IDAHO DEPARTMENT OF HEALTH & WELFARE

APPLICATION FOR MENTAL HEALTH SERVICES

Effective January 1, 2013

DBH-0050
(1/13)

Completion of this application serves as your request for Mental Health services through the Idaho Department of Health and Welfare. Following completion, this application will be reviewed by a Mental Health clinician and you will be contacted regarding the possible next steps in your, or if applicable, your child's eligibility for services.

I, _____, do hereby apply for Mental Health Services for
(*Name of Applicant OR Parent/Guardian*)
myself (or my child) from the Department of Health and Welfare as indicated below:

Name	
Address	
Phone Number	
Parent/Guardian's Name	

I am seeking services for myself (or my child) to address the following concerns:
(*Please print*)

_____

_____

_____

_____

_____

_____

(Please attach additional paper if needed)

By signing below, I am requesting mental health services. I understand that this application for services is not a guarantee of services. Further, I give consent for the Department to conduct a mental health assessment that could bring up potentially uncomfortable thoughts or feelings; I have been given the opportunity to ask questions about this consent. I have read and understand the above.

_____ _____
(Applicant's Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

IDAHO DEPARTMENT OF HEALTH & WELFARE

Notice of Privacy Practices

Effective September 23, 2013

HW-0320
Revised 08/2013

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.

- You may request a copy of this Notice at any time. Copies of this Notice are available at the Department of Health and Welfare offices. This Notice is also available on the Department of Health and Welfare's website at http://www.healthandwelfare.idaho.gov.

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- Use and disclose confidential information as required by law;
- Maintain the privacy of your information;
- Give you this Notice of our legal duties and privacy practices for your information; and
- Follow the terms of the Notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

If you ask to receive a copy of the information, we may charge a fee.

You will be told if there is information we are legally prevented from disclosing to you.

2. Right to Amend

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. Right to Restrict Health Information Disclosures

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request in writing.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction. In situations where you or someone on your behalf pays for an item or service, and you request that information concerning said item or service not be disclosed to a health insurer, we will agree to the requested restriction.

4. Right to an Alternate Means of Delivery

You have the right to ask that we communicate with you by alternative means or at alternative locations. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request if it is denied for some reason.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. Right to a Report of Health Information Disclosures

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment**. We may use and share your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care or payment of care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment**. We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations**. We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans Organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

Affected individuals will be notified following a breach of unsecured health information.

CHANGES TO THIS NOTICE

The Department has the right to change this Notice. A copy of this Notice is posted at our Department offices or at http://www.healthandwelfare.idaho.gov. The effective date of this Notice is shown at the top of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the Notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices or its website. To file a complaint with the Department, submit your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U. S. Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S. Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov.

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Acknowledgement of Receipt of the Notice of Privacy Practices

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name_____
(Please Print your First Name, Middle Initial and Last Name)

By the signature below, I acknowledge that I have received the Notice of Privacy Practices provided by the Idaho Department of Health and Welfare.

Your signature _____ **Date** _____

FAMILY EDUCATION AND SUPPORT SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

The **Idaho Department of Health and Welfare** contracts with **Idaho Federation of Families for Children's Mental Health** to provide education and support services to the families that are served by the Department's Children's Mental Health Program**.** By completing this form, you are authorizing the Department of Health and Welfare to release the information contained on this form to the Idaho Federation of Families. If at any time you, as the parent/guardian, wish to revoke your authorization or terminate your relationship with the Idaho Federation of Families, you may do so by contacting the Department of Health and Welfare or the Idaho Federation of Families.

I, _____, do hereby authorize the **Department of Health and Welfare** to release the information contained on this form to the Idaho Federation of Families**.**

Name of Person Completing this Form	
Family Address	*Clinician's Signature* _____ *Street Address* _____ *City* *State* *Zip Code*
Mailing Address *(If Different)*	_____ *Mailing Address* _____ *City* *State* *Zip Code*
Phone Number	( ) -
Email Address	
Name of Child	

By signing below, I understand that the Idaho Federation of Families will:
(Check preferences)

□ Place my name on their mailing list to receive information on training and family support services.

□ Contact me directly to offer education and support services to me and my family or provide training on how I can advocate for myself and other families in Idaho.

_____ _____

(Parent or Guardian Signature) *(Date)*

INITIAL HISTORY QUESTIONNAIRE

Form Completed by: _____ Date Completed: _____

Name of Child: _____ Age: _____

Date of Birth: _____ M F

FOR OFFICE USE ONLY

WITS ID # : _____

Priority Population ☐ #1 ☐ #2 ☐ #3

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

_____

If mother and father are not living together or child does not live with parents, what is the child's custody status?

