



Organization Name:	Date:	DOB:
Individual's Name (First MI Last):	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Record #:

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

<input type="checkbox"/> Call <input type="checkbox"/> Walk-in	<input type="checkbox"/> Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Other	If Other/Referral Source Name Reason for Referral:
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Phone Number Calling From:	Children Only – Name and Phone Number of Legal Guardian if different than the caller:
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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: <input type="checkbox"/> Individual is Homeless / Apt#:	City:	State:	Zip:	County:
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Individual's Mailing Address, if Different:	City:	State:	Zip:	County:
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Primary Telephone #: <input type="checkbox"/> Ok to leave message	Secondary Telephone #: <input type="checkbox"/> Ok to leave message
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Determination (For Agency Use Only) Not Applicable

<input type="checkbox"/> Program Assigned for Intake:		
Intake Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Name of Assigned Worker:
<input type="checkbox"/> Referred outside of agency: <input type="checkbox"/> N/A To:		Reason:
Completed By - Print Name/Credentials:		Date:

Part B - Demographics

Also Known As (AKA):	Age:	Last 4 SSN#:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown (OMH Only):
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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:



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Race: (OASAS-Select one; OMH Select all that apply.)		Hispanic Origin: (Select one)
<input type="checkbox"/> Alaska Native <input type="checkbox"/> Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown (OMH Only)	<input type="checkbox"/> Mexican <input type="checkbox"/> Not of Hispanic Origin <input type="checkbox"/> Hispanic, Not Specified <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
	Veteran Status: <input type="checkbox"/> No <input type="checkbox"/> Yes		U.S. Military Status (Select One, if applicable) <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserves/National Guard <input type="checkbox"/> Both Active Duty and Reserves/National Guard	

Individual's Place of Residence

(OASAS-Select one)

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



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(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	<p>Principal Referral Source:</p> <p>Criminal Justice Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Law Reform (DLR) District Attorney <input type="checkbox"/> DLR Court <input type="checkbox"/> DLR Probation <input type="checkbox"/> DLR Parole General <input type="checkbox"/> DLR Parole Release Shock <input type="checkbox"/> DLR Parole Release Willard <input type="checkbox"/> DLR Parole Release Re-sentence <input type="checkbox"/> Drinking Driver Referral <input type="checkbox"/> Police <input type="checkbox"/> Family Court 	<ul style="list-style-type: none"> <input type="checkbox"/> Other Court <input type="checkbox"/> Alternatives to Incarceration <input type="checkbox"/> City/County Jail <input type="checkbox"/> NYS Department of Correctional Services <input type="checkbox"/> Office of Children and Family Services <p>Self, Family, Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> Self-Referral <input type="checkbox"/> Family, Friends, Other Individuals <input type="checkbox"/> AA/NA and Other Self-Help 	<p>Chemical Dependence Treatment</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chemical Dependency (CD) Program in New York State <input type="checkbox"/> CD Program Out of State <input type="checkbox"/> CD VA Program <input type="checkbox"/> CD Private Practitioner <p>Prevention/Intervention Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> School-Based Prevention Program <input type="checkbox"/> Community-Based Prevention Program <input type="checkbox"/> Employee Assistance Program <input type="checkbox"/> Other Prevention/Intervention Program
	<p>Health Care Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Developmental Disabilities Program <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> Managed Care Provider <input type="checkbox"/> Health Care Provider <input type="checkbox"/> AIDS Related Services 	<p>Social Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local Social Services-Child Protect Services/Child Welfare Agency (CWA) <input type="checkbox"/> Local Social Services Dist-Income Maintenance <input type="checkbox"/> Local Social Services Dist Treatment Mandate/Public Assistance <input type="checkbox"/> Local Social Services Dist Treatment Mandate/Medicaid Only <input type="checkbox"/> Other Social Services Provider 	<p>Employer/Educational/Special Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employer/Union (Non-Employee Assistance Program) <input type="checkbox"/> School (Other than Prevention Program) <input type="checkbox"/> Special Services (Homeless/Shelters) <p>*****</p> <ul style="list-style-type: none"> <input type="checkbox"/> Other:
	<p>Referral meets priority access criteria: <input type="checkbox"/> No <input type="checkbox"/> Yes, if Yes Explain:</p>		
	<p>Are you mandated? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, by whom:</p>		



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Contact Information

<input type="checkbox"/> Family Member and/or <input type="checkbox"/> Legal Guardian #1: <input type="checkbox"/> NA			<input type="checkbox"/> Family Member and/or <input type="checkbox"/> Legal Guardian #2: <input type="checkbox"/> NA		
Family Member / Legal Guardian's Address:			Family Member / Legal Guardian's Address:		
/ Apt#:			/ 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: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where?					
Do you have a Case Manager? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization Number:
Managed Care Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date of Policy:
Managed Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Co-pay:
Medicare #:	Chemical Dependency Co-pay:
Child Health Plus <input type="checkbox"/> / Family Health Plus <input type="checkbox"/>	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: <input type="checkbox"/> Yes <input type="checkbox"/> No
	LCSW Required for social workers: <input type="checkbox"/> Yes <input type="checkbox"/> No



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Secondary Insurance Policy Number: <input type="checkbox"/> 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	
<input type="checkbox"/> None <input type="checkbox"/> Wages/Salary or self-employed <input type="checkbox"/> Alimony/Child Support <input type="checkbox"/> Department of Veterans Affairs <input type="checkbox"/> Veteran's Disability (OMH Only) <input type="checkbox"/> Veteran's Cash Assistance (OMH Only)	<input type="checkbox"/> Family and/or Spouse Contribution <input type="checkbox"/> Social Security retirement, survivor's or dependent's (SSA) <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Social Security Disability Income (SSDI) <input type="checkbox"/> Safety Net Assistance (SNA) <input type="checkbox"/> Temp Asst for Needy Families (TANF) <input type="checkbox"/> Other (Worker's Comp; Disability; Unemployment, ...):

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