



SBHI Hand Registration Form

Client Info				
Account #	UCI #	Title	Name	
AKA		SSN	Sex	Birth date
Address 1 (If homeless, place of last known address / County of residency)			Fax #	Date of first contact
Home Phone		Work Phone		Extension
Address 2		Cell Phone	Clinic: <input type="checkbox"/> Crisis Care <input type="checkbox"/> Montgomery <input type="checkbox"/> Preble	
City, State, Zip Code		County	E-mail	
Do you have a Social Security Card <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Note:
Type of Contact: <input type="checkbox"/> Emergency <input type="checkbox"/> Guarantor		Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Probation Officer (PO) <input type="checkbox"/> Children Service Bureau (CSB)		
Contact Name		Home Phone	Work Phone	Ext.
Address 1		Address 2		Date of Birth
E-mail		Fax		
City, State, Zip Code		SS#		

MACSIS/Demographics				
Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	Ethnicity <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Not Hispanic/Latino	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Program <input type="checkbox"/> 7461 YR <input type="checkbox"/> 7462 LSN <input type="checkbox"/> 7463 YC <input type="checkbox"/> 7464 DPS <input type="checkbox"/> 7465 VBS <input type="checkbox"/> 7466 PC <input type="checkbox"/> 7500 SCAD <input type="checkbox"/> 7525 CC	<input type="checkbox"/> Client is potentially SMD/SED <input type="checkbox"/> Notice of Enrollment given <input type="checkbox"/> Notice of Enrollment signed by staff <input type="checkbox"/> AoD Release of Information signed (AoD only) <input type="checkbox"/> Consent for treatment signed <input type="checkbox"/> Client refused to sign consent to treat (MH only) <input type="checkbox"/> In Crisis at Enrollment
Primary Language if not English	Family size	Gross monthly family income	Rider:	Subsidy: <input type="checkbox"/> Fee % <input type="checkbox"/> Co-Pay
Children Service Case Number		Medicaid #	Effective date:	Until:
<input type="checkbox"/> Leave Cost Center blank		<input type="checkbox"/> Leave account blank	<input type="checkbox"/> Accept Assignment	<input type="checkbox"/> Leave authorization for release of information blank

Program Enrollment (Program and clinic should be the same as above)				
Date of Enrollment	Date of current illness	Primary Therapist	Community Support Specialist	
HCFA Information	Patient Condition State _____ <input type="checkbox"/> Related to employment <input type="checkbox"/> Related to auto accident in this state <input type="checkbox"/> Related to other accident	Hospitalized from: _____ to _____ Date of Similar illness: _____ to _____ Unable to work from: _____ to _____	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student	

Policy Information 1				
Insurance Company	Co-Pay Fee %	Effective Date	Managed Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured is a: <input type="checkbox"/> Person <input type="checkbox"/> Non-person entity
Client Billing Name: (First, Middle Initial, Last)		Policy Number	Group Number	Insured ID
Insured Name: (First, Middle Initial, Last)		Employer		Relationship to insured
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Champus <input type="checkbox"/> Champva <input type="checkbox"/> Fed Black Lung <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Other Health Plan				

Policy Information 2				
Insurance Company	Co-Pay Fee %	Effective Date	Managed Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured is a: <input type="checkbox"/> Person <input type="checkbox"/> Non-person entity
Client Billing Name: (First, Middle Initial, Last)		Policy Number	Group Number	Insured ID
Insured Name: (First, Middle Initial, Last)		Employer		Relationship to insured
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Champus <input type="checkbox"/> Champva <input type="checkbox"/> Fed Black Lung <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Other Health Plan				