


BAYCARE BEHAVIORAL HEALTH SERVICES

MR# (Office Use Only):		Date:	Social Security#: _____ - _____ - _____			
Last Name:		First Name:			Middle Initial:	
Address 1 (Mailing):						
Address 2 (Physical):						
City:		State:		Zip:	County:	
Gender: ___ Male ___ Female				Date of Birth:		
Race (circle one): White Black Native American Asian Hawaiian/Pacific Islander Multi Racial						
Home Phone: ()		Work Phone: ()			Other Phone: ()	
Individual Income: \$		Circle One: Weekly Bi Weekly Monthly Yearly				
Total Family Income: \$		Circle One: Weekly Bi Weekly Monthly Yearly				
Number of Children in Household:			Number of Adults in Household:			
Marital Status (circle one): Single Married Divorced Separated Widow Cohabitate Child Reg Domestic Partner						
Employment Status (circle one)						
If Working: Active Military-Overseas Active Military-US Full Time Part Time Unpaid (Family Bus.)						
If Not Working: Homemaker Student Disabled/Unable to Work Criminal Inmate Inmate-Other Not Authorized to Work Retired On Leave Unemployed (in Labor Force)						
Education Level:		Student Status: Full Time Part Time Home Schooled None				
Living Arrangements (circle one)						
Dependent Living - with Relatives		Crisis Residence		Supported Housing		
Independent Living - Alone		Dependent Living - with Non-Relative		Hospital		
Independent Living - with Relatives		Group Home (Residential, Rehab, etc.)		Nursing Home		
Independent Living - with Non-Relatives		Not Available or Unknown		Homeless		
Mental Health Assisted Living Facility (ALF)		Children's Residential Treatment		DJJ Facility		
Assisted Living Facility (ALF)		Foster Care/Home		Correctional Facility		
Who referred you to BayCare Behavioral Health?						
Ethnicity (circle one): Puerto Rican Mexican Cuban Mexican -American Haitian Spanish/Latino Other Latino Non-Hispanic Other Hispanic						
Veteran Status - Questions 1 and 2 below are required for all clients regardless of veteran status.						
1) Family Member of Veteran		Yes	No	If Yes, Relation to Veteran (circle one):		
2) Military Service (self)		Yes	No	Child Spouse Parent Sibling Other:		
If you answered "NO" to Question 2 - Please STOP and go to the "DISABILITY STATUS" on next page						
Military Status:		Active	Reserve	National Guard	Inactive	Veteran Retired
Last Branch of Service:		Air Force	Army	Coast Guard	Marines	Navy Public Health
Discharge Type:		Honorable	General	Medical	Dishonorable	
Discharge Year:						
				Last Name: _____		
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				MR#: _____		

VA Service Connected Rating	Yes	No	If Yes, circle percent below: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%							
Served in Combat	Yes	No	If Yes, check theater(s) of operation below: ___ Afghanistan ___ Iraq ___ Liberia ___ Philippines ___ Vietnam ___ Beirut ___ Korea ___ Panama ___ Somalia ___ World War II Other ___ Grenada ___ Lebanon ___ Persian Gulf ___ Tehran ___ Yugoslavia							
Former Prisoner of War	Yes	No								
Purple Heart Recipient	Yes	No								
Do you have a copy of your DD214?	Yes	No	If No, do you need assistance securing a copy of your DD214? Yes No							
Disability Status - please circle Yes or No:										
Hearing Disability	Yes	No								
Physical Disability	Yes	No								
Visual Disability	Yes	No								
Speech Disability	Yes	No								
Learning Disability	Yes	No								
Limited English	Yes	No								
Insurance Information										
Circle One Insurance Type: No Insurance Medicaid Private Insurance Medicare Other: _____										
Private Insurance:					Policy #:					
Claim Filing Indicator Code					Payor Responsibility Sequence Code:					
Name of Person Financially Responsible:										
Address of Person Financially Responsible:										
SSN #: _____ - _____ - _____					DOB: ____ / ____ / _____					
Next of Kin										
Name:					Relationship:					
Address:										
City:			State:		Zip:		Phone: ()			
Emergency Contact:										
Name:					Relationship:					
Address:										
City:			State:		Zip:		County:			
Home Phone: ()			Work Phone: ()			Other Phone: ()				
Does the individual seeking services have a Legal Guardian: Yes No										
My signature is to certify that the above information is true and accurate.										
Signature of Individual Completing Form					Date					
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