HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

CLIENT ADMISSION- SAME DAY ACCESS

Date: _____

*Name of Client: _____
Last Name *Suffix (Jr., Sr. III)* *First Name* *MI*

If custody/visitation order, name(s) of child (ren): _____

_____

Date of Birth: _____ Age: _____ *Social Security#: _____

Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

*In what county do you currently live? If you reside in a group home or state facility, what county did you live in previously? (If homeless, check Henrico County).

- ❍ Charles City County
- ❍ Chesterfield County
- ❍ Goochland County
- ❍ Hanover County
- ❍ **Henrico County**
- ❍ New Kent County
- ❍ Powhatan County
- ❍ Richmond City
- ❍ Other _____

Phone number where we may contact you: *(If you do not wish to be contacted, leave blank)* (___) _____

Work phone: (___) _____ Ext: _____ Other phone (pager, cell, etc.) : (___) _____

Email Address: _____.

Primary Emergency Contact Person:

_____ _____ _____
Last Name First Name Middle Initial

Relationship to you: _____

Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____ Other phone: (___) _____

Secondary Emergency Contact Person:

_____ _____
Last Name First Name

Relationship to you: _____

Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____ Other phone: (___) _____

CLIENT ADMISSION- SAME DAY ACCESS

May we send correspondence to the following addresses during and/or after services?

Address of Client ❍ Yes ❍ No

Address of Primary Emergency Contact ❍ Yes ❍ No

Address of Secondary Emergency Contact ❍ Yes ❍ No

Legal Guardian

*Legal (Guardian) Status:

- ❍ Client is less than 18 years old and in parent(s)' care
- ❍ Client is less than 18 years old and has a court ordered guardian
- ❍ Client is over 18 years old and has legal guardian
- ❍ Client is over 18 years old and has an Authorized Representative
- ❍ Client is over 18 years old and has a Representative Payee
- ❍ Client is over 18 years old and is their own guardian
- ❍ Protective Payee
- ❍ Authorized Rep. Court Ordered

If there is a Guardian, complete:

Name of Legal Guardian: _____
Last Name First Name

Street address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____

* Are you a minor? ❍ YES ❍ NO If yes, with whom do you live?

Last Name	**First Name**	*Relationship to you

If you are a minor, please provide parents/caregivers names:

Last Name of **Mother**	First Name	Middle Initial	
Last Name of **Father**	First Name	Middle Initial	
Last Name of **Other Caregiver**	**First Name**	Middle Initial	*Relationship to you

*Gender: ❍ Male ❍ Female

If female, are you living with dependent children ages 0-17? ❍ Yes ❍ No ❍ Unknown

If female, are you currently pregnant? O Yes O No Due Date: _____

*What is your marital status? ❍ Never Married ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

CLIENT ADMISSION- SAME DAY ACCESS

*What is your race?

- ❍ Black/African-American
- ❍ American Indian or Alaska Native & White
- ❍ Asian & White
- ❍ African-American & White
- ❍ American Indian or Alaska Native & African-American
- ❍ American Indian
- ❍ Multi-Racial
- ❍ Alaskan Native
- ❍ Other
- ❍ Native Hawaiian/Pacific Islander
- ❍ Asian
- ❍ White/Caucasian

* Hispanic origin? check appropriate box below

❍ Cuban ❍ Puerto Rican ❍ Mexican ❍ Other Hispanic Origin ❍ Hispanic Specific Origin not known ❍ Not of Hispanic Origin

What is your preferred language? ❍ English ❍ Other:_____

*In what type of residence do you live (current location)?

