|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:** |  | **Staff collecting Information:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Source:** |  | **Referral Contact:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Phone #:** |  | **Contact E-Mail:** |  |

**Information about the individual who will be the primary client:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | DOB: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Ethnicity: |  | Primary Language: |  |
| Gender Identity: |  | Pronouns: |  |

Custody Info: Self/Independent  Guardian Custody  DCBS/DJJ/State Custody

|  |  |
| --- | --- |
| Parent/Guardian Name: |  |
| Phone Number: |  |
| E-Mail Address: |  |

Can we leave a voicemail at the number listed above? Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| Client Address: |  | | |
| City: |  | Zip Code: |  |

**Insurance Information:**

Does the client have a Medicaid-based insurance plan? Yes  No

|  |  |
| --- | --- |
| If yes, which plan? |  |

Is the client covered by other insurance plans? Yes  No

|  |  |
| --- | --- |
| If yes, which plan(s)? |  |

|  |  |
| --- | --- |
| Social Security Number: |  |
| Medicaid ID: |  |
| Insurance Policy Number(s): |  |

**Presenting Issues:**

Briefly describe the reason for referral and the current treatment/service needs:

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|  |

**Are services requested for an individual adult, a child, or a family? (Check all that apply)**

Individual Adult  Child  Family

**What services are you requesting? (Check all that apply)**

Therapy  Case Management  Community Support Associate

Psychiatry  SOC FIVE Services

**Can the individual/family participate in telehealth sessions?** Yes  No

**Where can services be provided? (Check all that apply)**

Home  School  Office  Telehealth

Is the client a former Haven Family Counseling client? Yes  No

**If applicable, what school does the client attend?**

|  |
| --- |
|  |

**Is the individual/family working with any other service providers? If so, please list below. Include name of provider, name of agency and contact information:**

|  |
| --- |
|  |
|  |

**Other family members needing services (If applicable):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | DOB: |  |
| SSN: |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | DOB: |  |
| SSN: |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | DOB: |  |
| SSN: |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | DOB: |  |
| SSN: |  |  |  |  |  |

For Office Use Only – Notes on Status:

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Intake Assigned To: |  | Date: |  |
| Staff Assigned: |  | Date: |  |