SOLUTIONS
Community Counseling and Recovery Centers

Admission Application

FY25- July 1, 2024 – June 30, 2025

☐ Mental Health (MH) ☐ Substance Use Disorder (SUD)

First Name:	Last Name:	Date of Birth:	Social Security #	Gender (at birth): ☐ Male ☐ Female
Preferred Pronouns: ☐ He/His ☐ She/Her ☐ They/Them ☐ Other _____				
Home Address: ☐ Check if Homeless	City:	State:	County:	Zip Code:
Home Phone:	Cell Phone:	Email:		
I consent for reminder call messages (call, text and email): ☐ Cell Phone ☐ Home Phone ☐ Text ☐ Email				
Guardian/Parent Name (if Applicable):	Phone:			
Race (check all that apply): ☐ African American ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ White/Caucasian ☐ Other Single Race ☐ Two or More races				
Ethnicity: ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not Latino				
Preferred Language:	Is an Interpreter needed? ☐ Yes ☐ No			
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Education (Current Level or Highest Level Achieved):				
Education Type: ☐ Pre-School ☐ K-12th Grade ☐ GED Classes ☐ College ☐ Not Enrolled ☐ Unknown ☐ Other School: Adult Basic Education, Literacy ☐ Vocation/Job Training ☐ Developmentally Delayed ☐ Hearing Impaired ☐ Regular ☐ Learning Disability ☐ Multi-Handicapped ☐ Visually Impaired ☐ Orthopedically Handicapped ☐ Severe Behavior Handicapped				
MH Education Type: ☐ Does not have an IEP ☐ Has an IEP ☐ Unknown				
Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked				
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Sheltered Employment ☐ Homemaker ☐ Student ☐ Unemployed (actively looking) ☐ Volunteer ☐ Retired ☐ Disabled ☐ Inmate ☐ Residential ☐ Other				
Emergency Contact:	Relationship:	Phone Number:		
Referral Source:	Any Special Accommodations?			
Do you feel like harming yourself or someone else today? ☐ YES ☐ NO				

Child & Adolescent Services ONLY:

What school does your child attend?
Would you prefer In Office services or School-Based? ☐ In Office ☐ School-Based

STAFF USE ONLY Date Paperwork Completed (Episode Date/Intake Date):

Case number:	Date Packet Received:	Date of First Appointment:
Staff Scheduled with:	Signature of who received this packet:	
Program Assigned: ☐ MHOP ☐ SUD ☐ IOP ☐ SED ☐ PACT ☐ SPMI ☐ ICM ☐ ACT ☐ ASUD		

FINANCIAL RESPONSIBILITY POLICY- FY25

July 1, 2024 – June 30, 2025

WELCOME to Solutions Community Counseling and Recovery Centers (Solutions CCRC). We are committed to providing exemplary behavioral healthcare that is effective and affordable. Our mission is to promote wellness in mind, body, and spirit through mental health and substance use services that promote recovery. As part of our relationship with you, it is important that you have an understanding of our financial policy and your responsibilities.

APPOINTMENTS –

- Be on time for your appointments as a courtesy to other clients and your provider. If you are going to be late or need to cancel your appointment, please call us as soon as possible.

ADDRESS & PHONE NUMBER CHANGES –

- Please let us know anytime there is a change to your address, telephone, or other contact information. We need to be able to contact you in case of appointment changes, reminder calls, etc.

INSURANCE OR OTHER PAYERS –

- A copy of your insurance, Medicare or Medicaid card is required if you have one- please keep your card with you. You should be able to provide all Insurance (or other payer) information at every visit. This is required for billing and for the Fee Subsidy eligibility. If there has been a change since your last appointment, please advise the front desk staff, your provider, or call us at **513-228-7800 ext. 654 or ext. 607.**
- Your health insurance policy is a contract between you and your Health Insurance Company. You need to understand your insurance benefits and limitation on coverage, such as In-Network or Out-of-Network benefits. Some insurance companies may not cover your service provider and may deny your claim for that reason.
- If a billing issue arises, please contact our Finance Department so that services can be billed to the correct payer.

FEES –

- You are responsible for any fees/charges according to your insurance company or your Fee Agreement (whichever is the lesser of the two).
- Discounts on service costs are offered to Warren and Clinton County residents based upon income and are subsidized by Mental Health Recovery Board Serving Warren and Clinton Counties. To be eligible, income and residency must be verified. If you qualify, you must notify Solutions of any changes in income, dependents, insurance, or county of residency within 30 days of the change.
- Self-Pay Clients should be prepared to pay at the time of each visit.
- Consumer Spending Accounts (FSA, HRA, HSA, HIA, etc.) may automatically deduct funds from this account as payment for deductibles, copays and coinsurances. These accounts are considered part of your insurance benefits, and we have no control of any automatic payments from these accounts.

BILLING –

- Solutions CCRC will bill for your services in the following order (if applicable & eligible):
    - Private/Commercial Insurance, Medicare, Medicare Advantage Plans, MyCare Plans, etc.
    - Medicaid
    - Self-Pay (including payments from Consumer Spending Accounts)
    - Mental Health Recovery Board Subsidy (if eligible)
    - You will be invoiced for your services on at least a quarterly basis- you can make payments at www.solutionsccrc.org

NON-PAYMENT/COLLECTIONS –

- **Payment according to your FY25 Fee Agreement is due at the time of service.** Paying as you go eliminates a large unmanageable account balance in the future. Failure to make payments for which you are responsible may result in your account being referred to a collection agency. In such circumstances, you will be responsible for the cost of collections, including court costs, collection agency fees and attorney fees. Please be aware that if a balance remains unpaid, you and/or your family members may not be rescheduled or they may be discharges from this agency.

