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| **CLIENT INFORMATION FORM** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **DIVISION:**  AOABH  BHCOE  CYBH | | | | | | | | | | | | | **FACILITY:** | | | | | | | | | | |
| **Date:** | | | | | | | | **INTAKE**  **UPDATE**  **SAME DAY REG / DC** | | | | | | | | | | | | | | | |
| **(Please Print Clearly and Fill Out the Information Below as Completely as You Can)** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Person Filling Out Form:** | | | | Client | | | | | | Parent | | | Guardian | | | | | Clinician | | | | | Other |
|  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | | | | |  |  | | | |
| Last Name | | | | | |  | First Name | | | | | | | | | | | |  | Middle Name | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | | | | |  |  | | | |
| Name You Prefer to Be Called | | | | | |  | Maiden Name | | | | | | | | | | | |  | Birth Name  Same as Above | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you or an immediate family member ever served in the US Military?** | | | | | | | | | | | | | | | | | | | | | | | |
| Definition of Immediate Family: Parent, Sibling, Child (birth / adopted / step) | | | | | | | | | | | | | | | | | | | | | | | |
| Self Only | | | Immediate Family | | | | | | | | | | | | | Both Self & Immediate Family | | | | | | | |
| None | | | Decline to State | | | | | | | | | | | | | Unknown | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | |  | | | | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
|  | | | |  | |
| Date of Birth | | | | |  | | | | Social Security Number | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Gender** | | | | | | | | | | | | | | | | | | | | | | | |
| Female | Male | | | | Transgender: | | | | | | | | Female to Male | | | | | | | | Male to Female | | |
| Unknown | Decline to State | | | | | | | | | | | | Other | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Sexual Orientation** | | | | | | | | | | | | | | | | | | | | | | | |
| Bisexual | | Gay | | | | | | | | | | | Heterosexual | | | | | | | | Lesbian | | |
| Questioning | | Decline to State | | | | | | | | | | | Other | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Gender Pronouns** | | | | | | | | | | | | | | | | | | | | | | | |
| He / Him / His | | | | | | She / Her / Hers | | | | | | | | | They / Them / Theirs | | | | | | | | |
| Decline to State | | | | | | Other | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Have You Gone by Other Names in the Past?** | | | | | | | | | | | | | | No | | | Yes | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | |  | | | | | | | | | | | |
| Previous Name #1 (Last, First, MI) | | | | | | | | | | |  | Previous Name #2 (Last, First, MI) | | | | | | | | | | | |

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| **CLIENT DEMOGRAPHICS** | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| Driver’s License / State ID Number | | | | | | | | |  | State of Issue | | | | | | | |  | Where Are You Currently Living? | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
| Mailing Address (Street or PO Box) | | | | | | | | | | | | | | | | | | | | | | | |  | Apt  Unit  Suite # | | |
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| City | | | | | | | | | | | State | | | | Zip | | | | | | | County of Residence | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
| Street Address Where You Are Currently Living  Same as Mailing Address | | | | | | | | | | | | | | | | | | | | | | | |  | Apt  Unit  Suite # | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| City | | | | | | | | | | |  | State | | | | | | | |  | Zip | | | | | |
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|  | | | | |  | |  | | | | | | | | | | | | | | |  |  | | | |
| Home Phone | | | | |  | | Cell Phone | | | | | | | | | | | | | | |  | Business Phone | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLACE OF BIRTH** | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| CA County of Birth | | | | | |  | | US State of Birth | | | | | | | | | | | | | |  | Country of Birth | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LANGUAGE / RELIGION** | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Primary Language | | | | | | | | | | | | |  | | Secondary Language | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  |  | | | | | | | | | | | | |
| Preferred Language | | | | | | | | | | | | |  | Family Language | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fluent | Limited | | | | | None | | | | | | |  | |  | | | | | | | | | | | |
| English Verbal Proficiency | | | | | | | | | | | | |  | | Religious Preference | | | | | | | | | | | |

