

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.

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

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

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

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

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

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

**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

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

X_____

Client Initials

**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

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.

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

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

PART A: BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Name: _____

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

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

12(c) What current or prior treatment/services, including medication, do you think have been the least helpful 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: CHILD	T19:	YES NO



ENCOMPASS
HEALTH SERVICES

Behavioral • Medical • Psychiatric

PATIENT INFORMATION (CHILD)		TO BETTER SERVE YOU, ALL FIELDS MUST BE COMPLETED	
PATIENT LEGAL FULL NAME		SOCIAL SECURITY NO	DATE OF BIRTH
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SCHOOL STATUS <input type="checkbox"/> FULLTIME <input type="checkbox"/> PART TIME	SCHOOL NAME	
PHYSICAL ADDRESS	CITY/STATE ZIP CODE	CURRENT GRADE:	
MAILING ADDRESS	CITY/STATE/ZIP ZIP CODE	Is it ok to receive mail at this Post office box? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOME/CELL#	MSG? YES <input type="checkbox"/> NO <input type="checkbox"/>	PARENT'S EMPLOYER:	
MESSAGE#	MSG? YES <input type="checkbox"/> NO <input type="checkbox"/>	PARENT'S EMPLOYER:	
PARENT/GUARDIAN NAME:		OTHER PARENT /GUARDIAN NAME:	
NUMBER OF HOUSEHOLD MEMBERS:	TOTAL MONTHLY INCOME:	OTHER CHILDREN IN HOME:	
EMERGENCY CONTACT NAME:		RELATIONSHIP:	PHONE:
EMERGENCY CONTACT PHYSICAL ADD:			
DO YOU HAVE INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> EAP Copy of both sides of the insurance card(s) needed for Enrollment			
INSURANCE TYPE: <input type="checkbox"/> AHCCCS <input type="checkbox"/> PRIVATE INSURANCE	INSURANCE COMPANY		ID#
AHCCCS ID #	AHCCCS PENDING?	PRIMARY INSURED NAME/DOB	
<input type="checkbox"/> STEWARD HEALTH CHOICE AZ <input type="checkbox"/> CARE 1 ST AZ <input type="checkbox"/> INDIAN HEALTH PLAN <input type="checkbox"/> OTHER:	PRIMARY INSURED EMPLOYER	RELATIONSHIP TO PATIENT <input type="radio"/> SELF <input type="radio"/> PARENT/GUARDIAN <input type="radio"/> OTHER	
PRIMARY CARE PROVIDER INFORMATION			
PRIMARY CARE PROVIDER/CLINIC		DATE OF LAST VISIT	PHONE
MEDICAL CONDITION(S)/DIAGNOSIS		ALLERGIES	
CURRENT MEDICATION(S)			
PREVIOUS BEHAVIORAL HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO	AGENCY/FACILITY 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.			
PARENT/GUARDIAN SIGNATURE		DATE	



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****