



Personal Information			Time:	Date:
Caller: <input type="checkbox"/> Self <input type="checkbox"/> Other		If "Other" What is Relationship:		
Person's Name (First MI Last):			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Phone Number Calling From: <input type="checkbox"/> NA		Also Known As (AKA):		
Organization Name:		Has the person received services here before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What has caused the person to seek services at this time?				
DOB:	Age:	SSN:	Best Phone Number to Contact: <input type="checkbox"/> Ok to leave message	
Secondary Phone Number to Contact: NA <input type="checkbox"/> <input type="checkbox"/> Ok to leave message		E-Mail Address: NA <input type="checkbox"/> <input type="checkbox"/> Ok to send message		
Person's Address: <input type="checkbox"/> Person is Homeless Apt #:		City:	State:	Zip:
Legal Guardian:		Phone:		
In Case of Emergency Contact:			Phone #:	

Ask The Person, "Are You in a Dangerous Situation?" – Yes No
 If 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(s)
 Language Interpreter Services Needed / Other Spoken Language:
 Other:

Special Physical Accommodations: None Reported

- Ethnicity: African American American Indian/Alaskan Asian Hispanic Multiracial
 Native Hawaiian/Pacific Islander Caucasian Unknown Comment:

Primary Payor/Insurance Information

No Insurance Self Pay Co-Pay/Amt.

Policyholder Insurance Company Name:	Pre-Authorization Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy Number:	Benefit Verification Phone No:
Policyholder Employer:	Pre-Authorization Phone Number:
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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Insurance Policy Number: <input type="checkbox"/> NA	Secondary Insurance Benefit Verification Phone No.: <input type="checkbox"/> NA

Determination

<input type="checkbox"/> Accepted for service(s): Type:	Person Served Preferences:	
<input type="checkbox"/> Referred Elsewhere: To: / Reason:	Schedule Time/Date (If Applicable):	
Staff - Print Name/Credentials:	Date:	Staff Signature: