TRI-COUNTY MENTAL HEALTH SERVICES, INC.

The following is needed to provide services. We ask that you fill out this form as completely as possible.

CLIENT INFORMATION: **SSN#**_____

Last Name:_____ **First Name**:_____ **M.I**._____

Address:_____ **City**:_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone**:_____ **County**:_____

_____

Sex: ☐ M ☐ F ☐ Transgender **Age**:_____ **D.O.B.**:_____/___/_____ **Highest Educational Level Achieved:**_____

Race: ☐ White ☐ African Am. ☐ Asian ☐ Hispanic ☐ Native Am. ☐ Pacific Islander ☐ Other:_____

If Hispanic, please check one: ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other _____

Employment Status: (check one) ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Unemployed ☐ Homemaker

Occupation: _____

Marital Status: (check one) ☐ 1. Never married ☐ 2. Married ☐ 3. Widowed ☐ 4. Divorced ☐ 5. Separated

Hearing Status: ☐ Normal ☐ Impaired ☐ Deaf **Veteran:** ☐ Yes ☐ No **Primary Language**: _____

FINANCIALLY RESPONSIBLE PARTY:

Last Name:_____ First Name:_____ Relationship to client: _____

Address:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Daytime Phone:_____ SSN:_____

Household Weekly Income: $ _____ Number of Dependents: _____ Number in Household:_____

Do you have ? ☐ Medicare #:_____ ☐ Medicaid #:_____

☐ Other Medical Insurance Policy #:_____ Company Name:_____ Phone #: _____

COMPLETE FOR CHILDREN ONLY:

Mother's Name:_____ Father's Name: _____

Step-Mother's Name: _____ Step-Father's Name: _____

Foster Mother's Name: _____ Foster Father's Name: _____

CUSTODY OF CHILD:

☐ Joint Custody of Parents-- Names of joint custodians: _____

☐ Sole Custody of Parent – Name of custodian: _____

☐ State Custody ** -- which Agency/Contact person: _____

***Copy of current court order showing custody is required.*

☐ Other – Please describe other legal authority and furnish documentation

Is there a LEGAL GUARDIAN? Yes ☐ No ☐ Copy of letters of guardianship provided to Tri-County: Yes ☐ No ☐

Guardian's Last Name: _____ Guardian's First Name: _____ Relationship to Client: _____

Home Phone: _____ Daytime Phone: _____ Address: _____

EMERGENCY CONTACT:_____ Home #:_____ Work #:_____

Address: _____ Rel. to Client: _____

VERIFICATION:

I verify that the above information is accurate.

Client Signature:_____ Date: _____

Parent/Guardian:_____

For Office Use Only

Staff:_____ New ☐ Readmit ☐ Update ☐ Admit Date: _____ MR #: _____

CLIENT INFORMATION SHEET