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| **ETHNICITY** | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Are You Spanish, Hispanic or Latino?** | | | | | | | | | Yes | | No | Unknown | | | | | |  |
|  | | | | | | | | | | | | | | | | | | |
| **Please Indicate Up to Two Ethnicities That Best Describe You:**  **“1”** for Primary and **“2”** for Secondary | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| \_\_\_ | Aleut | | | | | \_\_\_ | | Hawaiian Native | | | | | | | \_\_\_ | Pakistani | | |
| \_\_\_ | Algerian | | | | | \_\_\_ | | Hispanic-Other | | | | | | | \_\_\_ | Palestinian | | |
| \_\_\_ | Amerasian | | | | | \_\_\_ | | Indian (Asian) | | | | | | | \_\_\_ | Puerto Rican | | |
| \_\_\_ | Bangladeshi | | | | | \_\_\_ | | Iranian | | | | | | | \_\_\_ | Samoan | | |
| \_\_\_ | Black / African-American | | | | | \_\_\_ | | Iraqi | | | | | | | \_\_\_ | Somalian | | |
| \_\_\_ | Cambodian | | | | | \_\_\_ | | Japanese | | | | | | | \_\_\_ | South or Central American | | |
| \_\_\_ | Caucasian / European  / White | | | | | \_\_\_ | | Korean | | | | | | | \_\_\_ | Spanish | | |
|  | \_\_\_ | | Laotian | | | | | | | \_\_\_ | Srilankan | | |
| \_\_\_ | Chinese | | | | | \_\_\_ | | Lebanese | | | | | | | \_\_\_ | Thai | | |
| \_\_\_ | Cuban | | | | | \_\_\_ | | Mexican | | | | | | | \_\_\_ | Vietnamese | | |
| \_\_\_ | Egyptian | | | | | \_\_\_ | | Native American / Am Indian | | | | | | | \_\_\_ | Unknown | | |
| \_\_\_ | Eskimo | | | | | \_\_\_ | | Other Asian | | | | | | | \_\_\_ | Decline to State | | |
| \_\_\_ | Filipino | | | | | \_\_\_ | | Pacific Islander | | | | | | | \_\_\_ | Other | | |
| \_\_\_ | Guamanian | | | | |  | | (Not Hawaiian / Guamanian / Samoan) | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **FAMILY INFORMATION** | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Client Marital Status** | | | | | | | | | | | | | | | | | | |
| Single | | | Married | | | | | | | Divorced | | | | | | | Separated | |
| Widowed | | | Domestic Partnership | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **For how many people are you the Primary Caregiver?** | | | | | | | | | | | | | **Through Age 17** | | | | | |
| Definition of Primary Caregiver: 50% or More of Your Time | | | | | | | | | | | | | **18 or Older** | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | |  |  | | | |
| Mother’s Last Name | | | | |  | | Mother’s First Name | | | | | | |  | Mother’s Middle Name | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | | |  |  | | | |
| Mother’s Maiden Name | | | | |  | | Mother’s Date of Birth | | | | | | |  |  | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | |  |  | | | |
| Father’s Last Name | | | | |  | | Father’s First Name | | | | | | |  | Father’s Middle Name | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT EMPLOYMENT INFORMATION** | | | | | | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please select the option that best describes your current employment status:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Competitive F/T (>34hrs/wk) | | | | | | | | | Non-Competitive F/T (>34hrs/wk) | | | | | | | | | | | | | | | Student | |
| Competitive P/T (<34hrs/wk) | | | | | | | | | Non-Competitive P/T (<34hrs/wk) | | | | | | | | | | | | | | | Homemaker | |
| Retired | Volunteer | | | Actively Looking | | | | | | | | | | | | | Resident / Inmate | | | | | | | Other | |
| **Definition of Competitive and Non-Competitive Employment:**  **Competitive Employment** = Paid employment in the community in a position that is also open to individuals without a disability. This may include positions with ongoing on-site or off-site job-related support services provided (Supported Employment).  **Non-Competitive Employment** = Paid jobs in the community that are open only to individuals with a disability. | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Occupation | | | | | | | | | | | | |  | | | Employer | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CLIENT SCHOOL INFORMATION** | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Highest Education Completed:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kindergarten | | 1st Grade | | | 2nd Grade | | | | | | | | | | 3rd Grade | | | | | 4th Grade | | | | | 5th Grade |
| 6th Grade | | 7th Grade | | | 8th Grade | | | | | | | | | | 9th Grade | | | | | 10th Grade | | | | | 11th Grade |
| 12th Grade (HS Grad or GED) | | | | | | | | 1st Year College | | | | | | | | | | Associate Degree | | | | | | | |
| 3rd Year College | | | Bachelor’s Degree | | | | | | | | | | | 1st Year Grad Work | | | | | | | | | Master’s Degree | | |
| 3rd Year Grad Work | | | Doctorate | | | | | | | | None | | | | | | | | Unknown | | | | Other | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | | | | | | |  |  | | | |
| Name of School Attending | | | | | |  | Name of School Contact | | | | | | | | | | | | | |  | Contact’s Phone Number | | | |

