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 regarding the individual who will be receiving services.

LEGAL NAME Last: _____ First: _____ M.I. _____

Preferred/Chosen Name: _____

SSN: _____ DOB: _____

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

Primary Phone: _____ □ Cell □ Home □Work □Other (please specify): _____

Best Phone Number to Reach You: _____ □ Cell □ Home □Work □Other (please specify): _____

Email (please print clearly): _____

Communication Preference for appointment reminders: □ Cell Phone □ Home phone □ Text Message*

Although TCMHS takes every precaution to ensure my privacy, I acknowledge that TCMHS cannot guarantee the privacy, security and confidentiality of text messages or email messages

Biological Sex: □ M □ F **Gender Identity (optional):** □ Male □Female □Gender Fluid □Gender Queer □Non-binary

□Transgender □MTF □FTM □ Other: _____

My pronouns are: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ ze/hir

☐ Another pronoun (please specify): _____

Race: □ White □ Black/African Am. □ Asian □ Nat. Am./Alaskan Nat. □ Pacific Islander/Nat. Hawaiian □ Other: _____

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

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

Occupation: _____

Relationship Status: (check one) □ Never married □ Married □ Widowed □ Divorced □ Separated

Hearing Status: □ Normal □ Impaired □ Deaf

Primary Language: _____ Interpreter Needed? □ Yes □ No

Veteran: □ Yes □ No **If yes, are you eligible for VA benefits?** □ Yes □ No

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Is there a court ordered 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: _____

Phone: _____

Address: □ Same as Client Address If different from client's address:

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

Please complete the 2nd page →

FINANCIALLY RESPONSIBLE PARTY:

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

SSN: _____

□ Same as Client Address

If different from client's address:

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

Phone: _____

Insurance Policy #: _____

Medicare Medicaid Other Insurance: _____

EMERGENCY CONTACT:

Name: _____

Primary phone #: _____ Other phone #: _____

Relationship to Client: _____

Address: □Same as Client Address If different from client's address:

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

COMPLETE FOR CHILDREN ONLY:

Parent One Name: _____ Relationship: □Biological/Adoptive Parent □Step-Parent □Foster Parent

Parent Two Name: _____ Relationship: □Biological/Adoptive Parent □Step-Parent □Foster Parent

Parent Three Name: _____ Relationship: □Biological/Adoptive Parent □Step-Parent □Foster Parent

Parent Four Name: _____ Relationship: □Biological/Adoptive Parent □Step-Parent □Foster Parent

CUSTODY OF CHILD:

State Custody ** which Agency/Contact person: _____

VERIFICATION: I verify that the above information is accurate.

Client Signature: _____ **Date: _____**

Parent/Guardian: _____ **Date: _____**

For Office Use Only- For Clients Not Admitted Into Services

REASON: □ Does Not Meet Admission Criteria □ Missing Documentation □ Out of Catchment □ Guardian/Delegation
□ Out of Network □ CSTAR □ Services Requested Not Available □ Not Able To Stay □ After Open Access Hours

Follow-up resources provided: _____ Staff Signature: _____

IF APPROPRIATE, INDICATE WHICH TREATMENT COURT: _____ OR SCHOOL DIST. _____

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

CLIENT INFORMATION SHEET