

Call Intake

Client Name [Last, First MI] _____

Avatar MR#: _____

Applicant's Statement of Problem and Comments: _____

Intake Disposition: Select One

Appointment with: _____

Intake Appointment Date: _____

Appointment time: _____

Financial/Insurance Coverage [an additional Financial/Benefit form may also be completed]

Medicaid Number: _____

Medicaid Fee for Service

Medicaid Managed Care

Household Gross Annual Income: \$ _____

Private Insurance: _____

Client Admission

Sex: M F Date of Birth: ____/____/____. Pre-Admit/Admission Date: ____/____/____.

Program: * *

Type of Admission: Select One

Admitting Practitioner: _____

Source of Admission: _____

Social Security Number: _____

Primary Presenting Problems [Identify 3 choices by selecting appropriate checkboxes below]:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Physical Child Abuse Victim |
| <input type="checkbox"/> Adjustment Problems | <input type="checkbox"/> Drug Use [other than alcohol] | <input type="checkbox"/> Rape Victim |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Runaway |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Enuresis/Encopresis | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Appetite Problem | <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Self Abuse |
| <input type="checkbox"/> Attachment Problems | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Separation Problem |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Firesetting | <input type="checkbox"/> Sexual Child Abuse Perpetrator |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Gang Involvement | <input type="checkbox"/> Sexual Child Abuse Victim |
| <input type="checkbox"/> Child Neglect Victim | <input type="checkbox"/> Juvenile Justice Involvement | <input type="checkbox"/> Shoplifting/Burglary |
| <input type="checkbox"/> Coping Problems | <input type="checkbox"/> Family/Marital Problems | <input type="checkbox"/> Sibling Difficulties |
| <input type="checkbox"/> Criminal Justice Involvement | <input type="checkbox"/> Medical/somatic | <input type="checkbox"/> Sleep Problem |
| <input type="checkbox"/> Cruel to Animals | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Social/Interpersonal |
| <input type="checkbox"/> Dangerous/Assaultive | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Spouse Abuse Victim |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parent-Child Problem | <input type="checkbox"/> Suicide Attempt/Threat |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Peer Difficulties | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Thought Disorder |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Physical Child Abuse Perpetrator | <input type="checkbox"/> Verbal Aggression |

Client Demographics

Address: _____

Zip Code: _____

City: _____

County: _____

Home Phone: _____

Primary Language of Client: _____

Work Phone: _____

Language Spoken in the Home: _____

Is an interpreter needed: Yes No

If yes, in which language: _____

Country of Origin: _____

Place of Birth: _____

US Citizen: Yes No

Client Name [Last, First MI] _____

Avatar MR#: _____

Primary Race [Please Choose only one]:

- | | | |
|--|---|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> Declined to Answer |
| <input type="checkbox"/> No One Available to Identify/Child Unable | | |

Secondary Race [Please make additional selections as necessary]:

- | | | |
|--|---|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> Declined to Answer |
| <input type="checkbox"/> No One Available to Identify/Child Unable | | |

Client's Ethnicity [Please Choose only one]:

- | | | |
|---|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Declined to Answer | | |

Homeless Indicator: Select One

Other Client Data

Screened: Yes No Screened by Whom: _____

Date of Screening: ____ / ____ / ____

Parent/Guardian /Caregiver

Name: _____	Relationship to Client: <u>A to O Selection</u>	<u>P to Z Selection</u>
Date of Birth: _____	Social Security Number: _____	
Marital Status: <u>Select One</u>	Phone: _____	
Name: _____	Relationship to Client: <u>A to O Selection</u>	<u>P to Z Selection</u>
Date of Birth: _____	Social Security Number: _____	
Marital Status: <u>Select One</u>	Phone: _____	

Legal Status

Effective Date: ____ / ____ / ____ Legal Status: Select One
 Effective Time: ____ am pm

Emergency Contact

Name: _____ Relationship to Client: * P to Z Selection
 Home Phone: _____ Employer Phone: _____ Phone Other: _____

Next of Kin

Name: _____ Relationship to Client: Select One
 Home Phone: _____ Employer Phone: _____ Phone Other: _____

Previous Health Care Treatment

Previous Treatment Type: Select One
 Facility Name: _____ Admission Date: ____ / ____ / ____ Discharge Date: ____ / ____ / ____
 Reason for Services: _____

Client Name [Last, First MI] _____

Avatar MR#: _____

Referral Information

Primary Referral Source Code: Select One

Primary Referral Source – Contact: _____

Phone: _____

Supplemental Client Information

UNITY Person #: _____

SED Yes No

Date: ____/____/____.

SED Determination made by: _____

License Type: _____

School Name: _____

Special Education: Yes No

Grade: None

Date: ____/____/____.

Medical Clearance Complete: Yes No

Family of One: Yes No

Date: ____/____/____.

Date: ____/____/____.

Alien Registration#: _____ Date: ____/____/____.

