Did you know that AHCCCS health care benefits may help pay for your behavioral health services?

The screening for AHCCCS eligibility is quick and done online through the *Health-e Arizona* web site. The online screening tool will indicate one of the two options:

- **The person is potentially AHCCCS eligible.**
- **The person does not appear AHCCCS eligible, however eligible for the Federal Market Place.**

A curtesy screening for AHCCCS health care benefits and the Market Place will be conducted at your Intake appointment, please provide the following information.

To begin the Screening, tell us a little about the main contact person in the household.

First Name: _____ DOB:_____ Gender: _____

Please tell us about the people in this household & their relationship to the head of household above.

First Name	DOB	Age	Gender	Relationship

Is anyone in the household pregnant? ◯ Yes ◯ No Who is pregnant? _____

Does anyone have Medicare? ◯ Yes ◯ No Who has Medicare? _____

Is any adult unable to work because of a mental or physical condition that has lasted or may last 12 months or might result in death? ◯ Yes ◯ No Who is unable to work? _____

Does anyone in this household have income from work? Who has income? _____

Is anyone in the household self-employed? ◯ Yes ◯ No Who is self-employed? _____

Does anyone in the household receive money from another source? Who? _____

Household Income Details

First Name	Employer Name or Income Source	Rate of Pay	Hours per week	Frequency Paid (wk., bi-wk., mo.)	Gross amount paid before taxes

This screening is only an estimate. You must apply to receive an official decision. You must also bring supporting documentation to the screening interview to assist us in identifying if you could be AHCCCS eligible. We will be happy to assist with an AHCCCS application.

ENCOMPASS HEALTH SERVICES
Behavioral • Medical • Psychiatric

NO-SHOW POLICY

FOR COURT-ORDERED TREATMENT/SERVICES

Administrative/ Outpatient Office
P.O. Box 790
463 S. Lake Powell Blvd.
Page, AZ 86040
Phone: (928) 645-5113
Fax: (928) 645-3254

Fredonia Outpatient Office
P.O. Box 522
170 N. Main Street
Fredonia, AZ 86022
Phone: (928) 643-7230
Fax: (928) 643-7988

Littlefield Outpatient Office
P.O. Box 813
4103 E. Fleet, Suite 100
Littlefield, AZ 86432
Phone: (928) 347-4566
Fax: (928) 347-5174

Rural Substance Abuse Transitional Agency
P.O. Box 790
32 N. 10th, Suite 5
Page, AZ 86040
Phone: (928) 645-2966
Fax: (928) 645-3254

Liberty House Drop-in Center
P.O. Box 790
5 S. Lake Powell Blvd., Suite 3
Page, AZ 86040
Phone: (928) 645-4906
Fax: (928) 645-3254

Medical Center
P.O. Box 790
463 S. Lake Powell Blvd.
Page, AZ 86040
Phone: (928) 645-0945
Fax: (928) 645-2364

I understand that if I am not able to make my scheduled appointment (screening, intake, counseling, etc.), **I MUST CALL TO CANCEL IT** (PREFERABLY 24 HOURS IN ADVANCE).

X_____
Client Initials

I understand that if I fail to show up for my appointment and did not call in advance to cancel, I will be considered a "no-show" and Encompass is **REQUIRED BY LAW** to report me to the Court for non-compliance.

X_____
Client Initials

I understand that the Judge **WILL NOT ACCEPT WORK SCHEDULE CONFLICTS** as a reason for not completing treatment or for missing an appointment without notice.

X_____
Client Initials

I fully accept my personal responsibility to schedule my appointments at a time that I will be able to keep them.

X_____
Client Initials

I have read and understand the above "no-show" policy, and agree to comply with it fully by keeping my scheduled appointments or cancelling them in advance when necessary.

_____ _____
Print name Date

X _____
Signature

PART A: BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date of Birth_____ Client CIS ID#_____
(to be filled in by provider)

Accompanying Family Member/Significant Other (note relationship to person):_____
_____

1. Are you currently taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)? ☐ No, go to question 2.
☐ Yes, answer questions 1(a) - 1(e) below.

