Clara Martin Center
SAME DAY ACCESS FORM

Legal Name: _____

What name do you go by?_____ Legal Sex: _____
Social Security Number: _____ Date of Birth: _____
Primary Language: _____

Mailing Address:		
Physical Address:		
Home phone:	Cell:	Work phone:
Email address: _____		

Gender pronouns:
☐He/him/his ☐She/her/hers ☐They/them/theirs ☐Other_____

Communication Preference:			
☐Home Phone	☐Work Phone	☐Cell Phone	☐Text
☐Email	☐Regular Mail	☐Do Not Contact	
Is it okay to say that it's Clara Martin Center calling?		☐Yes	☐No
Is it okay to leave a message when we call?		☐Yes	☐No
Would you like a reminder for your appointment?		☐Text ☐Phone Call ☐Email	☐No (decline)
Would you like to be signed up for our Client Portal? This would allow you to communicate via email, see upcoming appointments, contact med team		☐Yes – a link will be sent to your email a link to sign up (check spam)	☐No

***If there is a legal custody arrangement, we will need official documentation of that arrangement.**

Parent/Guardian Information (if minor or adult with guardian):	
Parent/Guardian 1:	
Name:	Relationship:
Contact Information:	
Parent/Guardian 2:	
Name:	Relationship:
Contact Information:	
Additional Parent/Guardian information and Custody arrangement:	

Reviewed or Revised 9.3.2025

Emergency Contact	
Name:	Relationship:
Contact Information:	
Name:	Relationship:
Contact Information:	

Did someone recommend/refer you to CMC, if yes who: _____		
Are you here for mental health treatment?	☐Yes	☐No
Are you here for substance use disorder treatment?	☐Yes	☐No
If yes, explain: _____		
Are you currently getting services for mental health treatment?	☐Yes	☐No
Are you currently getting services for substance use disorder?	☐Yes	☐No
If yes, explain: _____		
What else would you like us to know about why you are here? _____		

Gross Annual Family Income:		
If unknown, please choose a range:		
☐0- $9,999	☐$40,000-$49,000	☐$80,000-$89,000
☐$10,000-$19,999	☐$50,000-$59,000	☐$90,000-$99,999
☐$20,000-$29,999	☐$60,000-$69,000	☐$100,000 or above
☐$30,000-$39,999	☐$70,000-$79,000	

Number of people living on family income?
Number of children under the age of 18 in the household?

Are you currently pregnant?		
☐Yes	☐No	☐Not Applicable

Do you need help with any of the following?				
☐Insurance	☐Housing	☐Fuel/Heat	☐Transportation	☐Finances
☐Employment	☐Medical	☐Food	☐Clothing	☐Childcare
☐Language Assistance/Interpreter Services		☐Assistive Technology		☐Literacy
☐Paperwork Assistance		☐Cultural		☐Other
If Other, please explain:				

Type of Insurance:					
☐Medicaid/Green Mountain Care		☐Medicare	☐BC/BS	☐Cigna	☐MVP
☐Tricare	☐Martins Point	☐CBA Blue	☐Other		
Policy #					
Policy Holder's Name (if different from client):					

Smoking Status:		
☐Never Smoked/Vaped	☐Current everyday smoker	☐Occasional Smoker
☐Current Vaper	☐Current Smokeless tobacco user	☐Former tobacco user

Advanced Directive:				
Do you have an advanced directive?	☐Yes	☐No	☐I don't know	☐ I would like help completing one
Would you like information about a Psychiatric Advanced Directive?			☐Yes	☐No

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Clara Martin Center Fee Schedule

Services	**Unit Cost Per Hour (unless otherwise indicated)**
Psychotherapy (includes individual, couples, family, and family w/ client not present)	$170.00
Group Therapy	$115.00
Case Management – includes Community Supports and Service Planning	$128.00
Group Community Supports	$62.00
Mental Health/Substance Use Evaluation	$158.00
Intensive Outpatient	$194.00 – per group
Psychiatric Evaluation – no discounts available for psychiatric services	$176.00
Medication Check with Therapy - cost varies depending on length of appointment and no discounts available for psychiatric services	10-19 Min. $ 90.00 20-29 Min. $106.00 30-39 Min. $159.00 40-54 Min $214.00

The Clara Martin Center is a private, not for profit agency. You may be eligible for reduced fees based on your household income and the number of people supported by that income. The cost of services may be subsidized by the Department of Mental Health or the Department of Substance Use.

