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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 ( )No  If 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:** | | | | |