CLOUD PEAK COUNSELING CENTER
401 South 23rd Street, Worland, WY 82401
Phone (307) 347-6165 Fax (307) 347-6166
www.cloudpeakcc.org

CHILD/ ADOLESCENT APPLICATION FOR SERVICES

Welcome to Cloud Peak Counseling Center (CPCC). Our agency exists for the benefit of the public and is staffed by well-trained professionals. We offer a variety of services and will do our best to provide the services you require. All information is confidential.

Today's Date: ____

CHILD'S INFORMATION

Child's Name: First__________________________ M.I._____ Last_________________________ Maiden Name _________________

Date of Birth: __________________ Age: _________ Social Security Number: ___________________________ Gender: __________

Place of Birth: ____ Mother's First Name: _________________________________

Residence Address: ____Apt #________________

City: ____ State: _______________________________ Zip: _______________

Mailing Address: ____Apt # _______________

City: ____ State: _______________________________ Zip: _______________

Home Phone: ________________________ Mobile Phone: ______________________ Work Phone: ____________________

May we contact you/ leave a message at: Home? Yes / No Mobile? Yes / No Work? Yes / No

May we send correspondence to your mailing address? Yes / No

If no, how would you like to receive written correspondence? ____

In Case of Emergency Contact: _____________________________________ Phone:____

Address: ____City: _________________________ State: ________ Zip:__________

DEMOGRAPHICS

SOURCE OF REFERRAL

___ Self
___ Family/ Friends
___ Police/ Law Enforcement
___ Court
___ Private Psychiatrist
___ Other Physician
___ Other Private Mental Health Practitioner
___ Clergy
___ Wyoming State Hospital
___ Other Inpatient Psychiatric Services
___ Drug/ Alcohol Abuse Treatment Facility
___ Shelter
___ Community Mental Health Center
___ Schools
___ Employer
___ Department of Family Services (DFS)
___ Division of Vocational Rehabilitation (DVR)
___ Nursing Home
___ Medical Hospital
___ Development Disability
___ Drug Court
___ Adult Probation and Parole
___ Juvenile Probation
___ Early Childhood Setting
___ Attorney
___ Veteran Affairs (VA)
___ Department of Corrections (DOC)
___ Other

RACE:

___ Caucasion
___ African American
___ Native American/ Alaskan
___ Asian
___ Other/ Unknown
___ Native Hawaiin/ Other Pacific Islander
___ More than One Race

HISPANIC ORIGIN:

___ Not Hispanic
___ Cuban
___ Puerto Rican
___ Mexican
___ Other Hispanic
___ Unknown

EMPLOYMENT STATUS:

___ Unemployed
___ Part-Time
___ Full-Time Name of Employer________________________
___ Homemaker
___ Retired
___ Disabled
___ Child Under 15
___ Student Over 15 Name of School________________________
___ Inmate of Institution
___ Other
___ Other

MARITAL STATUS:

___ Never Married
___ Now Married
___ Separated
___ Divorced
___ Widowed
___ Minor Child

VETERAN STATUS: Y / N

HIGHEST GRADE COMPLETED: __________

FAMILY MEMBERS

Please List All Family Members Residing In The Home:

Name	Sex	Age	Birth Date	Grade Completed
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______
______________________	____	____	________	_______

Parents' Marital Status (check all that apply)**:**

Mother: ___Currently married to child's father ___Previously married to child's father
___Currently married to someone other than child's father ___Never married ___Divorced ___Separated
___Widowed ___Other

Father: ___Currently married to child's mother ___Previously married to child's mother
___Currently married to someone other than child's mother ___Never married ___Divorced ___Separated
___Widowed ___Other

Child's Current Living Situation: ___On street or in shelter ___Private Residence ___Group Home ___Residential Treatment
___Boarding/Foster Home ___Jail/Correctional Facility ___Hospital ___Other Residential Setting

Family's Total Annual Income $____________________

MEDICAL HEALTH / PSYCHIATRIC HISTORY

Family Physician: _________________________ When was your child's last visit to his/her family physician? ___________________

Is your child currently being treated for a medical problem? YES / NO If yes, please explain: ______________________________
____

Has your child had any medical or psychological testing? YES / NO If yes, please explain:______________________________
____