- ❍ Boarding Home
- ❍ Community Residential (group home)
- ❍ Foster Home/Family Sponsor
- ❍ Homeless/Homeless Shelter
- ❍ Hospital
- ❍ Licensed Adult Care Residence (ACR)
- ❍ Local Jail or Detention
- ❍ Nursing Home/Physical Rehabilitation
- ❍ Other
- ❍ Other Institutional Setting
- ❍ **Private Residence/School Dormitory**
- ❍ Residential Treatment/Alcohol & Drug Rehabilitation
- ❍ Shelter
- ❍ State Correctional Facility

Have you ever been convicted of a crime? ❍ Yes ❍ No

Number of Arrests in the last 30 days? _____

Are you currently on probation or parole? ❍ Yes ❍ No

Have you ever been incarcerated? ❍ Yes ❍ No ❍ No Answer Provided

Have you been psychiatrically hospitalized in the last three months? ❍ No ❍ Yes If yes, how many times? _____

*How many prior treatment episodes have you received in any drug/alcohol treatment programs? _____
(Enter zero, if this is the first treatment or you have never been in a drug/alcohol treatment program.)

Employment and Education Information:

*Current employment status:

- ❍ Disabled: Unable to Work
- ❍ Employment Program
- ❍ Full-time (>35 hours per week)
- ❍ Homemaker
- ❍ Institution or Jail
- ❍ Not in Labor Force
- ❍ Other (includes unemployed and NOT seeking employment)
- ❍ Part-time (<35 hours per week)
- ❍ Retired
- ❍ Student/Job Training (FT or PT, no paid employment)
- ❍ Unemployed: Looking
- ❍ Self Employed- Full Time
- ❍ Self Employed- Full Time

*What is the highest grade you completed in school?

- ❍ Never Attended School
- ❍ Nursery, Pre-School, Head Start
- ❍ Kindergarten
- ❍ Grade 1
- ❍ Grade 2
- ❍ Grade 3
- ❍ Grade 4
- ❍ Grade 5
- ❍ Grade 6
- ❍ Grade 7
- ❍ Grade 8
- ❍ Grade 7
- ❍ Grade 8
- ❍ Grade 9
- ❍ Grade 10
- ❍ Grade 11
- ❍ Grade 12
- ❍ GED
- ❍ Vocational only
- ❍ Special Ed
- ❍ College Undergrad Freshman
- ❍ College Undergrad Sophomore
- ❍ College Undergrad Junior
- ❍ College Undergrad Senior
- ❍ Graduate or Professional Prgm
- ❍ Associates Degree

CLIENT ADMISSION- SAME DAY ACCESS

***School Attendance Status:** Currently is this client enrolled in School? (Preschool 3yrs old thru High School regardless of the type of school: Public, Private, Home or Special Education) ❍ Yes ❍ No

If Yes, has the client attended school at least one day during the past 3 months (Respond YES if on Summer Break) ❍ Yes ❍ No

***Military Status:**

- ❍ Armed Forces – Active Duty
- ❍ Armed Forces - Reserves
- ❍ National Guard – not mobilized
- ❍ Retired Armed Forces/National Guard
- ❍ Discharged Armed Forces/National Guard
- ❍ Dependent Family Member
- ❍ Never been in the Military/not a Military Dependent

If military, discharged or retired what was the year you began? _____ If discharged/retired what was the year you left? _____

General Medical Information:

Do you have a Primary Care Physician? ❍ Yes ❍ No ❍ Unknown
Preferred Primary Care Physician: _____
Street Address: _____

City:_____ State:_____ Zip: _____
Physician's Phone Number: (___)_____ Fax Number: (_____)_____

Name of Preferred Clinic or Hospital: _____
Street Address: _____
City:_____ State:_____ Zip: _____

Have you had a physical exam in the last 12 months? ❍ Yes ❍ No ❍ Unknown

If no or unknown, are you willing to get a physical examination, and provide us a copy?
❍ Yes ❍ No

Do you have any current or chronic medical conditions? ❍ Yes ❍ No ❍ Unknown If Yes, Please list medical conditions below:_____
_____

Do you have any allergies? ❍ Yes ❍ No ❍ Unknown
If yes, to what medications, foods or environmental conditions? _____

Do you have any communicable disease? ❍ Yes ❍ No. If yes, please indicate below:
❍ STD ❍ Tuberculosis ❍ Hepatitis ❍ Other _____

Do you have a Medical Advance Directive?

