FCCS INTAKE FORM

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

PATIENT DETAILS

Legal Name (first, middle, last): _____

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

ADDRESS

Address: _____ City: _____ Zip Code: _____

County Of Residence: _____ ☐Homeless ☐Unknown

CONTACT INFORMATION

Phone#:_____ Cell #:_____ Email: _____

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

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

OTHER DETAILS

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

MISCELLANEOUS

Advanced Directive:☐ Unknown ☐Yes ☐No Disability:☐ Unknown ☐Yes ☐No

INTAKE

Initial Contact Method: ☐ Phone ☐Walk-In Initial Contact Name: _____

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: _____

MENTAL HEALTH PROVIDER INFORMATION

Name (first, middle, last): _____

Address: _____ City: _____ Zip Code: _____

Phone#:_____ Fax #:_____

Notes: _____

EMERGENCY CONTACT INFORMATION

Name (first, middle, last): _____

Address: _____ City: _____ Zip Code: _____

Phone#:_____ Fax #:_____

Notes: _____

FCCS INTAKE FORM

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

Is Medicaid Your Primary Insurance?

☐ Yes ☐ No

Insurance Name: _____

Policy/Member ID: _____

Medicaid ID#: _____

Start Date: _____

Policy Holder: _____

Phone # on card _____

Do you have Private Insurance/Secondary Insurance? ☐ Yes ☐ No

Commercial Insurance Name: _____

Policy #: _____ **Start Date:** _____

Group #: _____

Primary Holder Name: _____ **DOB:** _____

Address: _____

Phone #: _____

Patient Relationship To Insured; _____

Co-pay: ☐ Yes ☐ No **Co-pay Amount:** _____

(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