helping people with developmental disabilities participate in our community...
Community Support Network, Inc
Collaborations

1191 North Sherman Avenue, Madison, Wisconsin 53704
Web: www.VisitCSN.org
Phone: 608-421-3239 Fax: 608-270-2238
...bringing our community together

Pre-Intake Screening Form
July 2014

Some clinics use the term "patient" or "client". At Collaborations, we use **"Person Seeking Support" (PSS)**.

- Each form is for one/single PSS.
- If there will be more than one PSS (for instance a couple or a family working together in therapy as patients) a form should be filled out for each person.

Date (Month, Day, Year):	How did you hear about Collaborations:
Name of PSS Given First Name: Middle Name: Last Name:	How would the PSS like to be addressed?
Date of Birth (Month, Day, Year):	Sex:
Contact information of PSS Phone number: Address: Email:	**Contact information of person filling in this form** Name: Relationship to PSS: Agency affiliation: Phone number: Address: Email:
If the PSS is under 18, the person who is legally responsible for the child Name: Relationship: Phone number: Address: Email:	**If the PSS is not their own guardian, their legal guardian(s) is/are** Name: Relationship: Phone number: Address: Email:
General medical doctor Name: Address: Affiliation: Phone:	**If applicable, psychiatrist** Name: Address: Affiliation: Phone:
Hospital preference for medical emergencies:	Hospital preference for psychiatric emergencies:
Please attach a complete medication list for the PSS Including names, doses, administration times, purposes and prescribers. If the PSS does not take medication, please write "NA" here: ___	If the PSS is a veteran, please list the branch of service and dates of service:

If the PSS has difficulty managing his/her anger, please describe:	If the PSS has thoughts of harming him/herself, please list the details:
If the PSS harms him/herself, please list the details:	If the PSS harms others, please list the details:
If the PSS has a history of suicidal thoughts, please list dates and details:	If the PSS has a history of suicide attempts, please list the dates and details:
If the PSS has access to weapons, please describe the weapons and their locations:	Please list the PSS's preferences for approaches used by Collaborations staff (see website for description of options):
What brings the PSS to Collaborations? Please list the PSS's goals in working with Collaborations:	
What accommodations may be needed? What barriers to treatment do you anticipate the PSS may experience?	

List of team members actively involved with the PSS (fill all applicable lines)

Parent(s) Name(s):
Contact Information

Guardian(s) Name(s):
Contact Information

Support Broker/Case Manager/Social Worker/Guidance Counselor (circle) Name:
Affiliation
Contact Information

Residential Provider Name:
Affiliation
Contact Information

Respite Provider Name:
Affiliation
Contact Information

School Contact Name:
Affiliation
Contact Information

Therapeutic Provider Name:
Affiliation
Contact Information

Primary Physician Name:
Affiliation
Contact Information

Psychiatrist/Prescriber (circle) Name:
Affiliation
Contact Information

Behavioral Specialist Name:
Affiliation
Contact Information

WIN Nurse Name:
Affiliation
Contact Information

Other (describe):
Affiliation
Contact Information

What additional support would other team members like from Collaborations (see website for description of options)?

Additional notes:

Please describe the PSS (choose as many as are applicable)

Feel free to add descriptive details

○ Cuddly	○ Emotionally reactive	○ Difficulty reading social cues
○ Withdrawn	○ Emotionally passive	○ Interested in having friends or relationships
○ Clingy	○ Friendly	○ Shy
○ Average activity level	○ Popular	○ Few friends
○ On the go	○ Leader	○ No Friends
○ Destructive	○ Follower	○ Not interested in friends
○ Lethargic	○ Used to have more friends	○ Other
○ Accident Prone	○ Socially awkward	○ Other

Additional Notes:

Symptoms displayed by the PSS (choose as many as are applicable)

For each symptom checked, please list:

- Severity (mild, moderate or severe)
- When the symptom started
- What treatment, if any has been tried
- What the response to treatment was

❑ Anxiety
❑ Delusions
❑ Impaired concentration
❑ Depressed mood
❑ Disruption of thoughts
❑ Dissociation
❑ Elevated mood
❑ Guilt
❑ Hallucinations
❑ Homicidal
❑ Hopelessness
❑ Hyperactivity
❑ Phobias (list):
❑ Impaired memory
❑ Impulsive
❑ Irritable
❑ Manic
❑ Obsessive
❑ Compulsive
❑ Problems at work or school
❑ Oppositional

