Human Services, Inc.
50 James Buchanan Dr.
Thorndale, PA 19372
P: 610-873-1010 F: 610-873-3317

Intake Contact:
intake@hsi-cmhs.org

610-873-1010 x165

Client Intake Referral Form

Date

Referral Source/Name of Organization

Phone #

Contact Information

Transfer of Care from Hospital or In Patient Facility - must complete additional form , if you do not have this form please send email request

Client Information

First Name

Last Name

Phone Number

Address

City

State

ZIP Code

DOB

Gender

Social Security Number

Emergency contact name and Phone Number (optional)

Insurance Provider (Primary)

Insurance Member ID

Insurance Provider (Secondary)

Insurance Member ID

Client on IOC (Y/N) (Court order

Probation/ CYF involvement

Please be advised: Form must be completed in its entirety. Incomplete forms will be returned.

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Please complete all of the following questions.

Do you currently have Suicidal or Homicidal Ideations?
☐ Yes ☐ No **If yes, please call 911 or go to E.R. for evaluation.**

Do you hear or see anything other people do not? Are you experiencing a Psychotic Episode?
☐ Yes ☐ No

Do you or have you used Illegal Substances?
☐ Yes ☐ No If yes: Drug of Choice & Last used _____

Do you or have you drank Alcohol?
☐ Yes ☐ No If yes: Last drank? _____How often?_____How much?_____

Do you Self Harm?
☐ Yes ☐ No

Are you experiencing Domestic Violence?
☐ Yes ☐ No

Are you currently pregnant?
☐ Yes ☐ No

Are you currently receiving any drug, alcohol, medication management or mental health services?
☐ Yes ☐ No
If yes, please state where: _____

Is patient currently hospitalized or recently discharged from hospital for mental or behavioral health?
☐ No ☐ Yes
If yes, Name of facility _____Dates of Admission_____

Per Human Services, Inc. policy, individuals cannot receive medication management alone. **You must participate in our Outpatient Therapy services.** Are there other services that you are interested in?

☐ Blended Case Management (BCM) ☐ Critical Time Intervention (CTI/housing)

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Are you currently on Probation?
☐ Yes ☐ No If Yes, Name & Number of Probation Officer _____

Are you court ordered to treatment? ☐ Yes ☐ No

If yes, please circle –
Mental Health Evaluation Anger Management Domestic Violence Sex Offender Retail Theft
Sentencing sheet showing court order must be provided prior to scheduling

Are you involved with Children and Youth Services?
☐ No ☐ Yes County/St_____ Caseworker Name & Ph #_____

Are you involved with Family Based Services, Wrap around Services or a Partial Program with another agency? ☐ No ☐ Yes -Please Specify:
_____

Do you have any Medical concerns or diagnosis we should be made aware of?
☐ Yes ☐ No
Please Specify: _____
_____

What concerns do you want addressed while at Human Services, Inc.? Any pre-existing diagnosis?
_____
_____
_____

Please know that we take many factors into scheduling our clients to best fit their needs. We cannot guarantee that all requests can be met, but we will try and work with you the best we can.

Please circle your preferences (if any) :

Office: Thorndale Oxford **Therapy Appt Times:** Day Evening (after 5pm) **Therapist**: Male Female

Do you have other household or family members that attend HSI for Outpatient services? If yes, who?
_____

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If you do not have insurance, have you applied for Medicaid? ☐ Yes ☐ No

If you are uninsured, do you understand you will need to provide financial information to this agency for county funding? If you fail to provide requested financial information at time of Intake, you will be responsible for the $300.00 visit fee and any other uncovered charges going forward.
☐ Yes ☐ No

Do you acknowledge that if insurance information, financial information, or payment is not presented at time of visit, your appointment will be rescheduled?
☐ Yes ☐ No

If you are a previous client, and have a balance on your account, you may be required to enter into a payment plan or pay the balance in full before resuming services.

I certify that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

Signature: _____ Date: _____

If client is under 18, Name and relationship of person completing form:

_____

Send Referrals to INTAKE@HSI-CMHS.ORG Type 'ENCRYPT' in the subject line to protect sensitive information.

_____For Intake Coordinator Use Only_____

Client ID_____ New or Returning D/C Date _____Reason_____

Other factors for scheduling_____

Waitlist _____Reason_____

Intake Scheduled _____OPT_____

Notes:

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Transfer of Care from Hospital or In Patient Facility

Client Name _____DOB _____

Name of Facility _____

Address _____

Phone_____ Fax _____Email_____

Date admitted _____Discharge Date _____

BH/MH Diagnosis(s) _____

Medical Diagnosis(s) _____

Medications being discharged on

Name	Dosing Instructions	Qty given

Please Email/Fax Copy of any Psych Evaluations performed while in your care

This form MUST be fully completed and submitted with completed referral form. Intake appointments will not be scheduled without this information.

Please be advised: Form must be completed in its entirety. Incomplete forms will be returned.