

Monthly Gross Income of Family: _____

Payment Arrangements: Medicaid Medicare Self-Pay Insurance Grant

Insurance/Grant Name: _____ Policy # _____

Subscriber's Name: _____ SS#: _____

***Please attach copy of current medical card**

Is This Referral Court Ordered? Yes No

Which Court: _____

Address: _____

Probation/Parole Officer: _____

Services Being Requested:

Mental Health Screening

Counseling Type: _____

Group- Which Group: _____

Assessment of What: _____

Medication/Somatic

Specific Reasons for Requesting Services:

Urgency: Emergency (is in immediate crisis, which may result in danger to self or others--client should be taken to Emergency Services rather than referred to Mid-Ohio Psychological Services, Inc.)

Urgent (client requires immediate intervention to avoid decompensation of behavior.)

Routine (client requires services, but will not likely decompensate significantly if not seen within seven days.)

For Office Use Only:

Date Authorization Materials Received _____

Appointment Offered (date/time) _____ Therapist _____

Appointment Scheduled (date/time) _____ Therapist _____

Client ID Assigned: _____ On Site Services Off Site Services

Program Enrollment: General Jail Court Diversion Juvenile Court Scioto County

Forensic AOD Sex Offender Anger Management Other (specify)

Will this case be: Full Service Screening Only