extend outside of the session unless I have signed an additional specific release allowing them to do so.

X_____ ____/____/____
Client's Signature Date

_____
Parent, Guardian, or Authorized Representative's Signature [7]

[7] Therapist/Case Manager, obtain proof of guardianship for the client record

3.1.3.1.1 SUBSTANCE USE SCREENING

Client Name: _____ Date: ___/___/___

Please answer the following questions as honestly and accurately as possible. This information is used for screening for the IOP (Intensive Outpatient) and other services at the Montrose Center. Please be advised that many factors go into whether someone is eligible for IOP, so completion of this screening and eligibility does not guarantee admittance into IOP or services at the Montrose Center. This information provided will be kept confidential and placed in your client file.

Who or what agency referred you to the Center? _____

Public Health Risks

Human Immunodeficiency Virus (HIV)

Have you had any unsafe exposure to anyone that might have HIV infections in the last 6 months? ☐Yes ☐No

Have you used needles to inject drugs:
- within the past two years? ☐Yes ☐No
- at any time within the past 20 years? ☐Yes ☐No

Have you shared injecting equipment:
- within the past two years? ☐Yes ☐No
- at any time within the past 20 years? ☐Yes ☐No

Have you had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier with person(s) whose HIV status is unknown:
- more than 10 times within the past two years? ☐Yes ☐No
- at any time within the past 20 years? ☐Yes ☐No

Have you had unprotected sex with someone known to inject drugs:
- within the past two years? ☐Yes ☐No
- at any time within the past 20 years? ☐Yes ☐No

Sexually Transmitted Infections (STIs)

Have you had any unsafe exposure to anyone that might have STDs in the last 3 months? ☐Yes ☐No

Have you had any unsafe exposure to anyone that might have Hepatitis in the last month? ☐Yes ☐No

Have you had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barrier with person(s) whose sexual history is unknown:
- within the past one month? ☐Yes ☐No
- within the past 6 months? ☐Yes ☐No

Tuberculosis (TB)

Have you been exposed to anyone that may have had TB in the last 3 months? ☐Yes ☐No

Have you had a persistent cough (longer than 3 months) for which you have not seen a physician? ☐Yes ☐No

Have you been tested (screened for TB) within the past year? ☐Yes ☐No

Mental Health

Have you ever:
- been depressed for weeks at a time? ☐Yes ☐No
- lost interest or pleasure in most activities? ☐Yes ☐No
- had trouble concentrating / making decisions? ☐Yes ☐No
- felt like giving up because you feel things are not going to get better? ☐Yes ☐No

Have you ever had a period of time:
- when you were full of energy and ideas came rapidly? ☐Yes ☐No
- when you talked nearly non-stop? ☐Yes ☐No
- when you moved quickly from one activity to another? ☐Yes ☐No
- when you needed little sleep? ☐Yes ☐No
- when you believed you could do almost anything? ☐Yes ☐No

Have you ever heard voices no one else could hear or seen objects/things others could not see? ☐Yes ☐No

Client Name: _____

Have you ever felt that people had something against you or tried to influence your thoughts? ☐Yes ☐No

Have you been experiencing any unusual things that others might not understand,or that would be hard to describe to other people? ☐Yes ☐No

Have you:

- thought of harming yourself or killing yourself in the last month? ☐Yes ☐No
- ever thought of harming yourself or killing yourself? ☐Yes ☐No
- ever attempted to harm/kill yourself? ☐Yes ☐No
- had intense violent feelings about hurting another person? ☐Yes ☐No
- If *yes* to any of the above four (4) questions, when? _____

Opioid Overdose Risk

In the last 30 days, have you been released from a controlled environment such as residential SUD treatment program, jail, or prison? ☐Yes ☐No

If *yes,* in the year before you entered the controlled environment did you use opioids? ☐Yes ☐No

Are you currently or have you ever been prescribed any of the following medications? ☐Yes ☐No

☐ Naltrexone ☐ methadone ☐ buprenorphine

If *yes*, have you recently stopped prescription use of any of the above? ☐Yes ☐No

Have you used opioids intravenously? ☐Yes ☐No

Have you experienced a non-fatal overdose? ☐Yes ☐No

If *yes*, have you ever been administered naloxone/Narcan? ☐Yes ☐No

Do you and/or your friends/family have access to naloxone/Narcan to reverse an overdose? ☐Yes ☐No

Do you have children in foster care? ☐Yes ☐No

Sexual Health in Recovery

In the past 12 months, have you had sex while high, intoxicated or drunk? ☐Yes ☐No

Do you feel more free to be sexual when you are high on drugs or alcohol? ☐Yes ☐No

Do you feel too self-conscious to enjoy sex when sober? ☐Yes ☐No

Are you convinced that your sexual activity is a signification concern for your recovery? ☐Yes ☐No

General Substance Use

In the past 12 months:

Have you ever gotten sick or had withdrawal if you quit drinking or missed taking a drug? ☐Yes ☐No

Have you used larger amounts of alcohol/drugs or used them for a longer time that intended? ☐Yes ☐No

Have you tried to cut down on alcohol or drugs and were unable to do it? ☐Yes ☐No

