

# Columbia Community Mental Health

# APPLICATION FOR SERVICES

**PLEASE READ:** Columbia Community Mental Health is a private, nonprofit community mental health agency. Our professional staff is committed to providing quality counseling and case management services to the needs of all members of our community who are in mental or emotional distress. Most treatment is in the form of brief counseling and intervention. If we believe it would be helpful, we will refer you to one of a number of ongoing psychotherapy groups.

**A SPECIAL NOTE FOR PARENTS:** We believe that *parents are the most important members of their children's treatment team. Because of this, parents of children receiving treatment at Columbia Community Mental Health are required to participate in the treatment* of their children. We cannot help your child without your active cooperation and participation.

NAME: \_\_\_\_\_  
First Middle Last Last Name at Birth

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

PARENT/FOSTER PARENT'S NAME (If client is a child): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_  
City State Zip

MAILING ADDRESS, IF DIFFERENT: \_\_\_\_\_  
City State Zip

PHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Msg/Cell(circle one): \_\_\_\_\_

DRIVERS LICENSE # \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Household information: Please list all people in the household.**

	Name	DOB	Relationship to client
Person 1(client)			Client
Person 2:			
Person 3:			
Person 4:			
Person 5:			
Person 6:			

**Please check all the following that apply TO THE CLIENT:**

**GENDER**

- Male  
 Female

**RACE**

- White (Non-Hisp)  
 Black (Non-Hisp)  
 Native American  
 Alaskan Native  
 Asian  
 Native Hawaiian/  
 Other Pacific Islander
- Hispanic (Mexican)  
 Hispanic (Puerto Rican)  
 Hispanic (Cuban)  
 Other Hispanic  
 Southeast Asian  
 Other Race/Ethnicity

**MARITAL STATUS**

- Never Married  
 Married  
 Widowed  
 Divorced  
 Separated  
 Living as Married

**HIGHEST GRADE**

**COMPLETED:**  
 \_\_\_\_\_  
 Enter K-17 or  
 0 for None or GED

**LIVING ARRANGEMENTS**

- Private Res-Alone  
 Private Res-w/Sig. Other  
 Private Res-w/Parent  
 Non-Rel Foster Home  
 Institution (Hospital/Corr)  
 Private Res-Friends  
 MH: Res Tx Fac/Home  
 MHT x Fstr Care (Yth)  
 MH: Other  
 Group Home  
 Transient/Homeless  
 A&D: Refused/Unknown  
 Unknown

**EMPLOYMENT STATUS**

- Employed Full-time (35+ hrs.)  
 Part-time (17-34 hrs.)  
 Irregular (less than 17 hrs.)  
 Not Employed, Looking  
 Not Employed, not Looking  
 Retired  
 Temp Layoff  
 Seasonal  
 Student  
 Incarcerated  
 Homemaker  
 Unable

**SOURCES OF INCOME**

- None  
 Wages, Salary  
 OSIP - State  
 Alimony/Child Support  
 Social Security  
 Public Assistance  
 SSI - Federal  
 Pension, Unemployment, VA  
 Unknown  
 Other  
 Dividends/Interest  
 Refused  
 Monthly Household Income:  
 \$ \_\_\_\_\_

**INSURANCE COVERAGE**

- Oregon Health Plan: G.O.B.H.I.  
 Oregon Health Plan: Open Card  
 Medicare  
 Tricare  
 VA  
 Private Insurance: Please Name: \_\_\_\_\_  
 Self/None

**Veteran**

- Yes  
 No

PLEASE DESCRIBE BRIEFLY THE PROBLEM YOU WANT HELP WITH (Use back of page, if necessary): \_\_\_\_\_  
 More on back.

PLEASE LIST ALL OTHER AGENCIES FROM WHICH YOU RECEIVE ANY KIND OF SOCIAL SERVICES: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_