Check whichever option applies to you/your family:

☐ I would like to apply for fee reduction based on my household income and family size. I agree to provide the required written verification of income to determine eligibility for changes to the fee schedule above.

☐ I agree to pay all fees for services provided according to the fee schedule above. I acknowledge that if I change my mind in the future, I can request an application for fee reduction and provide the required written verification of income to determine eligibility for changes to the fee schedule.

_____

I hereby authorize payment directly to CMC for any third-party benefits to which I am entitled. I also authorize the release of any information required to process such claims. I understand that my insurance company will be billed at full cost of service. I will be responsible for that portion of the cost not paid by my insurances; in no case will that amount exceed the agreed upon fee. I further acknowledge that in the case of Urine Screenings, Dominion Diagnostic Services will be utilized as a processing center and shall consequently be the biller noted for third party reimbursement purposes.

Signature of client/guardian: _____ Date: _____

Signature of CMC staff witness: _____ Date: _____

Created: August 2024
Reviewed and revised: August 2024

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Client ID_____

☐ No custody agreement necessary for my child

Proof of Custodial Role for Children

Dear Parent or Guardian:

In order to provide services for your child/children, the Clara Martin Center needs to establish who has the parental rights and custodial rights to make the decision for treatment. We will need a copy of a legal document that states that you are the parent who can make this decision. We need this document within 30 days.

Both parents should be aware of the arrangement that your child/children will be in treatment at our agency. If that is not possible, please explain the circumstances at the beginning of contact with the agency and include a document of that explanation.

If there is not clarity about which parent has custodial rights to approve treatment for the child/children, the Clara Martin Center will need to suspend treatment for your child.

Please send us a copy or bring a copy of your legal custody document to your first appointment (either at the screening or the intake assessment.

By signing this agreement, I am stating that I have the legal rights to engage my child/children in treatment for mental health or substance use. I will bring in copy of appropriate legal documents at the first appointment or within 30 days.

Parent Signature:_____

Parent Name: _____

For Minor:_____

Date Signed: _____

Form # 200 Created June 2020

Client Name: _____ Client ID: _____

DATE: _____

Clara Martin Center

Additional Demographic and Contact Information

Race:		
☐ White (Includes French Canadian)	☐ Alaskan Native	☐ American Indian
☐ Asian or Pacific Islander	☐ Black/African American	☐ Multi-Racial
☐ Other	☐ Unknown	☐ Declined to answer

Ethnic Origin:			
☐ Cuban	☐ Mexican/Mexican American	☐ Puerto Rican	☐ Other Hispanic
☐ Not of Hispanic Origin	☐ Unknown	☐ Declined to answer	

Marital Status:			
☐ Never Married	☐ Married	☐ Civil Union	☐ Separated
☐ Divorced	☐ Widowed	☐ Annulled	

Education:
Last Grade or Degree Completed?

