

CLIENT ADMISSION FORM

Name:				Account #:			
Program #				Facility			

DEMOGRAPHICS

3. Admission Date (mmddyyyy)							
5. Case Number							
10. County of Residence							
13. Living Arrangement (check one)							
<input type="checkbox"/> Homeless		<input type="checkbox"/> Dependent Living			<input type="checkbox"/> Independent Living		
14. Employment Status (check one)							
<input type="checkbox"/> Employed Full Time		<input type="checkbox"/> Employed Part Time			<input type="checkbox"/> Public Assistance Benefits Depleted		
<input type="checkbox"/> Unemployed		<input type="checkbox"/> Not in Labor Force					
15. Detailed Not in Labor Force (check one)							
<input type="checkbox"/> Homemaker		<input type="checkbox"/> Student			<input type="checkbox"/> Retired		
<input type="checkbox"/> Disabled		<input type="checkbox"/> Inmate			<input type="checkbox"/> Other		
17a. Has the client participated in a self-help group, support group (e.g., AA, NA, etc.) in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No							
17b. Attendance in the last 30 days? <input type="checkbox"/> None <input type="checkbox"/> 1-3 times in past month <input type="checkbox"/> 4-7 times in past month <input type="checkbox"/> 8-15 times in past month <input type="checkbox"/> 16-30 times in past month <input type="checkbox"/> Some							

TREATMENT AND REFERRAL

18. Days Waiting to Enter Treatment:			
Is client waiting for a higher level of care (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. Number of Prior CD Treatment Episodes			
20. Admission Status (check one):			
<input type="checkbox"/> Voluntary		<input type="checkbox"/> Forced Voluntary	
<input type="checkbox"/> Involuntary (commitment)		<input type="checkbox"/> Court Order	
21. IV Usage (check one):			
<input type="checkbox"/> Never		<input type="checkbox"/> Not in the last 12 months but since 1978	
<input type="checkbox"/> During the last 12 months		<input type="checkbox"/> Not since 1978 but before 1978	
22. Is the Client Adversely affected by his/her gambling? (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. Agency Referral Source (Write Description)			
24. Program Referral Source (Use Program Table)			
25. Detailed Criminal Justice Referral (check one)			
<input type="checkbox"/> State/Federal Court		<input type="checkbox"/> Diversionary Program	
<input type="checkbox"/> Other Court		<input type="checkbox"/> Prison	
<input type="checkbox"/> Probation/Parole		<input type="checkbox"/> DUI/DWI	
<input type="checkbox"/> Other Recognized Legal Entity		<input type="checkbox"/> Other	
26. Number of arrests in the last 30 days			

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FINANCIAL / ELIGIBILITY							
27. Household Income from all sources (<i>Annual</i>)							
<input type="checkbox"/> Client refused to give income related information.							
28. Pay Frequency (<i>check one</i>)							
<input type="checkbox"/> Weekly		<input type="checkbox"/> Every Two Weeks		<input type="checkbox"/> Bi-Monthly			
<input type="checkbox"/> Monthly		<input type="checkbox"/> Annually		<input type="checkbox"/> Day Labor			
29. Including yourself, how many dependents are in your household?							
30. Primary Source of Income (<i>check one</i>)							
<input type="checkbox"/> Salary		<input type="checkbox"/> Public Assistance		<input type="checkbox"/> Retirement/Pension			
<input type="checkbox"/> Disability		<input type="checkbox"/> Other		<input type="checkbox"/> None			
31. Primary Source of Payment (<i>check one</i>)							
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Worker's Comp		<input type="checkbox"/> No Charge		<input type="checkbox"/> Self-Pay	
<input type="checkbox"/> Medicare		<input type="checkbox"/> Other Government Pay		<input type="checkbox"/> Other Health Insurance		<input type="checkbox"/> Other	
		<input type="checkbox"/> BCBS		<input type="checkbox"/> Block Grant			
32. Health Insurance (<i>check one</i>)							
<input type="checkbox"/> Blue Cross/Blue Shield		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Insurance Benefits Depleted		<input type="checkbox"/> Other Private Insurance	
		<input type="checkbox"/> IHS		<input type="checkbox"/> CHIP (HMK)		<input type="checkbox"/> Medicare	
						<input type="checkbox"/> None	
						<input type="checkbox"/> ATR	

INTERIM SERVICES	
TB Services	
<input type="checkbox"/> Referral for Testing	<input type="checkbox"/> Counseling and Education
Pregnant Women	
<input type="checkbox"/> Referral for Testing	<input type="checkbox"/> Counseling and Education
IV Drug User	
<input type="checkbox"/> Referral for Testing	<input type="checkbox"/> Counseling and Education

CRITICAL POPULATIONS	
<i>Check All That Apply</i>	
<input type="checkbox"/> a. DUI Offender	<input type="checkbox"/> j. On Pre-Release
<input type="checkbox"/> b. Receiving Food Stamps	<input type="checkbox"/> k. Other Incarcerated Person
<input type="checkbox"/> c. Receiving Medicaid	<input type="checkbox"/> l. Pregnant Woman*
<input type="checkbox"/> d. Receiving AFDC	<input type="checkbox"/> m. Woman w/Dependents* <input type="checkbox"/> # staying/CBR
<input type="checkbox"/> e. Receiving SSI*	<input type="checkbox"/> n. Homeless*
<input type="checkbox"/> f. IV Drug User*	<input type="checkbox"/> o. Mandatory Monitoring
<input type="checkbox"/> g. Protective Services Case	<input type="checkbox"/> p. Receiving SSDI*
<input type="checkbox"/> h. Probation	<input type="checkbox"/> q. Infected AIDS*
<input type="checkbox"/> i. On Parole	