COUNSELING AND RECOVERY SERVICES OF OKLAHOMA
CONSUMER FINANCIAL AGREEMENT
BUSINESS WORKSHEET

INITIAL__

UPDATE __

Adult Child
PBIS CALM
Wraparound T-Harp

SPONSOR AND ELIGIBILITY CRITERIA INFORMATION

MEDICARE (MCR) YES NO MEDICARE #_____

MEDICAID (MCD) YES NO MEDICAID #_____

OTHER INSURANCE: _____If yes, attach verification form

POLICY NUMBER_____GROUP NUMBER_____

COPAYMENT YES NO If yes, attach verification form

Does the consumer meet any of the following T-19 eligibility requirements?

Is the consumer pregnant?	YES	NO
Is the consumer a minor child **and**:		
Is either parent absent from the home?	YES	NO
Is either parent disabled?	YES	NO
Is either parent deceased?	YES	NO
Are parents unemployed?	YES	NO
Is the consumer over 65 years of age?	YES	NO
Has the consumer been declared disabled by Social Security?	YES	NO

INCOME CALCULATIONS:

_____every week x 52 = _____ _____ every two weeks x 26 = _____

_____ twice a month x 24 = _____ _____ each month x 12 = _____

FAMILY SIZE _____ **GROSS ANNUAL HOUSEHOLD INCOME_____**

FY 10 Annual Income Eligibility Criteria:

No. in Household	Maximum Income	No. in Household	Maximum Income	Pay Scale
1	$22,980	5	$55,140	O A B C D
2	$31,020	6	$63,180	
3	$39,060	7	$71,220	
4	$47,100	8	$79,260	

DMH DEPARTMENT OF MENTAL HEALTH

Member ID _____

Date of Birth _____

Social Security _____

SELF PAY

CONSUMER NAME_____ **CHART NUMBER_____**

CHART LABEL

Counseling and Recovery Services of Oklahoma offers services to those individuals meeting criteria established by the Oklahoma Department of Mental Health and Substance Abuse Services. Financial eligibility is based on family size, gross income information and other resources such as health insurance. Individuals not meeting ODMHSAS guidelines may be eligible for a sliding scale for certain services.

1. No fee reduction will be applied until PROOF OF INCOME has been presented. Acceptable forms of proof are: previous year tax return, two most recent pay check stubs, signed employer statement, award letter for Social Security, Disability, Veterans Benefits, unemployment, etc. Payment is due at the time of service. Failure to pay at the time of service will result in all future appointments being cancelled. (It is the policy of this agency that no one will be denied services in an emergency. Crisis services will be available, at emergency rates, without regard to account status.)

2. Counseling and Recovery Services of Oklahoma requires 24-hour notice for all cancellations to allow time to offer this appointment to another consumer. Failure to provide this notice may result in an alteration of the consumer's freedom to schedule advance appointments as desired.

3. After assignment of insurance benefits the consumer will be responsible for deductible and co-insurance payments at the time of service. Additional payment responsibility (up to the sliding scale amount) will be determined after payment or denial by the insurance company. Any change in name, address, phone number, income, family size or insurance coverage should be reported to the business office immediately.

4. Any consumer who appears to meet Medicaid eligibility requirements and **chooses not to apply will not be eligible** for Counseling and Recovery Services of Oklahoma's medication assistance program. Any consumer who refuses to apply for all available Pharmaceutical Assistance Programs will not be eligible for Counseling and Recovery Services of Oklahoma's medication assistance program. **Please initial:** _____

I understand that I am responsible for all fees as circled below. Please initial: _____

I understand that if my income changes or I get insurance I will notify Counseling and Recovery Services of Oklahoma as soon as possible to update my fee agreement. I also understand that if Counseling and Recovery Services of Oklahoma is not notified that I could be responsible for past charges. Please initial: _____

ONE HOUR SERVICE RATE

SERVICE TYPE	0	A	B	C	D
ASSESSMENT	0.00	58.00	68.00	78.00	90.00
TX PLAN	0.00	95.00	115.00	135.00	140.00
INDIVIDUAL THERAPY	0.00	58.00	68.00	78.00	90.00
GROUP THERAPY	0.00	29.00	34.00	39.00	45.00
CASE MANAGEMENT	0.00	60.00	64.00	72.00	80.00
INDIVIDUAL REHAB	0.00	50.00	56.00	62.00	70.00
GROUP REHAB and/or PSR	0.00	20.00	20.00	20.00	20.00
HOMEBASED THERAPY	0.00	70.00	70.00	70.00	70.00
FAMILY THERAPY	0.00	86.00	90.00	92.00	95.00

THE DOCTOR VISIT IS $55.00 REGARDLESS OF INCOME AND DEPENDENTS FOR SELF PAY CONSUMERS.

