Healthy Transitions Referral/Intake Form

Client
Name:_______________________________
Referral Source:_______________________________
Date:_______________________________
Phone Number:_______________________________
Initial phone contact:
Date:_______________________________
Staff Initials:___________
Was contact made?
 o Yes
 o No
If yes:
Appointment date:_______________________________
Appointment time:_______________________________

Criteria:
___16-25 years of age
___Greene County Resident
___Serious Emotional Disturbance
___Serious Mental Illness
___Intellectual Disability
___Substance Abuse
___Co-occurring Disorders:_______________________________

Additional contact attempts:
2nd Attempt:
Date:___________Time:___________
3rd Attempt:
Date:___________Time:___________
4th Attempt:
Date:___________Time:___________
5th Attempt:
Date:___________Time:___________
Comments and additional attempts:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does potential client meet the criteria for HT program?
Yes_________
No_________
If criteria not met; referral made to:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**Client Information (Please Print):**

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Preferred Pronoun:</th>
<th>DOB:</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Phone:</th>
<th>Secondary Phone:</th>
<th>Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physical Address:**

**County:** | **City:** | **State:** | **Zip:** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mailing Address (If different than physical address):**

**County:** | **City:** | **State:** | **Zip:** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Marital Status:** | **Preferred Language:**
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Race (check one):**

- [ ] Asian
- [ ] Black/African American
- [ ] Hispanic or Latino
- [ ] Pacific Islander
- [ ] White/Caucasian
- [ ] American Indian or Alaskan Native
- [ ] Mixed race

**Emergency Contact:**

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>Relationship to Client:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Contact:**

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>Relationship to Client:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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*****

Email completed form to: ht@frontierhealth.org OR
Fax to: 423-798-2402 Attention: Healthy Transitions