Catalyst Life Services
741 Scholl Road
Mansfield, OH 44907
419-756-1717

ENROLLMENT INTO THE MULTI-AGENCY COMMUNITY SERVICES INFORMATION SYSTEM (MACSIS)

DISCLOSURE (BILLING AUTHORIZATION) STATEMENT

To be eligible to receive public funds to help pay for the cost of your mental health and/or substance abuse services (for example Medicaid) you will need to read and sign this statement to allow the agency to give billing information to the ___________________________________ County. Starting January 1, 1999, all agencies in the ___________________________________ County network will change how they submit bills to and receive payment from the ____ County.

Agencies will use a uniform sliding fee scale to determine what, if anything, you may need to pay for services. If you are eligible for Medicaid or other public funds, then the agency will submit billing information including your name and Social Security number to the ______________________________________ County. The Board will:

- enroll you in the ____ County Plan and
- determine what public funds can be used to pay for your services, and
- pay the agency through an information system (MACSIS) connected with the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Human Services.

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL, consistent with state and federal law. Name identified information will only be used to pay for services received. Other information will be kept without your name attached and will be stored by a unique number. This information will not be available to any other sources or used for any other purposes. You have the right to review your records and notify the provider of errors in the record. Billing information will be kept for seven (7) years after you have received services, and only demographic information will be kept after that time.

If you do not agree to sign this disclosure statement then the Board may not be able to use public funds to pay for your services. The agency may not be able to provide services after January 1, 1999 if you do not agree to allow the Board to determine if you are eligible for public funds. If you have questions please discuss with the Financial Registration Department.

Agency Name: Catalyst Life Services

Name of Client: (Please type or Print)____

Client ID# at Agency (UCI)_____________________________

Signature of Client/Guardian____ **Date:**_____________________

Agency Staff (Please type or Print)____ **Date:**_____________________

Out-of-County Form

Revised 8/27/14 Effective 8/27/14
Chart Section: Financial
Form Responsibility: Financial A/R
Paper Color: purple

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult **County:**

Client is an adult? **Yes** **No** **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	**Date**

Minor

Client is a Minor? **Yes** **No**	**If yes, indicate if child is legal custody of the following (this is not the foster parent).** **Parent** **CSB** **DYS** **Court** **Other (specify):_____________________**
Client Name (Please print)	
Name of Legal Custodian Marked Above	**Phone No. of Legal Custodian**
County of Legal Custodian	
If Parent, Address of Parent (If different from client's physical address on enrollment form)	
Signature of Legal Custodian	**Date**

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