Organization Name:	**Date:**	**DOB:**
Individual's Name *(First MI Last)*:	**Time:** ☐ **AM** ☐ **PM**	**Record #**:

PART A: Initial Demographics, Service Interest, and Crisis Status

☐ **Call** ☐ **Walk-in**	**Referral Source** ☐ **Self** ☐ **Other**	**If Other/Referral Source Name:** **Reason for Referral:**

Phone Number Calling From:	***Children Only* –** Name and Phone Number of Legal Guardian if different than the caller:

Why are you seeking services? *(Please also confirm any urgent medication/injection needs)***:**

Significant Other Seeking Treatment : ☐ No ☐ Yes **–** If yes, describe relationship:

Ask the Individual, "Are you in a Dangerous Situation or At Risk of Harm?" ☐ Yes ☐ No
If Individual reports yes, follow-up and document as per your agency protocols.

Special Needs: ☐ None Reported
☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Assistive Listening Device(s) ☐ Literacy Skills
☐ Language Interpreter Services Needed ☐ Medicaid Transportation ☐ Wheelchair Access ☐ Other:

Individual's Living Address: ☐ Individual is Homeless / Apt#:	**City:**	**State:**	**Zip:**	**County:**
Individual's Mailing Address, if Different:	**City:**	**State:**	**Zip:**	**County:**

Primary Telephone #: ☐ Ok to leave message	**Secondary Telephone #:** ☐ Ok to leave message

Determination (For Agency Use Only) ☐ Not Applicable

☐ **Program Assigned for Intake:**

Intake Date:	**Time:** ☐ AM ☐ PM	**Name of Assigned Worker:**
☐ **Referred outside of agency:** ☐ N/A **To:**		**Reason:**
Completed By - Print Name/Credentials:		**Date:**

Part B - Demographics

Also Known As (AKA):	**Age:**	**Last 4 SSN#:**	**Sex:** ☐ **Male** ☐ **Female** ☐ **Unknown (OMH Only):**

Primary Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ Greek ☐ Hindi ☐ Japanese ☐ Portuguese ☐ Russian ☐ Sign Language ☐ Spanish - ☐ Other: ☐ Unknown (OMH Only):

Preferred Language for discussing healthcare: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ Greek ☐ Hindi ☐ Japanese ☐ Portuguese ☐ Russian ☐ Sign Language ☐ Spanish - ☐ Other, specify:

Organization Name:	**Date:**	**DOB:**
Individual's Name *(First MI Last)*:	**Time:** ☐ **AM** ☐ **PM**	**Record #**:

Race: *(OASAS-Select one; OMH Select all that apply.)*

☐ Alaska Native
☐ American Indian
☐ Asian
☐ Black or African American
☐ Hawaiian or other Pacific Islander
☐ White
☐ Other (Specify):
☐ Unknown (OMH Only)

Hispanic Origin: *(Select one)*

☐ Not of Hispanic Origin
☐ Hispanic, Not Specified
☐ Cuban
☐ Mexican
☐ Puerto Rican
☐ Other Hispanic
☐ Unknown (OMH Only)

Comments:

Marital Status: ☐ Married ☐ Never Married ☐ Living as Married ☐ Separated ☐ Divorced ☐ Widowed

Has the Individual received services here before?
☐ No ☐ Yes - If Yes, When?

OASAS Only

Last Name First 2 Letters: (Birth Name)	**Last Name First 2 Letters**: (Current Name)	**Methadone Programs Only –** Mother's First Name: Mother's Maiden Name:
Program Number:		**CJ Consent Date:** / **NYSID:**
Provider Number:		**CJ Consent Revoke Date:** / **Special Project** *(See instructions):*
Provider Client ID Number:		**Total number of children:** **Total number of children living with the individual:** **Total number of children in foster care:** **Active Case with Child Protective Services:** ☐ **No** ☐ **Yes**
Veteran Status: ☐ **No** ☐ **Yes**		**U.S. Military Status (Select One, if applicable)** ☐ **Active Duty** ☐ **Reserves/National Guard** ☐ **Both Active Duty and Reserves/National Guard**

Individual's Place of Residence

(OASAS-Select one)

☐ Private Residence
☐ Homeless, Shelter
☐ Homeless, No Shelter
☐ Single Resident Occupancy
☐ CD Community Residence
☐ CD Supportive Living
☐ Office of Mental Health (OMH) / Office of People With Developmental Disabilities (OPWDD) Community Residence
☐ Other Group Residential Setting
☐ Institution,(other/Jail/Hospital)
☐ Other:

Organization Name:	**Date:**	**DOB:**
Individual's Name *(First MI Last)*:	**Time:** ☐ **AM** ☐ **PM**	**Record #**:

(OMH-Select one)

☐ Private Residence (home, apt., rooming house, hotel, motel, supported housing, supported SRO, permanent housing programs, transient housing programs, and shelter plus care housing)
☐ Inpatient setting or children's Residential Treatment Facility (RTF)
☐ Institutional setting for youth: Office of Children and Family Services (OCFS) Juvenile Justice Facility
☐ Institutional setting for youth: OCFS Residential Treatment Center (RTC)
☐ Youth community-based residence (OCFS, Dept. of Social Services)
☐ Incarcerated
☐ Adult home (Dept. of Health licensed residential program for adults)
☐ Agency-operated Boarding Home through DSS/ACS (Foster Home)
☐ OMH Residential Care, LICENSED programs, community residence (child or adult), crisis residence, congregate treatment, apt. support, congregate support, community residence-SRO
☐ Nursing or health-related facility (nursing home, skilled nursing facility)
☐ Homeless (e.g., shelter, street, transitional living center)
☐ Other (e.g., non-OMH residential care such as group home or halfway house)
☐ Unknown

