St. Christopher's Inn

CONFIDENTIAL

Main Menu= View | Edit Document **Virtual – Fillable, Intake Form**

- **Have Questions?** Please contact = **Billing & Client Benefits Services Office**, at **845-335-1030**
- **When completed, please Confidentially send an e-mail / Fax (with supporting documents and this form filled out, signed and dated) TO: InnResources@AtonementFriars.org**

Form Contents

Confidentiality Notice:

This notice may contain sensitive information that is confidential in nature and/or may accompany a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action in reliance on the contents of the information is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by e-mail and delete the original message.

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HOW TO FILL OUT AND SEND, DOCUMENTS NEEDED

Please review and fill out the following form and ensure that you sign and date where required.

*Send us a Completed Form and ensure that you Sign and Date the pages:

1. Fill out, then Print the Form
OR
Print, then Fill out the Form

2. Do one of the following:

- **Mail** in the completed form to:

  Attention: Billing and Client Benefits Department
  St Christopher's Inn
  21 Franciscan Way, Graymoor
  Garrison, NY 10524

OR

- **Fax** the completed form to: **845-424-3598**

OR

- **e-Mail: scan or take clear photos** of the completed form **, attach the** Updated form then send to **InnResources@AtonementFriars.org**

*Also, Documents Needed (Images/ Photos of the Front and Back):

1. Current, **Insurance Card Images**
2. Current, **Photo ID (Driver's License, State ID, Passport)**

Please DO NOT send us a copy of your Credit Card or Bank Cards

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DEMOGRAPHICS (All fields on all pages are required)

*Note: TA = Temporary Assistance (takes 45 days to process)

1	**DATE**	**7/1/20**
2	**First Name Middle Init. Last Name**	Click or tap here to enter text.
3	**Date Of Birth (MM/DD/YYYY)**	Click or tap here to enter text.
4	**Social Security Number**	Click or tap here to enter text.
5	**Phone Number with area code**	Click or tap here to enter text.
6	**E-Mail**	Click or tap here to enter text.
7	**Current, Home Address with Zip Code** (if homeless, put 'Homeless')	☐ **OK, to receive Mail at this address** **Street** : Click or tap here to enter text. **City, State:** Click or tap here to enter text. **Zip Code** : Click or tap here to enter text.
8	**County:** (Example: Putnam, Duchess, etc…)	Click or tap here to enter text.
9	**How will you Pay for Services?**	☐ **Insurance** OR ☐ **Self-Pay** (please contact us to fill out another form and to share Payment Information) OR ☐ **Guarantor** (please contact us to fill out another form and get the Guarantor & Payment Information) Please DO NOT send us a copy of your Credit Card or Bank Cards

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10	**If have Insurance, Name =** (ex. Healthfirst / Medicaid) _____ *Note: if you need to get Medicaid, please call 855-355-5777. All other insurances, please check a Directory and get an Insurance Policy.	Click or tap here to enter text. _____ ☐ **Self-Insured** OR ☐ **Dependent, Name and DOB of Primary Insured:** Click or tap here to enter text.
11	**Referred by?**	☐ **Self**, OR ☐ **Other, Institution:** Click or tap here to enter text.
12	**Court Mandated?**	☐ **No** | ☐ **Yes, Court Name =** Click or tap here to enter text.
13	☐ **Probation Or** ☐ **Parole Officer?**	☐ **No** | ☐ **Yes, Name of Officer =** Click or tap here to enter text.
14	**Have any State Income?** (**TA Qualifier,** $15,000 Limit)	☐ **No** | ☐ **Yes =** ☐ **SSI or** ☐ **SSDI or** ☐ **SSR?** **Amount = $** Click or tap here to enter text.
15	**What Month and Year did you Last work?**	**Month =** Click or tap here to enter text. **Year =** Click or tap here to enter text.
16	**What type of work did you last do/ What is your Profession?**	Click or tap here to enter text.
17	**You got Paid:**	☐ **On the Books** / ☐ **OFF the Books**
18	**Do you have Medicaid: Public / Temporary Assistance?**	☐ **No** | ☐ **Yes, Contact person =** Click or tap here to enter text. _____ For Office use only: [ ] INTRO Letter/e-mail within 72 hours [ ] Client Abstract Note created

