SOLUTIONS COMMUNITY COUNSELING AND RECOVERY CENTERS

FINANCIAL RESPONSIBILITY POLICY FOR FY21 (July 1, 2020 thru June 30, 2021)

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 advise us 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 have 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 limitations on coverage, such as In Network or Out-of-Network benefits. Some insurance companies may not recognize your service provider and may deny your claim for that reason.
- Some insurance companies (Anthem) will send you, not Solutions CCRC, the only copy of the Explanation of Benefits (EOB's) and payments for services. You are required to turn over all EOB's and payments to Solutions CCRC in order for us to process your claim for service. You may give it to your provider, the front desk, or mail to Solutions CCRC Attn: Finance Dept., 975 Kingsview Drive, Lebanon, OH 45036.
- If a billing issue arises, please contact our Finance Department so that services can be properly 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 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)

Non-Payment / Collections

Payment according to your FY21 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 discharged from this agency.

FEE AGREEMENT FOR FY21 (July 1, 2020 - June 30, 2021)

Effective Date of This Fee Agreement: _____ Client # _____

Form Completion Date: _____ Admission Date: _____

1. Client Information

Client Name: (First, MI, Last) _____

Physical Street Address: _____

City _____ State _____ Zipcode _____

Mailing Address if not the same as above : _____

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

Primary Phone: (_____) _____

2. Responsible Party (If Other Than Client)

Name: (First, MI, Last) _____

Address: _____

City _____ State _____ Zipcode _____

3. 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, or 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 any balance not covered by my insurance carrier.
5. A copy of this signature is as valid as the original document.

X _____ _____ _____

Signature of Client /Guardian/Responsible Party | Print Name | (Date Signed)

4. 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.

5. Application for Sliding Fee Subsidy provided by MHRB-only for WC and CC residents

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
1				$		
2				$		
3				$		
4				$		
5				$		
6				$		
7				$		

$ _____ TOTAL **MONTHLY** HOUSEHOLD INCOME before taxes-exclude income of minors

Proof of Income is required to be eligible for the Sliding Fee 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 a year) and Child Support. Exclude: Food Stamps / ADC, Bank Withdrawals, Student Benefits, Rebates, Grants, Loan disbursement (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 _____

6. 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 fees for 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.

X _____ _____ _____

Signature of Client /Guardian/Responsible Party | Print Name | (Date Signed)

FY2021 Fee-AGENCY STAFF TO COMPLETE

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

- ☐ Private Insurance
- ☐ Medicare (Traditional)
- ☐ Medicare (Advantage Plan)
- ☐ MyCare (Dual)
- ☐ MyCare (Medicaid Only)
- ☐ Mason Municipal
- ☐ WC Common Pleas
- ☐ WC Jail Contract
- ☐ Medicaid
- ☐ Other _____
- ☐ Other _____
- ☐ GOSH (MHRB Board)-WC and CC residents
  - ☐ 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 Board Serving Warren & Clinton Counties. Clients are obligated to notify provider of changes in income or dependents within 30 days of the change.

Waiver applies-check all programs that apply. Client owes 0%

- ☐ SED Program
- ☐ SPMI Program

If they do not have insurance but eligible must apply or provide a denial letter of Medicaid to be qualified

7. AGENCY CERTIFICATION

I certify that I have reviwed 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 ID# _____

Staff Name Printed

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

SOLUTIONS COMMUNITY COUNSELING AND RECOVERY CENTERS

975 Kingsview Drive (Main / Administration Office) Lebanon, OH 45036-9600
PHONE: 513-228-7800 FAX: 513-228-7846

Patient Name: Case #

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

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

MEDICARE PROVIDERS (7-1-2020)

Renu Kotwal, MD
Lucas Barton, MD
Dipika Shah, MD
Steven Rosen, DO

Russell Dern, Ph.D

James Roe, CNP
Jennifer Jones, CNP

Angela Johnsen, LISW-S
Michelle Box, LISW-S
Jane Groh, LISW-S
Mary Ann Rose, LISW-S
Julie Knueven, LISW-S
Rebecca Baker, LISW
Colleen McClanahan, LISW
Trina Slaughter, LISW

WHAT YOU NEED TO KNOW WHEN YOU HAVE TRADITONAL MEDICARE AS PRIMARY:

- **Seeing a Medicare Provider**
  If you receive services from a Medicare Provider - 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.

