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):** Child Spouse Parent Sibling Other:
2) Military Service (self)	Yes No	

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: _____

First Name: _____

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**

BAYCARE BEHAVIORAL HEALTH SERVICES **ADMISSION REPORT** BC BH 0211 **Page 2 of 2** Rev 06/11	Last Name: _____ First Name: _____ MR#: _____