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19	**Do you have Food Stamps?**	☐ **No** | ☐ **Yes**
20	**Do you have any Major Resources?** **(TA Qualifier only:** Up to $2,000.00 in bank OR 401k etc, Up to $10,000.00 vehicle value)	☐ **No** | ☐ **Yes** = (ex. Houses, Cars, Boats, 401k, 403B, Trust?), **Explain:** _____ **Paid Off?** ☐ **N/A** | ☐ **Yes** | ☐ **No, Paying =** **$** Click or tap here to enter text. _____ **Per**: ☐ week / ☐ month
21	**Marital Status?** **(TA Qualifier:** Except NYC / Manhattan)	☐ **Single / ☐ Married / ☐ Divorced** ☐ **Separated:** Click or tap here to enter text.
22	**Have any Children?** **(TA Qualifier:** Except NYC/ Manhattan)	☐ **No** | ☐ **Yes, Count =** Click or tap here to enter text. … **Child Support?** ☐ **No** | ☐ **Yes, Amount** = **$** Click or tap here to enter text.

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Items Needed for Aftercare (Half-way , Sober-Houses – where and when applicable) Please send images (**Front and Back** to: **InnResources@AtonementFriars.org**		
23	**Have an Insurance Card?**	☐ **Yes (can produce image)** | ☐ **No, explain** (ex. Lost, stolen)= Click or tap here to enter text. _____ *Note: if you need to get insurance OR get a replacement Medicaid Insurance Card, please call Medicaid at 855-355-5777. All other insurances, please check a Directory and request a replacement.
24	**Have a Photo ID?** (Driver's License, State ID, Passport)	☐ **Yes (can produce image)** | ☐ **No, explain** (ex. Lost, stolen)= Click or tap here to enter text. _____ *Note: if you need a replacement, go to your nearest DMV.
25	**Have a Social Security Card?**	☐ **Yes (can produce image)** | ☐ **No, explain** (ex. Lost, stolen)= Click or tap here to enter text. _____ *Note: if you need a replacement, go to your nearest Social Security Office.
26	**Birth Certificate?**	☐ **Yes (can produce image)** | ☐ **No, explain**(ex. Lost, stolen)= Click or tap here to enter text. _____ *Note: if you need a replacement, go to the Registrar in the town where you were born.

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THIRD PARTY RESOURCES & INCOME (Please Sign)

DATE: 7/1/20

Do you or any member of your family currently have or had health coverage or income from any of the following?
(If yes answer, share information in the 'Application Notes' section below)

1.	Coverage through private employer?	YES ☐	NO ☐
2.	Member of a Health Home? DON'T KNOW ☐	YES ☐	NO ☐
3.	Continuation of coverage after loss of employment? (COBRA)	YES ☐	NO ☐
4.	Former or current union membership?	YES ☐	NO ☐
5.	Coverage through an absent parent?	YES ☐	NO ☐
6.	Workman's Compensation Coverage?	YES ☐	NO ☐
7.	Champus or TriCare? (Military Insurance)	YES ☐	NO ☐
8.	UIB – Unemployment Insurance Benefits?	YES ☐	NO ☐
9.	Income from State of Federal Disability Program?	YES ☐	NO ☐
10.	Income from other source? (Specify):	YES ☐	NO ☐

Application Notes:
Click or tap here to enter text.

Click or tap here to enter text. x

Client Name (Please Print) **Client Signature**

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ASSIGNMENT OF BENEFITS (Please Review, Sign & Date)

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to St. Christopher's Inn Inc. and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify St. Christopher's Inn Inc. of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by St. Christopher's Inn Inc. and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received. *I also acknowledge that I have been advised that if my insurance terminates or is exhausted that there are other payment options that may be available to me including reapplication for Medicaid, Self-Pay and/or Full/Partial Scholarship*

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to St. Christopher's Inn Inc. for all covered medical services and supplies provided to me during all courses of treatment and care provided by St. Christopher's Inn Inc. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by St. Christopher's Inn Inc, and will constitute a continuing authorization, maintained on file with St. Christopher's Inn Inc, which will authorize and allow for direct payment to St. Christopher's Inn Inc. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by St. Christopher's Inn Inc.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by St. Christopher's Inn Inc. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by St. Christopher's Inn Inc.