SOLUTIONS
Community Counseling and Recovery Centers

Fee Agreement for FY25

July 1, 2024 – June 30, 2025

Client Name: _____ **Case Number:** _____

Effective Date of This Fee Agreement: _____ **Form Completion Date:** _____ **Admission Date:** _____

Client Information

Physical Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if not the same as above: _____

County of Residence: _____ *Proof of Residence is required for Warren or Clinton County*

☐ By checking this box, I am indicating that I do not have permanent housing.

Primary Phone: _____

Responsible Party (If Other Than Client)

Name: (First, MI, Last)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Payer Information

PRIMARY COVERAGE	SECONDARY COVERAGE
Insurance Name:	Insurance Name:
Member ID #:	Member ID #:
Group #:	Group #:
Deductible:	Deductible:
Copay/Coinsurance:	Copay/Coinsurance:
Subscriber's Name:	Subscriber's Name:
Client's Relationship to Insured/Subscriber:	Client's Relationship to Insured/Subscriber:
Self Spouse Child Other	Self Spouse Child Other
Subscriber's DOB:	Subscriber's DOB:
Subscriber's SSN:	Subscriber's SSN:
Employer:	Employer:
Employer Phone #:	Employer Phone #:
** If you have a **third payer** – please ask for an additional form	
I have a Health Reimbursement Account (HRA) ☐ Yes ☐ No	
I have a Health Savings Account (HSA) ☐ Yes ☐ No	

1. I authorize the release of any information necessary to process my claims, including any effective insurance that may not be listed above. This includes information about alcohol/substance abuse otherwise protected by Federal Law, myself, and/or my minor children.
2. I authorize payment of benefits directly to Solutions CCRC under the terms of my policy.
3. I understand that HIPAA allows disclosure of private health information claims processing without any additional authorization.
4. I understand that I am financially responsible (per Fee Agreement) for my balance not covered by my insurance carrier.
5. A copy of this signature is as valid as the original document.

Client Signature: _____ **Date:** _____

(Or Authorized Signature of Responsible Party/Guardian)

SOLUTIONS
Community Counseling and Recovery Centers

Fee Agreement for FY25

July 1, 2024 – June 30, 2025

Client fees are based on "Client out of Pocket Fee Schedule" (attached)

☐ **Client fees are 100% -** Does not reside in Clinton or Warren County. (See "Client out of Pocket Fee Schedule" at 100% for amount due after insurance.) No proof of income or residency required.

☐ **Client fees are 100% -** Did not provide (or does not want to provide) the required information. (See "Client out of Pocket Fee Schedule" at 100% for amount due after insurance.)

☐ **Client fees are 100% -** Chooses NOT to have insurance billed- 100% responsible for all services received at Solutions CCRC, payable at the time of service.

TO APPLY FOR THE MHRB SUBSIDY- FILL OUT THIS PORTION OF THE FORM

FAMILY SIZE/DEPENDENTS/MONTHLY INCOME AS REPORTED TO THE IRS

☐ Family size as reported to the IRS. For a minor client use the number of exemptions (dependents + self) that relate to the responsible party on the most recent tax return.

Name	DOB	Relationship to Client	Wages/Other Income*	Employer/Source of Income
			$	
			$	
			$	
			$	
			$	
			$	
$	TOTAL MONTHLY HOUSEHOLD INCOME before taxes- exclude income for minors Proof of income is required to be eligible for the Sliding Scale Subsidy			

**Other Income includes: Social Security/SSDI, SSI, Annuities/Pension, Dividends, Interest, Veteran's Pension/Compensation, Alimony, Net Income from business/Farm, Unemployment Compensation, Rental Income, other sources of Taxable Income, Worker's Compensation-Permanent Total Disability, Gifts or Inheritances (in excess of $10,000/yr) and Child Support.*
Exclude: Food Stamps/ADC, Bank Withdrawals, Student Benefits, Rebates, Grants, Loan disbursements (which require repayment), Utility Allowance, Worker's Compensation-Temporary Total Compensations, Training Stipends, Insurance Proceeds and Military Allowance.

If zero income, indicate source of financial support: _____

Client Certification

I certify that the information given is true and accurate. I further certify that I understand giving false information could result in my losing reduced fee eligibility. I agree to be responsible for all fees incurred per this agreement. I have read Solutions Financial Policy and understand that failure to comply may terminate any subsidy for services granted as part of the agreement. If I become ineligible for Medicaid or am no longer part of a fee subsidy program, I am responsible for 100% of fee services. My signature below acknowledges that I have read this agreement and policy and fully understand the contents thereof. If I have no income or insurance coverage, I have been given written information about support resources and insurance application, and assistance with applying for benefits has been offered. A copy of this signature is as valid as the original.