Living Arrangements: ☐ Living Alone ☐ Living w/ Non-Related Persons ☐ Living with Spouse/Relatives

OASAS Only

Principal Referral Source:

Criminal Justice Services
☐ Drug Law Reform (DLR) District Attorney
☐ DLR Court
☐ DLR Probation
☐ DLR Parole General
☐ DLR Parole Release Shock
☐ DLR Parole Release Willard
☐ DLR Parole Release Re-sentence
☐ Drinking Driver Referral
☐ Police
☐ Family Court
☐ Other Court
☐ Alternatives to Incarceration
☐ City/County Jail
☐ NYS Department of Correctional Services
☐ Office of Children and Family Services

Self, Family, Other
☐ Self-Referral
☐ Family, Friends, Other Individuals
☐ AA/NA and Other Self-Help

Chemical Dependence Treatment
☐ Chemical Dependency (CD) Program in New York State
☐ CD Program Out of State
☐ CD VA Program
☐ CD Private Practitioner

Prevention/Intervention Services
☐ School-Based Prevention Program
☐ Community-Based Prevention Program
☐ Employee Assistance Program
☐ Other Prevention/Intervention Program

Health Care Services
☐ Developmental Disabilities Program
☐ Mental Health Provider
☐ Managed Care Provider
☐ Health Care Provider
☐ AIDS Related Services

Social Services
☐ Local Social Services-Child Protect Services/Child Welfare Agency (CWA)
☐ Local Social Services Dist-Income Maintenance
☐ Local Social Services Dist Treatment Mandate/Public Assistance
☐ Local Social Services Dist Treatment Mandate/Medicaid Only
☐ Other Social Services Provider

Employer/Educational/Special Services
☐ Employer/Union (Non-Employee Assistance Program)
☐ School (Other than Prevention Program)
☐ Special Services (Homeless/Shelters)

*****
☐ Other:

Referral meets priority access criteria: ☐ No ☐ Yes, if Yes Explain:

Are you mandated? ☐ No ☐ Yes, If yes, by whom:

Organization Name:	**Date:**	**DOB:**
Individual's Name *(First MI Last)*:	**Time:** ☐ **AM** ☐ **PM**	**Record #**:

Contact Information

☐ **Family Member and/or** ☐ **Legal Guardian #1:** ☐NA	☐ **Family Member and/or** ☐ **Legal Guardian #2:** ☐NA
Family Member / Legal Guardian's Address: / Apt#:	**Family Member / Legal Guardian's Address:** / Apt#:
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Telephone #:	**Telephone #:**

In Case of Emergency Contact:	**Relationship:**	**Telephone #:**

Emergency Contact Address:

Are you currently receiving treatment services anywhere else: ☐ No ☐ Yes If yes, where?

Do you have a Case Manager? ☐ No ☐ Yes - If yes, name and contact information:

Additional Information:

Primary Payor/Insurance Information ☐ No Insurance

Medicaid Number	**For Office Use Only**
Medicaid Sequence #:	Name of caseworker (insurance) you spoke with:
Medicaid Active: ☐Yes ☐No	Authorization Number:
Managed Care Medicaid: ☐Yes ☐No	Effective Date of Policy:
Managed Medicare: ☐Yes ☐No	Mental Health Co-pay:
Medicare #:	Chemical Dependency Co-pay:
Child Health Plus ☐ / Family Health Plus ☐	Medicaid Spend-Down:
Policyholder Insurance Company Name:	Deductible Info if Applicable:
Insurance Company Telephone #:	Annual Benefits:
Policy Number:	Benefits already used:
Plan Type:	Number of Visits Authorized:
Policyholder Employer:	**Type of Sessions Authorized:**
Group Number:	Individual Session:
Policyholder Name:	Group Sessions:
Policyholder ID#:	Medication:
Policyholder DOB:	Licensed Therapist Required: ☐Yes ☐No
	LCSW Required for social workers: ☐Yes ☐No

Organization Name:	**Date:**	**DOB:**
Individual's Name *(First MI Last)*:	**Time:** ☐ **AM** ☐ **PM**	**Record #**:

Secondary Insurance Policy Number: ☐ NA

Policyholder Insurance Company Name:
Insurance Company Telephone #:
Policy Number:
Policyholder Employer:
Group Number:
Policyholder Name:
Policyholder ID#: (May be same as SSN)
Policyholder DOB:

Income

Total Monthly Income:
Number of Dependents:

Primary Source of Income at Admission	
☐ None	☐ Family and/or Spouse Contribution
☐ Wages/Salary or self-employed	☐ Social Security retirement, survivor's or dependent's (SSA)
☐ Alimony/Child Support	☐ Supplemental Security Income (SSI)
☐ Department of Veterans Affairs	☐ Social Security Disability Income (SSDI)
☐ Veteran's Disability (OMH Only)	☐ Safety Net Assistance (SNA)
☐ Veteran's Cash Assistance (OMH Only)	☐ Temp Asst for Needy Families (TANF)
	☐ Other (Worker's Comp; Disability; Unemployment, …):

Person Completing Form:		**Date**:
Completed By - Print Name:	**Signature:**	**Date:**