WHAT YOU NEED TO KNOW 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 the Secondary carrier - you will be billed according to the Medicare Explanation of Benefits or your signed Fee Agreement (whichever is lower).

- **Seeing a Non Medicare Provider**
  If you receive services from a Provider **NOT** listed above, and have Medicare as the Secondary carrier - You (or the responsible party) will be responsible for payment at the time of service according to the Primary Insurance's Explanation of Benefits OR the signed Fee Agreement (whichever is lower)

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

SOLUTIONS
Community Counseling and Recovery Centers

Client # _____

IMPORTANT MEMO FOR CLIENTS WITH ANTHEM INSURANCE

If you are seeing a Non Independently Licensed Provider

A few common examples are:
LSW – Licensed Social Worker
PC – Professional Counselor
MFT – Marriage and Family Therapist
LCDC – Licensed Chemical Dependency Counselor
LCDCII – Licensed Chemical Dependency Counselor -2

Due to the particular Anthem 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's) 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 sent to you), we are able to bill 1) your secondary insurance 2) Medicaid 3) Mental Health & Recovery Board Serving Warren and Clinton Counties. Without this information we are unable to bill anyone else; and the balance due becomes your responsibility.

- **Provide Solutions with the original (or copy) of every Explanation of Benefits (EOB) you receive for services rendered by Solutions CCRC**
- **Sign over Anthem checks you have received to "Solutions CCRC" for services rendered (or reimburse Solutions CCRC by check/ cash/ money order/ credit card)**

If you fail to forward the above EOB's and payments within 14 days of receiving, your Fee Agreement will be voided and you will be liable for 100% of the billed amount. Please review the Financial Policy Form included in your signed Fee Agreement.

Please give your Explanation of Benefits and any signed Anthem checks to:
Front Desk Staff / Your Provider / or Mail to:

Solutions CCRC
Attn: Finance Department
975 Kingsview Drive
Lebanon, OH 45036

If you have any questions concerning this policy – please contact 513-228-7800 # 654

_____ _____

Authorized Signature of Client / Guardian/Responsible Party (Date Signed)

_____ Initial that a copy of this form was provided to you

Revised 7/20

SOLUTIONS
Community Counseling and Recovery Centers

Client # _____

CONSENT TO BE TREATED BY AN OUT OF NETWORK (Non Credentialed) GROUP BASED PROVIDER

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, dependently or independently licensed. The exception is for clients who are covered by **United Behavioral Health, Optum, United Medical Resources, Golden Rule and Medical Mutual**; these services are billed under the name of the independently licensed clinical supervisor who is credentialed by these insurance carriers.

Effective July 1, 2020 – No Termination date

I understand and consent to treatment by a Mental Health/Substance Abuse (MHSA) 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.

_____
(Printed Name of Client)

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

_____ _____
(Witness Signature) (Date Signed)

Revised 7/20

SOLUTIONS
Community Counseling and Recovery Centers

SPRINGBORO CENTER	50 Greenwood Ln. Springboro, OH 45066 937.746.1154 • 937.746.8523 (Fax)
WILMINGTON CENTER	953 S. South St. Wilmington, OH 45177 937.383.4441 • 937.383.2616 (Fax)
LEBANON CENTERS	975 Kingsview Dr. Lebanon, OH 45036 (Main Office) 513.228.7800 • 513.228.7846 (Fax)

MHRS RESIDENCY VERIFICATION FORM

Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) uses public funds to pay for behavioral health services for local citizens based upon need. The benefits that MHRB provides are available to the residents of Warren and Clinton counties through a network of contract providers. The purpose of this form is to verify benefit eligibility based upon residency. All individuals seeking coverage of services by MHRB other than emergency or crisis need to complete it and provide proof of county residency. In most cases, residency is determined by a person's physical presence in the county and intent to remain there.