Prior Authorization#: _____ Date: ____/____/____.

Diagnosis – DSM IV

Date: ____/____/____. Time of Diagnosis: _____ am pm

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Principle Diagnosis [pick from list above]: _____

Check Axis IV below as they apply: _____

Primary Support Group Social Environment Educational Occupational Housing Economic Health Care Legal/Crime Other

Diagnosis - Axis V Current GAF: _____

Diagnosing Practitioner: _____

CAFAS Total [8 scale]: _____ Date: ____/____/____.

Diagnosis – DC: 0-3R

Date: ____/____/____. Time of Diagnosis: _____ am pm

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Diagnosis Axis I: _____

Diagnosis Axis II: _____

Diagnosis Axis III: _____

Principle Diagnosis [pick from list above]: _____

Check Axis IV below as they apply:

None Mild Moderate Severe

Check Axis IV below as they apply: None Mild Moderate Severe

Diagnosis - Axis V [5 point scale/CGAS]: _____

Diagnosing Practitioner: _____

PECFAS Total [7 scale]: _____ Date: ____/____/____.

Client Name [Last, First MI] _____

Avatar MR#: _____

Client Name [Last, First MI] _____

Avatar MR#: _____

Section 1: Personal Information – Natural/Adopted Parent

Natural/Adopted Father Information:

Name: _____

DOB: _____

Home Address: _____
number and Street

_____ Apt/Bldg

_____ City

_____ State

_____ Zip

Social Security #: _____

Home phone number: _____

Name of Employer: _____

Employer Address: _____
number and Street

_____ Apt/Bldg

_____ City

_____ State

_____ Zip

Name(s) of Dependents:

Natural/Adopted Mother Information:

Name: _____

DOB: _____

Home Address: _____
number and Street

_____ Apt/Bldg

_____ City

_____ State

_____ Zip

Social Security #: _____

Home phone number: _____

Name of Employer: _____

Employer Address: _____
number and Street

_____ Apt/Bldg

_____ City

_____ State

_____ Zip

Name(s) of Dependents:

Section 2: Medical Insurance

DOES THIS CHILD HAVE MEDICAL INSURANCE COVERAGE? (Medicaid included) The State of Nevada is not a provider under any HMO or Preferred Provider insurance, therefore all clients with an HMO or Preferred Provider insurance will be referred to seek services from providers covered by their insurance plan.

NO If no, please initial here and skip to the signature section _____ (initial).

YES Please read and complete the following section:

I understand that the Division of Child and Family Services cannot guarantee that any insurance company will accept either the diagnosis or treatment given to the youth or the credentials of the clinical staff member who rendered the services.

I further understand that if my insurance company pays insurance benefits directly to me I will, in turn, pay that amount to DCFS immediately.

I am fully aware that my insurance coverage will not reimburse the State of Nevada for services rendered. I do not want to seek services through my insurance providers and agree to pay the full cost of services to DCFS. Payment will be made at the time of each service.

I understand my insurance plan does not cover a specific service or if benefits have been exhausted, I will furnish a letter from my insurance company stating this before DCFS will provide service.

Client Name [Last, First MI] _____

Avatar MR#: _____

Name of primary insured: _____

DOB: _____

Social Security Number of Insured: _____

Member Number of Insured: _____

Name of Insurance Company/Administrator: _____

Policy/Group#: _____

Claim/Billing Address: _____
Street Address

_____ City

_____ State

_____ Zip Code

Claim/Billing Phone Number: _____

Prior Authorization Request Phone: _____

Prior Authorization Number: _____

Medicaid #: _____

Name of secondary insured: _____

DOB: _____

Social Security Number of Insured: _____

Member Number of Insured: _____

Name of Insurance Company/Administrator: _____

Policy/Group#: _____

Claim/Billing Address: _____
Street Address

_____ City

_____ State

_____ Zip Code

Claim/Billing Phone Number: _____

Prior Authorization Request Phone: _____

Prior Authorization Number: _____

Medicaid #: _____

I authorize payment of medical benefits to the STATE OF NEVADA, DIVISION OF CHILD AND FAMILY SERVICES. I also authorize the release of any medical or other information necessary to process this claim.

I agree to show/provide a copy of my insurance ID card (front and back) and/or the youth's current Medicaid card at this time.

Signature of Client or Parent or Responsible Party

Date

 Signature of DCFS Staff Person

 Title

 Date

Title XX Block Grant:

The Division has federal block grant funds available that may pay for your services. Your eligibility for these funds will be assessed at the time of intake, however if the funds are discontinued or are no longer available you will be informed and placed on a sliding fee schedule according to your income and number of dependents.

QUESTIONS?

If you have any questions regarding this information above, please call the Business Office Monday through Friday, from 8:00 a.m. until 4:30 p.m.

Las Vegas area phone number: 702-486-0000

Reno area phone number: 775-688-1600

Client Name [Last, First MI] _____

Avatar MR#: _____