DISC VILLAGE

CLIENT INFORMATION & REFERRAL FORM

Client Name: _____

Date of Referral: _____

Referral Name: *(i.e. PO, Case Worker)* _____

Referral Phone: _____

Referral Fax: _____

Referral Email: _____

If you are the **REFERRAL SOURCE**, complete **Sections I and II**. The **CLIENT** will complete **Section III** and any missing info from Section II.

If you are a **SELF-REFERRED CLIENT**, complete **Sections I, II and III**. **DISC VILLAGE STAFF** will complete **Section IV**.

Step 1: Answer the following:

1. Are you (client) pregnant? ☐ Yes ☐ No
2. Are you (client) using drugs intravenously ("shooting")? ☐ Yes ☐ No
3. Have you (client) used drugs within the past 30 days? ☐ Yes ☐ No
4. What type of insurance do you (client) have? _____

Step 2: Select your location in the table listed below.

☐ **Leon County Adult Services**
(Accepts Jefferson County)
1000 W. Tharpe St, Suite 14
Tallahassee, FL 32303
Office: (850) 487-0432
FAX: (850) 414-6876

☐ **Leon County Youth Services**
536 Appleyard Dr.
Tallahassee, Florida 32304
Office: (850) 575-4025
FAX: (850) 575-0047

☐ **Wakulla County Human Services Center (Adult & Youth)**
85 High Dr.
Crawfordville, Florida 32326
Office: (850) 926-2452
FAX: (850) 926-8355

☐ **Gadsden County Human Services Center (Adult & Youth)**
(Accepts Liberty County)
305 W. Crawford St., Suite 1
Quincy, Florida 32351
Office: (850) 627-3599
FAX: (850) 875-2938

☐ **Taylor County Human Services Center (Adult & Youth)**
(Accepts Madison County)
1012 South Jefferson St.
Perry, Florida 32348
Office: (850) 223-1003
FAX: (850) 223-0223

☐ **Franklin County Human Services Center (Adult & Youth)**
192 14th St.
Apalachicola, FL 32320
Office: (850) 653-1617
FAX: (850) 617-6282

Section I

REFERRAL INFORMATION: (Who referred you here today?)

☐ Self-Referral	☐ DCF/CHS/BBCBC:
☐ North Florida Safety Council/DUI School	☐ Pre-Trial
☐ Circuit/State Probation (DOC)	☐ County Probation:_____
☐ BOP/TDAT	☐ Department of Juvenile Justice
☐ Federal Probation (USPO)	☐ Drug Court
☐ Physician/Counselor	☐ Other: _____

COLLATERAL INFORMATION: (Referring Agency Only)

Please attached relevant information to this referral from and indicate below:

☐ Legal Charges ☐ Court Order ☐ Psychiatric/Medical Information

☐ Arrest Affidavit ☐ Disposition Order ☐ Expanded Facesheet

☐ PACT ☐ GAIN-Q ☐ State Attorney Recommendation (Non-Judicial)

☐ Case Plan ☐ Shelter Order ☐ Other _____

REQUESTED SERVICES: (Referring Agency Only)

If referring for specific services, please indicate below. Mark all that apply.

☐ Assessment & Recommendation ☐ Counseling

☐ Juvenile Drug Court ☐ Other:_____

ADDITIONAL REFERRAL COMMENTS: (Referring Agency Only)

_____

_____

_____

_____

_____

_____

_____

Section II

CLIENT INFORMATION: **MIS #:** *(Staff Use)* _____

Case #: _____ **Arrest Date:** _____

Client Name: _____ **Age:** _____

Check One: ☐ Adult ☐ Youth **Social Security Number:** _____

Date of Birth: **Gender:** ☐ Male ☐ Female **Race:** _____

Address: _____ **City/State:** _____

Zip Code: _____ **Email:** _____

Parent/Guardian Name *(for Adolescents)***:** _____

Home Phone: _____ **Cell Phone:** _____

School Name *(for Adolescents)***:** _____

Offense(s): _____

Co-Defendants: _____

By providing the above contact information, I hereby consent to receiving communication from DISC Village, Inc.

CLIENT EMERGENCY CONTACT INFORMATION: (*Must also sign PHI with info to be released*)

Contact Name: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

CLIENT QUESTIONNAIRE:

Why are you seeking services today? ☐ Want Help ☐ Information Only ☐ Required ☐ Vivitrol

Do you have any immediate needs such as food, shelter, medical/mental health?
☐ Yes ☐ No

If yes, what are they: _____

Currently prescribed medications
(Provide list of prescriptions) _____

Do you have any drug allergies? ☐ Yes ☐ No

If yes, what are they: _____

Are you interested in receiving services via the internet? ☐ Yes ☐ No

For New Moms Only: **Are you breastfeeding?** ☐ Yes ☐ No

Section III

HOUSEHOLD INCOME INFORMATION:

Income can come from many sources including employment, social security, disability, unemployment, retirement, grants, TANF Cash Assistance, Trust Payments, Annuities, etc.	**ATTENTION STUDENTS:** Did your parents claim you on their taxes? If the answer is YES, you will need THEIR tax information.