Date You Applied for Services: _____

Client's County of Residence: _____

Client's Name (last; first): _____

Client's Current Physical Address: _____

Client is: ☐ Adult ☐ Minor

☐ College Student ☐ Jail ☐ Migrant Worker ☐ Homeless or Resides at Homeless Shelter (Document Attached)

If Minor, legal custody status: ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____

Name of Parent/Legal Custodian: _____

County of Residence of Parent/Legal Custodian: _____

Address of Parent/Legal Custodian (if different than above): _____

If College Student, home address if different from above:

_____

If in jail, home address at time of arrest: _____

An individual's or Parent/Legal Custodian/Guardian's signature on this form along with the below documentation shall be sufficient for establishing 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 OF CLIENT OR PARENT/LEGAL CUSTODIAN/GUARDIAN (IF APPLICABLE)

Signature of Individual:	Date
If applicable, Printed Name and Signature of Parent/Legal Custodian/Guardian:	Date

FOR PROVIDER USE:

The following documentation is valid to verify an individual's county residency. Provider must copy any documentation the individual used to verify residency, that is consistent with the list below, and a copy must be part of the individual's record. In the case of a minor, documentation from parent/legal custodian shall be used.

☐ Current Ohio Driver's License with County Address same as Declared County Residence	☐ Current Utility Bill (gas, electric, water) with County Address same as Declared County Residence in clients' name*
☐ Current Ohio Personal Identification Card with County Address same as Declared County Residence	☐ Current Voter Registration Card that shows County Address same as Declared County Residence
☐ Current Ohio Medicaid Care that shows County Address same as Declared County Residence	☐ Current Mortgage Statement or Payment with County Address same as Declared County Residence in client's name*
☐ Current SSI/SSDI Benefit Eligibility Statement with County Address same as Declared County Residence	☐ Current Rent receipt with County Address same as Declared County in client's name*
☐ Current Pay Stub with Address same as Declared County in client's name*	* DOCUMENTS MUST BE WITHIN THE LAST 60 DAYS.

Provider must supply this form to COSH Administrator (along with any requested documentation) when enrolling a client in which:

- The legal county of residence of the Individual as noted on the enrollment form (minor or adult, out-of-county) does not indicate Warren or Clinton Counties.
- The physical address of the Individual as noted on the enrollment form does not match the legal county of residence of the Individual (example: domestic violence shelter case, individual temporarily living with relatives, child or adult, out-of-county).
- The minor's physical address as noted on the enrollment form does not match the legal custodian's address (minor only, in or out-of-county).

My signature indicates that I do not have permanent housing. I will notify Solutions when my situation changes. _____

Mental Health
Recovery Board

Service Provider Policies & Procedures

Attachment 1:

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

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 MHRB network is designed to help individuals and families deal with the behavioral health crises that they sometimes face.

How is the MHRB Network funded?

The MHRB 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 illnesses, 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. MHRB encourages you to work with your provider 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 locations at our website, MHRBWCC.org. A staff person will ask you about your situation to make sure the services the agency provides 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 MHRB, which accesses public funds. You will be asked during intake about your income, family size, whether you have private health insurance, or whether you are covered by Medicaid or Medicare. This information will be entered into a computerized billing system operated for MHRB.

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 co-pays.

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

(over)

Mental Health
Recovery Board

Service Provider Policies & Procedures

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?

MHRB 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 educational 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.

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.

What if I seek services outside my network?

Enrollees are encouraged to use local county providers 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 but some benefits may not be available.

Is my information kept confidential?

Yes. MHRB 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 any concerns regarding treatment with your provider. If the problem continues, you can file a formal grievance. MHRB 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 fully explained in the Client's Rights Policy and Grievance Procedure. A copy is available on our website, or you can call us at 513-695-1695.

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

Mental Health
Recovery Board
Serving Warren & Clinton Counties

Updated May 2020

Mental Health Recovery Board

Service Provider Policies & Procedures

Attachment 3:

CLAIMS AND INFORMATION SYSTEM NOTICE OF ENROLLMENT

To be eligible to receive public funds to help pay for the cost of your mental health and/or addiction 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 "GOSH" is administered on behalf of MHRB by the Clark, Greene, Madison Mental Health 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.

Name of Client: _____

Signature of Client: _____ Date _____

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 record.