Has your child had previous psychiatric/ psychological/ drug or alcohol evaluation or treatment? YES / NO
If yes, When? ___________________________ Where? ____

Has your child had previous hospitalizations, surgery, major illnesses, or any other serious medical problems? YES / NO

If yes: Dates of treatment/illness: Nature of medical problem: Outcome of condition/treatment:
____
____
____

Is your child taking medications (for medical and/or psychiatric health)? YES / NO If yes, please list below:

Physician	Medication	Dosage	How Long?	Reason
______________	_________________________	________	________	_______________________________
______________	_________________________	________	________	_______________________________
______________	_________________________	________	________	_______________________________

Does your child have any allergies? YES / NO If yes, please explain: ____
____

Are your child's immunizations up to date? YES / NO If no, what hasn't been completed: _____________________________
____

What problems has your family had with alcohol/ drugs? ____
____

What problems has your family had with mental illnesses? ____
____

Please answer the following questions regarding your child's developmental and prenatal history:
Y / N Was your child carried to full term (=40 weeks) during pregnancy?
Y / N Was the child's mother exposed to drugs or other toxic substances during pregnancy? If yes, what?___________________
Y / N Did the child's mother have any illnesses while pregnant? If yes, what?_________________________________

Birth weight of child: ________ pounds __________ ounces
Age at walking unassisted: _____________
Age baby spoke first words: ______________
Age at toilet training: ____________

PRESENTING PROBLEM

Family Stressors:

___Marital conflicts ___Parent/Child conflicts ___Financial problems
___Physical illness/Medical problems ___Recent death(s) ___Drug/Alcohol abuse by parents ___Frequent moves
___Sexual/physical abuse ___Other? ____________________

Does your child experience any of the following?

___Stuttering ___Hearing Problems ___Vision Problems ___Learning Disabilities

Please review the list of common behavioral/emotional problems and check all that apply to your child.
___Depressed or irritable mood, lack of interest or motivation, boredom or withdrawal from friends
___Sleep or appetite/weight changes
___Multiple apparently unfounded medical complaints
___Self-esteem decreased from previous level. Excessive self-blame and guilt
___Suicidal behavior and thoughts
___Increased tearfulness or lability of mood

___Over activity
___Distractibility/Inattentiveness
___Fidgeting
___Impulsivity
___Difficulty following through on instructions
___Loses things easily
___Shifts from one incomplete activity to another

___Argumentative, angry or vindictive behavior
___Refuses to comply with reasonable rules
___Annoys others deliberately
___Swears/uses obscene language
___Stealing/forgery/breaking and entering
___Running away from home, school truancy
___Lying
___Fire setting
___Homicidal/dangerous behavior or plans
___Cruelty to animals or people
___Sexual abuse of others
___Physical fights
___Arrests

___Binge eating
___Use of laxatives/diuretic/diet pills
___Fasting/Strict dieting
___Persistent concern with body shape/weight

___Fearful about being separated from you (at school, at night, being left with a sitter)
___Fears that harm will come to you/him or her during absences (killed, kidnapped, accident)
___Excessively shy when with unfamiliar people

___Preoccupation with cleanliness, excessive hand washing or peculiar orderliness
___ "Habits" that child just cannot seem to help
___Has unpleasant thoughts that go around in head or being afraid of something he might do

___Abnormal motor/movements, jerks, tics of the face, neck, shoulders, mouth, upper or lower body
___History of frequent coughing, throat clearing, stuttering, or unusual noises
___Soiling or wetting
___Substance use, abuse, or suspected abuse (Circle all that apply) alcohol marijuana cocaine Heroin opiates tranquilizers Hallucinogens methamphetamine other

Has your child been expelled or suspended from school during the last 30 days? If yes reason: ____

Has your child missed school in the last 30 days? If yes reason: ____

Has your child been seen at CPCC or WMHS before? YES / NO If yes, under what name?_________________________________

What do you hope to achieve by bringing your child to CPCC? ___Evaluation Only ___Second Opinion
___Counseling ___Medication Evaluation ___Letter to School or Agency
___Other:_____________________________________

Does your child receive any of these services?
___Speech Therapy
___Physical Therapy
___Counseling
___Occupational Therapy
___IEP

Please list other agencies in which you are involved: ____

BILLING INFORMATION

How do you plan to pay for services?

