



**Te Pou Ora O Te Piringatahi – Northland Primary Mental Health Pilots
SUBSIDISED COUNSELLING CLAIM FORM**

First Session – Form 1 (for subsequent sessions use Form 2 – over page)

Counsellors Name: _____

First Name:	Last Name:	NHI:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Street Address:			DOB:	
Suburb:	Phone:	Ethnicity:		
Town/City/District:				
General Practitioner:	PHO:	<input type="checkbox"/> Whangaroa PHO		
Practice:	<input type="checkbox"/> Hokianga Health Integrated PHO	<input type="checkbox"/> Kaipara Care		
	<input type="checkbox"/> Tihewa Mauriora PHO	<input type="checkbox"/> Te Tai Tokerau PHO		
1. Referred by:	2. Problem Type(s) – tick those relevant:	1. Contextual Problems		
<input type="checkbox"/> GP	<input type="checkbox"/> Substance Dependence	<input type="checkbox"/> Relationship Issues		
<input type="checkbox"/> Primary MH Coordinator	<input type="checkbox"/> Harmful Thoughts	<input type="checkbox"/> Financial Issues		
<input type="checkbox"/> Other Counsellor	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Employment Issues		
<input type="checkbox"/> Other	<input type="checkbox"/> Depression	<input type="checkbox"/> Problems Dealing with Agencies		
Full Name of Referrer:	<input type="checkbox"/> Stress Related Problems	<input type="checkbox"/> Other Medical Issues		
	<input type="checkbox"/> Something Else - Specify:	<input type="checkbox"/> Abuse – Historical		
		<input type="checkbox"/> Others - Specify:		

2. Date of First Session: _____

3. Which source of counselling funding would normally be the most appropriate for this client?

- A. ACC, “Mental injury caused by physical injury. Mental injury resulting from sexual abuse”
- B. Northland Health:
 - i. Alcohol & Drug service: \geq 18years and/or have a substance related diagnosis
 - ii. Child & Youth Mental Health and Alcohol & Drug Services 0-17yrs
- C. Family Court “people applying for (or heading toward) a separation, custody or access order.”
- WINZ support via special benefit paid weekly to the client:
- D. Client self-funded
- E. The client isn’t eligible for any of the above or able to self-fund

4. If you have ticked any boxes from A to E above please indicate the steps you have taken to pursue this funding source and why there is still a need for Subsidised Counselling :

5. Authorised for up to 6 Counselling Sessions by:

To be signed by Primary Mental Health Coordinator:	<input type="checkbox"/> Hokianga Health Integrated PHO	Brett Smith 09 405 7709
	<input type="checkbox"/> Tihewa Mauriora PHO Broadway	Gaynor Fiske 09 401 1556
	<input type="checkbox"/> Whangaroa PHO	Michelle Boyd 09 405 0340
	<input type="checkbox"/> Kaipara Care Inc.	Wendy Salter 09 439 7149
	<input type="checkbox"/> Te Tai Tokerau PHO	Richard Renwick (09) 408 4024 Hauora Whanui (Coord) 09 404 0241 Richard Watling (09) 408 4024

PLEASE FAX THIS TO 09 439 1389 (Changed from June 08) or POST TO KAIPARA CARE INC, PO Box 112, DARGAVILLE, BY THE LAST DAY OF THE MONTH.

Payments will be made by the 10th day of the following month by direct credit & KCI will provide a buyer created tax invoice to cover your monthly payment

Version 4 – This is the only acceptable form from 1 June 2008



KAIPARA CARE Inc. – SUBSIDISED COUNSELLING CLAIM FORM

Subsequent Sessions – Form 2 (for first session use Form 1 – over page)

Counsellors Name: _____

Client Full Name or NHI if previously supplied: _____

Session Number and Date: 2. _____ DNA (tick)

3. _____ DNA

(One session only is payable if client DNA's)

4. _____ DNA

5. _____ DNA

6. _____ DNA

Please indicate if this is the final session: YES

If this is the final session please tick or specify one or more outcomes:

- Issues are mostly resolved
- Issues are mostly not resolved
- Other actions are necessary
- Contact has been lost with the client
- Client has actively terminated the relationship
- More sessions would have been desirable
- Continuing to work with this client (funded or not)

Other comments: _____

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