FLACRA Intake Data Form

Complete ALL sections

Client Information

Name: ____

Address: ____

City: ___________________________________ Zip: ______________________

County: ____

Home #: _________________________ Cell #______________________________

DOB _________________ SS# _____________________

Gender: ☐ M ☐ F ☐ X Marital Status: _______________________

Ethnicity: _________________ Hispanic Origin: ☐YES ☐NO

Primary Language: ______________ Birth Last Name: _____________________

Do you have an order of Protection: ☐ YES ☐ NO

Military Veteran: ☐ YES ☐ NO

Are you a ☐New ☐ Returning ☐Transferring client?

Insurance & Financial (Remind to bring ALL Insurance cards and ID)

Ins Carrier: ______________________ Policy #: _____________________

Policy Holder Name: _______________________ DOB: _______________

Authorization Needed: ☐YES ☐NO ☐ Unknown Medicaid Restricted Recipient: ☐ YES ☐ NO

Currently Employed: ☐ YES ☐ NO

Employer: ___________________ Work #: ____________________ Wage/Salary__________ Hr/Wk/Mn/Yr

Number of Dependents: _______ **Self-Pay Amount: ____________**

Referral and Support Contact Information

Referral Source: ____________________

Reason for referral: ☐Substance Abuse ☐ Mental Health ☐ DWI ☐ DWAI ☐ Gambling ☐ Family ☐ Other:

Caller's Name: _____________________ Phone Number: _____________________

Referring Agency: __________________ Contact Person: _____________________

Emergency Contact/Recovery Support Delegate: ____________________ Phone Number: __________________

Please select the service(s) you are interested in

☐ Crisis Services – immediately call 833-435-2272
☐Detox
☐Residential Inpatient
☐ Community Residential
☐ Certified Community Behavioral Health Clinic (CCBHC)
☐ SUD Outpatient Services
☐ Mental Health Outpatient Services
☐ HCBS/ CORE
☐ Veteran Services
☐ Care Management
☐ Medication Assisted Treatment
☐ School Based Mental Health
☐ Family Navigator
☐ Peer Support Services