Employment Status:			
☐ Full Time	☐ Part-Time (20-34 hours/week)	☐ Part-Time (less than 20 hours/week)	
☐ Unemployed- Looking for work	☐ Unemployed- Not looking for work	☐ Retired	☐ Homemaker
☐ Volunteer	☐ Preschooler/Student	☐ Disabled	☐ Other:

Are you a veteran?			
☐ Yes	☐ No	☐ Currently Serving	☐ Family Member Currently Serving

Residential Arrangement:		
☐ Own Home/Condo/Trailer	☐ Rent	☐ Section 8/Subsidized Housing
☐ Residential Housing	☐ Nursing Home/Assisted Living	☐ Temporary Housing/Living Situation
☐ Homeless or Homeless Shelter	☐ Other	

Living Arrangement:		
☐ Living Alone	☐ Living with spouse and/or minor children	☐ Living with parents or other relative
☐ Living with Foster Parents	☐ Living with non-related persons	☐ Living in a group home
☐ Living in an institution	☐ Other	

Legal Status:		
☐ Voluntary	☐ Court/Legislatively Mandated DUI	☐ Involuntary-Civil
☐ Involuntary-Criminal	☐ Other Court Mandated	☐ Protective Services

SSI Eligibility:		
☐ Eligible and receiving payments	☐ Eligible but not receiving payments	☐ Determined ineligible
☐ Potentially eligible but have not applied	☐ Not applicable	☐ Other

Mother's Maiden Name: _____

Client Name: _____ Client ID: _____

Clara Martin Center

Additional Demographic and Contact Information

Did someone recommend you come in today or refer you here?	☐Yes	☐No	
If so, who?	☐DCF	☐Doctor's Office	☐Medication Assisted Treatment Program
☐Reach Up	☐Orange County Restorative Justice Center	☐Probation & Parole	☐Upper Valley Haven
☐Other _____			
Contact information: _____			

Emergency Contacts:	
Check here if Emergency Contact is the same as information for legal guardians:☐	
Name:	Relationship:
Phone number(s):	
Name:	Relationship:
Phone number(s):	

Client ID: _____

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Date: _____ Client Name: _____

AHC HRSN Screening Tool Core Questions

Living Situation

1.What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but **I am worried** about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2.Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

☐ Pests such as bugs, ants, or mice	☐ Mold	☐ Lead Paint or pipes
☐ Lack of heat	☐ Oven or stove not working	☐ Smoke detectors missing or not working
☐ Water Leaks		☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Often true	☐ Sometimes true	☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Often true	☐ Sometimes true	☐ Never true

Transportation

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes	☐ No

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes	☐ No	☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

7.How often does anyone, including family and friends, physically hurt you?

☐ Never (1)	☐ Rarely (2)	☐ Sometimes (3)	☐ Fairly often (4)	☐ Frequently (5)

8. How often does anyone, including family and friends, insult or talk down to you?

☐ Never (1)	☐ Rarely (2)	☐ Sometimes (3)	☐ Fairly often (4)	☐ Frequently (5)

Client Name: _____ Client ID: _____

9. How often does anyone, including family and friends, threaten you with harm?				
☐ Never (1)	☐ Rarely (2)	☐ Sometimes (3)	☐ Fairly often (4)	☐ Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?				
☐ Never (1)	☐ Rarely (2)	☐ Sometimes (3)	☐ Fairly often (4)	☐ Frequently (5)

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:

☐ Very Hard	☐ Somewhat hard	☐ Not hard at all

Employment

12. Do you want help finding or keeping work or a job?

☐ Yes, help finding work	☐ Yes, help keeping work	☐ I do not need or want help

Family and Community Support

13.If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

☐ I don't need any help	☐ I get all the help I need
☐ I could use a little more help	☐ I need a lot more help

14.How often do you feel lonely or isolated from those around you?				
☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always

Education

15. Do you speak a language other than English at home?

☐ Yes	☐ No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

☐ Yes	☐ No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

18. On average, how many minutes did you usually spend exercising at this level on one of those days?

☐ 0	☐ 10	☐ 20	☐ 30	☐ 40	☐ 50	☐ 60	☐ 90	☐ 120	☐ 150 or greater

Disabilities

25.Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

☐ Yes	☐ No

26.Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

☐ Yes	☐ No

Client ID:
Client Name:

Clara Martin Center

People Helping People

Randolph, VT 802-728-4466
Bradford, VT 802-222-4477
Wilder, VT 802-295-1311

Attendance Policy

The Clara Martin Center values providing effective and efficient services to everyone we serve. We understand that life can sometimes get in the way of scheduled appointments. If you need to reschedule your appointment, please give us at least 24-hour notice. If you cancel or reschedule with less than 24-hour notice, your appointment may be considered a "no-show."