Client Signature: _____ **Date:** _____
(Or Authorized Signature of Responsible Party/Guardian)

SOLUTIONS
Community Counseling and Recovery Centers

Fee Agreement for FY25

July 1, 2024 – June 30, 2025

FY25 Fee Agreement – AGENCY STAFF TO COMPLETE

PAYER INFORMATION verified – check all that apply (copy of applicable cards required)

☐ Private Insurance	☐ Mason Municipal
☐ Medicare (Traditional)	☐ WC Common Pleas
☐ Medicare (Advantage Plan)	☐ Medicaid
☐ MyCare (Dual)	☐ MHRB- WC and CC Residents
☐ MyCare (Medicaid Only)	☐ Other:

☐ Client % of the Sliding Fee for services covered (See "Client out of Pocket Fee Schedule").
Discounts on service costs are offered to Warren and Clinton County residents based upon income and are subsidized by Mental Health Recovery Board Serving Warren and Clinton Counties. **Clients are obligated to notify provider of changes in income or dependents within 30 days of the change.**

Waiver applies – check all program that apply. Client owes 0%

☐ SED Program ☐ SPMI Program

If they do not have insurance, but are eligible, they must apply for and/or provide a denial letter from Medicaid to be qualified.

Agency Certification

I certify that I have reviewed the financial documentation, including income and insurance, in determining eligibility for the MHRB subsidy and it is accurately reflected on the Fee Agreement and Payer Verification Forms.

Staff Signature: _____ **Date:** _____

Staff Name Printed: _____ **Staff ID #:** _____

☐ Staff initials to acknowledge that client was provided a copy of the Financial Policy and Fee Agreement

SOLUTIONS
Community Counseling and Recovery Centers

Advance Beneficiary Notice Of Non-Coverage (ABN) Medicare

FY25- July 1, 2024 – June 30, 2025

Client Name: _____ **Case Number:** _____

Note— We cannot bill Traditional Medicare for your services unless you are seeing one of the following providers:

MEDICARE PROVIDERS

Sunny Lu, MD	**James Roe, CNP**	**Angela Johnsen, LISW-S**
Lauren Bernard, LPCC	**Jennifer Jones, CNP**	**Julie Knueven, LISW-S**
Steven Rosen, DO	**Mary Ann Rose, LISW-S**	**Shelby Voss, LPCC-S**
Kara Caudell, LPCC-S	**Linda Endres, Ph.D.**	**Lorien Mason, LPCC**

WHEN YOU HAVE TRADITIONAL MEDICARE AS PRIMARY:

Seeing a Medicare Provider—

- If you receive services from a Medicare Provider (listed above) – we will make every effort to bill Traditional Medicare from the information you have provided to our agency.

Seeing a Non Medicare Provider—

- If you receive services from a Non Medicare Provider (not listed above) – our agency cannot bill Traditional Medicare.
- If you receive services from a Non Medicare Provider (not listed above) – our agency cannot bill your Secondary Insurance (if you have one) because there is no Medicare Explanation of Benefits (EOB) to attach to the Secondary claim form.
- If you receive services from a Non Medicare Provider (not listed above) – You (or the Responsible Party) will be responsible for payment at the time of service according to our Financial Policy, per the signed Fee Agreement.

WHEN YOU HAVE TRADITIONAL MEDICARE AS SECONDARY:

Seeing a Medicare Provider—

- If you receive services from a Medicare Provider (listed above), and have Medicare as a Secondary carrier – you will be billed according to the Medicare Explanation of Benefits (EOB) or your signed Fee Agreement (whichever bill is lower).

Seeing a Non Medicare Provider—

- If you receive services from a Non Medicare Provider (not listed above), and have Medicare as the Secondary insurance – you (or the responsible party) will be responsible for payment at the time of service according to the Primary Insurance's Explanation of Benefits (EOB) or the signed Fee Agreement (whichever bill is lower).

Client Signature: _____ **Date:** _____
(Or Authorized Signature of Responsible Party/Guardian)

SOLUTIONS
Community Counseling and Recovery Centers

Commercial Insurance Form

FY25- July 1, 2024 – June 30, 2025

Client Name:_____ **Case Number:**_____

Please provide payments and Explanation of Benefits (EOBs) not received by Solutions CCRC timely to maintain eligibility for the Sliding Fee Scale.

Examples of Dependently Licensed Providers:

LSW- Licensed Social Worker
CDCA- Chemical Dependency Counselor Assistance
LCDCII- Licensed Chemical Dependency Counselor 2
PC- Professional Counselor
MFT- Marriage and Family Therapist
LCDCIII- Licensed Chemical Dependency Counselor 3

Important Notes about Commercial Insurance—

- Anthem/Blue Cross Blue Shield (BCBS) Insurance- Due to the particular Anthem/BCBS insurance plan you are enrolled in, and the licensure type of the provider that renders the services, your insurance may send all Explanation of Benefits (EOB) and payments to you, the insured/policy holder.
- Solutions CCRC does not receive these EOB's, but we are required to have them in order to continue to process your services. Once we have a copy of your EOB (and any payment that Anthem has sent you), we are able to bill either 1) your secondary insurance, 2) Medicaid, or 3) Mental Health & Recovery Board Servicing Warren and Clinton Counties. Without this information we are unable to bill anyone else; and the balance due becomes your responsibility.
- Solutions Community Counseling and Recovery Centers provides counseling services by persons licensed to do so by various State of Ohio professional boards. In many instances, these professional boards recognize two or more levels of licensure or certification. Dependent levels of licensure or certification require that service providers practice under the clinical supervision of an independently licensed clinician.
- In most instances, Solutions CCRC bills for services in the name of the provider who actually performs the service – dependent or independently licensed. In certain cases, your insurance may allow us to bill under your Clinician's Independently Licensed Clinical Supervisor's name. This could result in better coverage by your insurance provider and less personal cost.
- Until your deductible is met, you are responsible for 100% of the costs incurred for your services.