- ❍ No
- ❍ Yes, and I will provide a copy
- ❍ Yes, but I do not want to provide a copy

Do you have a Recovery Plan such as WRAP or Psychiatric Advance Directive?

- ❍ No
- ❍ Yes, and I will provide a copy
- ❍ Yes, but I do not want to provide a copy

Do often do you participate in Peer Recovery Groups?
(Examples: Alcoholics Anonymous, Narcotics Anonymous, NAMI, SAARS)

CLIENT ADMISSION- SAME DAY ACCESS

❍ ID, Crisis, Eval Only Clients ❍ No participation past month ❍ Participation 1-2x's per week ❍ 1-3x's past month
❍ Participation 3-6x's per week ❍ Participation Daily

Do you use Tobacco products? ❍ Yes ❍ No

Smoking Status:
❍Current Everyday Smoker ❍ Current Status Unknown ❍ Never Smoked
❍ Current Some day Smoker ❍ Former Smoker

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

CLIENT ADMISSION- SAME DAY ACCESS

Client Name: _____ ***Case #:*** _____
Last ***First*** ***MI***

I hereby apply for the services of Henrico Area Mental Health & Developmental Services for myself as a Client or for the above named person whom I am legally authorized to represent and to act in his or her behalf.

I understand that use and disclosure of my information is governed as set out in the Privacy Notice that has been provided to me.

I authorize Henrico Area Mental Health & Developmental Services to disclose information to my insurance companies and other third party payors for the purposes of reimbursement and coordination of care. I understand that my written permission is required for the disclosure of my substance use information to my insurance company and other third party payors.

I understand that I have the right to restrict disclosure of health information to my insurance companies and other third party payors for services If I pay for out of pocket in full prior to the service being provided. The restriction will apply only if the disclosure is for purposes of payment or health care operations and the protected health information relates to a health care item or service for which I have paid HAMHDS in full prior to the services.

I understand that in the event of a medical emergency, qualified medical personnel will be contacted to administer the appropriate medical treatment.

I acknowledge that my records will be destroyed ten (10) years after my last treatment or twenty-eight (28) years after date of birth for minors.

It is recommended, as part of your initial comprehensive assessment, that you provide documentation of a current medical examination. You are asked to arrange this through your physician. If you do not have a physician, you may request help in obtaining one. Even though we encourage this, you have the right to decline and this will not affect the services for which you are eligible.

Do you wish to register to vote?

❍ ***I am registered or not eligible*** ❍ ***Yes*** ❍ ***No***

_____ _____
Signature of Client or Authorized Representative ***Date***

For PIP Program, enter Child ID Code: _____

CLIENT ADMISSION- SAME DAY ACCESS

Please Note: ***This form, which includes consent to treatment, must be completed before services can begin. If the legal guardian is unable to attend the initial appointment, he/she may show verification of guardianship and proof of identity to a Notary Public. The Notary Public should complete the section below and notarize (with seal). This notarized form, along with copies of the guardianship papers and proof of identity, may be submitted in person by a substitute custodian or via mail:***

Access
Henrico Mental Health & Developmental Services
10299 Woodman Road
Glen Allen, Virginia 23060

804-727-8515 for questions

If applicable: Verification of Guardianship or Authorized Representative: (e.g. court order)

- ☐ **Verification copied for Medical Record**
- ☐ **Identify verified and proof of Identity copied for Medical Record**

Notary Public verification (if Client Admission completed out of office)

Name of Notary Public: (please print) _____Date: _____

_____
Signature of Notary Public

Expiration of Commission: _____

Seal:

Completed by: _____ Staff Code: _____

Keying Staff Code: _____ Date Keyed: _____