Have you spent a lot of time getting alcohol/drugs, using them, or recovering from their use? ☐Yes ☐No

Have you ever gotten so high or sick from alcohol or drugs that it:

- kept you from doing work, going to school, or caring for children? ☐Yes ☐No
- caused an accident or became a danger to you or others? ☐Yes ☐No
- caused physical health or medical issues? ☐Yes ☐No

Have you spent less time at work, school, or with friends so that you could drink or use drugs? ☐Yes ☐No

Has your use of alcohol or drugs caused:

- emotional or psychological issues? ☐Yes ☐No
- issues with family, friends, work or police? ☐Yes ☐No

Have you increased the amount of alcohol or drugs taken to get the same effect as before? ☐Yes ☐No

Have you continued drinking or taking a drug to avoid withdrawal or to keep from getting sick? ☐Yes ☐No

Please give this form back to the Eligibility Associate after completing. Substance use Thank you!

Please complete for each substance used throughout your lifetime. Leave row blank if never used.	**Route** (oral, smoked, inhaled, injected, etc.)	**Total # Years Used**	**# times Used Last 30 Days**	**# times Used Last 7 Days**	**Age at First Use**
ALCOHOL & RELATED					
Beer / wine / liquor / mixed drinks / shots					
Naltrexone, *Vivitrol, Revia*					
STIMULANTS					
Methamphetamine, *meth, Tina, crystal, ice*					
Cocaine, *coke, crack*					
Amphetamine, *Adderall*					
Synthetic stimulants, *bath salts*					
Dextroamphetamine, *dexedrine*					
Benzedrine, diet pills					
Pseudoephedrine, *Sudafed*					
CANNABIS/ CANNABINOIDS					
Marijuana, *weed, pot, blunt*					
THC (oil, pills)					
Hashish, *hash*					
Synthetic cannabinoids, *kush, K2, spice*					
HALLUCINOGENS/ ANESTHETICS					
MDMA, *X, molly, ecstacy*					
Ketamine, *K, special K*					
GHB, *G*					
LSD, *acid*					
PCP, *angel dust, wets*					
Psilocybin mushrooms					
Mescaline / Peyote					
Dextromethorphan, *DXM*					
OPIATES/ OPIOIDS					
Heroin, *smack, tar, H*					
Oxycodone, *Oxycontin, oxy*					
Hydrocodone, *Vicodin*					
Morphine or similar (Demerol, Dilaudid)					
Synthetic opioids, *tramadol, fentanyl*					
Methadone					
Buprenorphine / nalaxone, *Suboxone, Buprenex*					
Kratom					
INHALANTS					
Alkyl/amyl nitrites, *poppers*					
Ethyl chloride / aerosols					
Solvents (glue, paint, markers, thinners)					
Nitrous oxide, gas, *whippets*					
SEDATIVES/ HYPNOTICS					
Alprazolam, *Xanax, bars*					
Lorazepam, *Ativan*					
Clonazepam, *Klonopin* / Clonazolam					
Barbituates (phenobarbital, pentobarbital)					
Methoqualone, *quaaludes*					
OTHER (specify):					

Substance **used the most**, or most problematic:	**Second** most-used substance:	**Third** most-used substance:
Date Last Used: / /	**Date Last Used:** / /	**Date Last Used:** / /

3.1.3.8 PARENTAL/GUARDIAN CONSENT CHECKLIST

Please use this checklist when a parent is signing a consent for a minor's services.

I, _____ certify that I am legally authorized to consent to services for my minor child/youth _____ through the following authority:

☐ I am a living birth or adoptive parents of the minor child/youth and:
- ☐ I live with the other parent and we are not involved in any divorce or custody proceedings,
- ☐ I have joint custody with the other living birth or adoptive parent and have provided a copy of the custody agreement resulting from a divorce or custody proceeding, or
- ☐ I am the sole living parent;

☐ I am the sole custodial parent for the minor child/youth and have attached a copy of the court order assigning me custody; or

☐ I have other legal authority to consent to behavioral health treatment for the minor child/youth and have attached a copy of proof of the authority.

X_____ ____/____/____
Parent, Guardian, or Authorized Representative's Signature * Date

If not signed in the presence of Montrose Center staff, this form needs to be notarized and all legal documents pertaining to the custody agreement must be on file prior to the minor child/youth beginning services.

State of:_____

County of:_____

Before me, a notary public, on this day and being first duly sworn declared that he/she signed this application in the capacity designated, if any, and further states that he/she has read the above application and the statements therein contained are true.

Signed and Sworn to before me on _____ _____, 20___

by _____. Seal Stamp

_____ ____/____/____
Notary Public Date

CHILDHOOD DEVELOPMENTAL MILESTONES

Describe any complications during pregnancy/birth for this child: _____

_____

Was the child born on time?

☐ Yes ☐ No

Was the child exposed to drugs before birth?

☐ Yes ☐ No

Child's development in general:

☐ on time ☐ all delayed ☐ only some areas delayed

Developmental milestones: (check only those the child did not do at expected age)

☐ sitting
☐ walking
☐ single words
☐ two/three words
☐ talk in complete sentences
☐ toilet trained (bladder)
☐ toilet trained (bowels)
☐ writing
☐ separating from parents with no difficulties