Provide the Following—

- Provide Solutions CCRC with the original (or copy) of every Explanation of Benefits (EOB) you receive for services rendered by Solutions CCRC.
- Sign over Anthem/BCBS checks you have received to "Solutions CCRC" for services rendered (or reimburse Solutions CCRC by check/cash/money order/credit card).
- Please give your Explanation of Benefits (EOB) and any signed Anthem/BCBS Checks to Front Desk Staff, Your Provider, or Mail To: **Solutions CCRC ATTN: Insurance Specialists – 975A Kingsview Drive, Lebanon, OH 45036.**
- If you have any questions concerning this policy – please contact our insurance billing specialist – **513-228-7800 ext. 654**

I understand the requirements outlined above. I understand and consent to treatment by a Mental Health/Substance Use Disorder Non-Credentialed Group Based Provider who is not credentialed by **United Behavioral Health, Optum, United Medical Resources, Golden Rule or Medical Mutual**. Services I receive from a dependently licensed provider will be billed to my insurance company in the name of my provider's clinical supervisor. Should my insurance coverage change to one of the identified insurance carriers in the future, I authorize Solutions CCRC to bill for services as described in this paragraph.

Client Signature: _____ **Date:**_____
(Or Authorized Signature of Responsible Party/Guardian)

MHRB Service Provider Policies & Procedures

Network Benefit Plan for Citizens of Warren & Clinton Counties

FY25- July 1, 2024 – June 30, 2025

Mental Health Recovery Board Serving Warren & Clinton Counties (MHRBWCC) oversees and pays for behavioral health services for local citizens based upon need. The benefits that MHRBWCC provides are available to the residents of Clinton and Warren Counties throughout network of provider agencies. MHRBWCC and its agency network work together to ensure quality service.

What is the Network Benefit Plan?
The Network Benefit Plan provides public funds to help pay for behavioral health services. These may include counseling, medication, case management, housing, job training, consultation with schools, social supports and developing everyday living skills. The MHRBWCC network is designed to help individuals and families deal with the behavioral health crises that they sometimes face.

How is the MHRBWCC Network funded?
The MHRBWCC network is funded by federal and state tax dollars (through the Ohio Department of Mental Health & Addiction Services) and a local levy.

What help does the Network Benefit Plan offer?
The Network Benefit Plan provides funding for quality behavioral health services, outpatient, and residential services to residents based on clinical and financial need.

What about more serious mental illnesses?
Serious mental illness, sometimes referred to as brain disorders, are conditions such as major depression, bipolar disorder, schizophrenia and obsessive compulsive disorder. These conditions may range from mild to severe and are treated by qualified providers in the network. MHRBWCC encourages you to work with your providers to create and participate in your treatment plan, as this increases the likelihood of progress.

How can I receive these services?
Contact the agency from which you would like to receive services. You can check agency hours and location at our website, MHRBWCC.org. A staff person will ask you about your situation to make sure the services the agency providers are appropriate for your needs.

What if I can't afford to pay for services?
Your agency will ask you for some financial information. This will be used to determine the amount of financial help needed. You must be a resident of Warren or Clinton Counties to receive financial assistance.

How do I become part of the Network Benefit Plan?
Warren and Clinton County residents who request clinical services will be given the opportunity to enroll in the Network Benefit Plan.

What does enrollment in the Network Benefit Plan Involve?
When you enroll you will be asked to sign a billing authorization statement and a Notice of Enrollment. These forms permit the provider to bill MHRBWCC, which accesses public funds. You will be asked during intake about your income, family size, whether you have private health insurance, or where you are covered by Medicaid or Medicare. This information will be entered into a computerized billing system operated for MHRBWCC.

Will my private insurance cover my care?
Most agencies accept private insurance. Those agencies will work with you to determine if your treatment is covered under your private insurance plan. Keep in mind that you may be responsible for paying any applicable deductibles and copays.

Can I help to make sure my treatment is successful?
Absolutely. In order for you and your family to receive the most benefit from services, you must think of yourself as part of the treatment team.

Do I have to enroll in the Network Benefit Plan?
No. You may choose not to enroll. If you choose not to enroll, you will not be considered for public funds. You will need to make other arrangements for covering the cost of your treatment, and you may be billed for those services.

What if I receive a bill for my "In-Network" benefit services?
If you are in the Network Benefit Plan and you receive a bill for services, please contact that agency and request that they review the billing for your services. Adjustments can be made if an error has been made.

How will I know I'm getting the best services?
MHRBWCC and the Ohio Department of Mental Health and Addiction Services review network agencies on a regular basis. Many agencies are also accredited by various professional organizations. Treatment staff must have specific educations degrees, certifications and trainings.

Can my family and I help decide on my treatment?
We encourage you to be involved in any decisions regarding your treatment. This is a right under state law. When there is no conflict with confidentiality, families are encouraged to be involved with the treatment being received. In most cases, the more a family is part of the individual's care, the more progress can be made.

What family supports are available?
Families dealing with a loved one's mental illness may wish to join the local chapter of the National Alliance on Mental Illness (NAMI) and other local support groups. Agencies also may have information available for alcohol and drug use support groups. In addition, support and education may be available for other mental health issues.

What if I seek services outside my network?
Enrollees are encouraged to use local county provider that are part of the network. If services are sought in another county or outside the network, and you are not Medicaid eligible, special requests can be considered by some benefits may not be available.

Is my information kept confidential?
Yes. MHRBWCC and each provider must comply with state and federal laws regarding confidentiality.

