WILLOW OAK COMMUNUTY 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:** ___ - ___ - ____	**Gender Expression:**
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		
Email Address:		**OK to contact?** ☐ Yes ☐ No
Driver's License #:	**List any Allergies:**	
Referral Source:	**How did you hear about us?**	**Agencies Requiring Services:**
Weight:	**Height:**	**Sexual Orientation:**

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 ☐ Vision impaired
☐ HIV+ ☐ Hearing impaired
☐ Pregnant ☐ SSI/Disabled
☐ Veteran ☐ IV Drug User

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

# of People in Household

Household Income

Source of Payment: *Check all that apply*
☐ Self-Pay
☐ Insurance
If insurance, complete insurance section below

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

Preferences for Treatment:
Please select which format you would prefer for treatment. This format is not guaranteed:
☐ Virtual ☐ 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:**
Subscriber Email:	**Subscriber Email:**

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

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

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

Pharmacy:	**Primary Care Physician:**
Name:	Name:
Address:	Address:
Fax Number:	Fax Number:
Phone Number:	Phone Number:

Representative Payee:	
Representative Payee Legal Name:	
Address:	City/State/Zip Code:
Phone Number:	Email Address:

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** ☐ **NATURAL FATHER** ☐ **FOSTER MOTHER** ☐ **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