_____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home?

_____

Physician: Last Seen Dentist: Last Seen:

Birth History

Birth weight _____

Was the baby born at term? [ ] Yes [ ] Early? [ ]Late?

If early, how many week's gestation? _____

Was the delivery [ ] Vaginal? [ ] Cesarean?

If cesarean, why?

Did the baby have any problems right after birth?

[ ] Yes [ ] No Explain _____

_____

Was initial feeding [ ] Breast? [ ] Bottle?

Did the baby go home with mother from the hospital?

[ ] Yes [ ] No Explain _____

_____

Prenatal Care

Did mother have any illness or problem with her pregnancy?

[ ] Yes [ ] No Explain _____

During pregnancy, did mother

Smoke [ ] Yes [ ] No Drink alcohol [ ] Yes [ ] No

Use drugs or medication [ ] Yes [ ] No

What _____ When _____

General

Do you consider your child to be in good health? [ ] Yes [ ] No Explain _____

Does your child have any serious illness or medical condition? [ ] Yes [ ] No Explain _____

Has your child had serious injuries or accidents? [ ] Yes [ ] No Explain _____

Has your child had any surgery? [ ] Yes [ ] No Explain _____

Has your child ever been hospitalized? [ ] Yes [ ] No Explain _____

Is your child allergic to any medicine or drugs? [ ] Yes [ ] No Explain _____

Development

Are you concerned about your child's physical development? [ ] Yes [ ] No Explain _____

Are you concerned about your child's mental or emotional development? [ ] Yes [ ] No Explain _____

Are you concerned about your child's attention span? [ ] Yes [ ] No Explain _____

Is your child in school? [ ] Yes [ ] No [ ] Home schooled

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? [ ] Yes [ ] No If yes explain _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes, or has an IEP? [ ] Yes [ ] No If yes explain_____

Child's Past History

Does you child have, or has he/she ever had?

Chickenpox [ ] Yes [ ] No When _____

Frequent ear infections [ ] Yes [ ] No Explain _____

Problems with ears or hearing [ ] Yes [ ] No Explain _____

Nasal allergies [ ] Yes [ ] No Explain _____

Problems with eyes or vision [ ] Yes [ ] No Explain _____

Asthma, bronchitis, bronchiolitis, or pneumonia [ ] Yes [ ] No Explain _____

Any heart problem or heart murmur [ ] Yes [ ] No Explain _____

Child's Past History (cont.)

Does you child have, or has he/she ever had?

Anemia or bleeding problem	[ ] Yes	[ ] No	Explain _____
Blood transfusion	[ ] Yes	[ ] No	Explain _____
Frequent abdominal pain	[ ] Yes	[ ] No	Explain _____
Constipation requiring doctor visits	[ ] Yes	[ ] No	Explain _____
Bladder or kidney infection	[ ] Yes	[ ] No	Explain _____
Bed-wetting (after 5 years old)	[ ] Yes	[ ] No	Explain _____
(For girls) Has she started her menstrual periods?	[ ] Yes	[ ] No	When _____
(For girls) Are there problems with her periods?	[ ] Yes	[ ] No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc)	[ ] Yes	[ ] No	Explain _____
Frequent headaches	[ ] Yes	[ ] No	Explain _____
Convulsions or other neurological problem	[ ] Yes	[ ] No	Explain _____
Diabetes	[ ] Yes	[ ] No	Explain _____
Thyroid or other endocrine problem	[ ] Yes	[ ] No	Explain _____
Any other significant problem	[ ] Yes	[ ] No	Explain _____

Family History

Please indicate if any of the child's family members have had any of the following:

Deafness	[ ] Yes	[ ] No	Who _____	Comments _____
Asthma	[ ] Yes	[ ] No	Who _____	Comments _____
Tuberculosis	[ ] Yes	[ ] No	Who _____	Comments _____
Heart attack (before 50 years old)	[ ] Yes	[ ] No	Who _____	Comments _____
High blood pressure (before 50 years old)	[ ] Yes	[ ] No	Who _____	Comments _____
High cholesterol	[ ] Yes	[ ] No	Who _____	Comments _____
Anemia	[ ] Yes	[ ] No	Who _____	Comments _____
Bleeding Disorder	[ ] Yes	[ ] No	Who _____	Comments _____
Liver disease (Hepatitis)	[ ] Yes	[ ] No	Who _____	Comments _____
Kidney disease	[ ] Yes	[ ] No	Who _____	Comments _____
Diabetes (before 50 years old)	[ ] Yes	[ ] No	Who _____	Comments _____
Bed-wetting (after 10 years old)	[ ] Yes	[ ] No	Who _____	Comments _____
Epilepsy or seizures	[ ] Yes	[ ] No	Who _____	Comments _____
Immune problems, HIV, or AIDS	[ ] Yes	[ ] No	Who _____	Comments _____
Alcohol abuse	[ ] Yes	[ ] No	Who _____	Comments _____
Drug abuse	[ ] Yes	[ ] No	Who _____	Comments _____
Cancer	[ ] Yes	[ ] No	Who _____	Comments _____
Mental illness	[ ] Yes	[ ] No	Who _____	Comments _____
Mental retardation	[ ] Yes	[ ] No	Who _____	Comments _____
Domestic Violence	[ ] Yes	[ ] No	Who _____	Comments _____
Involvement with law enforcement	[ ] Yes	[ ] No	Who _____	Comments _____

Additional family history _____

Child's Emotional / Behavioral

Has your child's behavior, thinking, and/or feelings made a turn for the worse since being on a particular medication, developing a physical illness or physical trauma? [ ] Yes [ ] No If yes, explain _____

Do you suspect that your child uses alcohol or drugs?

[ ] No, I know for sure that my child doesn't use any of those things
[ ] I am not sure, sometimes I wonder if my child uses alcohol or drugs
[ ] Yes, I know for sure that my child uses alcohol or drugs

Does your child act as if he or she is hearing voices that only he/she can hear?

[ ] I don't know
[ ] No
[ ] Yes, some of the time
[ ] Yes, most of the time
[ ] Yes, all of the time

Child's Emotional / Behavioral (cont.)

Does your child act as if he/she is seeing things that only he/she can see?
[ ] I don't know
[ ] No
[ ] Yes, some of the time
[ ] Yes, most of the time
[ ] Yes, all of the time

Please rate each the following emotions

My child seems *happy*	My child seems *sad*	My child seems *anxious*	My child seems *irritated*
[ ] All of the time	[ ] All of the time	[ ] All of the time	[ ] All of the time
[ ] Most of the time	[ ] Most of the time	[ ] Most of the time	[ ] Most of the time
[ ] Some of the time	[ ] Some of the time	[ ] Some of the time	[ ] Some of the time
[ ] Rarely	[ ] Rarely	[ ] Rarely	[ ] Rarely
[ ] None of the time	[ ] None of the time	[ ] None of the time	[ ] None of the time

Does your child have significant sleeping problems (for example: he sleeps too much or too little, or his sleep is often interrupted)?
[ ] No
[ ] Yes, but rarely
[ ] Yes, some of the time
[ ] Yes, most of the time
[ ] Yes, all of the time

Does your child seem no longer interested in doing things that he/she usually enjoys (for example: talking to friends, fishing) ?
[ ] No
[ ] Yes, but rarely
[ ] Yes, some of the time
[ ] Yes, most of the time
[ ] Yes, all of the time

Does your child ever talks about suicide or attempted suicide before? [ ] Yes [ ] No If yes explain _____

Does your child seem to worry too much about any particular member of your family's well being for no apparent reason?
[ ] Yes [ ] No If yes, explain _____

Does your child complain about feeling sick or having an illness or disease that you know doesn't exist?
[ ] Yes [ ] No If yes, explain _____

Does your child have trouble being apart from you or your home to the point that he/she becomes excessively worry?
[ ] Yes [ ] No If yes, explain _____

Does your child fear being humiliated in social setting or situations?
[ ] Yes [ ] No If yes, explain _____

Please indicate which of the following strong fears, if any, your child displays. These are fears that would usually cause him/her to feel very nervous, make him cry, throw tantrums, freeze, or cling to an adult.

[ ] A particular animal such as dogs
[ ] A particular insect such as spiders
[ ] Objects in the natural environment such as storms
[ ] Seeing blood or an injury or receiving an injection
[ ] Specific situation such as tunnels, heights, flying, etc.
[ ] No fears

Has your child ever experienced a trauma or shock in his lifetime that still bothers him/her?
[ ] Yes [ ] No if yes, please explain _____

Child's Emotional / Behavioral (cont.)