What if I'm not satisfied with my care?
The network aims to provide only quality services, but you are encouraged to discuss and concerns regarding treatment with your provider. If the problem continues, you can file a formal grievance. MHRBWCC and each provider have a plan for dealing with such complaints. To begin this process, ask to speak to the agency's Client's Rights Officer. Your rights are also full explained in the Client's Rights Policy and Grievance Procedures. A copy is available on our website, or you can call us at 513-695-1695.

What if I have questions about MHRB's benefits or payments?
MHRBWCC provides funding on a service continuum that covers most behavioral health needs. If you have questions about available services, or disagree with payment of your services, please call (513) 695-1695 and ask to speak with the MHRBWCC Clients Rights Officer. We can assist you in understanding the Benefit Rules and funding that you have.

For a complete list of provider agencies, visit our website at MHRBWCC.org

SOLUTIONS
Community Counseling and Recovery Centers

MHRB Service Provider Policies & Procedures

Claims and Information System Notice of Enrollment

FY25- July 1, 2024 – June 30, 2025

Overview of Claims and Information System Notice of Enrollment Form

Ohio's Personal Information Systems Act "PISA" (Ohio Revised Code (ORC) Chapter 1347) requires every state and local agency that maintains a "personal information system", such as the claims and information systems used by Boards, to comply with certain requirements in regards to that system and the information it contains. Many of the requirements of the Act are duplicative of what is required by HIPAA such as breach reporting, protecting the information against unauthorized use or disclosure and providing individuals with access to their own information upon request. Boards comply with those requirements through their compliance with the HIPAA Privacy and Security Rules. There are some requirements of the Act, however, that are not duplicative of HIPAA's requirements.

PISA requires that when persons are asked to supply personal information to a governmental system, they are informed whether they are required to, or may refuse to, supply that information. ORC 1347.05(E). It also requires that when personal information is placed into a system that is connected to or combined with that of another organization, individuals must be provided with "information relevant to the system, including the identity of other agencies or organizations that have access to the information in the system". ORC 1347.071(C).

For Boards, this means that Boards must inform persons that if they wish to receive any publicly-funded services, their personal information is required to be entered into the system used by the Board. Other information relevant to the system must also be provided to the individual, including the names of other entities that have access to the information in the system.

The law does not require these notices to be signed by the individual, although it is a good practice to do so in order to show that the Board has complied with the Act. It also does not require any specific statements or information to be included in the notice beyond what is required by ORC 1347.071(C). The attached Claims and Information System Notice of Enrollment is a sample notice that can be used to comply with the Act.

Since the Act does not require the notice to be signed by the individual, it is acceptable to attempt to have a client experiencing a crisis or lacking capacity sign the form at a later date, such as when on-going services commence.

Some Boards have asked whether they can comply with the Personal Information Systems Act by including the required information in their HIPAA-required Privacy Notice. It is important to note that the Act requires that an individual receive information about the system before it is entered into that system. Since Boards typically do not provide their Notice of Privacy Practices to individuals until after they are entered into the system, a separate notice containing the information required by the Act must be provided to individuals at the time they are asked by the provider to supply the information.

Please note that this is not an authorization to disclose information under the confidentiality laws. Providers are responsible for ensuring that any required authorizations are obtained from the client prior to disclosing information to Boards. Boards are responsible for ensuring that individuals receive the information required by the Personal Information Systems Act prior to being entered into the billing management system used by Boards.

MHRB Service Provider Policies & Procedures

Claims and Information System Notice of Enrollment

FY25- July 1, 2024 – June 30, 2025

To be eligible to receive public funds to help pay for the cost of your mental health and/or addition services, your personal information must be entered into the claims and information system used by Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB). The billing system "SmartCare" is administered on behalf of MHRB by the Stark County Mental Health & Addiction Recovery Board.

This information will be used by the Board to:

- **Enroll you in the Board's Benefit Plans**
- **Determine your eligibility for publicly-funded services**
- **Pay the provider for those services**
- **Fulfill the Board's legal responsibilities**

If applicable law requires you to consent to the disclosure of this information to the Board, your information will not be entered into the system without your written consent. Once in the system, your information will only be used or disclosed by the Board as authorized by you or as permitted by applicable law.

Other County Behavioral Health Boards that pay for your services may utilize the same billing management information system as the Board but will only access your personal information as authorized by you or as permitted by applicable law.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

STAFF ONLY –

I have read and explained this information to the above-named individual.

Provider Agency Staff: _____ Date: _____

Client has refused or is unable to sign this form but has been informed of its contents. ☐ (Check if applicable)

If Refusal, note reason: _____

*This form must be completed for every client seeking publicly-funded services. This form must be kept with the client's records.

Primary Provider Network

Beech Acres Parenting Center • Butler Behavioral Health Services

Greater Cincinnati Behavioral Health • Sojourner Recovery Services, Inc.• Solutions Community Counseling & Recovery Centers

Talbert House • New Housing Ohio

SOLUTIONS
Community Counseling and Recovery Centers

SmartCareMCO Residency Verification Form

FY25- July 1, 2024 – June 30, 2025

Client Name: _____ **Case Number:** _____

Instructions: Fill out only the "Adult" section and the associated signature and date fields if the client is a legal adult or emancipated minor. Fill out only the "Minor" section and the associated signature and date fields if the client is a legal minor. If the form is completed by hand rather than electronically, please print legibly.

If client is an Adult

Client Name: _____

Enter the client's street address, city, state, and ZIP for residency determination purposes.

