Counseling Screening: Submission Checklist

Please read the following carefully to ensure that your application is complete, so that an appointment can be scheduled in a timely fashion.

- ☐ All spaces on the application are filled in completely. Make sure all spaces are filled in. Incomplete applications cannot be processed so will be returned to you for correction.

- ☐ Each person interested in attending counseling sessions has completed a *Counseling Screening form (two pages)*.

- ☐ Financial information is provided and attached as identified at the bottom of page 2. For example, a copy of your last two paycheck stubs, unemployment payment stub, tax return, other additional income and/or food stamp reimbursement verification.

If you have insurance

- ☐ I have filled out the insurance information section and enclosed a copy of my insurance card (front and back). If you're not able to return a copy of your card with the paperwork, you must bring it to your first appointment.

If this is court ordered counseling

- ☐ I have enclosed a copy of the court order and/or DSS Treatment Summary with my application.

- ☐ Return all forms to Compass of Carolina. These may be mailed, dropped off, faxed or scanned (with original signatures) and emailed.

If you have any further questions, please contact Compass of Carolina at (864) 467-3434 or from outside the Greenville area at (800) 203-9692.

*NOTE: You will be required to pay for services prior to each appointment. If you are using our sliding fee scale, a determination on the amount of your payment will be discussed with you prior to your first appointment. Modifications to the fee required may be made as financial needs change.

Counseling Screening Form

Personal Information: Note: Please read and complete the submission checklist to ensure that all required information is provided. Incomplete applications can not be processed.

Today's Date: _____

Name: _____ Marital Status: _____

Address: _____

_____

Email address (for follow up purposes):_____

Best Number to Contact you: _____ Type: ☐ Mobile ☐ Home ☐ Office

Initial Here _____ to authorize our staff to leave a voicemail at this number in the event you don't answer.

Date of Birth: _____/_____/_____ Age*: _____ Social Security Number: _____-_____-_____

* If this is a minor child please answer the following:

Name of Responsible Party: _____ Relationship to Minor: _____

Number of people living in your household: Adults: _____ Children: _____

Insurance Information:

Primary Care Physician (PCP) _____ Phone Number of PCP _____

Name and Phone Number of Insurance Company _____

*** A copy of your insurance card (front and back) must be provided ***

Please complete the following if you are insured by another individual's policy:

Full Name of Insured: _____Relationship to Client:_____
Address:_____Phone Number:_____
Social Security Number: _____-_____-_____ Employer: _____
Insured's Date of Birth: _____/_____/_____

Finance Verification:

What is your gross income (amount before taxes and deductions)? Amount $_____

This amount is per (select one): ☐ Year ☐ Month ☐ Week ☐ Every Two Weeks ☐ Other: _____

If you are seeking to use our sliding scale fees, please attach proof of income. For example, a copy of your last two paycheck stubs, unemployment payment stub, tax return, other additional income and/or food stamp reimbursement verification.

I have attached the following (name of document(s): _____

Additional Information

1. Who would we contact in case of an emergency? Name: _____

   Best Phone: _____ Alternate Phone: _____ Relationship: _____

2. Do you experience thoughts of self-harm or are you at risk of being harmed? ☐ Yes* ☐ No

   If yes, please specify: _____

* If you are in immediate danger, please call for help **now**.

   - 911
   - National Suicide Prevention Lifeline. 1-800-273-8255
   - National Domestic Violence Hotline. 1-800-799-SAFE (7299)

3. Please describe your current situation (why you are seeking services) and the type of support you are looking for.

   _____

   _____

   _____

   _____

   _____

4. Please describe your current housing situation. (i.e. is it stable, safe and healthy or are there support needs present)

   _____

   _____

   _____

5. Please include any additional information you feel would be helpful.

   _____

   _____

   _____

   _____

Signature of applicant (or guardian): _____ Date: _____

Thank you for taking your time to complete this form. The information contained will assist Compass of Carolina in guiding you to the best resource for your individual needs. A team member will be in touch with you soon to schedule time for your assessment. Once the assessment is complete, you may be enrolled into Compass of Carolina services or will be provided with referrals to other providers that can better support your needs.

Counseling Screening Addendum

OFFICIAL USE ONLY

Verification of Benefits:

Date Contacted:_____ Phone Number (if different from above)_____

	Yes	No		Yes	No	
Mental Health Benefit:	○	○	PCP referral needed:	○	○	
Pays for LMSW/LPC:	○	○	Deductible:	○	○	If yes: Total amount: $_____
Pre-cert required:	○	○				Amount paid: $_____
# of covered visits:	_____		Co-pay:	○	○	If yes: Amount: $_____

Outcome of Screening

An Assessment is scheduled with _____ on _____.

Name of Staff Date

If services are not going to be offered from Compass of Carolina list the reason. _____

_____

_____

Referrals given to (list): _____

_____

_____

Other related information: _____

_____

_____

_____ _____

Staff name and signature Date