

CHOUTEAU COUNTY MENTAL HEALTH
1020 13th Street P.O. Box 459
Fort Benton, MT. 59442
(406)622-5414

APPLICATION FOR MENTAL HEALTH SERVICES

1. Name of person(s) applying and birthdates:

Name:	Birth date:	SSN:
_____	_____	_____

2. Other family members, birthdates, and SSN

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Mailing Address: _____

4. Telephone Numbers: H: _____ W: _____ C: _____

5. Medical Insurance: Yes: _____ No: _____ Policy Holder: _____

Company Name and Address: _____

Cert # _____ Group # _____

6. Medicaid: Yes: _____ No: _____ Card # _____

7. Place of
Employment: _____

8. Current Primary Care Provider/Address/Phone #: _____

9. By whom were you referred for
services: _____

10. Briefly explain the reason for
services/problem: _____

FINANCIAL INFORMATION:

GROSS INCOME FOR HOUSEHOLD: _____ PER WEEK
_____ PER MONTH
_____ PER YEAR

- If you are unable to meet your financial responsibility, please contact our office for arrangements. A 24 hour notice is required for all cancellations or appointments that need to be rescheduled.

TERMS:

1. I hereby authorize a Chouteau County Mental Health representative to contact my medical insurance company about reimbursement information.
2. I will be responsible for reimbursement to the county from my insurance payment.
3. I further agree to hold harmless the Chouteau County and their representatives from any claim that may arise from the release of any information which has been agreed to on this form.

Signature: _____

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Office Use

Application: Approved: _____ Denied: _____

Clients Financial Responsibility: _____

Date: _____

SIGNATURE ON FILE

I request that payment of medical insurance benefits be made either to me or on my behalf to CHOUTEAU COUNTY MENTAL HEALTH or its agents for any services furnished to me by a contracted mental health professional.

I authorize any holder of medical information about me to release to Chouteau County Mental Health and its agents; any information needed to determine these benefits for the benefits payable to related services.

SIGNATURE:

DATE: _____