Address 1 _____ Address 2 _____

City: _____ State: _____ ZIP: _____ County of Residence: _____

If client is a Minor

Indicate if minor is in legal custody of the following: ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____

Client Name: _____ Legal Custodian Name: _____

If the parent or guardian address is different enter below.

Address 1 _____ Address 2 _____

City: _____ State: _____ ZIP: _____ County of Residence: _____

The purpose of this form is to clarify which PartnerSolutions board is responsible for adjudicating claims for behavioral health services provided to the client being enrolled in SmartcareMCO. The form should be completed at the time the client first presents for treatment/services at the submitting agency and whenever a change in the client's residency occurs. The form should be presented to the appropriate PartnerSolutions board enrollment contact when:

1.) The county of the submitting agency does not match the legal county of residence of the client as noted on the enrollment form.

2.) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client.

3.) The minor's physical address as noted on the enrollment form does not match the legal custodian's address.

4.) The board staff person responsible for processing the enrollment requests the form, such as in cases when a client needs to be transferred from one PartnerSolutions board's coverage plan to another's in SmartCareMCO.

A client or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Signatures

Signature Must be

Client Signature (if Legal Adult or Emancipated Minor)_____ Date_____

Legal Custodian Signature (if Legal Minor) _____ Date_____

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

SOLUTIONS
Community Counseling and Recovery Centers

Client Orientation & Handbook Checklist

FY25- July 1, 2024 – June 30, 2025

Client Name: _____ Case Number: _____

Solutions Community Counseling and Recovery Centers values you as a client and wants to ensure that you are involved in and understand exactly what will happen as services are delivered. By signing below I acknowledge that I have received a copy of the Client Handbook and I have read it and the content has been fully explained to me. Also by signing, I agree to comply with all regulations as stated in the handbook.

AREAS OF ORIENTATION

1. Hours of Operation
2. Code of Ethics
3. Rules, Regulations and Expectations – copy received
4. Client Rights and Responsibilities of Person Serviced – copy received, reviewed with client
5. Client Fee System Explanation, Financial Arrangements, Fees and Obligations
6. Grievance and appeal procedures/Complaint Process – copy received
7. Full Disclosure on All Levels, Types and Duration of Services and Activities
8. Access to After-Hours Services
9. Identification of Counselor/Service Coordinator
10. Ways in Which Client Input is Given RE: Quality of Care, Outcomes and Satisfaction
11. Copy of Program Rules to client specifying the restrictions the program may place on a person, events, behaviors, or attitudes that may lead to a loss of privileges and the means by which the lost rights/privileges can be regained by the client
12. Developing Feasible Goals and Achievement of Outcomes
13. Confidentiality Policies- 42 CFR Part 2 and Part B, Paragraph 2.22 – copy received
14. Reports to Referral Sources for Mandated Persons Serviced
15. Site and Safety Organization (Familiarization with premises, emergency exits and/or shelters, fire suppression equipment, first aid kids, etc.)
16. Tobacco Policy
17. Purpose and Process of Assessment
18. Description of how the Individual Service Plan is developed and client participation in it.
19. Information on Discharge/Transition Criteria and Procedures
20. Aftercare and Discharge/Transition Planning
21. Person Responsible for Service Coordination
22. Policy on Seclusion and Restraint
23. HIV, Hepatitis B and C, Tuberculosis – copy received
24. Information Primary provider of a Communicable Disease
25. Education on Advanced Directives, as appropriate
26. Illicit/Licit Drugs/Weapons Brought onto Premises
27. Transportation (Consent to Transport)
28. No Show/Late Cancellation

A copy of the handbook can be found electronically at https://www.solutionsccrc.org/resources/

Client Signature: _____ Date: _____
(Or Authorized Signature of Responsible Party/Guardian)

SOLUTIONS
Community Counseling and Recovery Centers

Consent for Treatment

FY25- July 1, 2024 – June 30, 2025

Client Name:_____ **Case Number:**_____

Treatment Agreement—

I consent to ☐ **MENTAL HEALTH** and/or ☐ **SUBSTANCE USE DISORDER** treatment by Solutions Community Counseling and Recovery Centers. I understand that one or more of the following services may be provided, based on my individual needs:

Mental Health Services: Assessment, Individual and Group Counseling, Psychiatric services, Crisis Intervention and/or Community Support.

Substance Use Disorder Services: Assessment, Individual and Group Counseling and/or Crisis Intervention, Medication Assisted Treatment.

I agree to inform my Therapist of all other counseling and medical, psychiatric and spiritual care which I am/may be involved. I agree to respect the confidential nature of all transactions with this Agency. I understand and agree that Solutions cannot be held responsible for my personal conduct or safety outside the agency offices. I understand agree that my Individual Client Record (ICR) may be reviewed for audits by State, Local or Governing bodies, Multi-County Peer Reviews, Quality Assurance and discussed by an inter-disciplinary team.

Risks and Benefits of Treatment—

I understand that engaging in treatment may result in unforeseen outcomes, such as changes in my relationship with family members or friends. I understand that obtaining the desired results of treatment depends on factors such as effort I make toward changing, the consistency with which I keep appointments and follow treatment recommendations, or changes in my family or other life circumstances. I understand that the decision not to engage in treatment may also result in unforeseen or undesirable consequences. My behavior and ability to make use of a particular service will determine my eligibility to receive those services. I understand that I am free to seek this or any other treatment elsewhere and that, if a particular service is not available at this agency, I may be referred to another treatment provider.

