

WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

APPLICATION FOR SERVICES

A photocopy of the applicant's picture ID and insurance card must be submitted with application.

Date: _____

Last Name:		First Name:				Middle Name:			
Date of Birth:		Age:		SSN:		-		Sex:	
Home Phone:			Business Phone:				Cell/Other:		
OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No			OK to Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No				Ok to Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Address:									
City:			County:			State:		Zip:	
OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Mailing Address:									
City:			County:			State:		Zip:	
OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Email Address:						OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Driver's License #:				List any Allergies:					
Referral Source:				How did you hear about us?					
Agencies Requiring Services:									
Race:				Marital Status:			Ethnicity: Hispanic/Latino Origin <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other				<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married			English Proficiency: <input type="checkbox"/> Proficient in English <input type="checkbox"/> Limited – Spanish primary language <input type="checkbox"/> Limited – Primary language Other		
Special Population: <i>Check all that apply</i>			Communication:			# of People in Household		Source of Payment: <i>Check all that apply</i>	
<input type="checkbox"/> None <input type="checkbox"/> Vision impaired <input type="checkbox"/> HIV+ <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Pregnant <input type="checkbox"/> SSI/Disabled <input type="checkbox"/> Veteran <input type="checkbox"/> IV Drug User			<input type="checkbox"/> No Impairment <input type="checkbox"/> American Sign Language <input type="checkbox"/> Single Words or Gestures <input type="checkbox"/> Utilizes Language Technology					<input type="checkbox"/> Self-Pay <input type="checkbox"/> Insurance If insurance, complete insurance section below	
Living Situation:						Preferences for Treatment:			
<input type="checkbox"/> Institutional Care/Nursing Home <input type="checkbox"/> Psychiatric Residential Facility <input type="checkbox"/> Private Residence <input type="checkbox"/> Residential Care			<input type="checkbox"/> Homeless but not in shelter <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Jail/Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Other			Please select which format you would prefer for treatment. This format is not guaranteed: <input type="checkbox"/> Virtual <input type="checkbox"/> In-Person			
Primary Insurance Name:					Secondary Insurance Name:				
Primary Insurance Group #					Secondary Insurance Group #				
Policy #					Policy #				
Subscriber Name:					Subscriber Name:				
Subscriber SSN:			DOB:		Subscriber SSN:			DOB:	
Pre-Cert Number:					Pre-Cert Number:				
Employment Status:		<input type="checkbox"/> Full Time <input type="checkbox"/> Part time		<input type="checkbox"/> Job Training <input type="checkbox"/> Under 18		<input type="checkbox"/> Over 64 <input type="checkbox"/> Mother/child < 6		<input type="checkbox"/> Disabled <input type="checkbox"/> No Job	
Legal Custody:		<input type="checkbox"/> DFCS Custody			<input type="checkbox"/> Other Court Appointed Guardian				

Last Name:	First Name:	Middle Name:
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Emergency Contact:		Legal Guardian:	
Name:		Name:	
Address:		Address:	
Phone Number:		Phone Number:	

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

Legal Involvement:	<input type="checkbox"/> Treatment Court	<input type="checkbox"/> Adult Probation	<input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Parole
<i>Check all that apply</i>	<input type="checkbox"/> Probate Court	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> 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	<input type="checkbox"/> Enrolled Mainstream School	<input type="checkbox"/> Enrolled in Home School
		<input type="checkbox"/> Enrolled in Alternative School	<input type="checkbox"/> Enrolled in Technical School
		<input type="checkbox"/> Enrolled Psycho-Education Center	<input type="checkbox"/> 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: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			

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

Individual Signature

Date