|  |  |  |
| --- | --- | --- |
| **Persons Name**(First, MI, Last): | **Date:** | **Time:** |
| Caller: ( ) Self ( ) Other | If “Other” What is Relationship: |
| Gender: ( ) Male ( ) Female ( ) Transgender | Diagnosis: |
| Organization/Program Name:  | Has the person received services here before? ( ) Yes ( ) No |
| What has caused the person to seek services at this time? |
| DOB: | Age: | SSN: | Best Phone Number to Contact: |
| Secondary Phone Number to Contact: ( ) NA ( ) Ok to leave message | E-Mail Address: |
| Persons Address: City: State: Zip: |
| **Legal Guardian:**  | **Phone #:** |
| **Emergency Contact:** | **Phone #:** |
| Ask Person “Are you in a Dangerous Situation?” –( ) Yes ( )NoIf the person reports yes, follow and document as per your emergency protocols. |
| Special Communication Needs: ( ) None Reported ( ) TDD/TTY Device ( ) Sign Language Interpreter ( ) Assistive Listening Device( )( ) Language Interpreter Services Needed/ Other Spoken Language( ) Other: |
| Occupation: | * Full-Time
 | * Part-Time
 | * Unemployed
 | * Student
 |
| **Special Physical Accommodations:** ( )None Reported  |
| Ethnicity:  | * African American
* Native Hawaiian/ Pacific Islander
 | * American Indian/Alaskan
* Caucasian
 | * Asian
* Unknown
 | * Hispanic
* Multiracial
 |
| Prefer Language: ( ) English ( ) Spanish Other: |
| **Primary Payer/Insurance Information** ( ) No Insurance ( ) Self Pay ( ) Co-Pay/Amt. |
| Policyholder insurance Company Name: | Pre-Authorization Required? ( ) Yes ( ) No |
| Policy Number: | Benefit Verification Phone #: |
| Policyholder Employer: | Pre-Authorization Phone #: |
| Group Number: | Pre-Authorization Confirmation #: |
| Policyholder Name: | Number of Sessions Authorized: |
| Policyholder SSN: | Name of Authorizer: |
| Policyholder ID # :( May be same as SSN) | Re-Authorization Date: |
| Policyholder DOB: | Secondary Insurance: ( ) Yes ( ) No |
| Secondary Insurance Policy #: ( ) NA | Secondary Insurance Benefit Verification Phone #: ( ) NA |
| **INTERNAL USE ONLY** |
| * Accepted for Service(s): Type:
 | Person Served Preferences: |
| * Referred Elsewhere: To: /Reason:
 | Schedule Time/Date (if Applicable): |
| **Clinician Assign To:** | **Date:** | **Staff Assigning The Case:**  |