



5815 Broadway • Great Bend, KS 67530
 800-875-2544 • 620-792-2544 • 620-792-7052 (fax)

REGISTRATION FORM

CLIENT INFORMATION

Last Name:		First Name:		Middle:	<input type="checkbox"/> Jr. <input type="checkbox"/> Sr.	Maiden Name:	
					<input type="checkbox"/> Other_____		
Sex:	Birth date:	Age:	Social Security Number:		Marital status (circle one)		
<input type="checkbox"/> M <input type="checkbox"/> F	- -		- -		Single / Mar / Div / Sep / Widow		
Have you been seen previously at this office?		If yes, what year and under what name?			E-mail Address:		
<input type="checkbox"/> Yes <input type="checkbox"/> No							
Street address:				P.O. Box:			
City:		State:	ZIP Code:		County:		
Home Phone Number:		Cell Phone Number:		Contact Phone Number:		Work Phone Number:	
()		()		()		()	
Referral Source: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> SRS Area Office <input type="checkbox"/> Social/Community Agency <input type="checkbox"/> Court <input type="checkbox"/> Other:_____							
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic				Education: <i>(Highest level completed & School)</i> _____			
Race: <input type="checkbox"/> Am. Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African Am. <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other							
Hospitalization (Most Recent): <input type="checkbox"/> None <input type="checkbox"/> State Mental Health Hospital <input type="checkbox"/> Private Psychiatric Hospital <input type="checkbox"/> Out of Home Crisis Stabilization <input type="checkbox"/> General Hospital Psychiatric Ward <input type="checkbox"/> Inpatient Substance Abuse Treatment (excluding detox) <input type="checkbox"/> Residential Mental Health Treatment within a state correctional facility							

CONTACT PERSON INFORMATION

Relationship to Client: <input type="checkbox"/> Self (use previous info.) <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other							
Name:			Home Phone no.:			Cell Phone no.:	
Street address:				P.O. Box:			
City:			State:		ZIP Code:		

LEGAL GUARDIAN INFORMATION

Name:			Home Phone no.:			Address: City – State:	
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FOR BUSINESS OFFICE USE ONLY

Admission Date:		Time:		Therapist:	
Assigned ID #:			Generic ID #:		
Unique ID #:			Registration:		<input type="checkbox"/> Enrolled <input type="checkbox"/> Not-Enrolled
FAR Program Involvement		<input type="checkbox"/> N/A = 0	<input type="checkbox"/> Primary Person Involved = 1		<input type="checkbox"/> Secondary Involvement (family member) = 2
Funding Source:	(1)	(2)	(3)	(4)	
Personal payment responsibility:			Discount:		
Net Family Annual Income:			Number of persons supported by this income:		
Begin Date:		End Date:			

CLIENT INFORMATION

Supplemental Security Income or Social Security Disability Insurance Eligibility: Not Applicable Eligible and Receiving Payments Eligible but not Receiving Payments Potentially Eligible (*case not yet submitted for Determination*) Determined to be Ineligible by Review and Decision Determination Decision on Appeal

Employment: Part-time Full-time Retired Unemployed Not in Labor Force

Employer:

Employer phone no.:

Length of Employment:

ADULT CLIENT (SELECT ONE OPTION FOR EACH CATEGORY)

Current Educational Status: No Educational Participation Vocational Educational Involvement Pre-Educational Explorations Working on GED Working on English as Second Language Basic Educational Skills Attending Vocational/High School Attending College (1-6 hrs.) Attending College (7/more hrs.) Other _____

Current Residential Arrangement: Nursing Home NFMH Group Home Boarding Home Lives w/Relative (heavily dependent) Lives w/Relatives (largely independent) Supervised Housing Program Independent Living Other Precariously Housed Homeless

Current Vocational Status: No Vocational Activity Prevocational Activity Screening and Evaluation of Vocational Interests and Abilities Active Job Search Participating in Sheltered Work Program Employed in Transitional Employment Volunteer Activity Care Taker (children or others) Working less than 30 hrs. per week Working more than 30 hrs. per week Other Retired

CHILDREN/YOUTH CLIENT (SELECT ONE OPTION FOR EACH CATEGORY)

Custody Status: Child in JJA Custody and out of home placement Child in JJA Custody and lives at home Child is under supervision of JJA, but not in their custody Child is in SRS custody and out of home placement Child is in SRS custody and lives at home Child is under SRS supervision, but not in their custody No JJA or SRS involvement

Foster Care Contractor: Not Applicable KCSL (foster care) The Farm UMY KCSL (adoption) KVC St. Francis DCCA

Current Educational Status: Not Applicable Institutional Instruction Residential School Home-based Instruction f/School District Special Education Reg. Classroom w/Special Ed. Services Regular Classroom Home Schooling not provided by School District Not in School (suspended) Not in School (graduated) Not in School (working on GED) Not in School (expelled) Not in School (drop-out) Preschool Other Alternative Education w/Intensive Psychosocial Not in School (summer break) Therapeutic Services for Preschool Children Enrolled in Post-Secondary Education

Current Residential Setting: Jail/Detention State Hospital Inpatient Psychiatric Unit Crisis Resolution/Stabilization Unit Drug/Alcohol Treatment Center Residential Treatment/Level VI Group Home (Levels III, IV, V) Emergency Shelter Therapeutic Foster Care Foster Home Temporarily living w/ Relative or Family Friend Permanent Home(biological/adoptive) Independent Living Homeless

Total Number of Arrests: _____ Number of Adjudicated Felonies for crimes: _____ Number of Adjudicated Felonies for property crimes: _____ Number of Adjudicated Felonies for crimes against persons: _____ Number of Adjudicated Misdemeanors: _____ Number of Law Enforcement Contacts: _____

PRIMARY INSURANCE INFORMATIONSubscriber's relationship to Client: Self Spouse Child Other _____

Subscriber's Name (Policy Holder):

Social Security No.:

Birth date:

P.O. Box:

Street address:

City:

State:

ZIP Code:

Phone no.:

Employer:

Employer phone no.:

Policy No.:

Group No.:

Insurance Co. Name:

Effective Date:

Street address:

P.O. Box:

City:

State:

ZIP Code:

Phone no.:

SECONDARY INSURANCE INFORMATIONSubscriber's relationship to Client: Self Spouse Child Other _____

Subscriber's Name (Policy Holder):

Social Security No.:

Birth date:

P.O. Box:

Street address:

City:

State:

ZIP Code:

Phone no.:

Employer:

Employer phone no.:

Policy No.:

Group No.:

Insurance Co. Name:

Effective Date:

Street address:

P.O. Box:

City:

State:

ZIP Code:

Phone no.:

RESPONSIBLE PARTY INFORMATION (PERSON LIABLE FOR PAYMENT)Relationship to Client: Self (use previous info.) Spouse Mother-Father Other _____

Responsible Party Name:

Social Security No.:

Birth date:

P.O. Box:

Street address:

City:

State:

ZIP Code:

Phone no.:

Employer:

Employer phone no.:

Length of Employment:

Gross Family Annual Income: \$

Number of person's supported by this income (must be living in home):