Eligibility Info:
(Office Use Only)

# Reliance Health Inc.

## INTAKE REFERRAL FORM

Referral Date: _____
Contact Date: _____
Intake Date: _____
Intake Completed By: _____
Pending Disposition: _____

#_____

| | | | | | | |
|---|---|---|---|---|---|---|
| Last: _____ First: _____ M.I: Phone: (_____) _____-_____<br>Preferred Name or Nickname: Email: | | | | | | |
| Date of Birth: ___/___/_____ Age: ____ Gender: _____ Social Security Number _____-_____-_____ | | | | | | |
| Address:<br>Street _____ City _____ State _____ Zip Code _____ | | | | | | |
| Communication Preference:<br>☐ Cell phone<br>☐ Home phone<br>☐ E-mail<br>☐ Mail | Can we leave a message at this number?<br>◯ Yes ◯ No | Best time to Reach you: | Height: | Hair Color:<br>Eye Color: | Distinguishing Marks: | Any Known Allergies: |
| Place of Birth: | Length of time in Norwich: | Number of Children in Residence: | Former Member?<br>◯ Yes ◯ No<br>If yes, what program and when? | Language<br>(Primary and Secondary): | Highest Grade Completed: | Literacy Level:<br>☐ Below Basic<br>☐ Basic<br>☐ Intermediate<br>☐ Proficient |
| Religion: | Are you satisfied with your current housing situation?<br>◯ Yes ◯ No | If no, what would you like your living situation to be? | Pregnant:<br>◯ Yes ◯ No | Veteran:<br>◯ Yes ◯ No | Branch of Service: | Enlistment Dates:<br>___/___/___to<br>___/___/___ |
| Are you a smoker?<br>◯ Yes ◯ No<br>Please check one:<br>☐Current Every Day Smoker<br>☐Current Some Day smoker<br>☐ Former Smoker<br>☐ Never Smoked<br>☐Smoker, Unknown Status<br>☐ Unknown if ever smoked<br>☐Heavy Smoker: Equal or more than 25 cigarettes per day<br>☐Light Smoker: Equal or less than 5 cigarettes per day | Services Needed:<br>☐ Housing<br>☐ Budgeting<br>☐ Employment<br>☐ Education<br>☐ Socialization<br>☐ Paperwork<br>☐ Living Skills<br>☐ Counseling<br>☐ Other:<br>_____ | Marital Status:<br>☐ Never Married<br>☐ Married<br>☐ Divorced<br>☐ Separated<br>☐ Widowed<br>☐ Other:<br>_____ | Reside with:<br>☐ Spouse<br>☐ Partner<br>☐ Parent(s)<br>☐ Alone<br>☐ Roommate<br>☐ Children<br>☐ Homeless<br>☐ Congregate<br>☐ Other:<br>_____ | Ethnic Origin:<br>☐ Hispanic-Cuban<br>☐ Hispanic-Mexican<br>☐ Hispanic-Puerto Rican<br>☐ Hispanic-Other<br>☐ Non-Hispanic<br>☐ Unknown | Race:<br>☐ American Indian/Native American<br>☐ Asian<br>☐ Black/African American<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ Other<br>☐ Unknown<br>☐ White/ Caucasian | |

Continues On Reverse Side…

| | | | | | |
|---|---|---|---|---|---|
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| Do you currently have a service provider (therapist, psychiatrist, case manager)? | | If yes, name and agency: | Who referred you to Reliance House? | What other services have you had in the past? | |
| Do you have a mental health diagnosis?<br>◯ Yes ◯ No<br>If no, have you within the last two years?<br>◯ Yes ◯ No | | If yes, identify the diagnosis(es): | Other Information: | | |

**INSURANCE AND FINANCIAL INFORMATION**

*(Please have your insurance card available.)*

| | | | | |
|---|---|---|---|---|
| HUSKY/Medicaid #: | | Medicare #: | | Other: |
| | | | | |
| Conservator (Person):<br>◯ Yes ◯ No | Conservator (Estate):<br>◯ Yes ◯ No | Name and Address of Conservator (Person): | Name and Address of Conservator (Estate): | Phone Number of Conservator:<br>(_____) _____-_____<br>Fax Number of Conservator:<br>(_____) _____-_____ |
| Representative Payee<br>◯ Yes ◯ No | | Name and Address of Payee: | | Payee Phone Number:<br>(_____) _____-_____ |

Income:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SSI $: | SSDI $: | VA $: | Employment $: | State Cash Assistance $: | Food Stamps $: | DSS $: | Other $: |

**IN CASE OF EMERGENCY**

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|---|---|---|---|
| Name of friend or relative: | Relationship: | Phone Number:<br>(_____) _____-_____ | Address: |
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