

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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