MHID: _____

Office Use Only

HIGHLAND RIVERS HEALTH

Please complete each field on the attached forms to the best of your ability.
If you have any questions, please ask the Front Office staff for assistance.

Please provide the following items:

Child/Adolescent:

- Parent or legal guardian's picture I.D.
- Insurance Card (if applicable)
  - If the child/adolescent is not covered by insurance, you have 60 days to apply for Medicaid and to provide an approval/denial letter along with proof of income in order to be covered by our sliding fee scale.
  - Proof of Income - If you do not have insurance coverage, we ask that you provide proof of income in order to be covered by our sliding fee scale. Examples of acceptable proof of income are:
    - Wage and Earnings Statement from the Department of Labor
    - Bank statement
    - One month's worth of check stubs
    - Formal letter from employer on company letterhead
    - For additional examples of acceptable proof of income, please ask the Front Office
- Proof of guardianship (birth certificate, court documentation stating legal guardianship)

General Demographic Information

Were you just released from the Hospital? ☐ Yes ☐ No

Were you just released from jail? ☐ Yes ☐ No

Individual Being Served Contact Information:

Name _____ | _____
First Last Preferred Name

Physical Address _____
Street City, State, Zip

Mailing Address _____
Street City, State, Zip

Primary Phone Number_____ Secondary Phone Number_____

Date of Birth: _____ Social Security #:_____

Legal Guardian Name:_____ Legal Guardian Phone _____

Primary E-Mail Address: _____

Gender ☐ Male ☐ Female **Pronouns:** She/Her/Hers He/Him/His They/Them/Theirs

What is your current gender identity?

☐ Identifies as Male ☐ Identifies as Female ☐ Female to Male(FTM)/Transgender Male/Trans Man

☐ Male to Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female

☐ Additional gender category or other, please specify ☐ Choose not to disclose

Race _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Native American

Marital Status ☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ Widowed ☐ Partnered

Primary Language _____ **Need an Interpreter?** ☐ Yes ☐ No

Smoking Status ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker-Daily ☐ Current Smoker- Occasional

Military Status ☐ Active ☐ Inactive ☐ Veteran ☐ Retired ☐ None

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker ☐ SSI

Highest Level of Education _____ **School Name** _____

Place of Birth _____

Emergency Contact Information:

Emergency Contact Name _____ **Relationship** _____

Emergency Contact Address _____
Street City, State, Zip

Emergency Contact Phone Number _____

Insurance Information:

Insurance Name (if no insurance coverage, write "NONE") _____

Policy Number _____ **Group Number** _____

Name of Policy Holder _____ **Policy Holder Birth Date** _____

Address of Policy Holder _____
Street City, State, Zip

Financial Information:

Are you claimed as a dependent on someone's federal or state income taxes? ☐ Yes ☐ No
If yes, what is the relationship? ☐ Legal Guardian ☐ Parent ☐ Other Relative ☐ Other

***Monthly* Income** please list the dollar amount received next to all that apply:

Your Gross Wages	$	**SSI**	$	**Child Support**	$	**Trust Fund**	$
Spouse Gross Wages	$	**TANF**	$	**Alimony**	$	**Other**	$
Legal Guardian A Gross Wages	$	**VA**	$	**Social Security**	$		
Legal Guardian B Gross Wages	$			**Retirement/Pension**	$		

Do you have any non-cash benefits? ☐ Georgia Housing Voucher ☐ Other Source

☐ Other TANF-Funded Services ☐ Section 8 / Public Housing / Ongoing Rental Assistance ☐ WIC ☐ SNAP

☐ TANF Child Care ☐ TANF Transportation ☐ Temporary Rental Assistance

***Monthly* Expenses** please list the dollar amount paid next to all that apply:

Child Support	$	**Child Care Payment Necessary to Work**	$	**Medical Expenses in excess of 5% gross income**	$
Alimony	$	**Non-Court Ordered Child Support Payment**	$		

Name of Pharmacy _____

Phone _____ **City**_____

Screening Questions:

Select all that apply:

☐ Vision Impaired ☐ Hearing Impaired ☐ SSI/Disabled ☐ Pregnant ☐ IV Drug User ☐ HIV+ ☐ Veteran ☐ N/A

Number of people in your household that are claimed on your taxes: _____

How may we contact you? ☐ Home Phone ☐ Work Phone ☐ Other Phone

How were you referred to Highland Rivers Health? _____

Is there an agency requiring you to receive services here?

☐ DFCS ☐ Adult Probation ☐ Jail/Law Enforcement ☐ Parole ☐ Probate Court ☐ Juvenile Justice

☐ Adult Criminal Court ☐ Treatment Court ☐ None

Please answer the following questions:

What services are you seeking from Highland Rivers Health? (Counseling, Medications, etc.)

Complaint/Presenting Problem? (What brought you to Highland Rivers Health?)

Medical Problems (not psychological) and prior treatment (Example: high blood pressure, asthma, diabetes, etc.)

Within the last 18 months <u>how many times</u> have you been admitted for:

Inpatient Hospitalization for Mental Health _____ Date of last admission: _____

Crisis Stabilization Program _____ Date of last admission: _____

ER/Crisis Team Involvements _____ Date of last admission: _____

Substance Abuse Detox Attempts _____ Date of last admission: _____

☐ None of the above

Thank you for this information.

Please return this packet to the staff at the front desk along with your documents and items listed on the first page.