A NEW DAY counseling
HEALTH | WELLNESS | SUPPORT

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Screening AND/OR Referral FORM

This form is used to Screen potential clients for Services and/or Refer them to a more appropriate service or level of care.

DATE: _____ Email:_____ Electronic/Phone Correspondence OK? YES ☐ NO ☐

SOURCE OF REFERRAL: HEALTH PLAN _____ PCP _____ SCHOOL _____ DHS _____ OTHER _____

NAME AND RELATION OF PERSON MAKING THE REFERRAL: _____

(Please fill out as much contact information as possible, an Intake Coordinator will make contact within 1 business Day)

NAME OF REFERRAL: _____ **DATE OF BIRTH:** _____ **SS#:**_____

PARENT/GUARDIAN: _____ **CONTACT #:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

IF CHILD, NAME OF SCHOOL & GRADE:_____

CONCERN/PRESENTING PROBLEM: _____

_____

What scheduling needs are you requesting (Day/Time)? _____

*******Please understand that afternoon/evening appts are limited. Morning/Daytime will be scheduled quicker.*******

PAYMENT SOURCE INFORMATION:

PLEASE CALL YOUR INSURANCE CARRIER TO KNOW & UNDERSTAND YOUR BENEFITS!

☐ MEDICAID (SOONER CARE) #_____ ELIGIBILITY CHECKED: YES ☐ NO ☐

☐ OTHER INSURANCE(PRIVATE/EAP): _____ BENEFITS CHECKED: YES ☐ NO ☐

SUBSCRIBER ID: _____GROUP #:_____ PRIMARY INSURED: YES ☐ NO ☐

PRIMARY INSURED IF NOT CLIENT: _____ DATE OF BIRTH OF PRIMARY: _____

DEDUCTIBLE INFO (AMOUNT MET):_____ DATE OF VERIFICATION: _____

FOLLOW UP W/ CLIENT (PAYMENT FEE, INSURANCE INFO DISCUSSED & VERBAL AGREEMENT): YES _____ NO _____ DATE:_____

If we are In-Network w/ your insurance company, you are responsible for contacting your insurance company for coverage amounts. We must have a copy of the front & back of your insurance card prior to the start of services. Your deductible is the amount you must pay before your insurance company will begin paying for or 'covering' your services. If your Deductible has not been met, you are responsible for the full contracted rate until your Deductible is met. Deductible Verified Date: _____

***Self-Pay:** If you are **NOT** In-Network w/ an Insurance Panel we accept, you are considered a "Self-Pay" Client & responsible for all charges.
***Private Pay:** If you choose **NOT** to use Insurance Benefits for Reimbursement, you are considered a Private Pay Client & responsible for all charges.

----------FOR OFFICE USE ONLY, PLEASE DO NOT WRITE BELOW----------

REFERRAL TAKEN BY: _____ **REFERRED TO (NAME/CREDENTIALS):** _____

BEHAVIORAL HEALTH: Yes ☐ No ☐ **SUBSTANCE ABUSE/INTEGRATED:** Yes ☐ No ☐ **GAMBLING:** Yes ☐ No ☐ **TRAUMA:** Yes ☐ No ☐

DANGER TO SELF OR OTHERS? YES ☐ NO ☐ EXPLAIN:_____
ANY URGENT OR CRITICAL MEDICAL NEEDS? YES ☐ NO ☐ EXPLAIN:_____
IMMEDIATE THREAT(S)? YES ☐ NO ☐ EXPLAIN:_____
UNSAFE SUBSTANCE USE? YES ☐ NO ☐ EXPLAIN:_____
IN "OUT OF HOME" PLACEMENT? YES ☐ NO ☐ EXPLAIN:_____
CURRENTLY PREGNANT? YES ☐ NO ☐ EXPLAIN:_____
HAVE PRENATAL CARE? YES ☐ NO ☐ EXPLAIN:_____
INVOLVEMENT W/ COURT/CRIMINAL JUSTICE SYSTEM? YES ☐ NO ☐ EXPLAIN:_____
CURRENTLY HOMELESS? YES ☐ NO ☐ EXPLAIN:_____

DATE OF 1ST SCHEDULED APPOINTMENT OFFERED FOR INTAKE: _____ **INTAKE COMPLETED:** ☐ Yes ☐ No ☐ Rescheduled

DATE OF 1ST SCHEDULED APPOINTMENT W/ PROVIDER: _____

If Declining referral or Person is a Non-Admit referral, give reason, disposition, when notification to client occurred, & alternate referral resources:

_____

ADDITIONAL NOTES: *(Time & Date of Meeting held to discuss/staff the new client or Special Accommodations Request?)*

_____

ASSIGNED TO WAITING LIST? ☐ **YES** ☐ **NO** **WHAT PROVIDER?** _____ **DATE OF FOLLOW UP:**_____

ASSIGNED COUNSELOR SIGNATURE/CREDENTIALS: _____ **DATE:** _____