___ Self Pay: *Person Responsible for Payment*____

___ Equality Care (Medicaid): *Equality Care Number*____

___ Kid Care CHIP: *Kid Care Number*____

___ Department of Family Services: *Name of Caseworker*____

___ Department of Vocational Rehabilitation

___ Other Contract: *Agency*___________________________ *Contact Person*________________________ *Phone*_________

___ Veteran Affairs

___ EAP: *Employer*___________________________ *Phone*____________ *Authorization Number*____________________

___ Health Insurance (Please fill out the following information):

PRIMARY INSURANCE

Policy Holder Information:

Name of Policy Holder: ________________________________ Date of Birth: ___________ Social Security Number: ______________

Address: ____City: ______________________State: ______________Zip: ________

Home Phone: _____________________ Employer: ____ Phone:__________________

Name of Insurance Company: ____ Phone: _______________________

Identification Number: _____________________________ Group Number: __________________ Relationship to Client: ___________

Insurance Company's Address:____

City: ____ State: ____________________________ Zip: _____________________

SECONDARY INSURANCE

Policy Holder Information:

Name of Policy Holder: ________________________________ Date of Birth: ___________ Social Security Number: ______________

Address: ____City: ______________________State: ______________Zip: ________

Home Phone: _____________________ Employer: ____ Phone: __________________

Name of Insurance Company: ____ Phone: _______________________

Identification Number: _____________________________ Group Number: __________________ Relationship to Client: ___________

Insurance Company's Address:

____

City: ____ State: ____________________________ Zip: _____________________

For Questions About Billing Please Contact:

Rachel Wade
Billing Manager/ Managed Care Coordinator

(307) 347-6165
(307) 347-6166 Fax
rachel@cloudpeakcc.org

Have you considered whether or not you are eligible for Equality Care/ Kid Care CHIP health benefits? If you are interested in the eligibility requirements or would like to apply for these benefits please ask our front office staff for an application. Completed applications must be returned to Department of Family Services for a final determination.

USE FINANCIAL AGREEMENT PAGE UPDATED-ADULTS--NOT THIS ONE

FINANCIAL AGREEMENT

Name: ____ Social Security Number:_____________________________

1. Cloud Peak Counseling Center (CPCC) is a private, non-profit organization, established to help people with emotional and/or behavioral problems and to provide consultation and education to community organizations. CPCC receives some public funding, but that funding provides only a part of the financial support needed to operate CPCC. The balance must come from the individuals who receive services. Fees for services are assessed on an "ability to pay" basis, as shown on the Fee Schedule.

2. If you have health insurance, we will bill your insurance company CPCC's full provision of services rate. The current rates of service are posted. However, the client is always responsible for payment for services assessed at his or her adjusted income rate, unless the adjusted income rate plus the insurance payment exceeds current rates. In that case, the client is responsible only for the difference between the insurance payment rate and CPCC's full provision of services rate.

3. If you have Equality Care (Medicaid), we will bill the charges directly to Equality Care for services covered. If you receive services from CPCC not covered by Medicaid, you will be charged according to your adjusted income rate.

4. A No-Show Fee of $10.00 will be charged if you fail to show up for a scheduled appointment.

5. **The recipient of services is required to make full payment at the time services are provided, unless other arrangements have been made with the business office in advance. All statements of account are due and payable in full upon receipt.**

6. Delinquent accounts may be turned over to a professional collections agency for appropriate action. CPCC uses NCO Financial Systems, Inc. for collection of delinquent accounts. The client is responsible for all collection fees, which is an additional 35% of the total bill. The client hereby agrees to hold CPCC harmless for any breach of confidentiality necessary by the collection procedures. Collection fees will be payable by the guarantor.

FEE SCHEDULE

Gross Annual Family Income $_________________. Number of dependent persons in family _____ x $1,000 deductions __________

Adjusted Gross Income $_____________________.

