JOHNSON COUNTY KANSAS
Mental Health

6000 Lamar Ave, Suite 130, Mission, Kansas 66202
1125 W. Spruce St., Olathe, KS 66061 or
6440 Nieman Rd, Shawnee, KS 66203
(913) 826-4200 phone (913) 826-1608 fax
jocogov.org/mentalhealth website

Client Registration

Client First Name:_____**MI**:_____**Last Name**:_____**SS#**_____

Maiden Name:_____**Previous Name**:_____ **Date of Birth**:_____**Gender**:_____

Address:_____**Apt/Unit#**:_____**City**:_____**State**:_____**Zip:**_____

Main Phone:_____ **Additional Phone**:_____

Client Ethnicity: Asian ☐ Black/African American ☐ Pacific Islander ☐ Native American ☐ White/Caucasian ☐

Other:_____

Are you of Latin or Hispanic ethnicity? Yes ☐ No ☐

Relationship Status: Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together ☐

Client Education (Please Indicate the Highest Level Completed): School Grade _____ High School Graduate ☐

GED ☐ Vocational Training Beyond High School ☐ Some College (# of years) _____

College Degree _____ Graduate Work, No Degree _____ Master's Degree _____ JD _____

Doctorate Degree _____

Client Employment Status: Student ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Part-time ☐ Full Time ☐

If Employed, Employer Name: _____

Client Smoking Status: Currently, Everyday ☐ Currently, Sometimes ☐ Never ☐ Former ☐

Military Status: Has the Client Ever Served in the Military? Yes ☐ No ☐

If Client is Under 18, Has the Parent/Guardian Ever Served in the Military? Yes ☐ No ☐

Emergency Contact Information

Name: _____ Phone: _____

Relationship to Client: _____ Reside with Client? Yes ☐ No ☐

Please tell us why you are here today.

Spouse or Parent/Guardian 1

Name: _____

SS#: _____ DOB: _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Phone#: _____ Employer: _____

Does Client Reside With Above? Yes ☐ No ☐

Parent/Guardian 2

Name: _____

SS#: _____ DOB: _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Phone#: _____ Employer: _____

Does Client Reside With Above? Yes ☐ No ☐

Name of Person (*other than client*) Completing this Form: _____

Relationship to Client: Spouse ☐ Parent ☐ Non-Custodial Parent ☐ Legal Guardian ☐ Step-Parent ☐ Family Member ☐

Foster Parent ☐ Case Manager ☐ Adoptive Parent ☐ Other: _____

Office Use Only

Check in Time: _____ Previous Client of JCMHC? Yes No Avatar/Luci Number: _____

Insurance? Yes No If yes, What Insurance Carrier? _____

ID? Yes No FD staff initals ____

Client Name: _____ Client #: _____

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FEE AGREEMENT / ASSIGNMENT OF BENEFITS

Client ID:_____ Client Name: _____ DOB:_____

Client or Guardian initial:

— **Financial Responsibility**

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Johnson County Mental Health Center (JCMHC) for any charges not covered by health care benefits. It is my responsibility to notify JCMHC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by JCMHC and/or my insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment of services and/or treatment provided.

For ACT Only:

— ACT payment is based upon a 28 day stay at the daily rate divided by 3. The first payment due at admission, the second at discharge and the third 30 days after discharge. Your daily rate is $ _____ x 28 days / 3 = $ _____.

— You will be responsible financially for any cost of repair or replacement for any intentional damages to premises or property damage during stay.

____ Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicaid and Medicare, to Johnson County Mental Health Center (JCMHC) for all covered services provided to me during all courses of treatment and care provided. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by JCMHC, and will constitute a continuing authorization of any insurance policy that is in effect at the time of service, maintained on file with JCMHC, which will authorize and allow for direct payment to JCMHC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, and care provided. This serves as a lifetime consent for Medicare. I acknowledge Johnson County Mental Health Center (JCMHC) will provide information from the medical records of the above-mentioned client for the purpose of accessing insurance benefits. This information may include diagnoses and dates and type of treatment received. Additional information may be requested before claim payment is made and may include, but not limited to, items such as the intake report, treatment plan, progress notes, medications prescribed, and discharge report.

____ Policy on Missed Appointments

Appointments made on your provider's schedule are reserved for you and represent a mutual commitment. You will be charged your ability fee for appointments not kept unless arrangements are made to cancel or change them **at least one day (24 hours) in advance.** Exceptions to this policy may be made under unusual circumstances. If you are unable to keep your appointment, please call the appointment **Cancellation Line at: 913-715-7849.** Prepaid fees are subject to forfeiture if appointment is not canceled following the cancellation policy.

