Eligibility Info:
(Office Use Only)

#_____

# Reliance Health Inc.

## INTAKE REFERRAL FORM

Referral Date: _____
Contact Date: _____
Intake Date: _____
Clinician: _____
Disposition: _____

**Last**: _____ **First**: _____ **MI**: ___ **Preferred Name**: _____

**DOB**: _____/ _____/ _____ **Age**: _____ **SS#** _____ - _____ - _____ **Email**: _____

**Phone**: (_____) _____ - _____ ☐Cell ☐Home ☐Work - **Can we leave a msg?** ☐Yes ☐No

**Secondary**: (_____) _____ - _____ ☐Cell ☐Home ☐Work - **Can we leave a msg?** ☐Yes ☐No

**Communication Preference**: ☐Cell ☐Home ☐Email ☐Mail

Address:

**Street**: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Mailing (if different): **Street**: _____ **City**: _____ **State**: _____ **Zip Code**: _____

**Sex Assigned at Birth:**
☐Female
☐Male
☐Intersex

**Gender Identity:**
☐Female
☐Male
☐Nonbinary
☐Transgender MTF
☐Transgender FTM
☐Other: _____

**Pronouns:**
☐He/him
☐She/her
☐They/them
☐Other: _____

**Sexual Orientation:**
☐Heterosexual ☐Lesbian
☐Bisexual ☐Gay
☐Asexual ☐Pansexual
☐Prefer not to say ☐Questioning
☐Other: _____

**Marital Status:**
☐Never married
☐Married
☐Divorced
☐Separated
☐Widowed
☐Other:

| **Language (Primary and Secondary):** | **Religion/Spiritual Affiliation:** | **Place of Birth:** | **Length of time in Norwich:** | **Highest Grade Level Completed:** | **Literacy Level:** |
|---|---|---|---|---|---|
| | | | | | ☐Below Basic<br>☐Basic<br>☐Intermediate<br>☐Proficient |

| **Pregnant:** | **Height:** | **Eye Color:** | **Hair Color:** | **Allergies:** | **Distinguishing Marks/Features:** (tattoos, birthmarks, scars, etc.) |
|---|---|---|---|---|---|
| ☐Yes ☐No | | | | | |

**Are you a smoker?**
☐Yes ☐No
☐Current Every Day
☐Current Some Days
☐Former Smoker
☐Never Smoked
☐Heavy Smoker: 25 or more cigarettes/day
☐Light Smoker: 5 or less cigarettes/day

**Reside with:**
☐Spouse
☐Partner
☐Parent(s)
☐Alone
☐Roommate
☐Children
☐Relatives
☐Other: _____

**Current Living Situation:**
☐Private residence, owns or holds lease
☐Private residence, does not own or hold lease
☐Renting single room
☐Congregate or group home
☐Domestic violence shelter
☐Homeless on street
☐Homeless – couch surfing
☐Homeless in shelter
☐Other: _____

**Ethnic Origin:**
☐Hispanic-Cuban
☐Hispanic-Mexican
☐Hispanic-Puerto Rican
☐Hispanic-Other
☐Non-Hispanic
☐Unknown

**Race:**
☐American Indian/ Native Alaskan
☐Asian
☐Black/African American
☐Native Hawaiian/ Other Pacific Islander
☐White/ Caucasian
☐Unknown
☐Other: _____

Continues on Reverse Side…

**Services Needed:**

☐Budgeting
☐Employment
☐Outreach to Homeless
☐Education
☐Socialization
☐Paperwork
☐Living Skills
☐Outpatient Mental Health
☐Health Management
☐Recovery - Substance use and/or (other) Addiction
☐Other:

_____

**Who referred you to Reliance Health?**

**Do you currently have a service provider?**

Therapist: ☐Yes ☐No

Name/Agency: _____

Psychiatrist: ☐Yes ☐No

Name/Agency: _____

Case manager: ☐Yes ☐ No

Name/Agency: _____

Other: ☐ Yes ☐ No

Name/Agency: _____

**Do you have a mental health diagnosis?**

☐Yes ☐No

**If no, have you within the last two years?**

☐Yes ☐No

**If yes, what diagnosis(es):**

**Have you received services from us in the past?**

☐Yes ☐No

**Are you receiving housing services from Behavioral Health Homes (BHH)?**

☐Yes ☐No

**Are you receiving CHESS services, or do you have a housing voucher through CHESS?**

☐Yes ☐No

**Veteran:**

☐Yes ☐No

Branch:_____

Enlistment dates:

_____/_____/_____ to

_____/_____/_____

***(Please have your insurance card(s) available)***

| **HUSKY/Medicaid #:** | **Medicare #:** | **Other:** |
|---|---|---|
| | | |

**Conservator of Person**

☐Yes ☐No

Name: _____

Agency/Relationship: _____

Address: _____

_____

Phone Number of Conservator:

(_____) _____- _____

Fax Number of Conservator:

(_____) _____- _____

Email:_____

**Conservator of Estate**

☐Yes ☐No

Name: _____

Agency/Relationship: _____

Address: _____

_____

Phone Number of Conservator:

(_____) _____- _____

Fax Number of Conservator:

(_____) _____- _____

Email:_____

**Representative Payee**

☐Yes ☐No

Name: _____

Agency/Relationship: _____

Address: _____

_____

Phone Number of Payee:

(_____) _____- _____

Fax Number of Payee:

(_____) _____- _____

Email:_____

**Income:** ☐Yes ☐No **Occupation (if applicable):** _____

| SSI: | SSDI: | VA: | Employment: | State Cash Assistance: | Food Stamps: | Other: |
|---|---|---|---|---|---|---|
| $ | $ | $ | $ | $ | $ | $ |