THE DOCTOR VISIT IS $14.00 REGARDLESS OF INCOME AND DEPENDENTS FOR MEDICARE CONSUMERS.

The financial policy of Counseling and Recovery Services of Oklahoma has been explained to me and I agree to abide by these requirements. I understand that a change in the agency's full fee rate may result in a change in my cost for services. Counseling and Recovery Services of Oklahoma agrees to notify all consumers in the case of a rate change.
I certify that all information provided to Counseling and Recovery Services of Oklahoma to assist in determining my eligibility for services is true and correct.

CONSUMER SIGNATURE_____ **DATE**_____

STAFF SIGNATURE_____ **DATE**_____

CHART LABEL

COUNSELING AND RECOVERY SERVICES OF OKLAHOMA
CLIENT FINANCIAL AGREEMENT
BUPRENORPHINE PROGRAM
BUSINESS WORKSHEET

SPONSOR AND ELIGIBILITY CRITERIA INFORMATION

MEDICAID (MCD) YES NO MEDICAID #_____

OTHER INSURANCE: _____If yes, attach verification form

POLICY NUMBER_____GROUP NUMBER_____

COPAYMENT YES NO If yes, attach verification form

All fees are due at the time of the appointment. Failure to pay at the time of the appointment will result in all future appointments being canceled.

Cancellation Policy: 24-hour notice is required for all cancellations. Failure to provide this notice will result in a no show fee of $50.00.

Clients having insurance are required to provide a copy of their insurance information and to completed an assignment of benefits. The client will be responsible for all feeds until insurance information has been confirmed and an assignment of benefits is completed and coverage is verified. After the assignment of benefits, the client will be responsible for the deductible and co-insurance payments at the time of services. Additional payment will be determined after payment or denial by the insurance company. Any change in name, address, phone number, income, family size or insurance coverage should be reported to the business office immediately.

I understand that I am responsible for all fees below. Please initial: _____

I understand that if my income changes or I get insurance I will notify Counseling and Recovery Services of Oklahoma as soon as possible to update my fee agreement. I also understand that if Counseling and Recovery Services of Oklahoma is not notified that I could be responsible for past charges. Please initial: _____

FEES:

1st month Bundled Rate (Includes Behavioral Health Screening, Induction, Treatment planning, 2 follow up Dr. appts, 3 drug tests & 1 group session)	**$375.00**
Follow Up Doctor's Appointments	**$75.00**
Treatment Plan Update	**$50.00**
Mental Health Assessment	**$110.00**
Individual Therapy	**$90.00**
Group Therapy	**$45.00**
Drug Testing	**$10.00**
Treatment Related Letters	**$15.00**

These fees do not include the price of the medication needed for this program. Unless covered by your insurance provider, you ae responsible for the medication costs as well as the fees described above.

The financial policy of Counseling and Recovery Services of Oklahoma has been explained to me and I agree to abide by these requirements. I understand that a change in the agency's full fee rate may result in a change in my cost for services. Counseling and Recovery Services of Oklahoma agrees to notify all consumers in the case of a rate change.
I certify that all information provided to Counseling and Recovery Services of Oklahoma to assist in determining my eligibility for services is true and correct.

CONSUMER SIGNATURE_____ **DATE**_____

STAFF SIGNATURE_____ **DATE**_____

CHART LABEL

ACT PHARMACY, LLC

It is the goal of ACT Pharmacy, LLC. to ensure that all individuals receiving physician services through Counseling and Recovery Services of Oklahoma are able to obtain prescribed medications. To meet this goal ACT Pharmacy, LLC provides assistance in applying for free/low cost medication through various programs and no one will be denied medication because of an inability to pay.

I agree to apply for Medicaid to determine eligibility for this funding source for medications.

I agree to apply for Medicare D if determined that I may be eligible.

I agree to apply for medications through available Pharmaceutical Assistance Programs and to provide required financial and other information to apply for these programs. I understand that ACT Pharmacy, LLC will receive these medications on my behalf and I agree ACT Pharmacy, LLC will have full variance control over these medications, and distribution will be made only under a physician supervised treatment plan.

_____ _____

Client Signature and Date Agency Representative Signature and Date

_____

Print Name