Open Access New Client Intake Package

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Pre-Admission Screening Form for Open Access

Last Name:	First Name:		MI:
Address:	City:	State:	Zip:
DOB:	SSN:	Age:	Phone:
Gender Assigned at Birth:	Gender Identity:	Preferred Pronouns:	

DATE: ____________________

What services are you interested in? ☐ Individual Therapy ☐ Family/Couples Therapy

☐ Community Support Groups ☐ Outpatient Group Therapy ☐ Residential Services

☐ Case Management

What type of insurance do you have? ______________________________________

Are you currently receiving therapy or psychiatric services? ☐ Yes ☐ No

If yes, please list: ____

Do you currently use substances (such as Alcohol, Cocaine or Marijuana)? ☐ Yes ☐ No

If yes, please list substance(s) and frequency: _________________________________

Are you taking any psychiatric medication? ☐ Yes ☐ No

If yes, please list: ____

Are you currently having thoughts about hurting yourself? ☐ Yes ☐ No

If yes, please explain: ____

Are you currently having thoughts about hurting other people? ☐ Yes ☐ No

If yes, please explain: ____

Do you feel that you are in psychiatric crisis and need to speak to a crisis worker immediately?
☐ Yes ☐ No

Have you had any recent psychiatric hospitalizations? ☐ Yes ☐ No

If yes, please explain (including dates): ____
____

How did you hear about Turning Point? ☐ My doctor ☐ A current or past TP client

☐ Friends or family ☐ Heartland Health Care Referral ☐ Researching online

☐ Another organization (please specify) _____________ ☐ Other (please specify) ____________

TVC 9.20.22

Please Note that Turning Point does not offer services for the following Emergency Housing, Psychological Testing, Substance Abuse, Eating Disorders, Vocational Services, Psychiatry, and Domestic Violence. We do not provide services to children under the age of 6.

FOR STAFF USE ONLY:

- If client answered yes to SI/HI/Crisis questions, was EST (or TLR) called? ☐ Yes ☐ No
  If no, please indicated reason: ______________________________________
- Open Access clinician client was assigned to: __________________
- Was client seen by the OA clinician on the schedule for that day? ☐ Yes ☐ No
- If bonus email was sent asking for coverage volunteers, please indicate why (too many clients called, scheduled clinician called in sick, etc.):
  ____
  ____

If client was NOT sent on to a clinician for an Open Access Assessment, please indicate the reason below:

☐ Not appropriate for services/looking for services we don't provide

☐ Turning Point is not paneled with client's insurance

☐ Referred to EST/The Living Room

☐ Waiting list

☐ Other: ____

Please indicate the plan for the client (given resources, seen by Crisis staff, directed to come back another day, etc.):

____

____

NOTES:

Turning Point BHCC

Client Information Profile

Date: ____________

Name *(First, Middle Initial, Last)*: ____

DOB: __________ Family size: ______ Household Annual Income: ______________________

Client's Mother's Maiden Name *("Unknown" if not known)*: ______________________________

Emergency Contact: ______________________________ Phone Number: ______________________

Legal Guardian (*if not self*):____

Interpreter *(please circle one)*: 0 Not Needed 1 American Sign 2 Foreign Language (Language________)

For the following questions, please circle the correct response.

SEX: F—Female M—Male

LANGUAGE:

10 English
20 Spanish
90 Other
99 Unknown

RACE *(If Hispanic, choose 90)*:

10 White
20 Black/African-American
30 Asian
40 American Indian
50 Pacific Islander
90 Other
99 Unknown

HISPANIC ORIGIN *(If not Hispanic, choose 00)*:

00 Not Hispanic
11 Mexican/Mexican American
12 Puerto Rican
13 Cuban
14 Central or South American
18 Other Hispanic
19 Unspecified Hispanic
99 Unknown

MARITAL STATUS:

1 Never Married
2 Married
3 Widowed
4 Divorced
5 Separated
9 Unknown

EDUCATION LEVEL:

00 Never Attended School
___ Appropriate grade level (01-12)
20 Preschool/Kindergarten
30 High School Diploma
31 GED
32 Spec Ed Certificate
40 Post-Secondary Training
41 One year college
42 Two year college
43 Three year college
50 College Degree
60 Post Graduate
99 Unknown

EMPLOYMENT STATUS:

10 Employed *(Including vacation/sick)*
11 Full-Time
12 Part-Time
13 Full/Part-Time Subsidized
14 Vocational
20 Unemployed
30 Retired, Student, Homemaker
90 Other
99 Unknown

SSI/SSDI ELIGIBILITY:

0 Not applicable
1 Eligible, Receives Payment
2 Eligible, No Payment
3 Eligible, Pending
4 Eligible, Not Applied
5 Not Eligible
9 Unknown

CITIZENSHIP:

Y U.S. Citizen
N Not U.S. Citizen
U Unknown

COURT/FORENSIC:

00 Not Applicable
01 Dept. of Corrections
02 Unable to Stand Trial
03 Unable to Stand Trial—Extended Term
04 Unable to Stand Trial—G2
05 Not Guilty by Reason of Insanity
06 Civil Court Ordered
07 Criminal Court Ordered Treatment
08 Court Ordered Evaluation
99 Unknown

MILITARY STATUS:

0 Not Veteran
1 Veteran
2 Active Duty
9 Unknown

HOUSEHOLD COMPOSITION:

10 Lives Alone
20 Lives W/One or More Relatives
30 Lives W/Non-Related Person
99 Unknown

RESIDENTIAL TYPE:

10 Homeless
21 Private Resident (Patient Supervised)
22 Private Resident (Patient Unsupervised)
31 Other Resident (Patient Supervised)
32 Other Resident (Patient Unsupervised)
40 Stated Operated Facility
50 Jail or Correction Facility
60 Other Institution Setting
80 Boarding School
90 Other
99 Unknown

Turning Point Behavioral Health Care Center

Client Fee Agreement

Please complete all sections:

Client Name:

Name of person to be billed: Relationship to client:

Insurance Coverage: (Please check all that apply)

Self-Pay: ______

Private Ins: ______ Name of Private Ins:

Medicare: _______ Medicaid: _______

Medicaid Managed Care: _________ Name of Medicaid Managed Care Insurance: ____________________________

Medicare Medicaid Alignment Initiative (MMAI): ____ Name of MMAI Insurance:

Other Coverage Type: ____

____

____

Service Fee Schedule:

Per Hour

Service	Fee
Therapy (Individual/Family/Couples)	$160
Group Therapy	$ 24
PSR Group	$ 24
Case Management	$ 75

Per visit

Service	Fee
Psychiatric Evaluation	$180
Medication Monitoring	$150

Client Fees (Based on household income):

Per Hour

- Therapy (Individual/Family/Couples)
- Group Therapy
- PSR Group
- Case Management

Per visit

- Psychiatric Evaluation
- Medication Monitoring

Medicaid Copay Information:

The psychiatrist visit copay for adult clients with Medicaid coverage is $3.90 per the state of Illinois for clients not covered under Medicaid Managed Care Plans; some Allkids plans have a copay for psychiatric visits which will be applied once payment is received from the State of Illinois. For clients who have dual Medicaid/Medicare coverage, the psychiatry copay does not apply.

Private Insurance Deductible/Copay Information:

Please note that you will be billed at the time of your appointment only your estimated co-insurance or copay amount. Any additional charges, including deductible charges, will be applied to your account based on the explanation of benefits (EOB) sent back to Turning Point from your insurance company after claims have been submitted, and are your responsibility to pay. Please be advised that if your policy has a fixed number of visits allowed per calendar year, you will automatically be billed your self-pay fee when you have maximized your benefits. Self-pay fees are based on income and household size, so it is essential to present income verification. If proof of income is not presented, you will be charged the full fees for services.

General Insurance Information for All Clients:

Turning Point Behavioral Health Care Center offers a sliding fee scale to persons deemed eligible for a fee reduction, or those who do not have insurance benefits. The client must provide evidence of income at the time of their initial appointment(s) to apply for this benefit. The standard rate is expected from those who are determined to have the financial capacity to pay the actual cost of services. Fees are reviewed annually or as required. Clients are responsible for notifying Turning Point of all Insurance coverage changes (including Medicaid coverage becoming inactive) as soon as possible so we may verify coverage and inform you if we accept your new insurance. If you are no longer covered by any type of insurance, an appointment should be made with a member of our Billing Team to reconfigure your fees based on your income level. This should be done in a timely manner so that you are not being back billed for services received after your insurance has been terminated.

Insurance Acknowledgements:

1. Payment is due at time of service. If payment is not made at the time of service, you will not be seen for your appointment.
2. Turning Point reserves the right to suspend services if the account balance exceeds two times the individual therapy fee.
3. Telephone contacts with the clinician lasting more than five minutes may be charged on a prorated basis according to the individual treatment (IT) fee.
4. Fees are based upon treatment offered and provided, not upon outcome.
5. If you have a Medicaid spenddown, you will be responsible for paying the client rate for all services provided until you have met your spenddown and your Medicaid is active. If you do not meet your spenddown and lose your Medicaid, Turning Point will bill you your self-pay fee for all dates of services not covered by Medicaid.
6. Case Management Services and Psychosocial Rehabilitation (PSR) are not covered by private insurance or Medicare.
7. I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Turning Point Behavioral Health Care Center. A photocopy is to be considered as valid as the original.
8. I hereby authorize Turning Point Behavioral Health Care Center to release any information acquired during my examination or treatment to my insurance carrier. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original.

