Personal Information Form

The Personal Information Form has been created to capture a minimum number of demographic data fields that need to be recorded for each Individual. This form serves as a companion to the Comprehensive Assessment form to provide initial required information about the Individual. This form can be completed by support staff, clinical staff, or some combination of the two, as long as the form is completed on initial contact (via phone or walk-in).

Data Field	Identifying Information Instructions
Organization name	Document agency name
Time & Date & Record #	Complete all fields.
Call, Walk-in, Self, Other	Check the appropriate box.
If "Other" What is the Relationship	If someone other than the Individual is calling, describe the relationship of the caller to the Individual.
Referral Source	Indicate referral source and phone number.
Name	Record the first name, last name, and middle initial of the Individual being served.
Also Known As (AKA):	Record other names the Individual uses or has used in past., including maiden name(s)
Maiden Name	Indicate maiden name, if applicable (required for OASAS programs only).
Phone # Calling From	Record the phone number the Individual is calling from. Check N/A if walk-in.
Gender	Indicate Individual's gender by checking the appropriate box. If checking "Other" box, also complete box of current gender designation for insurance purposes.
Why are you seeking services?	Indicate reason for seeking services at this time.
Ask the Individual, "Are you in a dangerous/at risk situation?"	Specifically ask the Individual if they are in a dangerous situation and check the appropriate box. If the Individual reports yes, follow-up and document as per your emergency protocols.
Primary Language	Check appropriate box and specify if "Other."
Date of Birth	Ask and record the Individual's date of birth.
Age	Ask and record the Individual's age.
Social Security Number	Ask and record the Individual's social security number.
Marital Status	Check appropriate box
Has Individual Received Services Here Before	Check the appropriate box to determine if the Individual has received services here previously.
Methadone Programs Only	Enter mother's first name.
Individual's Address	Record primary address of Individual. If homeless, indicate.
Primary Telephone #	Ask and record the best phone number to reach the Individual. Ask and check the appropriate box if the Individual gives permission to leave a message at the identified number.
Secondary Telephone #	Ask if the Individual would like to offer a secondary contact number and record, including if ok to leave a message, if so indicated. If N/A- check this.
Legal Guardian #1	Indicate the name of the individual's parent, guardian, or custodian and their address and phone number. If the Individual is his/her own guardian, record "self." .
Legal Guardian #2	Indicate the name of the individual's parent, guardian, or custodian and their address and phone number. If the Individual is his/her own guardian, record "self."
Emergency Contact	Indicate the name, address, relationship and phone number of an emergency contact Individual.

Are you currently receiving treatment services anywhere else?	Check appropriate box and if "Yes" specify.
Are you currently taking any medications?	Check appropriate box. If "Yes", ask when refill is needed and specify Name, Dose, Frequency, and Prescriber of psychotropic medication(s).
Have you used drugs/alcohol within the last month?	Check appropriate box. If "Yes", specify Type, Frequency, Amount, and Date of last use.
Legal Status	Check appropriate box, if applicable. If court involvement, specify name of court. If "Other" checked, provide details.
Are you mandated?	Check appropriate box. If "Yes", indicate by whom.
Special Needs	Ask and record whether or not the Individual is in need of special assistance. If none is needed, check the "none reported" box.
Additional Information	Identify any additional information provided
Data Field	**Determination**
Agency Program Referred to	Fill in type of program.
Individual Served Preferences	Enter any specific preferences of the person applying for service.
Intake Date, Time, Worker	Enter the applicable information.
Referred to outside of agency, and Reason	For any applicant that is determined not to be appropriate for services provided by the agency, indicate the alternate agency/program and the reason the individual is not appropriate for service here
Alerts	Enter all high risk or potentially dangerous situations identified, (e.g., out of medication, allergies, etc.).
Staff Print Name and Credentials and Date	The person completing the form enters their name, their degree/license or title, and the date the form is completed.
Primary Payor/ Insurance Information / Authorizations / Secondary Insurance	Complete all areas that apply for this section (The section titled "For Office Use Only" will be completed per each agency's protocol). Check the payor source for the Individual and indicate the respective benefit/plan number(s)/phone numbers. Complete all areas that apply related to initial authorization. Be sure to list the full name of authorizer. Complete secondary insurance information if Individual has another insurance benefit.
Income	Obtain monthly income and # of dependents. Specify all current sources of income.