HOH REQUEST FOR SERVICES

NON-RESIDENTIAL-Downtown
Service Requested: Primary Evening

Date requesting services: _____

Legal Name: _____ Sex: _____ DOB: _____ Age: _____
Physical Address: _____ Race/Ethnicity:_____
City, State, Zip: _____ SS#: _____
Mailing Address: (if different from above) _____ Home or Cell Phone: _____
City, State, Zip: _____ Are you ok with receiving text messages? No
E-mail: _____ Student Status: Non-Student
Employer: _____ Work Status: Disability

Marital Status: Widowed
Spouse/SO/Parent: _____ Contact Number: _____
Address: _____ City, State, Zip: _____

Referred by: _____ **Referral Phone Number:**_____
PMI#: _____ **Direct Access Approved:** No
Insurance: _____ **County:** _____
Policy Holder Name: _____ **Insurance Phone**:_____
Policy Holder DOB: _____ Policy Holder Employer: _____
Policy Holder Address: _____
Policy ID Number: _____ Group Number: _____
Client Relationship to Insured: Life Partner
Insurance Verified: No
If no insurance/eligible for Direct Access? No Have you applied for MN Sure? No

Reason for requesting service: _____
_____
Drug of Choice/date of last use: _____
Do you have a Medical Marijuana card? NO **Prescriber?**_____
Dosage_____ **DispensaryUsed**_____
Do either of these apply to you? Are you an IV drug user or pregnant?_____
Assessment (where? when?): _____
_____
Prior treatment: _____
_____
Probation: Charges? Upcoming Court dates? _____
Drug Court? County? _____
Are you on Furlough/ISR? No **Any Restraining orders/OFP/DANCO?** No
Details:_____
Have you ever been convicted of a sexual offense? No
Are you required to register? What level?_____
Mental Health Diagnois?_____
Hx of suicide or suicidal thoughts? _____
Physical Health issues?_____
Have you recently been exposed to someone who has been diagnosed with COVID-19? No
Allergies?_____

Have you been diagnosed with a developmental disability? No **What?**_____

Related conditions: Have you been diagnosed as having a severe, chronic disability that meets ALL of the following conditions:

No **Attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome or any other condition other than mental illness or an emotional disturbance**

No **Manifested before the age of 22**

No **Likely to continue indefinitely**

No **Results in substantial functional limitations in three or more of the following areas of major life activity**

- ☐**Self care**
- ☐**Understanding and use of language**
- ☐**Learning**
- ☐**Mobility**
- ☐**Self-direction**
- ☐**Capacity for independent living**

IF THE CLIENT ANSWERS "YES" TO HAVING A DEVELOPMENTAL DISABILITY OR RELATED CONDITION PLEASE COMPLETE THE PSR COLLATERAL CONTACT FORM PRIOR TO SCHEDULING.

REFERRALS TO BE INCLUDED IN TREATMENT:

Involved	Title	Name	Phone Number:	Address:	Fax:
No	County Funding Agent				
No	Probation				
No	Child Protection				
No	MH Therapist				
No	Commitment Worker				
No	Emergency Contact				
No	Other				

Notes: _____

_____

ALL PROGRAMS:

Form Completed By: _____ **Information Source:** _____

Admit Date and Time: _____

Submit