I acknowledge and accept the above conditions:

Client Signature: ______________________________ Witness Signature: ______________________________

Turning Point Behavioral Health Care Center
Communication Permission Form

Name: ____ Date: ____________

There will be times when we need to reach you regarding scheduling or other non-clinical issues. In order to ensure that we maintain confidentiality, please indicate which methods you will allow us to contact you, and if messages can be left if you are not available when we call.

If this information changes at any time, it will be your responsibility to contact us with the updated information.

When contacting you, can we:

1. **Call: ______Yes ______No**

   Preferred Phone Number: (_____) ____________________ (Home/Cell/Work-circle one)

2. **Leave a Message (identifying Turning Point) ______Yes ______No**

3. **Send Text Reminders for appointments: ______Yes ______No**
   Cell # (for text message reminders): (___) ________________

Cell Phone Carrier (must be completed for text message reminders): ___________________
Standard message data may apply

4. **Send emails: ______Yes ______No**

   Email: ______________________________ *Please Print Clearly*

I consent for my treatment providers at Turning Point to communicate with me in the formats indicated above. I understand that there are risks with electronic communication, and that if my digital device(s) does not have a security code, others who have access to them might be able to view my email/text messages/call log/voicemail. I also understand that the preferred way to communicate with my treatment providers is through face-to-face sessions or the telephone. In an emergency, I will call 911 or go to the emergency room for immediate assistance. I will call the Emergency Services Team at Turning Point at 847.933.0051 at any time if I am experiencing a crisis. This consent is valid for my length of treatment. I understand that I can revoke this consent at any time.

____ ______________
CLIENT SIGNATURE DATE

____ ______________
PARENT/GUARDIAN SIGNATURE DATE

____ ______________
CLIENT SERVICES STAFF SIGNATURE DATE

Turning Point Behavioral Health Care Center
No Show Policy for Clients
March 2022

1. Clients of Turning Point must attend at least one individual appointment with a therapist or case manager a month in order to stay open to services. If a client fails to follow this rule, services may be terminated.

2. If a client checks in at reception (or fails to answer a phone or video call) **more than 10 minutes** after the start of their appointment time, they will not be seen for that appointment and it will be **considered a no show**.

3. When there are attendance issues, clients can expect the therapist or case manager to be in touch regarding any possible barriers to treatment and to close clients when necessary.

4. Clients are to be placed on an attendance contract if any of the following missed appointment patterns emerge:
    a. A client no-show/late cancels 3 appointments over a 90-day period,
    b. A client has two no-show/late cancellations in a row,
    c. A client cancels (with 24 hour notice) 4 appointments over a 90-day period.

    At this point, the therapist or case manager may initiate phone outreach to the client. If the client cannot be reached by phone, the therapist or case manager will send a letter giving details about attending an appointment within the time frame given. The letter may also list the details of an attendance contract. If the client does not attend the appointment, then the client's case will automatically be closed. If the client attends the appointment, then the client will remain open and the client must abide by an attendance contract.

    Missing any appointments (regardless of the reason) while engaged in an attendance contract will result in the immediate termination of services unless the clinician calls for an exception.

5. If a client successfully abides by the attendance contract for at least four appointments in a row, they can return to the regular scheduling procedure.

6. If a client is closed due to an engagement issue, the client will not be opened to the agency for **45 days from the deadline listed in the letter or the date of a failed attendance contract**. The therapist or case manager will put an alert in the client's electronic medical record notifying the clinician and support staff that the client cannot access services during this window of time.

7. Upon the 3rd violation of this policy in an episode of care, services will automatically be terminated. The client will not be allowed to re-enroll for 6 months following termination of services.

<u>No Show Policy Acknowledgement</u>

My signature below indicates that I have received a copy of Turning Point's No Show Policy.

The document has been reviewed with me by staff and I understand the content. I agree to follow these policies and procedures while participating in Individual Therapy and/or Case Management.

________________________________	________________________________
Client Signature, **Date**	Client Printed Name
________________________________	________________________________
Parent/Guardian Signature, **Date**	Parent/Guardian Printed Name
________________________________	________________________________
Staff Signature, **Date**	Staff Printed Name