ADJUSTED INCOME	PERCENT OF FULL FEE
$0 – $9,999	5%
$10,000 - $19,999	10%
$20,000 - $29,999	20%
$30,000 - $39,999	30%
$40,000 - $49,999	40%
$50,000 - $59,999	50%
$60,000 - $69,999	60%
$70,000 - $79,000	70%
$80,000 - $89,000	80%
$90,000 - $99,999	90%
$100,000 And Above	100%

Your adjusted income rate for individual out-patient therapy is ________ percent of the full fee. Charges for services other than out-patient therapy, such as books, testing materials and fees, evaluations, and some workshops or classes may not be adjusted to our sliding fee scale. If you believe that the fee set by the sliding scale is unreasonably inconvenient, discuss this with your therapist.

If your financial or insurance situation changes while you are receiving services, it is your responsibility to report your new status to CPCC.

CHECK APPROPRIATE BOX:

( ) I hereby state that I do have insurance coverage with ____________________________________ and that I will provide CPCC with all appropriate claim forms in order for direct payment to be made to CPCC. I authorize release of information necessary to process insurance claims and authorize direct payment of benefits to CPCC. If payment is made directly to me, I hereby agree to promptly remit such payments to CPCC. I understand that I will be responsible for payment for any services not covered by my insurance.

( ) I hereby state that I have no health insurance coverage. If I obtain such coverage in the future, I will immediately notify CPCC.

I acknowledge that I have read and understand the foregoing Financial Agreement and agree to abide by all of its terms and conditions.

____ ____

Signature of client, parent, guardian or person authorized to sign for client. Date   Witness Date

YOUR RIGHTS & RESPONSIBILITIES

RIGHTS

In accordance with Wyoming Statues, clients served by mental health centers have the right to impartial access to services, regardless of race, religion, gender, sexual orientation, ethnicity, age, handicap, or sources of financial support.

You have the right to have your personal dignity and privacy recognized and respected in the provision of all services.

You have the right to receive services without worry about abuse, financial or other exploitation, retaliation, humiliation, and neglect from staff.

As a Cloud Peak Counseling Center (CPCC) client, you have a right to an individual plan for your treatment which provides for the least restrictive care that may be expected to benefit you.

Written and verbal communications between clients and staff and the content of clinical records shall be held in confidence by all staff. Confidential information shall be revealed or released only with the client's informed and written consent, instances of legally reportable child or adult abuse and neglect, criminal activity on CPCC premises or against CPCC staff, and to qualified State and Federal personnel, and to authorized peer reviewers under written oath of confidentiality.

Federal confidentiality rules (42-CFR Part 2) prevent use of any information we have obtained to criminally investigate or prosecute any alcohol or drug patient. Disclosure of client identifying information is permitted if authorized by a court order, after application showing good cause.

You have the right to initiate a grievance and obtain a mechanism for requesting a review of the grievance. You have the right to bring legal representation to the hearing to assist you in presenting the grievance. Suggestions, complaints, or grievances should be taken to the Director of Cloud Peak Counseling Center; in the event of a grievance, you will be provided a copy of our Client Grievance and Hearing Policy.

You have the right to have access to your own records, except when CPCC feels it would not be in your best interest.

You have the right to access legal entities for appropriate representation.

You have the right to access self-help and advocacy support service.

You have the right to be notified under what conditions these rights may be restricted including criteria for resolution and return to treatment.

RESPONSIBILITIES

To provide true facts about your illnesses, medications and previous treatments.

To report any changes in your medications or symptoms to your therapist/ case manager.

To ask questions about your care or treatment plan.

To follow the recommendations/ instructions of your therapist/ case manager.

To realize that the problems caused by your failure to follow your treatment plan or therapist instructions are your responsibility.

To pay your bills and work out financial arrangements for covering the cost of your treatment.

To be considerate to other staff, visitors and other clients by respecting their rights and confidentiality.

To notify your therapist/ case manager if you are unable to attend a scheduled appointment as soon as you become aware that you will not be able to attend it.

I acknowledge that I have read and understand my RIGHTS, including my rights to confidentiality and the financial agreement. I hereby give permission and consent to services by a representative of CPCC. If this application is for services for a child or ward, I authorize a representative of CPCC to interview and provide the recommended services to the child (may include transportation).

____ ____________________

Signature of Client, Parent, Guardian or person Authorized to sign for Client — Date

____ ____________________

Witness — Date