If you have two or more no-show appointments within 30 days or two consecutive, no-show appointments:

- You must speak with an Engagement Specialist before we schedule another appointment. The specialist will discuss barriers to attendance and the scheduling plan moving forward.
- Your future appointments may be scheduled to be less frequent.

I have reviewed and understand the no-show policy.

Client signature: _____ Date: _____

Clinician signature: _____ Date: _____

Reviewed or Revised June 2024

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Client ID:_____

Date:_____

Clara Martin Center Client Medical History

Name:	**D.O.B**
Height:____ft ___in	**Weight:**_____lbs.
Legal Sex: ☐Male ☐Female ☐Choose not to disclose	

Gender Identity:	**Personal Gender Pronouns:**
☐Agender ☐Boy/Man	☐He/Him/His
☐Girl/Woman ☐Gender Expansive	☐She/Her/Hers
☐Genderqueer ☐Trans Man/Trans Boy	☐They/Them/Theirs
☐Trans Woman/Trans Girl	☐Other_____
☐Choose not to disclose ☐Other_____	

Primary Care Physician and Dentist
Dr.'s Name_____Phone Number:_____
Dentist Name_____Phone Number:_____

Primary Care Facility Name			
☐Alice Peck Day	☐Ammonoosuc Health Center	☐Barre Internal Medicine	☐VMC Adult Primary Care Berlin
☐CVMC Associates In Pedicatrics	☐CVMC Family Medicine- Berlin	☐CVMC Family Medicine-Mad River	☐CVMC Family Medicine-Waterbury
☐CVMC- Green Mountain Family Practice	☐CVMC Integrative Family Medicine-Montpelier	☐DHMC	☐DHMC-Heater Road
☐DHMC-Lyme	☐Gifford Medical Center	☐Gifford-Berlin	☐Gifford-Bethel
☐Gifford-Chelsea	☐Gifford-South Royalton	☐ Hardwick Area Health Center	☐Ideal Primary Care
☐Little Rivers Health Care	☐Montshire Pediatrics	☐Mt. Ascutney Health Center	☐Newbury Health Clinic
☐Ottaqueeche Health Center	☐Plainfield Health Center	☐Rowe Health Center	☐Upper Valley Pediatrics
☐UVM	☐White River Family Practice	☐White River Junction VA	
☐Other_____			

Client Name: _____ Client ID: _____

Pharmacy Information
Pharmacy Name:_____
Pharmacy Phone Number:_____

Personal Health History

Date of last Physical Exam: _____
Are all immunizations up to date? ☐ Yes ☐ No
List any medical/mental health problems that other doctors have diagnosed you with

Have you had an ER visit in the last 6 months? ☐ Yes ☐ No

Other hospitalizations ☐ **None**		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers ☐ **None**		
Name the Drug	**Strength**	**Frequency Taken**

Client Name: _____ Client ID: _____

Allergies to medications	☐ **None**
Name the Drug	**Reaction You Had**

Do you have any concerns in the following areas		
Sensory (vision, hearing, sense of touch/smell, reactions to sensory stimulation, hallucinations, etc.)	☐ Yes	☐ No
Motor (coordination, gait, balance, posture, movements, tics, nervous habits or mannerisms)	☐ Yes	☐ No
Language (delays, comprehension problems, speech difficulties)	☐ Yes	☐ No

FAMILY HEALTH HISTORY				
Is there a family history (parents, grandparents, siblings) in any of the following?				
☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Liver Disease
☐ Lung Disease		☐ Seizure Disorder	☐ Thyroid Disease	