UNION COUNTY COUNSELING SERVICES, INC.
APPLICATION/ INFORMED CONSENT FOR SERVICES

Date:_____

Name:_____
First MI Last Maiden

Address:_____
Street PO Box County

_____
City State Zip Code

Home phone:_____ Cell phone:_____ E-Mail:_____

Social Security:_____-____-_____ Date of Birth:_____ Age:_____ Sex: ___Male ___Female

Race: ___Caucasian ___African American ___Hispanic ___Other:_____
Marital Status: ___Single ___Married ___Divorce ___Separated ___Widowed
Are you or a close family member a current or former service member? ___Yes ___No
Are you a US Citizen? ___Yes ___No Mother's Maiden Name:_____
Spiritual Preference:_____ Highest Level of Education:_____
Are you Currently Employed? ___Yes ___No Occupation:_____

Primary language or method of communication: ___English ___Spanish ___Other:_____

Do you need any communication or physical accommodations? ___Yes ___No
(specify)_____
Legal Status: ___Own Guardian ___Minor ___Guardian
Are you on Probation or Parole? ___Yes ___No Reason:_____

In case of emergency, please list someone we can contact:

Name:_____ Relationship:_____

Phone:_____ Work Phone:_____
Please list the Name and Age of all persons living in you household:

Name	Age

Total monthly family income $_____per month (include income of all family members living in household)

Source of income:	amount	Do you have verification?
_____	_____	___Yes ___No
_____	_____	___Yes ___No
_____	_____	___Yes ___No

****(Individuals who reside in Union County and do not have medical coverage **may qualify to receive services for a reduced fee based on household resources**) In order to qualify for sliding scale fee verification of income and household size will be needed at initial appointment.

Client Name: Agency ID:

Do you have a medical card? ___Yes ___No

Medicaid ID#_____ Case ID#_____

Do you have a spend down? ___Yes ___No (if so amount) $_____

Do you have Medicare? ___Yes ___No

#_____

Do you have private insurance? ___Yes ___No (if so) name of company:_____

Name of primary policy holder(PPH):_____ DOB of PPH:_____

Policy #:_____ Group #_____

Initial Consumer Statement:

Please describe the issues, concerns, or problems that bring you to the agency:

_____

_____

_____

_____

Who Referred you to this agency? _____

Have you ever received services here before? ___Yes ___No (if yes, indicate reason and dates of service)_____

_____

1. I have provided the above information as an application for services with the understanding that all information is held in the strictness of confidence and will and will only be released with my signed consent or my guardian's consent.
2. I have been provided information about the services available and consent to treatment. I understand that there are potential risks and benefits of any treatment and will be advised of the nature of treatment, the potential risks, as well as possible alternative treatments based on my identified needs and goals. I agree to participate in a service needs assessment to help determine the best services available to assist me.
3. I understand that if I am a resident of Union County **and do not have medical insurance I may qualify for a reduced** fee based on my household income and resources. If I do not live in Union County I will be responsible for the full fee for services received. I further understand that my insurance company, if I am insured, will be billed accordingly.
4. I understand that I will need to provide verification of family income and household size in order to receive services.
5. I understand that I **may** be charged my regular office visit fee for appointments that I do not cancel 24 hours in advance.

_____ Date:_____

Signature of Applicant

_____ Date:_____

Signature of Parent or Guardian

_____ Date:_____

Signature of Witness

Client Name: Agency ID:

Rev: **12/2018;** 9/2017

Documentation of Consumer Choice to Receive DHS-Funded Services

The Department of Human Services (DHS) may pay for some or all of the costs of your community mental health services. If DHS is to pay for these services, the provider must report certain personal information to the Department. If you do not want the provider to report this information, you must decline to be a recipient of DHS funding. If you do not decline, the provider will report all of the following information to the Department of Human Services.

- Your full name (first, last, and middle initial)
- Your social security number
- Your birth date
- Your gender (male, female)
- Your county of residence
- Your household income and size
- All mental health services for which the provider expects payment

Consumer name (please print) _____

To ACCEPT being considered as a DHS consumer

____I choose to have provider bill DHS for my services and I understand the provider will report the information above to the Illinois Department of Human Services.

_____ _____

Signature of Consumer of Parent or Guardian Date

To DECLINE being considered as a DHS consumer

_____ I DO NOT choose to have a provider bill DHS for my services, and I understand the provider will NOT report the information above to the Illinois Department of Human Services.

_____ _____

Signature of Consumer of Parent or Guardian Date

Explanation by the provider why consumer was not documented.

Rev:**12/2014;** 08/2013 02/2013; 04/2011; 04/2009

Client Name: Agency ID:

UNION COUNTY COUNSELING SERVICES, INC.
204 SOUTH STREET, PO BOX 548
ANNA, IL 62906
PH: 618-833-8551 FAX: 618-833-2911

SIGNATURE ON FILE

Initial lines only

____ I authorize use of this form on ALL my insurance submissions.

____ I authorize release of information to all my insurance companies.

____ I understand that **I AM RESPONSIBLE** for my bill and established fees are due upon receipt of service.

____ I authorize Union County Counseling Services, Inc. to act as my agent in helping me obtain payment from my insurance companies.

____ I authorize payment directly to Union County Counseling Services, Inc.

____ I permit a copy of this authorization to be used in place of the original.

____ I authorize Union County Counseling Services, Inc. to obtain a Recipient Identification Number (RIN) on my behalf for billing purposes.

____ I authorize Union County Counseling Services, Inc. to submit my billings electronically.

____ I acknowledge that if I fail to pay the established fee, I will be liable for collection fees such as court costs and attorney costs.

****Individuals who reside in Union County and do not have access to medical coverage may qualify for a reduced fee based on my household resources. In order to determine my fee I will need to provide** verification of income and **the number of individuals who live in my** household. At initial appointment.
(*to be completed by staff)* based on my **insurance or family resources** and proof of my residency in Union County, my assigned fee/co-pay per session would be:

$_____

_____	_____	_____
Client Name Printed	Client Name Signed	Date
_____	_____	_____
Guardian Name Printed	Guardian Name Signed	Date
_____	_____	_____
Staff Name Printed	Staff Name Signed	Date

Client Name: Agency ID: