FCCS INTAKE FORM

Requested Services: ☐ Mental Health ☐ Substance Use ☐ Behavioral Health (Both MH/SA)

CLIENT / CHILD'S INFORMATION

Legal Name (first, middle, last): _____

Gender: ☐ Female ☐Male ☐Other ☐Unknown DOB: _____ S.S. #: _____

Address: _____ City: _____ Zip Code: _____

County Of Residence: _____ ☐Homeless ☐Unknown

PARENT/GUARDIAN CONTACT INFORMATION

Phone#:_____ Cell #:_____ Email: _____

Address (If different fromChild): _____

City: _____ Zip Code: _____County Of Residence: _____ ☐Homeless ☐Unknown

Preferred Contact Method: ☐Main Phone ☐Cell ☐Text ☐Email ☐Postal

Contact Notes (Calling Preferences/ Allowed to Leave a Message): _____

OTHER DEMOGRAPHIC INFORMATION (CHILD)

Sexual Orientation:☐ heterosexual ☐Gay/Lesbian ☐Bi-sexual ☐Questioning ☐: Unknown

Gender Identity: Male ☐ Female ☐Gender Non ☐Intersex ☐Other: _____ ☐Unsure

Race: ☐White ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐American Indian/Alaskan Native

☐Asian ☐Other:_____ ☐Declined to Provide

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Declined to Provide

Citizenship Status: ☐US Citizen ☐Green Card Holder ☐Refugee

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Primary Language: ☐English ☐Other_____

Advanced Directive:☐ Unknown ☐Yes ☐No

Disability:☐ Unknown ☐Yes ☐No

INTAKE

Initial Contact Method: ☐ Phone ☐Walk-In ☐Website

Initial Contact Name: _____
(Person completing form)

REFERRAL

Heard about us from ☐ Community Event ☐Walk-In ☐ Community Provider ☐Website ☐Other
Referred By: Name: _____ Referral Phone: _____ Referral Source:_____
Reason for Referral:_____

PRIMARY CARE PHYSICIAN INFORMATION

Name (first, middle, last): _____

Address: _____ City: _____ Zip Code: _____

Phone#:_____ Fax #:_____

Notes: _____

***Please note if child is in foster care or if there is an open DCBS case. Please note which county**

MENTAL HEALTH PROVIDER INFORMATION

Name (first, middle, last): _____

Address: _____ City: _____ Zip Code: _____

Phone#:_____ Fax #:_____

Notes: _____

FCCS INTAKE FORM

EMERGENCY CONTACT INFORMATION

Name (first, middle, last): _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone#:_____ **Fax #:**_____

Notes: _____

AVAILABILITY FOR APPOINTMENTS

Please Check ALL Best Days and Time:

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday**

☐ **Morning** ☐ **Afternoon** ☐ **Afterschool** ☐ **Evenings** ☐ **Anytime**

Do you have transportation available to you? ☐ **YES** ☐**NO**

PRIMARY INSURANCE

Do you have commercial insurance? ☐ **YES** ☐**NO**

Insurance Company_____ **Policy#**_____

Policy Holder Name_____ **DOB**_____ **Last 4 SSN**_____

Member ID # _____ **Group #**_____

TPL Billing Address_____

TPL Phone #_____

Individual Plan or Family Plan?_____ **Deductible**_____ **CoInsurance**_____

MEDICAID INSURANCE

Do you have Medicaid Insurance? ☐ **YES** ☐**NO** **Is Medicaid your primary/only insurance?** ☐ **YES** ☐**NO**

Managed Care Company_____ **Start Date**_____

ID #_____ **KY Medicaid ID#**_____

(OFFICE USE ONLY)

Date Referral Received:	**Screening Taken by:**

Efforts to Contact:

1. **Date:**	**Results:**
2. **Date:**	**Results:**
3. **Date:**	**Results:**
4. **Date Letter Sent:**	**Results:**

Administrative Assistants:

☐ Intake Entered into ClinicTracker ☐ Insurance Benefits Checked ☐Medicaid/Commercial Insurance Eligibility Checked

☐Co-pay Fees Collected ☐Track: Type, Status, Key Dates, Assignments ☐ Original Copy Filed