Department of Public Health
Chouteau County
1020 13th Street Fort Benton MT 59442 (406) 622-3771

CHOUTEAU COUNTY MENTAL HEALTH

APPLICATION FOR MENTAL HEALTH SERVICES

1. Name of person(s) applying and birthdates:

   Name: Birth date: SSN:

   _____ _____ _____

2. Mailing Address: _____

3. City_____ State_____ Zip_____

4. Telephone Numbers: H:_____ W:_____ C: _____

5. Occupation_____ Employer_____

   Length of employment_____

6. Medical Insurance: Yes:___ No:___ Policy Number:_____

   Company Name and Address: _____

   Primary Insured's Name: _____ DOB_____

   SSN_____

7. Medicaid: Yes:_____ No:_____ Card # _____

8. Marital Status: Circle what applies;

   Single Married Divorced Blended Family Significant Relationship Widowed

9. Number of years in present relationship_____

10. Other household members names, relationship, date of birth (Use additional page if necessary)

_____ _____ _____

_____ _____ _____

_____ _____ _____

11. Please describe the main problem that motivated you to seek counseling:

_____

_____

12. How were you referred to our services_____

13. Your education level: (please circle)
8th grade Some high school GED High School graduate Vocational Training
Some college College Graduate Graduate School

14. Emergency Contact
Name/Relationship: _____ Number:
_____

15. Current Primary Care Provider Name/Address/Phone #:_____

_____

Permission to release information to your primary care provider: YES or NO

16. Please list diagnosed medical conditions:_____

_____

_____

17. Please list all current medications: (Use additional page if necessary)

_____ _____ _____

_____ _____ _____

_____ _____ _____

18. List any recent major life changes:_____

_____

19. List hobbies or things you enjoy doing in your leisure time:_____

20. Who raised you? (Circle) Parents – Mom or Dad or Both Adoptive Parents Relatives Foster Care Other: _____

21. Do you drink alcoholic drinks? YES or NO
If yes, please circle the amount used weekly – 1 2 3 4 5 6 7 8 9 10 15 20 25 30+

Does your partner drink? YES or NO
If yes, please circle the amount used weekly – 1 2 3 4 5 6 7 8 9 10 15 20 25 30+

22. Do you use any legal or illegal substances (this includes tobacco)? YES or NO
Please list all substances and how often:

_____

Does your partner use any legal or illegal substances (this includes tobacco)? YES or NO
Please list all substances and how often:

_____

23. How satisfied are you with your relationship with your partner: (Circle one)
Very satisfied Somewhat satisfied Mixed Somewhat dissatisfied Very dissatisfied

24. How satisfied are you with your relationship with your child(ren)?
Very satisfied Somewhat satisfied Mixed Somewhat dissatisfied Very dissatisfied

25. How satisfied are you with your job?
Very satisfied Somewhat satisfied Mixed Somewhat dissatisfied Very dissatisfied

26. Sometimes I find it difficult to (circle all that apply to you or your family)

Manage the children	Control my temper	Make ends meet financially
Make decisions	Ask for help	Accept help
Find energy	Trust others	Respond to the task at hand
Set goals	Achieve goals	Share my opinion
Express myself	Remain positive	Stay focused
Find time for my spouse	Get ahead	Relax without alcohol/drugs
Admit I am wrong	Listen and understand	Say no
Take on one task at a time	Sleep	

HIPPA DISCLOSURE FORM

Dear Patients.

We consider the privacy of your health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously. We have taken the following steps to protect your privacy.

1. We train our staff members on their responsibility to maintain the confidentiality of your health information and hold them accountable for their actions.

2. We do not sell your information to any organization.

To help us comply with the law, we ask that you do the following:

1. Sign below acknowledging that you have received and/or read a copy of our HIPPA policy and are in agreement.

Signed: _____ Date: _____

Print Name: _____

FINANCIAL INFORMATION:

GROSS INCOME FOR HOUSEHOLD: _____PER WEEK

_____PER MONTH

_____PER YEAR

- We have a sliding fee scale for our clients based on income. You are responsible at each visit for this determined amount. If you are unable to meet your financial responsibility, please contact our office for arrangements. Failure to meet your financial responsibility may result in a loss of services.

- A 24 hour notice is required for all cancellations or appointments that need to be rescheduled.

TERMS:

1. I hereby authorize Chouteau County Mental Health representative or affiliates to contact my medical insurance company about reimbursement information.

2. I will be responsible for reimbursement to the county from my insurance payment.

3. I further agree to hold harmless the Chouteau County and their representatives from any claim that may arise from the release of any information which has been agreed to on this form.

Signature: _____

……

Office Use

Application: Approved: _____ Denied: _____

Clients Financial Responsibility: _____

Date: _____