

BEACON MENTAL HEALTH

The following is needed to provide services. We ask that you fill out this form as completely as possible regarding the individual who will be receiving services.

LEGAL NAME Last: _____ First: _____ M.I. _____

Preferred/Chosen Name: _____

Social Security Number: _____ Date Of Birth: _____ Age: _____

Address: _____ Apt/Lot/Suite #: _____

City: _____ State: _____ Zip: _____ County: _____

Preferred Phone # (circle) Cell / Home / Work: _____

Preferred Email (please print clearly): _____

Biological Sex: M F Gender Identity (optional): Male Female Gender Fluid Gender Queer

Non-binary Transgender MTF FTM Other: _____

My pronouns are: he/him/his she/her/hers they/them/theirs ze/hir Unknown/Unsure

Another pronoun (please specify): _____

Race: White Black/African Am. Asian Nat. Am./Alaskan Nat. Pacific Islander/Nat. Hawaiian Other: _____

If Hispanic, please check one: Mexican Cuban Puerto Rican Other

Employment Status: (check one) Full Time Part Time Disabled Retired Unemployed Homemaker Student

Occupation: _____

Relationship Status: (check one) Never married Married Widowed Divorced Separated

Sexual Orientation (optional): Straight Lesbian Gay Bisexual Queer Pansexual Asexual

Unknown Questioning Something else (please specify): _____

Hearing Status: Normal Impaired Deaf

Primary Language: _____ Interpreter Needed? Yes No

Veteran: Yes No If yes, are you eligible for VA benefits? Yes No Unsure

Is there a court ordered LEGAL GUARDIAN? Yes No

Copy of current letters of guardianship must be provided to Beacon Mental Health:

Guardian's Last Name: _____ Guardian's First Name: _____

Relationship to Client: _____

Phone: _____

Address: Same as Client Address If different from client's address:

Address: _____ City: _____ State: _____ Zip: _____

Please complete the 2nd page →

FINANCIAL INFORMATION:

Insurance Policy #: _____

Medicare Medicaid Other Insurance: _____

Household Income: \$ _____ Weekly Bi-weekly Monthly Yearly

Total Number in Household: _____ Number of Dependents: _____

FINANCIALLY RESPONSIBLE PARTY (if different from client):

Last Name: _____ First Name: _____ Relationship to client: _____

SSN: _____ Phone: _____

Address: Same as Client If different from client's address:

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Client: _____

Primary phone #: _____ Other phone #: _____

COMPLETE FOR CHILDREN ONLY (if not applicable, proceed to VERIFICATION):

Parent One Name: _____ Relationship: Biological/Adoptive Parent Step-Parent Foster Parent

Parent Two Name: _____ Relationship: Biological/Adoptive Parent Step-Parent Foster Parent

Parent Three Name: _____ Relationship: Biological/Adoptive Parent Step-Parent Foster Parent

Parent Four Name: _____ Relationship: Biological/Adoptive Parent Step-Parent Foster Parent

If there is a Delegation of Parental Authority, please list name of delegate: _____

**copy of current delegation (within the last year) must be provided to Beacon Mental Health*

If client is in State Custody, please list which Agency/Contact Person: _____

** copy of current court order showing custody must be provided to Beacon Mental Health*

VERIFICATION: I verify that the above information is accurate. I understand that I may receive appointment reminders and/or telehealth links via text or email, and I have the right to opt out of these notifications.

Client Signature: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

For Office Use Only- For Clients Not Admitted Into Services

Follow-up resources provided: _____ Staff Signature: _____

IF APPROPRIATE, INDICATE WHICH TREATMENT COURT: _____ **OR SCHOOL DIST.** _____

Staff: _____ New Readmit Update Admit Date: _____ MR #: _____