How many people did you claim on your taxes last year? (*Be sure to include yourself)* _____

Your (Client) Gross Income:	$ _____	**INCOME VERIFICATION:** **[Documentation Must Be Attached]**
Parent/Guardian #1 Gross Income:	$ _____	☐ Previous Year Tax Return
Parent/Guardian #2 Gross Income:	$ _____	☐ Current Payroll Stub
Spouse/Significant Other Gross Income:	$ _____	☐ W2
Adult Child Living at Home Gross Income:	$ _____	☐ Signed Letter from Current Employer
Other Gross Income:	$ _____	☐ Other
TOTAL HOUSEHOLD INCOME:	**$** _____	☐ Date Financial Info. Reviewed: _____

Full Rate: _____ (*Initial if you prefer not to provide income and/or insurance information).* I prefer not to provide DISC Village with documentation of my income or insurance coverage. I understand that I will be charged the full rate for all services. I also understand that payment in full is expected at the time of service delivery.	**Medicaid Coverage:** _____ *(Initial if you have active Medicaid coverage at the time of admission)*. I understand that if during treatment my Medicaid coverage stops, I will be required to bring in proof of income in order to have my copay determined. I also understand that should I fail to provide income documentation. I will be required to pay the full rate for services.	**Foster/Group Home:** _____ *(Initial if you currently live in a foster or group home)*. I acknowledge that DISC Village has asked me for documentation of my parents' income. However, because of my living situation I do not have access to my parents' financial information.

Cancellation Policy: DISC Village will schedule your appointment more than 24 hours in advance and will reserve this session time for you. If you will be unable to attend your session you must notify our agency at least 24 hours before the scheduled appointment so that we may use this spot for another client. All cancellations with less than 24-hour notice, other than due to illness or emergency as evidenced by appropriate documentation, will result in a **failure to cancel fee of $25.00**. This fee must be paid in full before any further services are received.

_____ (Initial) I have read and agree with the **Cancellation Policy.**

_____ (Initial) **I agree that I am responsible for part or all of the costs associated with my treatment**. I understand that fees are based on the financial and insurance information that I provided, and I attest to the accuracy of the provided information.

_____ (Initial) **Sliding Scale Acceptance**: DISC Village utilizes a Sliding Fee Scale based on Florida Administrative Code 65E-14.018. DISC Village Sliding Fee Scale is calculated on the Federal Poverty Income Guidelines, the number of people in a household and annual income. **Urinalysis testing is not subject to Sliding Fee Scale. We cannot notify your referring agency of your completion of treatment until all assessed fees have been collected.**

Client Signature ***[Parent/Guardian Signature if client is under 18 years of age]***	**Date**	**Staff Signature**	**Date**

Section IV

CLIENT FINANCIAL & INSURANCE INFORMATION (*STAFF ONLY)*

Client Name: _____

MEDICAID INFORMATION:

Medicaid Number: _____

Type of Medicaid

☐ Managed Care (Wellcare/Staywell, Lighthouse, Humana, Sunshine Health/Cenpatico, Magellan Complete Care, Concordia Behavioral Health, Clear Choice Alliance)

List Managed Care Plan: _____

☐ Fee for Service (Full Medicaid) [Managed Care section does not list any Managed Care information.]
Medicaid Co-Pay Amount**: $ 2.00 per day***
*(*Does Not Apply to Managed Care Clients.)*

Medicaid Eligibility as of today: ☐ Eligible ☐ Ineligible

Check Reason If Not Eligible:

- ☐ Client Not Enrolled in Medicaid
- ☐ Not Eligible on Date of Service
- ☐ Family Planning Medicaid
- ☐ Limited to Medicare Premiums
- ☐ Limited to Transportation

INSURANCE INFORMATION:

Instructions for Intake Staff: Make copy of front & back of insurance card. Ensure that the copy is large and clear enough to read. Write your initials/date at the bottom of the copy.

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Holder's SSN:_____ Relationship to Client:_____

Type of Insurance: _____

☐ Copay Amount: $_____

☐ Co-Insurance Amount: $ _____

☐ 70/30 ☐ 80/20 ☐ Other: _____

Annual Deductible Amount: _____

How much of the deductible has been paid?

_____

How much is left on the deductible: _____

What billing protocol is accepted by the insurance company?

☐ Per Visit Amount: $_____

☐ Based on Procedure Codes for services

Does the client's insurance plan cover substance abuse treatment? ☐ Yes ☐ No

If yes, indicate level of care covered:

- ☐ *Non-Residential (Outpatient)*
- ☐ *Residential*
- ☐ *Both*

Youth Drug Court Program Fees:

See the Youth Drug Court Sliding Fee Scale

☐	**Level 6**	**$ 1,500.00**
☐	**Level 5**	**$ 1,250.00**
☐	**Level 4**	**$ 340.00**
☐	**Level 3**	**$ 320.00**
☐	**Level 2**	**$ 160.00**
☐	**Level 1**	**$ 80.00**
☐	**Below FPGL**	**$ 60.00**

Non-Insurance Sliding Fee Co-Pay Amounts:

Assessment (Per Exam): **$** _____

Individual (Per Session): **$** _____

Group/Family (Per Session): **$** _____

Residential (Per Day): **$** _____

UA Fee: **$** _____

Full Pay Service Rates:

Assessment (Per Exam): **$ 150.00**

Individual (Per Session): **$ 116.00**

Group/Family (Per Session): **$ 29.00**

Residential (Per Day): **$ 206.00**

Medicaid and insurance information verified by:

_____ _____

Staff Signature **Date**