Elite Cognition, LLC

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ELITE COGNITION NEW CLIENT REFERRAL

☐Self/Private Pay ☐CCS ☐IRIS ☐Quartz ☐Other ___________

We currently work with the following programs. Please select the one that applies best to you.

Client Information	
Today's Date:	
Client's Name: Legal name (if different):	Date of Birth: Current Age:
Gender/Pronouns:	Email:
Address:	Phone Number:
Mental Health Diagnosis or Current Struggles: (List all known)	
History of suicidal ideation/previous suicide attempts. ☐Yes ☐ No ☐Unknown	Is there a crisis, safety, or behavioral plan in place? ☐Yes ☐ No ☐Unknown **If yes**: ☐Crisis ☐Safety ☐Behavioral
If client is a minor or has a healthcare power of attorney- please complete the following:	
Guardian's Name:	Phone Number:
Address (if different than client):	Email:
For minors, what school do they currently attend? *Do they have a regular weekly early dismissal?*	

Requested Service(s): *EC offers the following psychosocial rehabilitative (mental health) services*	
☐ Psychotherapy (Therapy)	☐ Art Therapy
☐ Medication Management (non-prescriber)	☐ Physical Health Monitoring
☐ Individual Skill Development & Enhancement	☐ Employment Related Skill Training
☐ Individual and/or Family Psychoeducation	☐ Wellness Management and Recovery/ Recovery Support Services
Diagnostic Evaluation & Assessment. Please select the service(s) below that you are requesting	
☐ Adult (age 18+) BSP (Behavioral Support Plan)	☐ LEP (Law Enforcement Protocol) for Adult
☐ Minor (age 5-17) BSP (Behavioral Support Plan)	☐ LEP (Law Enforcement Protocol) for Minor
☐ Minor age Safety Protocol (Home/Community)	☐ FBA (Functional Behavioral Assessment)
☐ ALSUP (Assessment of Lagging Skills & Unsolved Problems) using CPS (Collaborative Problem Solving) Model	
Provider Gender Preference? ☐Female ☐ Male ☐ No Preference	
List a couple possible days/times here that would work for a free 10-minute meet and greet appointment, to confirm a good therapist-client match is made.	

Office Use Only: Confirmation of receipt date ________________ Waitlist Date: ____________________ Placement Date: ________________________

Employee Assigned: ____ Connected to SF/Client: ☐Yes ☐No ☐ CCS Hours Approved

☐CoPay amount per session: $__________ ☐Out of Pocket amount per session $_______ ☐Accessing Slide Scale? _____

Rev. 2/2022

Scheduling. When scheduling sessions, we will offer you the time/day that our therapist/provider has available within their caseload. To support scheduling, please select ***all times*** of day/days of the week that ***might*** work for you to come to the office for session.

	Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***
*Early Morning** ***6a – 8a***	☐	☐	☐	☐	☐
Morning 8a – 11a	☐	☐	☐	☐	☐
Lunchtime 11a – 1p	☐	☐	☐	☐	☐
Early Afternoon 1p – 4p	☐	☐	☐	☐	☐
Late Afternoon 4p – 6p	☐	☐	☐	☐	☐
*Evening** ***6p – 8p***	☐	☐	☐	☐	☐

*Early morning and evening appointments are rare and at provider discretion.
**For school aged minors, if during the school day times are selected, we are assuming this means you are comfortable pulling them from school for session.
***__**Mental health services are medical appointments**__. If you need a letter for missed school and/or work, please let us know and we will be happy to complete one for you.

***CCS Consumers ONLY.** What environment will you be most successful meeting your goals? ☐ At the Office ☐ In my home ☐ In the Community; *describe briefly:*

Description of presenting barriers, needs, wants, goals & strengths. Why are you seeking services?

Do you currently receive any other Mental Health services? If yes, where and what services do you receive?

Payment Options. Select the option that best applies to you

☐ **Out Of Pocket** (Private Pay)

Clients wishing to pay for services out of pocket will be contacted to set up payment by a member of our staff. Staff will provide information to you on rates for services requested. We do offer a sliding scale for services, when needed based on the Federal Poverty Rate.

☐ I am interested in applying for sliding scale rates.

☐ Elite does not accept my health insurance. I know that I am responsible for upfront payment of all services. I plan to contract my insurance to see if I have OON (Out of network benefits) and I will need a Superbill.

☐ **Insurance** Payment

We currently accept **Quartz** Insurance – all plans. Attach a copy of the front and back of your current insurance card to this referral form. A photo, screen shot, scan or copy are all acceptable.

☐ **IRIS** (Include, Respect, I, Self-Direct) Program

☐ **CCS** (Comprehensive Community Services) Program

Service Facilitator/ Case Manager when applicable

Completed referrals can be sent via any of the following methods: Emailed to: info@elitecognitionllc.com
Fax: 608-440-2954 Mailed: Elite Cognition, c/o Bryenne Alesch, 5900 Monona Drive, Suite 102, Monona WI 53716
Further Questions? Call 608-286-1132 or check our website www.elitecognitionllc.com

Name:	Agency:
Phone Number:	Email:

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