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| **GENERAL MEDICAL CONDITIONS** | | |  | | | |
|  | | | | | | |
| Please Indicate Any General Medical Conditions: List **“1”** for Primary and **“2”** for Secondary.  Place a check mark next to any additional General Medical Conditions if you have more than two (2). | | | | | | |
| \_\_\_\_ | Patient Denies Any Medical Conditions | | | \_\_\_\_ | Hypercholesterolemia | |
| \_\_\_\_ | Allergies | | | \_\_\_\_ | Hyperlipidemia | |
| \_\_\_\_ | Anemia | | | \_\_\_\_ | Hypertension | |
| \_\_\_\_ | Arterial Sclerotic Disease | | | \_\_\_\_ | Hyperthyroid | |
| \_\_\_\_ | Asthma | | | \_\_\_\_ | Hypothyroid | |
| \_\_\_\_ | Back / Neck Pain | | | \_\_\_\_ | Immunologic Disorder | |
| \_\_\_\_ | Blind / Visually Impaired | | | \_\_\_\_ | Infertility | |
| \_\_\_\_ | Blood Disorder (other than Anemia) | | | \_\_\_\_ | Migraines | |
| \_\_\_\_ | Cancer | | | \_\_\_\_ | Multiple Sclerosis | |
| \_\_\_\_ | Carpal Tunnel Syndrome | | | \_\_\_\_ | Muscular Dystrophy | |
| \_\_\_\_ | Chronic Obstructive Pulmonary Disease (COPD) | | | \_\_\_\_ | Musculoskeletal Problem (not back/neck) | |
| \_\_\_\_ | Cirrhosis | | | \_\_\_\_ | Neurologic Disorder | |
| \_\_\_\_ | Congenital Disorders | | | \_\_\_\_ | Obesity | |
| \_\_\_\_ | Congestive Heart Failure | | | \_\_\_\_ | Osteoarthritis | |
| \_\_\_\_ | Cystic Fibrosis | | | \_\_\_\_ | Osteoporosis | |
| \_\_\_\_ | Deaf / Hearing Impaired | | | \_\_\_\_ | Pain (Chronic) | |
| \_\_\_\_ | Dementia | | | \_\_\_\_ | Parkinson’s Disease | |
| \_\_\_\_ | Dermatologic Disorder / Skin Lesions | | | \_\_\_\_ | Physical Disability | |
| \_\_\_\_ | Diabetes | | | \_\_\_\_ | Psoriasis | |
| \_\_\_\_ | Digestive Disorder | | | \_\_\_\_ | Renal Failure / Disease | |
| \_\_\_\_ | Ear Infections | | | \_\_\_\_ | Rheumatologic Arthritis | |
| \_\_\_\_ | Endocrine Disorder | | | \_\_\_\_ | Rheumatologic Disorder | |
| \_\_\_\_ | Epilepsy / Seizures | | | \_\_\_\_ | Sexually Transmitted Disease (STD) | |
| \_\_\_\_ | Gall Bladder Problems | | | \_\_\_\_ | Stroke | |
| \_\_\_\_ | Genitourinary Disorder | | | \_\_\_\_ | Tinnitus | |
| \_\_\_\_ | GERD | | | \_\_\_\_ | Ulcers | |
| \_\_\_\_ | Headaches (not Migraines) | | | \_\_\_\_ | Underweight | |
| \_\_\_\_ | Heart Disease | | | \_\_\_\_ | Other | |
| \_\_\_\_ | Hepatitis | | | \_\_\_\_ | Unknown / Not Able to Assess | |
|  |  | | |  |  | |
|  | | | | | | |
| **REFERRAL INFORMATION** | | |  | | | |
|  | | | | | | |
| **How did you find out about our services?** | | | | | | |

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| **EMERGENCY CONTACTS** | | *Who should we contact in case of an emergency?* | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary** - Client’s Relationship to Emergency Contact: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | |  | | | | | | | | | | | |
| Name (Last, First) | | | | | | | | | |  | | | | Address | | | | | | | | | | | |
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| City | | | | | | | | | |  | | | | State | | | | | | | | |  | | Zip |
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| Home Phone | | | | | | |  | Business Phone / Ext. | | | | | | | | | | |  | Cell Phone | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Secondary** - Client’s Relationship to Emergency Contact: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | |  | | | | | | | | | | |
| Name (Last, First) | | | | | | | | | | |  | | | | Address | | | | | | | | | | |
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| City | | | | | | | | |  | | | | State | | | | | | | | |  | | Zip | |
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|  | | | | | | |  |  | | | | | | | | | | |  |  | | | | | |
| Home Phone | | | | | | |  | Business Phone / Ext. | | | | | | | | | | |  | Cell Phone | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CONSERVATORSHIP** |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are You on Conservatorship?**  Yes  No  Unknown | | | | | | | | | | | | | | | | |  |  | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | Client Relationship to Conservator | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | | | | | | | | | | | | |  | |  | | | | |
| Conservator Last Name | | | |  | | Conservator First Name | | | | | | | | | | | | |  | | Conservator Middle Name | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | |  | | | | |
| Conservator Mailing Address (Street or PO Box) | | | | | | | | | | | | | | | | | | | | | Apt  Unit  Suite # | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | |  | | | | | |  | |  | |
| Conservator Mailing Address City | | | | | | | | | | | |  | | | | State | | | | | |  | | Zip | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | |  | |  | | | | |
| Home Phone | | |  | | Cell Phone | | | | | | | | | | | | | |  | | Business Phone / Ext | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | | | | | | | | |  | | | | | | |
| Court Case Number | | |  | | Is Conservator PAPG or Private? | | | | | | | | | | | | | |  | | | | | | |

**STOP**

The last two pages are for clinical use only. Please return this packet to front office staff.

The last two pages are for clinical use only.

Please return this packet to front office staff.

**STOP**

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| **FOR CLINICIAN USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CLIENT DEMOGRAPHICS** | | | | | | | | | | | | | | | | | **Admission Living Arrangement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-12 (Group Home Level)  13-14 (Group Home Level)  Acute Psychiatric Inpatient  Board and Care  Cerritos College Hospital  Coastal Community Hospital  Convalescent Home  Costa Mesa College Hospital  Daily Support Req in House/Apt  Extended Care West Anaheim  Extended Care Westminster  Foster Care  Homeless/No Identifiable Res.  IMD (Institution for Mental Disease) | | | | | | | | | | | | | | | | | | | Jail/Correctional Facility  JH (Juvenile Hall)  Joplin Youth Camp  Kaiser Hospital  Medical Hospital  MHRC (MH Rehab Center)  No Support Req in House/Apt  Non-Contracted Facility  OCFC (Orangewood)  Out of State Res Tx Center  Parent/Guardian Home (Minor)  Prison  Psychiatric Hospital - Other  Psychiatric Residential Tx Center | | | | | | | | | | | | | | | | | | Regional Center Group Home  Residential/Recovery Facility  Res Rehabilitation Facility  RFE (Res Facility for the Elderly)  Room and Board  RTRC (Santa Ana Royale)  Shelter  SNF (Skilled Nursing)  Sober Living Home  Social Rehab Facility  Some Support Req in House/Apt  State Hospital  STEPs MHRC  STEPs Res Rehab Facility | | | | | | | | | Supported Housing  UCI Med Center  VA Hospital  WMA (West Med – Anaheim)  YGC (Youth Guidance Center)  YLA (Youth Leadership Academy)  Unknown/Not Reported  Other: | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SCHOOL INFORMATION** | | | | | | | | | | | | | | | | | | For Educationally Related Mental Health Services (ERMHS) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ERMHS Referral**: | | | | | | No | | | | | Yes | | | | | | | | | | **Home School District:** | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Eligibility** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autism | | Deaf-Blind | | | | | | | | | | | | | | | | | Deaf/Hard of Hearing | | | | | | | | | | | | | | | | | Developmental Delays (Ages 3-9) | | | | | | | | | | Emotionally Disturbed | | | | | |
| Limited IQ | | | | | | | | | | | | | | | | | | | Non-Cat/Med Condition (0-5) | | | | | | | | | | | | | | | | | Orthopedically Impaired | | | | | | | | | | Other Health Impaired | | | | | |
| Specific Learning Disability | | | | | | | | | | | | | | | | | | | Speech & Language Impaired | | | | | | | | | | | | | | | | | Traumatic Brain Injury | | | | | | | | | | Visually Impaired | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Setting** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Instruction | | | | | | | | Non-Public School | | | | | | | | | | | | | | | | | Regular Classroom | | | | | | | | | | RSP (Resource Specialized Program) | | | | | | | | | | | | SDC (Special Day Class) | | | | |
| State School | | | | | | | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ENCOUNTER INFORMATION** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Program Specialty** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **BHS Special Population** | | | | | | | | | | | | **CalWORKS** | | | | | | | | | | | | | | | **None** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TX TEAM INFORMATION** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HCA Providers** | | | (Last Name, First Name) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Psychiatrist / Nurse Practitioner | | | | | | | | | | | | | | | | | | | | | |  | | | | Medical Physician / Nurse Practitioner | | | | | | | | | | | | | | |  | | Care Coordinator / Case Manager | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Clinician | | | | | | | | | | | | | | | | | | | | | |  | | | | Auxiliary Service Provider | | | | | | | | | | | | | | |  | | Auxiliary Provider Type | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Service Chief / Program Director | | | | | | | | | | | | | | | | | | | | | |  | | | | CYS MHSA Tx Provider Type | | | | | | | | | | | | | | |  | |  | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LEGAL INFORMATION** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Court / Conservator Status** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| PC2974 | Probate 1400 | | | | | | | | | | | | | | W300 Juvenile Dependent | | | | | | | | | | | | | | | | | W5008 (Murphy Conservator) | | | | | | | | | | | | W5353 (Temp Conservator) | | | | | | | |
| W5358 LPS Conservator | | | | | | | | | | | | | | | W5686 | | | | | | | | | W601 Juvenile Status Ward | | | | | | | | | | | | | | | W602 Juvenile Ward | | | | | N/A | | | Unknown/Not Reported | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **W & I Code Legal Class** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other - Civil Involuntary Status | | | | | | | | | | | | | | Other - Criminal Involuntary Status | | | | | | | | | | | | | | | | | | | | PC1026 | | | | | | PC1370 | | PC2684 | | | | PC47.6, 47.8 | | |  | | |
| Sexual Psychopathy / Related Categories | | | | | | | | | | | | | | | | | | | | | | | W5150 | | | | | | W5250 | | | | | W5260 | | | | | | W5270.15 | | W5300 | | | | W5585 | | W6000 | | W709 | |
| N/A | | | | Unknown/Not Reported | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EOC INFORMATION** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EOC Start Date** | | | | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | **EOC Name** | | | | | | | | | | | | | | | | | | | | |