Treatment Agreement for Drug and Alcohol Clients Only—

Federal Law governing confidentiality of Alcohol and Drug abuse records 42 C.F.R. Part 2 requires that a minor (14yo) must give consent for disclosures of their records to a parent, guardian, or other person legally responsible for the minor.

Parental Consent for Treatment of a Minor Mental Health Only—

As a Parent/Person Legally Responsible, I agree to allow my child to be treated by Solutions. I have provided the most up to date custody paperwork to the agency and have authority to seek treatment for my child. I understand that in any shared parenting arrangement, Solutions will seek input from the other parent as to any treatment involving this child. As a Parent/Person Legally Responsible, I agree to participate in my child's counseling program.

Consent for Use of Protected Health Information—

I understand that as a condition to my receiving treatment from this agency, Solutions may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of Solutions. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me and which I have a copy and had the opportunity to review. I understand that the privacy practices described in the Privacy Notice may change over time and that I have the right to obtain any revised Privacy Notice by contacting the Medical Records Coordinator to make such a request. I also understand that I have the right to request Solutions to restrict how my health information is used or disclosed. Solutions does not have to agree to my request for the restriction, but if it does agree, it is bound to abide by the restriction as agreed. Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Solutions has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdrawal my consent.

My signature indicates my consent for treatment with Solutions CCRC. This consent applies to me and/or my child(ren). My signature on the actual treatment plan will indicate my agreement with the plan outlined.

Client Signature: _____ **Date:** _____

Family Member or Person Legally Responsible: _____ **Date:** _____

I hereby refuse to consent for treatment.

Client Signature: _____ **Date:** _____

Family Member or Person Legally Responsible: _____ **Date:** _____

SOLUTIONS
Community Counseling and Recovery Centers

Telehealth Consent for Treatment

Client Name:_____ **Case Number:** _____

I understand that I may receive telehealth services from my Solutions CCRC provider. These appointments allow for more access and can be just as effective as an in-person appointment. Client preference and best clinical practice will determine if ongoing telehealth services can or will be provided. There are other times, like during inclement weather, that these services may be offered on a short-term basis.

At the beginning of every session, your provider will need to verify your identity, your current location and a contact number in case the connection is interrupted. You must physically be in the State of Ohio at the time of the appointment. You should be in a location that is both free from noise and private to protect your confidential information. You must not be in transit during the visit.

The video conferencing technology used is secure and meets HIPAA guidelines. At every session we will need to verify the connection is sufficient from both sides. I understand that services provided via video will not be the same as a direct in person visit due to the fact that I will not be in the same room as my provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the connections are not adequate for the situation.

Your protected health information may be shared with other individuals at Solutions CCRC for scheduling and billing purposes. The above mentioned people will all maintain confidentiality of the information obtained.

If you choose to participate in telehealth services, realize that not every type of service can be conducted remotely. At any time, you can ask to have an in-person session. Realize your insurance may not cover these services provided by telehealth and you are encouraged to contact your insurance company to verify your benefits.

In an emergent situation, I understand that the responsibility of the telehealth provider is to advise their supervisor and/or the local police department.

If you have any questions regarding this modality please contact Solutions CCRC staff.

I have read this document carefully, and understand the risks and benefits of the telehealth services. I hereby consent to participate in a telehealth sessions (for myself or for my child) under the terms described.

Client Signature: _____ **Date:** _____

Family Member or Person Legally Responsible:_____ **Date:** _____

Preferred email for telehealth:_____

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*I decline to have any telehealth services at this time. (**Only sign below if you are <u>DECLINING</u> Telehealth Services)***
By signing below, All your appointments will be in person

Client Signature: _____ **Date:** _____

Family Member or Person Legally Responsible: _____ **Date:** _____

A copy of this form is available upon request.

SOLUTIONS
Community Counseling and Recovery Centers

Intake Questionnaire

FY25- July 1, 2024 – June 30, 2025

Client Name: _____ **Case Number:** _____

DIRECTIONS- In order to best serve you, the following questions help us to identify the most appropriate providers and services. Mark the response that best fits you. Please pay attention to the timeframes for each section. If the client is under 13yo, then the parent/guardian should complete this form.

Psych. Distress Scale- Answer based on the past 30 days

Score: _____

1. **How often did you feel so sad that nothing could cheer you up?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

2. **Nervous?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

3. **Restless or fidgety?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

4. **Hopeless?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

5. **That everything was an effort?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

6. **Worthless?**

☐ 4- All of the time, ☐ 3- Most of the time, ☐ 2- Some of the time, ☐ 1- A little of the time, ☐ 0- None of the time

Short SASSI: Answer based on the last 6 months

Score: _____

1. **Have you used alcohol or other drugs?** ☐ Yes ☐ No
   (Wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens or inhalants)
2. **Have you felt that you use too much alcohol or other drugs?** ☐ Yes ☐ No
3. **Have you tried to cut down or quit drinking or using alcohol or other drugs?** ☐ Yes ☐ No
4. **Have you gone to anyone for help because of your drink or drug use?** ☐ Yes ☐ No
   (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Counselors or a Treatment Program.)
5. **Do you feel that you have a drink or drug problem now?** ☐ Yes ☐ No

SOLUTIONS
Community Counseling and Recovery Centers

Intake Questionnaire

FY25- July 1, 2024 – June 30, 2025

Brief Biosocial Gambling Screen: Answer based on the last 12 months **Score:** _____

1. **Have you become restless, irritable or anxious when trying to stop/cut down on gambling?** ☐ Yes ☐ No
2. **Have you tried to keep your family or friends from knowing how much you gamble?** ☐ Yes ☐ No
3. **Did you have such financial trouble that you had to get help from family or friends?** ☐ Yes ☐ No

ACE: Answer based on the first 18 years of your life **Score:** _____

1. Did a parent or other adult in the household often swear at you, insult you, put you down or humiliate you? OR act in a way that made you afraid that you might be physically hurt? ☐ Yes ☐ No
2. Did a parent or other adult in the household often push, grab, slap or throw something at you? OR ever hit you so hard that you had marks or were injured? ☐ Yes ☐ No
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR try to or actually have oral, anal or vaginal sex with you? ☐ Yes ☐ No
4. Did you often feel that no one in your family loved you or thought you were important or special? OR your family didn't look out for each other, feel close to each other or support each other? ☐ Yes ☐ No
5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes and had no one to protect you? OR your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐ Yes ☐ No
6. Were your parents ever separated or divorced? ☐ Yes ☐ No
7. Was your mother or stepmother often pushed, grabbed, slapped or had something thrown at her? OR sometimes or often kicked, bitten, hit with a fist or hit with something hard? OR ever repeatedly hit over at least a few minutes or threatened with a gun of knife? ☐ Yes ☐ No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? ☐ Yes ☐ No
9. Was a household member depressed or mentally ill or did a household member attempt suicide? ☐ Yes ☐ No
10. Did a household member go to prison? ☐ Yes ☐ No

Client Signature: _____ **Date:** _____
(Or Authorized Signature of Responsible Party/Guardian)

SOLUTIONS
Community Counseling and Recovery Centers

Columbia Scale

FY25- July 1, 2024 – June 30, 2025

Client Name:_____ **Case Number:**_____

NOTE – If client is under 12yo, the parent should complete this scale.

Answer Questions 1 and 2	In the Past Month		Lifetime	
1. Have you wished you were dead or wished you could go to sleep and not wake up?	**Yes** ☐	**No** ☐	**Yes** ☐	**No** ☐
2. Have you actually had any thoughts about killing yourself?	**Yes** ☐	**No** ☐	**Yes** ☐	**No** ☐
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6				
3. Have you thought about how you might do this?	**Yes** ☐	**No** ☐	**Yes** ☐	**No** ☐
4. ***Have you had any intention of acting on these thoughts of killing yourself? (As opposed to you have the thoughts but you definitely would not act on them.)***	**Yes** ☐	**No** ☐	**Yes** ☐	**No** ☐
5. ***Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you intend to carry out your plan?***	**Yes** ☐	**No** ☐	**Yes** ☐	**No** ☐

	In Your Lifetime	
6. ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Yes** ☐	**No** ☐
IF YES: Was this within the past 3 months?	**Yes** ☐	**No** ☐
If YES, what did you do?		

Client Signature:_____ **Date:**_____
(Or Authorized Signature of Responsible Party/Guardian)

Solutions Community Counseling and Recovery Centers

Revised 05-29-2024

Client Out of Pocket Fee Schedule

FY25 (July 1,2024 - June 30, 2025)

		Client out of Pocket %									
		100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
	Unit										
Diagnostic Assessment w/o Medical	Encounter	$125.28	$112.75	$100.22	$87.70	$75.17	$62.64	$50.11	$37.58	$25.06	$12.53
Diagnostic Assessment w/ Medical	Encounter	$162.75	$146.48	$130.20	$113.93	$97.65	$81.38	$65.10	$48.83	$32.55	$16.28
Individual Counseling (16-37 Minutes)	Encounter	$71.16	$64.04	$56.93	$49.81	$42.70	$35.58	$28.46	$21.35	$14.23	$7.12
Individual Counseling (38-52 Minutes)	Encounter	$92.51	$83.26	$74.01	$64.76	$55.51	$46.26	$37.00	$27.75	$18.50	$9.25
Individual Counseling (53+ Minutes)	Encounter	$135.71	$122.14	$108.57	$95.00	$81.43	$67.86	$54.28	$40.71	$27.14	$13.57
Family Psychotherapy	Encounter	$115.32	$103.79	$92.26	$80.72	$69.19	$57.66	$46.13	$34.60	$23.06	$11.53
Group Psychotherapy	Encounter	$37.31	$33.58	$29.85	$26.12	$22.39	$18.66	$14.92	$11.19	$7.46	$3.73
SUD Group	15 Minutes	$12.43	$11.19	$9.94	$8.70	$7.46	$6.22	$4.97	$3.73	$2.49	$1.24
Intensive Outpatient Group	Encounter	$168.99	$152.09	$135.19	$118.29	$101.39	$84.50	$67.60	$50.70	$33.80	$16.90
Evaluation & Management Established	Encounter	$181.67	$163.50	$145.34	$127.17	$109.00	$90.84	$72.67	$54.50	$36.33	$18.17
Evaluation & Management New Client	Encounter	$260.61	$234.55	$208.49	$182.43	$156.37	$130.31	$104.24	$78.18	$52.12	$26.06
Nurse Services	15 Minutes	$46.23	$41.61	$36.98	$32.36	$27.74	$23.12	$18.49	$13.87	$9.25	$4.62
Psych Testing Battery	Encounter	$34.79	$31.31	$27.83	$24.35	$20.87	$17.40	$13.92	$10.44	$6.96	$3.48
Integrated Report Writing and Feedback	Encounter	$66.82	$60.14	$53.46	$46.77	$40.09	$33.41	$26.73	$20.05	$13.36	$6.68