Please rate the following behaviors

My pays attention very well
[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Rarely
[ ] None of the time

My child has respect for rules or for authority
[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Rarely
[ ] None of the time

My child is as active as any other child of his/her age
[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Rarely
[ ] None of the time

My child plays well with others
[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Rarely
[ ] None of the time

My child has consideration for the rights of others
[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Rarely
[ ] None of the time

Does you child have any history of sexual abuse as a Victim [ ] Yes [ ] No Perpetrator [ ] Yes [ ] No

Does your child have any history of physical abuse as a Victim [ ] Yes [ ] No Perpetrator [ ] Yes [ ] No

Has your child had any contact with law enforcement, Department of Juvenile Corrections, or Juvenile Probation before?
[ ] Yes [ ] No if yes, please explain _____

_____

_____

Does you child have any odd or unusual behavior that concerns you very much? [ ] Yes [ ] No If yes, explain

_____

_____

_____

Please provide a list of your child's strengths:

1 _____
2 _____
3 _____
4 _____

Please provide a list of child's weaknesses:

1 _____
2 _____
3 _____
4 _____

By the signature below, I acknowledged that I have read and understood this questionnaire and provided information to the best of my knowledge and ability.

_____
Signature/Date

THANK YOU!

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Information

Client Name_____ Date of Birth _____Telephone _____
(First, MI, Last)

Mailing Address _____State_____Zip Code_____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (if different than client) _____Telephone _____

Mailing Address _____State_____Zip Code_____

Authorization Details

I authorize the following individual, organization or business _____

_____

to disclose my confidential information to: Name_____

Address:_____ State_____Zip Code_____

for the purpose of _____

*Please describe in detail the information to be disclosed*_____

_____

_____

_____

This authorization will expire in 6 months unless another date or event is specified here_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature _____**Date** _____

Your signature must be notarized if we are unable to verify your identity and you submit this request by mail.

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DEPARTMENT OF HEALTH AND WELFARE
MENTAL HEALTH SERVICES
FEE DETERMINATION

SECTION I – CLIENT/RESPONSIBLE PARTY INFORMATION:

Client's Name: _____ SSN: _____
Medicaid Number: _____

Responsible Party: _____ Relationship: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____

Do you have Insurance: ___Yes ___No Name of Insured: _____
Insurance Company: _____Telephone: _____
Address: _____
Group Number: _____ Subscriber Number: _____

Does your spouse have Insurance: ___Yes ___No Name of Insured: _____
Insurance Company: _____Telephone: _____
Address: _____
Group Number: _____ Subscriber Number: _____

Section II – FEE DETERMINATION:

(Your income, minus allowable deductions and the number of dependents in your household will be used with our sliding fee scale to determine what percentage of our fees you will be required to pay.)

Gross Monthly Income for **Adult** Clients:

1. Self _____
2. Spouse _____
3. Other _____
4. Total _____

Gross Monthly Income for **Child** Clients:

1. Self _____
2. Father _____
3. Mother _____
4. Other _____
5. Total _____

Number of Dependents in Household: _____

Allowable Monthly Deductions:
1. Court Ordered Obligations: …… _____
2. Dependent Support: …… _____
3. Child Care Expenses Necessary for Parental Employment: …….. _____
4. Medical Expenses: …….. _____
5. Transportation: ……_____
6. Extraordinary Rehabilitative Expenses: …… _____
7. State and Federal Tax Payments (including FICA taxes): ……. _____
8. Total Monthly Deductions: …… _____

(Office Use Only)

Sources of Income/Deduction Verification: _____
_____

Total Monthly Income: …….. _____
Allowable Monthly Deductions: - _____
Adjusted Monthly Income: ……. _____ X 12 = _____ Adjusted Annual Income.

SECTION III – PAYMENT AGREEMENT:

Under Sections 16-2433, 19-2524, 20-520(i), 20-511A, and 39-3137, Idaho Code, the Director is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. Under Section 39-309, Idaho Code, the Board of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers.

Based on your adjusted annual income and the number of dependents, it has been determined that your financial responsibility will be _____ percent of the fees charged for services. This includes any portion of your fees not covered by insurance, CHAMPUS, or services not covered by Medicaid.

I affirm that the statements made by me herein are true and correct to the best of my knowledge.

I understand that I am responsible for the total amount due by me and agree to pay at the time of service or on a monthly basis as per prior arrangements. If it becomes necessary for the Department to initiate collection action to recoup unpaid fees, I understand that I am responsible for all cost incurred by the Department.

_____ _____
Client/Parent/Responsible Party Signature Date

I affirm that I have requested verification of income and allowable monthly deductions from the family. I have accurately and completely documented all information made available to me, attached copies of all available documents verifying income and monthly expenses, and used information provided to me to calculate the family's financial responsibility according to Division of Behavioral Health rules.

_____ _____
Staff Signature Date