beechacres
PARENTING CENTER

MHA Date & Time:

BEYOND THE CLASSROOM™

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 ☐ 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:

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.