

Financial Information and Intake Form

please print

ADIS Number: _____
 Client Name: _____ Home Phone: _____ Work Phone: _____
 Address: _____ County: _____

If Minor, Parent or Guardian Name and Address: _____

Person To Contact In Case of Emergency: _____

Household Information (include information about everyone who lives with you, starting with yourself on the first line):

	Name	Relationship to you	Date of Birth	Gender (M or F)	Social Security Number	Marital Status S=Single, M=Married, D=Divorced, W=Widowed	U.S. Citizen Y or N	Montana Resident Y or N
1		Self						
2								
3								
4								
5								
6								
7								
8								
9								

- Is any person(s) listed in your household 22 years old or younger and attending a college, university, or vocational-technical school? Yes _____ No _____

- If yes, please complete: Name of Student _____
 Name of college, university, or vocational-technical school _____

Income

A. INCOME RECEIVED FROM EMPLOYMENT (GROSS INCOME)

List all members of the home who currently work. Include full-time, part-time, and seasonal employment, temporary or spot jobs, tips, and commissions. For self-employment, include income less cost-of-doing-business expenses and state average monthly income.

Name of household member	Name of employer	Start date	Average hours worked per week	Pay/wages per hour	If tip income is earned, amount of tips per week	Is this job seasonal? If yes, number of weeks or months worked per year.

B. INCOME RECEIVED FROM SOURCES OTHER THAN EMPLOYMENT OR SELF-EMPLOYMENT:

List all unearned income received by all household members, including children. Unearned income includes, but is not limited to, Social Security Disability, Unemployment Insurance, Pensions, Military Allotments, Child Support, Alimony, Lease or Rental Income, Supplemental Security Income (SSI), Foster Care Payments, Veteran's Benefits, Retirement Income, Tribal Assistance Payments, Dividends, Interest, Temporary Disability.

Name of household member	Type of income	Source of income	How often is income received? (weekly, bi-weekly, monthly, semi-monthly, annually)	Amount received

Insurance:

Do you have health insurance coverage? Yes: _____ No: _____
Do you have Medicaid coverage? Yes: _____ No: _____
If no, how do you intend to pay for services? _____

If yes, please complete the following:

Insurance Company Information: Blue Cross: _____ Champus/TriCare: _____
Medicaid: _____ Medicare: _____
Cigna: _____ Teamsters: _____
CHIP: _____ IHS: _____
Other: _____

Policy #: _____
Enrollment/Plan/Group Number: _____ Effective Date: _____
Calendar Year Deductible: \$ _____ Deductible Year Starts: _____
Deductible Met For Year?: Yes: _____ No: _____

Co-payment required: _____ Is Outpatient Group Therapy Covered? Yes: _____ No: _____
Must referrals be made by a primary care physician or gatekeeper? Yes: _____ No: _____

Any exclusions or limitations affecting this therapy, including number of sessions, types of therapy excluded from coverage, monetary caps, conditions not covered: _____

Name of Policy Holder, if different from client: _____
Client's Relationship to Policy Holder: _____
Provider's Address: _____ Provider's Phone: _____

Pre-approval or pre-authorization required? Yes: _____ No: _____
Pre-approval for specific provider? Yes: _____ No: _____
Pre-approval authorization number: _____
Number/Type Sessions Pre-approved: _____
Person at Insurance Company Contacted: _____ Date: _____

I grant this agency permission to release any information obtained during assessments or treatment which is necessary to support insurance claims for my/our treatment. I understand that I am responsible for all charges, regardless of my insurance coverage.

Rights and Responsibilities

I understand I must report any changes in the information provided on this application to the Department of Public Health and Human Services (DPHHS) Addictive and Mental Disorders Division. Late reporting may cause incorrect benefits. Changes must be reported within 10 days of my knowledge of the changes.

I must provide proof that my children are eligible for benefits. I may receive help in gathering documents or contacting individual or agencies by calling (insert program phone number here).

I know the information I have given may be reviewed and verified by a representative of the State of Montana or (insert name of program). I also understand that I must cooperate fully with state, federal, and (insert name of program) staff if my case is reviewed. By signing this application, I have given my permission for the State of Montana and (insert name of program) to obtain verification and information necessary to determine my eligibility or my children's eligibility. I understand that my permission includes the use of my social security number and/or my children's social security number to obtain the information.

I know the information I have given is confidential. I agree that medical information about myself or my children can be released only if needed to administer, including billing for, the services received. Information will be forwarded to other agencies or organizations only if I have given my permission on this form.

If my children are enrolled in Medicaid, their health insurance or other third party payments are automatically assigned by law to the State of Montana. Montana law requires that any money received by my household for medical expenses that are previously paid by Medicaid must be reimbursed to the State.

I understand that I may request a Fair Hearing if I disagree with any action taken as the application for children's health care is processed, and that the request for Fair Hearing must be in writing.

I know this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of Montana and (insert name of provider here) to make necessary contacts to check my statements. I understand that my permission includes use of my social security number and/or my children's social security number to obtain the information. I agree that medical information about myself or my children can be released only if needed to administer, including billing for, the services received.

Signature of Client or Guardian: _____

Date: _____

Signature of Witness: _____

Date: _____

Previous Treatment:

Number of previous treatment episodes: Outpatient: Inpatient:
Number of previous: DUI's: MDD's: MIP's:

Public Assistance:

Receiving Public Assistance: Food Stamps: SSI: AFDC:
Medicaid: SSDI:

Probation:

Name of Probation Officer: _____ Name of Referrant: _____

Criminal Justice?: Yes: No:

OFFICIAL USE ONLY

Payment Method:

State Outpatient Contract: Yes: No:
Medicaid: Yes: No:
CHIP: Yes: No:
Family Services: Yes: No:
Personal Insurance: Yes: No:
Individual: Yes: No:
Sliding Fee: Yes: No:

Diagnosis Code: Alcohol: Female with dependent children:
Drug: Pregnant Female: