Healthy Transitions Referral/Intake Form

Client Name:________________________________

Referral Source:_______________________________

Date:_________________________________

Phone Number:_________________________

Initial phone contact:

Date:______________

Staff Initials:___________

Was contact made?

- Yes
- No

If yes:

Appointment date:_________________________

Appointment time:_________________________

Additional contact attempts:

2nd Attempt:

Date:_____________Time:_____________

3rd Attempt:

Date:_____________Time:_____________

4th Attempt:

Date:_____________Time:_____________

5th Attempt:

Date:_____________Time:_____________

Comments and additional attempts:

____
____
____
____
____
____
____
____

Criteria:

___16-25 years of age

___Greene County Resident

___Serious Emotional Disturbance

___Serious Mental Illness

___Intellectual Disability

___Substance Abuse

___Co-occurring Disorders:________________________________
____

Does potential client meet the criteria for HT program?

Yes_________

No _________

If criteria not met; referral made to:

____
____
____
____
____
____

Client Information (Please Print):

Legal Name:	Preferred Pronoun:	DOB:	SSN
Primary Phone:	Secondary Phone:	Email:	
Physical Address:			
County:	City:	State:	Zip:
Mailing Address (If different than physical address):			
County:	City:	State:	Zip:
Marital Status:		Preferred Language:	

Race (check one):

_____Asian _____Black/African American _____Hispanic or Latino _____Pacific Islander

_____White/Caucasian _____American Indian or Alaskan Native _____Mixed race

Emergency Contact:	Phone Number:	Relationship to Client:
Emergency Contact:	Phone Number:	Relationship to Client:

Reason for referral:

____

____

____

____

____

Currently Justice Involved? If yes, when? Reason?

____

____

____

____

____

Currently employed: If yes, where? Phone number?

____

____

Currently a student? If yes, high school or college? Where?

____

____

Currently seeing a Therapist with Frontier Health? If yes, name and TIER # :

____

____

Currently have a substance abuse and/or mental health diagnosis? ____Yes ______No ______Both

If yes, what substance?____

Diagnosis? ____

If no, do you currently feel like you have a substance or mental health concern? Please explain:

____

____

____

____

____

Is the client currently receiving any of the following:

_____SNAP/Supplemental Nutrition Assistance Program Benefits (EBT)

_____TANF/Families First Benefits

_____Medicaid

_____Unemployment Benefits

_____Reside in Section 8 Housing

_____Reside in Low Income/Public Housing

_____NSLP-Free/Reduced Lunch

Application completed by:_____Self _____Other

Date Completed:_______________________________________

Referred by:____

Phone Number:____

Relationship to client:___________________________________

Client Signature:____________________________________ Date:______________ Time:_____________

*******Official Use Only*******

____

Screener Name Date Time

Email completed form to: ht@frontierhealth.org OR

Fax to: 423-798-2402 Attention: Healthy Transitions