PIPBHC - Intake Form

Date of Session: _____ Client Name: _____

Client DOB: _____ Client ID: _____

Client Address: _____

Client Phone #'s: _____

Care Coordination Provider and Organization: _____

Section I - The client is eligible for the PIPBHC grant if question 1 is answered Yes. The client is eligible for Recovery Support Services if questions 1 and 2 are answered Yes and the agency has obtained the required documentation that the individual meets the federal poverty guidelines. If there are extenuating financial circumstances, please contact IDPH.

Eligibility

1. The client must be 18 years of age or older, state of Iowa resident and has received a diagnosis for a substance use disorder and meet one of the two following criteria:

   a. has or is at risk of a chronic physical health condition and/or;

   b. has received a diagnosis of a serious mental illness (serious mental illness is defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities).

2. The client is at or below 200% of the current Federal Poverty Level Guidelines. Please refer to the current Federal Poverty Level Guidelines at http://aspe.hhs.gov/poverty.

   YES _____ NO _____

3. Services should be extended, when deemed appropriate, to family members of the clients enrolled.

Section II - Document client needs and requests for specific PIPBHC covered services.

All PIPBHC clients receive the following covered services:

- PIPBHC Assessment with NOM's Intake Interview (1 session)
- Care Coordination (up to 10 sessions)
- Care Coordination with NOM's Discharge Interview (1 session)
- Care Coordination with NOM's Follow-up Interview (1 session)

Document need, request, and lack of other payment for the following PIPBHC covered services:

Recovery Support Services

☐ Child Care: _____

☐ Drug Testing Incentives or Contingency Management: _____

☐ Education: _____

☐ Sober Living Activities: _____

☐ Supplemental Needs – Gas Cards: _____

☐ Supplemental Needs – Wellness: _____

☐ Transportation – Bus: _____

☐ Transportation – Cab: _____

Client Signature: _____ Date: _____

Provider / Witness Signature: _____ Date: _____