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

Referring Organization

Contact Information

Client Information

First Name

Last Name

Phone Number

Address

City

State.

ZIP Code

DOB

Gender

Social Security Number

Emergency contact/Number (optional)

Insurance Provider

Insurance Member ID

Insurance Provider

Insurance Member ID

Client on IOC (Y/N)

Probation/ CYF involvement

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

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

Discharge Paperwork must be sent with referral.

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Presenting Concerns:

Do you currently have thoughts of hurting yourself of someone else?
☐ Yes ☐ No

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/ have you used Illegal Substances?
☐ Yes ☐ No If yes: Drug of Choice & Last used ______________________________________

Do/have you drank Alcohol?
☐ Yes ☐ No If yes: Last used ______________________________________

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: ____

Per Human Services, Inc. policy, individuals cannot receive medication management alone, must attend other program within the agency. Please select preferred services:
☐ Outpatient Therapy ☐ Blended Case Mgmt (BCM) ☐ Critical Time Intervention (CTI)

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

Are you court ordered to treatment?
☐ Yes ☐ No

Please specify (circle): Mental Health Evaluation, Anger Management, Domestic Violence, Adult Sex Offender, Juvenile Sex Offender, Retail Theft

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Are you involved with Children and Youth Services?
☐ Yes ☐ No

Are you involved with Family Based Services, Wrap Around Services or a Partial Program?
☐ Yes ☐ No
Please Specify: ____

____

Do you have any Medical concerns?
☐ Yes ☐ No
Please Specify: ____

____

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

____

____

____

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

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: ____________

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