Insurance Information:

Primary Ins: _____ Group#: _____ ID#: _____

Policy Holder: _____ Date of Birth: _____ SS#: _____

Relationship to Client: _____

Secondary Ins: _____ Group#: _____ ID#: _____

Policy Holder: _____ Date of Birth: _____ SS#: _____

Relationship to Client: _____

Estimated Household Income: $_____ Household Size: _____

SSI Benefits: Eligible Yes ☐ No ☐ Receiving Yes ☐ No ☐ SSDI Benefits: Eligible Yes ☐ No ☐ Receiving Yes ☐ No ☐

Client or Guardian initial:

— I understand that my insurance company will be billed at the full cost for service, and not my ability fee.

— I understand that payments from HRA/HSA/FSA and other insurance managed fund accounts will be applied to the full amount of the patient responsibility as determined by my insurance, and not my ability fee.

— I understand that the Mental Health Center is subsidizing a portion of the full cost until my insurance company reimburses.

— I understand that my authorization allows the Mental Health Center to collect up to the full cost of services.

— Client is not covered under any health care plan.

— Client has insurance but does not wish services to be billed to them. This constitutes FULL FEE FOR SERVICES.

_____ _____ _____

Client or Guardian or Insured (Signature) Print Name Date of Signature

_____ _____

JCMHC Staff (Signature) Date of Signature

* **ATTENTION JOHNSON COUNTY RESIDENTS**: An Application for Reduced Fee is included in your packet. Please complete the application and submit with the required documentation to be considered for reduced fees.

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Johnson County Mental Health Center
Fee Schedule

Billing Code	Description of Service	Current Full Rate	
90791	Intake-Planning Session	230.00	Session
90792	Intake-Planning Session w/ Medical Services	230.00	Session
+90785	Interactive Complexity	30.00	Session
90832 / 90834 / 90837	Individual Therapy	75/150/225	Session
90847	Family Therapy	175.00	Session
90847HK	In Home Family Therapy	215.00	Session
90853	Group Therapy	87.50	Hour
96372	Injection Service	30.00	Session
96130-96136	Psych Testing & Report	225.00	Hour
99201-99205	New Patient Evaluation and Management	50/100/150/215/285	Session
99211-99215	Est Patient Evaluation and Management	30/60/85/130/175	Session
+99354	Add On Code for Prolonged Service in Association with E & M Codes first hour	230.00	
+99356	Add On Code for Prolonged Service in Association with E & M Codes for each additional 30 minutes	115.00	
99366 / 99367 / 99368	Case Conference	175.00	Hour
A0160	Support Services	25.00	Hour
H0001	KCPC (Alcohol & Drug Intake Assessment)	230.00	Session
H0004	SUD Individual Therapy	175.00	Hour
H0005	SUD Group Therapy	87.50	Hour
H0006	SUD Case Management	60.00	Hour
H0014	Adult Residential (ADU) Daily Rate	125.00	
H0018	Adolescent Center for Treatment (ACT) Daily Rate	345.00	
H0036	CPST (Case Management)	127.60	Hour
H0036HH	CPST IDDT (Dual Diagnosis)	138.80	Hour
H0036HJ / H0036HK	CPST Supported Employment / Strength Based	133.60	Hour
H0038	Peer Support Individual	54.52	Hour
H0038HQ	Peer Support Group	17.50	Hour
H2011	Crisis Intervention - Attendant	87.00	Hour
H2011HK	Crisis Intervention - Bachelors	139.20	Hour
H2011HO	Crisis Intervention - LMHP	174.00	Hour
H2017	Psychiatric Rehabilitation - Individual	54.52	Hour
H2017HQ	Psychiatric Rehabilitation Group - Adult	17.50	Hour
H2017TJ	Psychiatric Rehabilitation Group - Child	35.00	Hour
H2021	Wraparound Facilitation	87.00	Hour
H2025	PRTF Employment Prep and Support	40.00	Hour
S5110	Parent Support Services	43.48	Hour
S5110TJ	Parent Support and Training Group	13.04	Hour
S5150	Respite Care	26.08	Hour
T1017	Targeted Case Management	43.32	Hour
T1019HE	MH Attendant Care	27.84	Hour
T1019HK	Waiver MH Attendant Care	26.08	Hour
T2038	Independent Living/Skill Building	43.49	Hour
99408 / 99409 / H0048 / H0049	SBIRT Screen	24/ 48	Session
H0050	SBIRT Brief Intervention	96.00	Hour
H2027/H2027U3	PBS Environmental Assessment/Treatment		
90882-22	PBS Person Centered Planning		
*	30 Min Ind/Fam-60 Min Grp Unkept	87.50	Session
*	60 Min Ind/Fam-120 Min Grp Unkept	175.00	Session
*	90 Min Grp Unkept	131.25	Session
*	Court Testimony/Deposition	175.00	Hour
*	Expert Witness/Attrny Requested	175.00	Hour
*	Pre-K Mentor Group	20.00	Hour
*	Mental Health First Aid	50.00	Session
*	Transportation	3.00	Ticket/ 15 miles
*	Adult Residential Center (ARC) Group Meetings	10.00	Session

