|  |
| --- |
| MHA Date & Time: |

****

****

|  |  |
| --- | --- |
| 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 |

|  |  |
| --- | --- |
| 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) |

|  |
| --- |
| Presenting Concerns:  |
| Is client currently on any medication: [ ] Yes [ ]  NoPlease list if any:   |
| Is JFS involved: [ ] Yes [ ]  No | If yes: Please list JFS worker name and contact infoName: 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:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

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:

|  |  |
| --- | --- |
|  |  |
|  |  |

 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.