- ❑ Panic attacks
- ❑ Paranoia
- ❑ Poor judgment
- ❑ Suicidal
- ❑ Difficulty in community settings
- ❑ Sexual issues
- ❑ Tearful
- ❑ Physical complaints (list)
- ❑ Sense of worthlessness
- ❑ Irresponsible
- ❑ Problems with mobility
- ❑ Lack danger recognition
- ❑ Poor money management
- ❑ Poor social relationships
- ❑ Marriage/family problems
- ❑ Learning problems
- ❑ Cognitive problems
- ❑ Grief
- ❑ Anger
- ❑ Fear
- ❑ Thinks of dying
- ❑ Difficulty concentrating
- ❑ Arguments

❑ Avoiding things/places/people
❑ Getting into trouble
❑ "Peculiar" thoughts
❑ Increased stress in life
❑ Low energy
❑ Headaches
❑ Chest pain
❑ Dizziness
❑ Trembling
❑ Lying
❑ Stealing
❑ Refusal to participate in scheduled activities
❑ Struggles in social situations
❑ Rage
❑ Poor hygiene
❑ Poor organizational skills
❑ Unmotivated
❑ Lack of coordination
❑ Elope/run away
❑ Other
❑ Other

Additional Notes:

Professional Diagnoses previously given (choose as many as are applicable)
Please only check off diagnoses given by a health care professional.

For each diagnosis checked, please list:

- Severity (mild, moderate or severe)
- When the diagnosis was given
- What treatment, if any has been tried
- What the response to treatment was

❑ Adjustment Disorder
❑ Anxiety
❑ Attention Deficit/ Hyperactivity Disorder (ADD/ADHD)
❑ Autism Spectrum Disorder (Autism, Asperger's syndrome, pervasive developmental disorder)
❑ Bipolar Disorder (manic depression)
❑ Cognitive Impairment
❑ Delusions
❑ Dementia/Alzheimer's
❑ Depression
❑ Eating Disorder
❑ Epilepsy/Seizure Disorder
❑ Gender Identity Disorder
❑ Learning Disability
❑ Obsessive Compulsive Disorder (OCD)
❑ Panic Attacks
❑ Personality Disorder
❑ Schizophrenia
❑ Schizoaffective Disorder
❑ Post-Traumatic Stress Disorder (PTSD)
❑ Traumatic Brain Injury (TBI)
❑ Other
❑ Other

Additional:

Alcohol and drug use displayed by the PSS (choose as many as are applicable)

If no alcohol or drug use, check here _____ and skip the rest of this page

Substances used	Type of use according to the PSS (experimental, recreational, abusive, dependent, minimal, destructive)	Date of onset (actual date or age range)	Person filling out this form thinks the PSS uses the following drugs or alcohol "too much"	If diagnosed with issue, treatment received (dates, locations, providers and responses to treatment)
❑ Alcohol			❑ Alcohol	
❑ Marijuana			❑ Marijuana	
❑ Cocaine			❑ Cocaine	
❑ Heroin			❑ Heroin	
❑ Ecstasy			❑ Ecstasy	
❑ Huffing (gas, aerosol, etc)			❑ Huffing (gas, aerosol, etc)	
❑ Prescription drug use that is not prescribed			❑ Prescription drug use that is not prescribed	
❑ Other			❑ Other	
❑ Other			❑ Other	

Symptoms exhibited in relation to alcohol and/or drug use by the PSS (choose as many as are applicable)

❑ Blackouts, related to use of:
❑ Cravings, related to use of:
❑ Nausea, related to use of:
❑ Dizziness, related to use of:
❑ Trembling, related to use of:
❑ Sweats, related to use of:
❑ Pass out, related to use of:
❑ Paranoia, related to use of:
❑ Lethargy, related to use of:
❑ Slurred speech, related to use of:
❑ Rage, related to use of:
❑ Depressed mood, related to use of:
❑ Hyper, related to use of:
❑ Extreme thirst, related to use of:
❑ Unstable gait, related to use of:

Additional Notes:

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This box is for office use		
PSS Name:	PSS Number:	Date:
Clinician Name and Credential:		Clinician Title:

Insurance Information and Payment Contract for Services Form - Updated July 2014

Insured Party Information (If a child, give names of parents. If you are married or partnered and the policy holder is your significant other, give name of significant other.):

Name:	Sex: M F	Birthdate:
Address (number/street/apt):	City:	State/Zip:
Home tel: ( )	Work tel: ( )	Cell tel: ( )
Employer:	Relationship to insured:	
PSS full Name:	PSS Birthdate:	PSS Sex: M F

Insurance Information Primary Company:

Insurance Company Name:	Policy Holder:
Group #:	ID#:
Effective date of policy:	Insurance Company tel: ( )

Insurance Information Secondary Company:

Insurance Company Name:	Policy Holder:
Group #:	ID#:
Effective date of policy:	Insurance Company tel: ( )

Person Responsible for Payment (who should be billed if insurance does not cover services)

Name:	Sex: M F	Birthdate:
Address (number/street/apt):	City:	State/Zip:
Home tel: ( )	Work tel: ( )	Cell tel: ( )

Authorization for the payment of benefits
I hereby authorize payment directly to Community Support Network, Inc. (CSN), if otherwise payable to me, for outpatient mental health services rendered at Collaborations. I understand and accept all financial responsibility for the deductible amount and for any outstanding amount after payment of such benefits.

I hereby authorize CSN to release the following information necessary to process my medical insurance claims and the claims of my family members covered by my medical insurance company: name, date of birth, name of the insurance company, subscriber's name, effective date of policy number, policy number, group number and dates and times services are provided. Additionally, I hereby authorize CSN to release treatment details required to justify payment of services, such as case records (diagnosis, case notes, psychological reports, testing results) or other requested materials, for the purpose of receiving payment directly to CSN.

I understand this authorization is revocable by me at any time but that my revocation of this authorization will result in my personally assuming financial responsibility for services rendered on my behalf that otherwise would have been reimbursed by my insurance company. I understand that a photocopy of this assignment shall be considered as valid as the original.

Signature of PSS or parent or guardian: _____ Date:____/_____/_____

Signature of PRP (if different than PSS, parent or guardian): _____ Date:____/_____/_____

Contract

PSS Name(s): PSS(s) Address (Number/Street/Apt, City, State, Zip):
Bill to Person Responsible for Payment (PRP): Address (Number/Street/Apt, City, State, Zip):

Federal Truth in Lending Disclosure Statement for Professional Services

Part One: Fees for Professional Services
I (we) agreed to pay Community Support Network, Inc (CSN), hereafter referred to as CSN the following rates:

- Diagnostic Evaluations/Assessments/Intakes: $140 up to 90 minutes in length
- Individual therapy sessions, Couples, Family and/or Team therapy and Collaborative Participant Exchanges: $140 per 60 minute session ($70 per 30 minute session, $105 per 45 minute session)
- Explanations and/or preparations of treatment progress and/or advising on how to assist the PSS: $140 per hour (billed in quarter hour increments)
- Groups sessions $20.00 per 75 minute session, per participant
- Cancellations with less than 24 hours' notice will be billed at 50% the designated rate for the appointment type

A 30 day notice will be provided (verbally and in writing) any time there is a fee adjustment.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)
CSN has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1. $ _____ Deductible amount (paid by insured party)
2. Co-payment _____% ($_____/hour) for first _____visits.
3. Co-payment _____% ($_____/hour) for first _____visits.
4. The policy limit is _____ per year: _____ annual _____ calendar

We suggest you confirm these provisions with the insurance company. The PRP shall make payment for services which are not paid by your insurance policy, all co-payments and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three: All Clients/PSSs
Payments, co-payments and deductible amounts are due at the time of service.

Release of Information Authorization to Third Party
I (we) authorize CSN to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to CSN.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose work is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice and after one year this consent expires. I (we) have been informed what information will be given, its purpose and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Signature of Person Responsible for Payment (PRP): _____ Date:____/_____/_____

Signature of PSS: _____ Date:____/_____/_____

Signature of Guardian, if applicable: _____ Date:____/_____/_____