* Denotes services not reimbursed by third party insurance.

Eff. Date 07/19

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APPLICATION FOR REDUCED FEE FOR JOHNSON COUNTY RESIDENTS

Johnson County Mental Health Center (JCMHC) is supported by client fees, insurance, and county and state funds. If you live in Johnson County, you may qualify for a reduced fee. No resident of Johnson County will be denied service because of an inability to pay. Services may be limited or delayed because of refusal to pay. This form is used to determine how much assistance a Johnson County resident may qualify for in paying for services at JCMHC. If you need assistance in completing this form, contact Billing at 913-826-1551 or by email at MNH-Billing-Info@jocogov.org. **Proofs of income and residency are required.** Samples of acceptable proofs are provided on the back of this form.

HOUSEHOLD INFORMATION

Person receiving services _____ DOB: _____

List people in your household, including you, who are dependent on this income (do not include children for whom you make child support payments):

Name:	Relationship:	Age:

HOUSEHOLD INCOME

Income should reflect the gross amount paid to or on behalf of any member of the household, before any deductions are taken out. Other Income includes but is not limited to income from savings, dividends, trusts, and estates.

☐ I have Medicaid or ☐Household income is $0.00, explain:_____

	Self		Spouse/ Partner/ Other		(For Office Use Only) Annual Income
☐Wages ☐Salary	$ ____/hr	_____hrs/week	$ ____/hr	_____hrs/week	$ _____
Self-Employment	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Social Security/Retirement	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Unemployment	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Child Support	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Alimony	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Disability/Workers Compensation	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
Other Income: _____	$ _____	☐ week ☐ month	$ _____	☐ week ☐ month	$ _____
				TOTAL ANNUAL INCOME (FOR OFFICE USE ONLY)	$ _____

I certify that the information provided is an accurate and wholly true statement of my gross income and household size. Further, I agree to inform JCMHC immediately if my income and/or the number of my household members change. My fee may change as a result.

Signature: _____ Date:_____

Office Use Only

□ Copy of picture ID provided. Comments:_____
□ Copy of proof of Johnson County Residency provided. Comments:_____
□ Copy of proof of household income provided. Comments:_____
□ Missing Documentation:_____

Client Name: _____ Client #: _____

SAMPLES OF ACCEPTABLE FORMS OF PROOFS OF INCOME:

Income is described as earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, Veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rent, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits such as food assistance programs and housing subsidies do not count as income. Acceptable forms of proof of income:

a. Pay stubs;
b. Income tax returns;
c. Letter of unemployment benefits
d. Bank statement;
e. Annual benefits letter;
f. Letter from employer if client is paid in cash;
g. Statement from a family member or third party verification, including address, upon which the client is dependent upon for food and shelter;
h. Signed letter on agency letterhead from a criminal justice staff person or probation officer;
i. Signed letter on agency letterhead from a social services staff person or similar professional;
j. State of Kansas Benefit Card for the Food Assistance Program;
k. State of Kansas Medicaid eligibility for adults. NOTE: Children with Medicaid only will be proof of eligibility for lowest ability fee. Children with Medicaid AND Waiver eligibility will require additional proof as listed above for eligibility for lowest ability fee.

SAMPLES OF ACCEPTABLE FORMS OF PROOF OF RESIDENCY:

l. Valid Kansas Driver's License/Kansas ID showing a Johnson County address;
m. Rent or lease agreement in the client's name and with a Johnson County address;
n. Valid vehicle registration showing Johnson County address;
o. Pay stub showing Johnson County address;
p. Signed letter on agency letterhead from a criminal justice staff person or probation officer;
q. Signed letter on agency letterhead from a social services staff person or similar professional;
r. Statement from a family member, including address, upon which the client is dependent upon for food and shelter;
s. Personal property tax statement showing a Johnson County address (residence);
t. Exception: Homeless client. Determined case-by-case by staff member, a signed attestation will be completed.