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| **FOR SAME DAY ADMISSION AND DISCHARGE** | | | | | |  | | | | | | | | |
| **Behavioral Health Treatment Linkage / Referral** | | | | | | |  | | | | | | | |
| ADAS Community Support | | | | | AMHS STEPs LPS | | | | | | | CYS Youth Resource Center | | |
| ADAS Medical Detox | | | | | AMHS STEPs MHRC | | | | | | | Domestic Violence Shelter | | |
| ADAS Outpatient | | | | | ASO (Administrative Services Organization) | | | | | | | Out of County Behavioral Health Service | | |
| ADAS Residential | | | | | CYS CAST | | | | | | | Non-Profit Organization | | |
| ADAS Social Detox | | | | | CYS CAT | | | | | | | PCP (Primary Care Physician) | | |
| AMHS Adult Outpatient Services | | | | | CYS CCPU | | | | | | | PEI OC CREW | | |
| AMHS Collaborative Court | | | | | CYS CEGU OCFC | | | | | | | Psychiatrist Private | | |
| AMHS Extended Care West | | | | | CYS CEGU Probation | | | | | | | Residential Tx Center for Children | | |
| AMHS Extended Care West Anaheim | | | | | CYS Contract Regional Outpatient | | | | | | | Student Health Service | | |
| AMHS FSP | | | | | CYS County Regional Outpatient | | | | | | | Therapist Private | | |
| AMHS LPS Unit (Lanterman - Petris - Short) | | | | | CYS CSP Children’s Residential Program | | | | | | | VA Health Care | | |
| AMHS Recovery Center | | | | | CYS FSP | | | | | | |  | | |
| AMHS OAS (Older Adult Services) | | | | | CYS Juvenile Drug Court | | | | | | | Client Declined Referral | | |
| AMHS PACT(Program Assertive Community Treatment) | | | | | CYS OC CAPC (In Home Crisis) | | | | | | | Client Unavailable for Referral | | |
| AMHS PACT TAY | | | | | CYS Phoenix Academy | | | | | | | N/A No Referral | | |
| AMHS Royale MHRC | | | | | CYS SCCS TAY Crisis Residential Program | | | | | | | Other | | |
| AMHS Royale TRC | | | | | CYS SCCS TAY Social Rehabilitation Program | | | | | | |  | | |
| AMHS SHOPP | | | | | CYS Touchstones | | | | | | |  | | |
|  | | | | | | | | | | | | | | |
| **Discharge Reason** | | | | | | | | | | | |  | | |
| Client Declined Services | Hospitalized | | | Linked to BHS Contract Provider | | | | | | Linked to BHS Provider | | | | Linked to non-BHS Provider |
| Does Not Meet Medical Necessity (NOA) | | | Does Not Meet Program Criteria | | | | | Other: | | | | | | |
|  | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **Facility EOC / Discharge Date** | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **EOC Name** | | ­­­­­­­­­­­­ | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Office Staff** | | | | | |
| **Initials** | |  | | | |
| **Print / Type Name:** | | | | | | | | | **Date Processed:** | | | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | |