REQUEST FOR SERVICES – Part 1A

Name: _____ Last First Middle Suffix				**Date:**
Maiden Name (If applicable):				
Source of Information:				
Address:				
City/State/Zip Code:			**County:**	
Phone #:	**SS#:**		**Gender:**	
DOB: _____ Month/Day/Year				

Reason for Seeking Services / Services Requested

_____

_____

_____

_____

What are your immediate/urgent needs (including medical)? _____

_____

Are you currently having thoughts of harming yourself and/or others? ☐ Yes ☐ No

Have you ever been treated for any mental health and/or substance use problems? ☐ Yes ☐ No If yes, please list how many times you have received treatment?

Mental Health: In a hospital _____ In outpatient facility _____

Substance Abuse: In a hospital _____ In outpatient facility _____

Previous services at this agency: ☐ Yes ☐ No If yes, when: _____

Are you currently taking psychiatric medication? ☐ Yes ☐ No
If yes, what medications are you currently taking? _____

_____

_____

Referred by: ☐ Physician ☐ DHS ☐ Self ☐ Family ☐ Other: _____ ☐ Court (If remanded through the court or criminal justice system to this facility for Treatment, what is the county in which the legal proceedings took place?_____)

Current Residence: ☐Private Residence ☐On the Street ☐Residential Care Home ☐Institutional Setting ☐Nursing Home ☐Community Shelter ☐Supported Living ☐Residential treatment ☐Specialized Community Group Home ☐Foster Care ☐Group Home

Current Living Situation ☐ Alone ☐ With Family/Relatives ☐ With Non-Related Persons ☐ With Batterer

Are you currently homeless? ☐Yes ☐No If yes, how long have you been homeless? _____

Have you been homeless at any time during the past 3 years? ☐Yes ☐No If yes, how many times? _____

Race (Check all that apply) ☐ White ☐ Asian ☐ American Indian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ Hispanic/Latino

Annual Household Income: $	**# in Household:**
Source(s) of Income:	
☐ SSI ☐ Employment	
☐ SSDI ☐ TANF	
☐ Food Stamps ☐ Other: _____	

Client Name _____ Chart # _____

Insurance ☐ Private Insurance: _____ ☐ Private Pay
☐ Medicaid #:_____ ☐ Medicare ☐ Other:_____ ☐ None

Emergency contact name:	
Relationship:	
Phone #:	**Address:**
Legal Guardian/Custodian name (if applicable): **Relationship** ☐ **Legal Document Obtained**	
Phone #:	**Address:**

Guardian/Custodian able/willing to participate in services? ☐ Yes ☐ No ☐ Not Applicable

Preferred Language	**Other Languages Spoken**

IC with _____ **on** _____ **at** _____

Staff Signature: _____