ANA·ZAO
COMMUNITY PARTNERS

Intake Face Sheet

Client Name: _____ _____ _____ **DOB:** _____
First *Middle* *Last* *Mo/Day/Year*

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Contact: _____ _____ _____ _____
Cell *Home* *Work* *Email*

SSN: _____ **In Case of Emergency, contact:** _____
###-##-#### *Name/Relationship to Client*

_____
Phone

Contact Permission: Check the boxes that apply, below.

	You may email me information about services.
	You may text me information about services.
	You may leave messages about services at my **cell** number.
	You may leave messages about services at my **home** number.
	You may ask for return calls to Anazao at my **work** number.

Race: *Check all that apply*

	White		Native American/Alaskan
	Black/African American		Asian
	Hispanic/Latino		Hawaiian/Pacific Islander

Ethnicity: *Check one*

	Hispanic
	Not Hispanic

Consents and Client Rights:

By signing below, I consent to behavioral health treatment by Anazao Community Partners (ACP). I have been advised of the risks and benefits of treatment. I have been advised of my rights as a client or parent/guardian of a client. I understand that ACP uses an Electronic Health Record (EHR) as part of the PartnerSolutions Health Informatics Consortium (PSHIC). I understand that private information may be shared with other partners in this consortium through the EHR. I understand that in order to determine my eligibility for public funds to pay for services, private information will be disclosed to the Mental Health and Recovery Board (MHRB) of Wayne and Holmes Counties and to the Ohio Department of Mental Health and Addiction Services (OMHAS) through the PSHIC, the NextGen EHR, the SmartCare, Medicaid Information Technology System (MITS) or Managed Care claims systems. I understand that any records that are specifically related to substance use are protected by federal law (42 CFR Part 2) and cannot be disclosed without my written consent and that federal rules restrict the use of this information to criminally investigate or prosecute me. I understands that each client at ACP has a number of rights and that these include, but are not limited to: being treated with respect, dignity, autonomy and privacy; being served in a humane setting; being informed of condition, services and alternatives; the right to refuse any service; being served with a current and collaborative treatment plan; the right to confidentiality of and personal access to treatment records; freedom from discrimination and the right to file a grievance. I understand that Mark Woods, Executive Director, serves as the agency's Client Rights Officer and that he can be reached at 330-264-9597. I understand that I can review this information in full detail at www.anazao.co.

Signature of Client: *(if 12 or older)* _____ Date: _____

Guardian: *(if Client under 18)* _____ Date: _____

Witness: _____ Date: _____

For questions about this form, or assistance completing the form, please call our office at 1-800-721-9472.

ANA·ZAO
COMMUNITY PARTNERS

Financial Agreements

Please review and complete each section of this form.

Insurance and/or Medicaid Information

Name of Insurance Company or Medicaid Managed Care Organization*	Policy-Holder Name & Date of Birth	Policy-Holder Relationship to Client	County of Public Assistance
Policy or ID Number	Group or Case Number	*Presumptive Medicaid, Aetna, Buckeye, CareSource, Molina, Paramount, United, or Other (Write-in)	
Address or 800 # for Claims			

Financial Agreements:

By signing below, I authorize enrollment in the Mental Health and Recovery Board (MHRB) plan and PartnerSolutions Health Informatics Consortium (PSHIC). I request that ACP bill any eligible charges under that plan, and authorize payment of benefits to ACP for services provided. I understand that ACP uses a scale based on the size and income of my household to determine fees. I understand that I may be responsible for payment for services denied by my insurance or Medicaid/Managed Care Organization (MCO) plan. I understand that I must provide proof of income (current pay stub, recent tax form, statement from employer) to determine eligibility for some funding. I understand that if my family has no income, I must attest to this. I understand that I must provide ACP with proof of any change of income. I understand that not providing proof of income may result in my being charged the full hourly fee (up to $131 per hour) until this is provided. I understand that once my fee has been calculated, this will be provided to me. I understand that payment is due at the time of service. I understand that delinquent accounts may be turned over to a collection agency. This information is also available for me to review at www.anazao.co.

Income Statement

This information is used to determine fee reductions or eligibility for other funding (including TANF) for your services.

Name of individuals in home:	Age:	Relationship to client:

List all income for household members: *Enter Either Weekly or Monthly, not Both*

Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			
Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			
Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			

I authorize payment of services provided by ACP to be paid directly to ACP. I authorize ACP to release any information regarding claims for services to my insurance carrier/managed care organization.

Client (adult) or Guardian: _____ Date: _____

Policy-Holder: *if different from Guardian* _____ Date: _____

Witness: _____ Date: _____

REVISION 7.30.19

For questions about this form, or assistance completing the form, please call our office at 1-800-721-9472.