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| MHA Date & Time: |

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| Referral source |  | | | |
| Primary Doctor |  | | | |
| Primary Doctor Phone |  | | | |
| Date of Referral |  | | | |
| Client Name |  | | | |
| SSN |  | | | |
| DOB (mm/dd/yyyy) |  | Gender: | | Male  Female |
| School | | Grade | | |
| Ethnicity: -Not Hispanic -Hispanic  -Cuban -Puerto Rican  -Other Hisp -Mexican | | | Race (Check all that apply):  -Asian -Black/African Amer White/Cauc -Alaskan Nat Native Hawaiian/Pacif Islander  -Native American | |

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| --- | --- | --- | --- | --- |
| Street Address: | | | | Apt. (if app) |
| City: | County: | | Zip Code: | |
| Guardian Name(s): | | | | |
| Relationship to client: | | | | |
| Guardian Phone: | | Email address: | | |
| Guardian address (If different) | | | | |
| Are custody documents needed:  Yes No  (Custody papers are required if guardian is not biological parent, and must be obtained before an assessment is scheduled) | | Custody situation (please check one):  Parents are married/living together  Other parent aware of service:  List other parent name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other parent not involved. Are there documents limiting rights? yes no  (If so, we must obtain a copy) | | |

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| Presenting Concerns: | |
| Is client currently on any medication: Yes  No  Please list if any: | |
| Is JFS involved:  Yes  No | If yes: Please list JFS worker name and contact info  Name:  Phone: |
| Is child suicidal? Yes  No Were they Referred to the hospital? Yes No | |

Insurance / Income (please ensure this section is completed)

Number of family members:

Sources of income (any income that comes in: Monthly Amount:

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Adjustment to income (\*adjustments are expenses over 7% of gross income, such as paying child support, alimony, and medical expenses. Housing, food, credit card payments, food stamps **are not** considered adjustments to income)

Adjustment: Monthly Amount:

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Total Monthly Income:

Medicaid  Care Source  United Health Care Medicaid Paramount  Buckeye Molina No insurance  Private Insurance (**please fill out Private Insurance Verification form**)

MMIS Number:

Member ID Number (if applicable):

Client may be eligible for a subsidy to be paid from the Hamilton County Mental Health Levy funds equal to

% of the cost of services received.