PLACE LABEL HERE

Park Place Behavioral Health Care

CLIENT APPLICATION FOR SERVICES

Do not complete this Application for Services if you do not agree to all of the agency policies, terms and conditions.

Please complete all information as it applies to the applicant.

Date: _____ – _____ – _____

Name: _____
LAST NAME *FIRST* *MIDDLE INITIAL* *MAIDEN NAME*

Date of Birth: _____ – _____ – _____ **SSN:**_____ – _____ – _____

Country of Birth: _____ **Age:**_____ **Gender:** □ M □ F

Ethnicity 1. Puerto Rican 2.Mexican 3.Cuban 4.Other Hispanic 5.Haitian 6.None of these 7.Mexican American 8.Spanish/Latino

Race: 1. White 2. Black 3. American Indian or Alaskan Native 7. Asian 8. Native Hawaiian/Pacific Islander 9. Multi-Racial

Current Address:_____
STREET ADDRESS *CITY* *STATE* *ZIP CODE*

Permanent Address:_____
(If different than Current Address) *STREET ADDRESS* *CITY* *STATE* *ZIP CODE*

Home Telephone: (_____)_____ **Work:** (_____) _____

Cell: (_____)_____ **Other:** (_____) _____

Who referred you to us?_____
NAME *ADDRESS* *CITY, STATE &ZIP* *TELEPHONE*

Marital Status
1. Single 3. Widowed 5. Separated 7.Registered Domestic Partner
2. Married 4. Divorced 6. Unreported 8.. Legally Separated

Are you a United States Veteran? □Yes □No

Employment Status
10. Active military, overseas 40. Part Time 81. Homemaker 85. Other Inmate
20. Active military, USA 50. Leave of Absence 82. Student 86. Not authorized to work
30. Full Time 60. Retired 83. Disabled
31. Unpaid Family Workers 70. Terminated/ unemployed 84. Criminal Inmate

Religious Preference
1. Protestant 3. Jewish 9.None/ Unknown
2. Catholic 4. Latter Day Saints 10.Other_____

What is the highest grade level you have completed in school? _____

Did you take, or are you currently enrolled in any Special Education classes? □ Yes □ No

Primary Income Source {circle all that apply}
1. Salary 4. Disability 7. Unknown
2. TANF Retirement 5. Other
3. Retirement/Pension/SSI 6. None

Are you currently involved with the legal system? □Yes □No

If yes, explain_____

PLACE LABEL HERE

Park Place Behavioral Health Care

Residential Status

01. Independent living- Alone
02. Independent living-with Relatives
03. Independent living-with Non-Relatives
04. Dependent living-with Relatives
05. Dependent living-with Non-Relatives
06. Assisted living Facility(ALF)
07. Foster Care/Home
08. Group Home
09. Homeless
10. Hospital
11. Nursing Home
12. Supported Housing
13. Correctional Facility
14. DJJ Facility
15. Crisis Residence
16. Children Residential Treatment Facility
17. Limited Mental Health Licensed ALF
99. Not Available or Unknown

Financial Information of Responsible Party:
How many dependents do you have? _____ How many dependents live in your house? _____

In the boxes below put the number of people by age group living with you in your house:

Age Group	**0 to 5 years**	**6-12 years**	**13-18 years**	**18 or more**	**Total # in House**
How Many?					

Current or Most Recent Employer: (Client or Parent/Guardian)

_____
COMPANY NAME ADDRESS CITY, STATE &ZIP TELEPHONE DATES WORKED

Who do you want us to contact in case of an emergency involving the applicant?

_____
NAME RELATIONSHIP ADDRESS CITY, STATE &ZIP TELEPHONE

If applicant for services is under 18: Parent or guardian's SSN: _____–_____– _____

_____
PARENT/ GUARDIAN'S NAME RELATIONSHIP ADDRESS CITY, STATE &ZIP TELEPHONE

Household Income: $_____**per {Circle}** □ *week* □ *two weeks* □ *month* □ *year*

Insurance Information: {*Such as Medicare, Medicaid, an HMO, etc.*}
(Please provide your insurance card(s) for the receptionist to copy)

☐ Card Attached:

_____
POLICY HOLDER'S NAME INSURANCE COMPANY GROUP# POLICY # TELEPHONE

☐ Card Attached:

_____
POLICY HOLDER'S NAME INSURANCE COMPANY GROUP# POLICY # TELEPHONE

_____ _____ – _____ – _____
Client Signature ***Date***

_____ _____ – _____ – _____
Parent/ Guardian Signature ***Date***

_____ _____ – _____ – _____
Witness Signature ***Date***