

Panhandle Mental Health Center
 Main Office, 4110 Avenue D, Scottsbluff, NE 69361
 (308) 635-3171

ADMISSION FORM

Date: _____ __ Admission __ Re-admission __ Update Acct # _____

Client Last Name	MI	Client First Name	Suffix (Jr, Sr, I, II, etc)	Maiden Name
DOB: _____		SSN: _____		Land Line # _____
Address: _____				Mobile # _____
City: _____	State: _____	Zip: _____		Message Phone # _____
Email Address: _____				Phone #s will be used for Appointment Reminders
Employer/School: _____				Work Phone# _____
County of legal residence: _____		County of current residence: _____		
Gender: __M __F		Veteran: __Yes __ No		Citizenship: __ Yes __ No
Marital Status: __Never married __Married __Divorced __Separated __Cohabiting __Widowed				
Race: __White __Black/African American __American Indian __Alaskan Native				
__Asian __Other Pacific Islander __Native Hawaiian __Unknown __Other: _____				
Ethnicity: __Cuban __Hispanic, specific origin unknown __Mexican __Not of Hispanic Origin __Puerto Rican				
__Other Specific Hispanic __Unknown				
Preferred Language(s): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____				

Responsible Party Information (if minor or guardian)

(Last Name)	(First Name)	M.I.	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Payee
Relationship to client: _____	DOB: ____/____/____	SSN: _____ - ____ - _____			
Address: _____			Mobile # _____		
City: _____	State: _____	Zip: _____	Land Line # _____		
Employer: _____		(Please complete insurance information on next page if applicable.)			

In case of emergency, notify:		
Name: _____	Relationship: _____	Phone #: _____
Physician: _____		Phone #: _____

Client Name _____
 Acct # _____

INSURANCE INFORMATION

Number of Dependents (including client): _____ Annual Household Gross Income \$ _____

Third-Party Payor: Self Pay Medicare Medicaid Private Insurance Other _____

Name of carrier: _____ HMO PPO Policy # _____

Policy Holder: _____ Relationship to Client: _____

Name of carrier: _____ HMO PPO Policy # _____

Policy Holder: _____ Relationship to Client: _____

Notes: _____

FINANCIAL INFORMATION

SSI/SSDI

Eligible, receiving payments
 Eligible, not receiving payments
 Determined to be ineligible
 Potentially eligible
 Not applicable

Medicare/Medicaid

Eligible, receiving payments
 Eligible, not receiving payments
 Determined to be ineligible
 Potentially eligible
 Not applicable

Household Income Source

None
 Public Assistance
 Disability
 Retirement/Pension
 Employment (parent or guardian)
 Other _____

DISABILITY STATUS

Developmental Disabilities/Mental Retardation Blindness or Severe Visual Impairment
 Non-Ambulation or Major Difficulties in Ambulation Deafness or Severe Hearing Loss
 Non-Use/ambulation No Observable Handicap or Impairment

SOCIO/ECONOMIC INDICATORS

Living Situation: **check all that apply**

<input type="checkbox"/> Live Alone	<input type="checkbox"/> Private Residence w/ Housing Assistance	<input type="checkbox"/> Jail/Correctional Facility
<input type="checkbox"/> Live with Relatives	<input type="checkbox"/> Private Residence w/ support services	<input type="checkbox"/> Other 24 hr residential care
<input type="checkbox"/> Live with Non-related Person(s)** ** spouse, roommate, significant other	<input type="checkbox"/> Private Residence w/o support services	<input type="checkbox"/> Other institutional setting
<input type="checkbox"/> Independent Living or Private Residence/Household	<input type="checkbox"/> Child living with Parent/Relatives	<input type="checkbox"/> Regional Center
	<input type="checkbox"/> Child in Residential Treatment	<input type="checkbox"/> Homeless/Shelter
	<input type="checkbox"/> Youth Living Independently	<input type="checkbox"/> Residential Treatment
	<input type="checkbox"/> Foster Home	

EDUCATION

12 years (or G.E.D.) >12 years 11years </= 10 years Highest grade completed _____
(such as 2nd, 3rd, 4th, 5th, 6th, 7th, 8th)
 Associate Degree Bachelor's Degree Master's Degree Doctorate Unknown

EMPLOYMENT STATUS

Employed Full-time (35 hrs+) Employed Part-time (<35 hrs/wk) Active in the Armed Forces
 Unemployed (laid off/looking) Sheltered Workshop Supported Employment Resident of Institution

Client Name _____

Acct # _____

