WILLOW OAK GEORGIA

APPLICATION FOR SERVICES

Date: _____

Last Name:	**First Name:**	**Middle Name:**
Date of Birth: **Age:**	**SSN:** ☐☐☐-☐☐-☐☐☐☐	**Sex::**
Home Phone:	**Business Phone:**	**Cell/Other:**
OK to contact? ☐ **Yes** ☐ **No**	**OK to Contact?** ☐ **Yes** ☐ **No**	**Ok to Contact?** ☐ **Yes** ☐ **No**
Home Address:		
City:	**County:**	**State:** **Zip:**
OK to contact? ☐ **Yes** ☐ **No**		
Mailing Address:		
City:	**County:**	**State:** **Zip:**
OK to contact? ☐ **Yes** ☐ **No**		
Driver's License #:	**List any Allergies:**	
Referral Source:		
Agencies Requiring Services:		

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White ☐ Multi-Racial ☐ Other

Marital Status:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Never Married

Ethnicity: Hispanic/Latino Origin ☐ Yes ☐ No

English Proficiency:
- ☐ Proficient in English
- ☐ Limited – Spanish primary language
- ☐ Limited – Primary language Other

Special Population: *Check all that apply*
- ☐ None
- ☐ HIV+
- ☐ Pregnant
- ☐ Veteran
- ☐ Vision impaired
- ☐ Hearing impaired
- ☐ SSI/Disabled
- ☐ IV Drug User

Communication:
- ☐ No Impairment
- ☐ American Sign Language
- ☐ Single Words or Gestures
- ☐ Utilizes Language Technology

Source of Payment: *Check all that apply*
- ☐ Self-Pay
- ☐ Private Insurance
- ☐ Amerigroup
- ☐ Wellcare/Magellan
- ☐ Peachstate/Cenpatico
- ☐ Medicaid

Medicaid No.

Group No.

Member No.

Insurance

Pre-Cert Number:

Living Situation:
- ☐ Institutional Care/Nursing Home
- ☐ Psychiatric Residential Facility
- ☐ Private Residence
- ☐ Residential Care
- ☐ Homeless but not in shelter
- ☐ Homeless shelter
- ☐ Jail/Correctional Facility
- ☐ Foster Home
- ☐ Other

Number of Individuals in Family:	**Adjusted Monthly Income:**

Employment Status: ☐ Full Time ☐ Part time ☐ Job Training ☐ Under 18 ☐ Over 64 ☐ Mother/child < 6 ☐ Disabled ☐ No Job

Legal Custody: ☐ DFCS Custody ☐ Other Court Appointed Guardian

Emergency Contact:	**Legal Guardian:**
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Last Name:	**First Name:**	**Middle Name:**

Representative Payee:	**Primary Care Physician:**
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Legal Involvement: *Check all that apply*
☐ Treatment Court ☐ Probate Court ☐ Adult Probation ☐ Juvenile Justice ☐ Jail/Law Enforcement ☐ Adult Criminal Court ☐ Parole ☐ DFCS

Justice System Involvement:
Have you been involved with criminal/juvenile system in past year? ☐ Yes ☐ No

Number of arrests, regardless of offense or outcome, in past 30 days: _____

Probation/Parole Officer's Name and Address:

Education:

School Setting
☐ Enrolled Mainstream School
☐ Enrolled in Alternative School
☐ Enrolled Psycho-Education Center
☐ Enrolled in Home School
☐ Enrolled in Technical School
☐ Not enrolled in School

Highest Level of Education Completed?

Number Days Absent from School/Work in Past Month: _____

Please complete this section if the person receiving services is under 18 years old or in foster care

INFORMATION ABOUT NATURAL MOTHER OR NATURAL FATHER

Last Name: First Name: Middle Name:

Home Phone: Business Phone: Other Phone:

Home Address:

City: County: State: Zip:

Place of Employment: Occupation:

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

INFORMATION ABOUT FOSTER MOTHER OR FOSTER FATHER

Last Name: First Name: Middle Name:

Home Phone: Business Phone: Other Phone:

Home Address:

City: County: State: Zip:

Place of Employment: Occupation:

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

I attest that the information provided is accurate as of the date completed;

_____ _____

Individual Signature Date