1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

Name of Medication	Dosage/Frequency	Reason for Taking Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1(b) Have any of your medications been changed in the last month? ☐ No ☐ Yes**,** list the medications that have changed and explain why they were changed._____
_____
_____

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?)_____
_____

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking._____
_____
_____

1(e) Do you have any abnormal/unusual muscle movements? ☐ No ☐ Yes, how is it being treated?_____
_____

2. Are you **allergic** to any medications? ☐ No ☐ Yes, which ones?_____

3. Do you have any other **allergies**? ☐ No ☐ Yes, describe them._____

4. When was the last time you saw your **primary care physician/dentist** and what was the purpose of that visit?_____
_____

5. Do you have any history of **head injury** with concussion or loss of consciousness? ☐ No ☐ Yes, describe._____
_____

6. Are you currently **pregnant**? ☐ No ☐ Yes ☐ Unsure

7. Are there any **medical problems** that you are currently receiving treatment for? ☐ No, go to question 8. ☐ Yes, answer 7(a) and 7(b) below.

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem	Type of Treatment Receiving
_____	_____
_____	_____
_____	_____

7(b) Does your current medical condition(s) create problems in how you deal with life, including pain? ☐ No ☐ Yes, if yes explain._____
_____
_____
_____

8. Have you recently experienced any of the following?

Ear/Nose/Throat:
Severe dry mouth ☐ No ☐ Yes, when _____
Ear infections ☐ No ☐ Yes, when _____
Persistent sore throat ☐ No ☐ Yes, when _____

Respiratory System:
Respiratory infections ☐ No ☐ Yes, when _____
Persistent cough ☐ No ☐ Yes, when _____
Shortness of breath ☐ No ☐ Yes, when _____

Cardiovascular:
Chest pain ☐ No ☐ Yes, where _____
Swelling in legs, ankles, feet ☐ No ☐ Yes, where _____

Gastro-intestinal:
Persistent nausea / vomiting ☐ No ☐ Yes, when _____
Self-induced vomiting ☐ No ☐ Yes, when _____
Frequent or prolonged diarrhea / constipation ☐ No ☐ Yes, when _____
Excessive use of laxatives ☐ No ☐ Yes, when _____
Weight loss / gain ☐ No ☐ Yes, when _____
Blood in stools ☐ No ☐ Yes, when _____
Abdominal pain ☐ No ☐ Yes, when _____

Genitourinary:
Urinary discomfort ☐ No ☐ Yes, when _____
Frequent urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes, when _____

Musculoskeletal:
Joint pain ☐ No ☐ Yes, when _____
Back pain ☐ No ☐ Yes, when _____

Neurological:

Facial or muscle twitching/jerking ☐No ☐Yes, when _____
Seizures ☐No ☐Yes, when _____
Passing out ☐No ☐Yes, when _____
Dizziness ☐No ☐Yes, when _____
Headaches ☐No ☐Yes, when _____

Infectious Diseases:
Sexually Transmitted Diseases ☐No ☐Yes, when _____ what_____

Other:
Inappropriate defecation (bowel elimination) ☐No ☐Yes, when _____
Inappropriate bed wetting ☐No ☐Yes, when _____
Dry skin ☐No ☐Yes, when _____
Hair loss ☐No ☐Yes, when _____
Unusual sweats or chills ☐No ☐Yes, when _____
Surgeries ☐No ☐Yes, when _____what _____
Problem with sleeping ☐No ☐Yes, indicate more or less sleep _____

Other conditions not listed above (signs and symptoms)

9. Do you **use tobacco**? ☐No ☐Yes, how much per day?_____ How long have you been using tobacco?_____ (yrs/mths)

10. Do you consume **caffeine**? ☐No ☐Yes, how many cups/cans do you drink per day?_____

11. In total, how much **fluid** do you drink, i.e., how many cups/cans of total fluids do you drink per day? _____

12. Have you **ever received out-patient** (office-based) **services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**?
☐No, go to question 13.
☐Yes, answer questions 12(a) – 12(c).

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When and Where Received
_____	_____
_____	_____
_____	_____
_____	_____

12(b) What current or prior treatment/services, including medication, do you think have been the <u>most helpful</u> in addressing your behavioral health symptoms? Explain _____
_____

12(c) What current or prior treatment/services, including medication, do you think have been the <u>least helpful</u> in addressing your behavioral health symptoms? Explain _____
_____

13. Describe any current or past **behavioral health issues** (including substance abuse) in your **family.** (*For purposes of this question family may include birth family, adopted family, foster family and/or family person is or has lived with.*)

If the person seeking behavioral health services was provided assistance in filling out this questionnaire, please provide the name,date of completion and telephone number of the individual providing this assistance.

Name (please print)_____ Date_____ Phone_____

FOR OFFICE USE ONLY										
COUNSELOR:		FUNDING:						CO-PAY:		
INTAKE DATE:		POP:	MH ☐	A ☐	D ☐	SMI ☐		T19:	YES ☐	NO ☐

PATIENT INFORMATION (ADULT)		TO BETTER SERVE YOU, ALL FIELDS MUST BE COMPLETED			
PATIENT LEGAL FULL NAME			SOCIAL SECURTY NO		DATE OF BIRTH
GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS: ☐ MARRIED ☐ WIDOW ☐ SINGLE ☐ SEPARATED ☐ DIVORCED	EMPLOYER/CO NAME	POSITION		☐ FULLTIME ☐ PART TIME
PHYSICAL ADDRESS		CITY/STATE ZIP CODE		Schooling Level comp:	
MAILING ADDRESS		CITY/STATE ZIP CODE		Is it ok to receive mail at this Post office box? ☐ Yes ☐ No	
HOME/CELL#	MSG? YES ☐ NO ☐	VETRAN STATUS ☐ ACTIVE MILITARY ☐ VETERAN ☐ RETIRED ☐ DISABLED			
MESSAGE #	MSG? YES ☐ NO ☐	BRANCH SERVED:	FROM:	TO:	

SPOUSE/OTHR	PHONE	CHILDREN'S NAME(S)
NUMBER OF HOUSEHOLD MEMBERS:	TOTAL MONTHLY INCOME:	SPOUSE'S EMPLOYER OR OTHER INCOME SOURCE:
EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE
EMERGENCY CONTACT PHYSICAL ADD:		

DO YOU HAVE INSURANCE? ☐ YES ☐ NO ☐ EAP	Copy of both sides of the insurance card(s) needed for Enrollment	
INSURANCE TYPE: ☐ AHCCCS ☐ PRIVATE INSURANCE	INSURANCE COMPANY	ID#
AHCCCS ID #	AHCCCS PENDING?	PRIMARY INSURED NAME/DOB
☐ STEWARD HEALTH CHOICE AZ ☐ CARE 1ST AZ ☐ INDIAN HEALTH PLAN ☐ OTHER:	PRIMARY INSURED EMPLOYER	RELATIONSHIP TO PATIENT ◯ SELF ◯ PARENT/GUARDIAN ◯ SPOUSE

PRIMARY CARE PROVIDER INFORMATION		
PRIMARY CARE PROVIDER/CLINIC	DATE OF LAST VISIT	PHONE
MEDICAL CONDITION(S)/DIAGNOSIS	ALLERGIES	
CURRENT MEDICATION(S)		
PREVIOUS BEHAVIORAL HEALTH? ☐ YES ☐ NO	AGENCY/FACILTY NAME / ADDRESS / PHONE	

I UNDERSTAND THAT THIS TIME HAS BEEN RESERVED FOR ME ALONE AND I WILL CALL IN ADVANCE IF I AM UNABLE TO KEEP THIS APPOINTMENT.	
CLIENT SIGNATURE	DATE

ENCOMPASS HEALTH SERVICES

Behavioral • Medical • Psychiatric

INTAKE DOCUMENTS

INSURANCE

Insurance Card *See note
Social Security Card
Valid Driver License or Arizona Photo ID
Current Paycheck Stubs (past 30 days)

AHCCCS

AHCCCS Card
Social Security Card
Valid Driver License or Arizona Photo ID
Current Paycheck Stubs (past 30 days)

NO INSURANCE

Social Security Card
Valid Driver License or Photo ID
Current Paycheck Stubs (past 30 days)
AHCCCS Screening Form

ALL ADULTS

Advanced Directive
Living Will
Health or Mental Care Power of Attorney

ALL CHILDREN

Birth Certificate
Social Security Card
C.I.B. (Certificate of Indian Blood)
Valid Driver License or Arizona Photo ID-if child is 16 or over
Parents Valid Driver License or Arizona Photo ID
Legal Guardian Papers-(if foster child or guardian is different than natural parents)

*All SRP Employees with Gilsbar Insurance, prior to Intake are required to contact COMPSYCH at 1-800-272-7255 for prior authorization.
If you have any questions, please ask for Michelle Herder, Insurance Billing Specialist.

C.I.B. Some funding requires CIB verification. If you have one, please provide.

If court ordered, NEED court paperwork before appointment can be made.

****PARENTS NEED TO BE PRESENT WITH MINORS****