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ASSIGNMENT OF BENEFITS (Cont'd, please read above and Review then Sign & Date Below)

Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Patient/Insured (Printed Name)	**Date of Birth**	**Social Security Number**

x

Patient/Insured (Signature)

7/1/20

Date of Signature

Witness (BILLER –REVIEWER, Signature)

BILLER –REVIEWER, Date of Signature

Witness (BILLER –REVIEWER), PRINT Name:

Confidentiality Notice:

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – INSURANCE (Please Sign)

I Click or tap here to enter text. **Authorize**

ST. CHRISTOPHER'S INN

(Name or general designation of alcohol/drug program making disclosure)

Current, Insurance Provider Name >> Click or tap here to enter text.

(Name of person or organization to which disclosure is to be made)

The following information: **Residence @ SCI, treatment plans, progress, discharge plans, compliance in program**
(Nature and amount of information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this consent is for the Entire Billing Revenue Cycle:

TO OBTAIN MEDICAL INSURANCE

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

WHEN BILLING IS COMPLETE

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally St. Christopher's Inn may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: **7/1/20**

x _____
Signature of Client

x _____
Signature of parent, guardian or authorized representative (when required)

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – possible Aftercare (Please Sign)

I Click or tap here to enter text. **Authorize**

ST. CHRISTOPHER'S INN

(Name or general designation of alcohol/drug program making disclosure)

to disclose to **NYS Ofc of Temp + Dis Ass Comp Corp, NYSOH, DSS, DCMH, HCA, NYDOH**
(Name of person or organization to which disclosure is to be made)

The following information: **Residence @SCI, treatment plans, progress, discharge plans, compliance in program**
(Nature and amount of information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this consent is to:

TO OBTAIN MEDICAID AND/OR PUBLIC ASSISTANCE FOR CONTINUUM OF CARE

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

WHEN BILLING PROCESS IS COMPLETE

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally St. Christopher's Inn may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: **7/1/20**

x _____
Signature of Client

x _____
Signature of parent, guardian or authorized representative (when required)

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – Share Billing Information

(Please Sign ONLY IF sharing Billing information with someone or Agency)

I Click or tap here to enter text. **Authorize**

ST. CHRISTOPHER'S INN

(Name or general designation of alcohol/drug program making disclosure)

to disclose to:

Click or tap here to enter text.

(Name of person or organization to which disclosure is to be made)

The following information: (Nature and amount of information to be disclosed, as limited as possible regarding Billing)

Click or tap here to enter text.

The purpose of the disclosure authorized in this consent is to: (Purpose of disclosure, as specific as possible)

Click or tap here to enter text.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event **this consent expires automatically as follows:**

Click or tap here to enter text.

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally St. Christopher's Inn may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: **7/1/20**

x _____

Signature of Client

x _____

Signature of parent, guardian or authorized representative (when required)

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CONSENT FOR THE RELEASE OFCONFIDENTIAL INFORMATION- Representation Authorization – Insurance Mail (Please Sign)

I hereby appoint the Billing and Client Benefits Services department at St. Christopher's Inn acting in capacity as Billing Coordinators, as my attorneys-in-fact, with all necessary authority to represent me to other agencies (i.e. DSS, Social Security, Private and Commercial Insurance Companies, New York State of Health etc.) for the purpose of obtaining benefits to which I may be entitled.

Mail Disclosure:
St. Christopher's Inn may open any mail I receive directly pertaining to or that will impact my Medicaid case/ Insurance and any medical bills.

☐ YES ☐ NO

x _____
Client Signature

x _____
Biller Signature

Biller, PRINT Name:

_____

7/1/20
Date

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PROHIBITION ON REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT CONFIDENTIAL INFORMATION – FYI

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For Office Use Only

Cerner/System #:		**Date:**	
BILLER / Reviewer:			
STATUS:	☐ On Hold	☐ **Ready for Billing**	
DOCUMENTATION RECEIVED BY:	☐ - Mail	☐ - Fax	☐ - e-mail
Supporting Documents:	☐ - Insurance Card Images ☐ - Photo ID Image (D/Liscence, NY State ID/ Passport), ☐ - Other:		
Pre-Admission Previously Completed	☐		
Billing Intake Creation Completed	☐		
Self-Pay Form Review & Payment (where applicable)	☐		
Guarantor- Pay Form Review & Payment (where applicable)	☐		
Cerner Updated	☐		
RU Updated	☐		
TA Letter (where applicable) -see pg. 3 #18	☐		
Notes:			

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