

Baltimore County &
Baltimore City
Fax: (410) 780-5205



Anne Arundel, Howard,
Prince Georges &
Montgomery Counties
Fax: (410) 987-4301

Phone (410) 780-5203

Returning Client: ☐ Yes ☐ No

Date: _____

☐ Male ☐ Female

Client Name: _____ Date of Birth: _____

SS# _____ MA Insurance#: _____

Address: _____

Adult Client or Parent/Guardian:

Name: _____

Guardian Relationship: _____

Contact Information:

Mobile: _____

Home: _____

Email: _____

Client lives in: (Circle One)

Home Foster Group Shelter
Care Home

Referral Source:

Name: _____

Relationship: _____

Agency/School: _____

Contact Information:

Office: _____

Mobile: _____

Email: _____

Please answer the following:

| | |
|---|---|
| Is the consumer of Hispanic, Latino, or Spanish origin? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unavailable |
| Race: | <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Not Available |
| How well does the consumer speak English? | <input type="checkbox"/> Well <input type="checkbox"/> Not so well <input type="checkbox"/> Not at All |
| Does the consumer speak another language other than English at home? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what is the language? | <input type="checkbox"/> Spanish <input type="checkbox"/> Other |
| Number of Arrests in the Past 30 days? | <input type="checkbox"/> None <input type="checkbox"/> 1-99 |
| Is the consumer deaf or do they have hearing difficulty? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

Reason for Referral

Please specifically note any of the following whether current or a history of: Recent Hospitalizations, Suicide Attempts or Ideation, Self-Harm, Aggression or Violence towards others, Domestic Violence, Psychotic Symptoms, Substance Abuse, Behavior Problems, & Mood Related Symptoms (such as depression, anxiety, anger control issues, & mood lability)

| | | | |
|--------------------|-----------|------------|-----------------------|
| Internal Use Only: | M#: _____ | EMR# _____ | Effective Date: _____ |
|--------------------|-----------|------------|-----------------------|

*If client is referred by hospital please fax discharge papers along with referral

**If DSS/DJS has full or shared guardianship, referring worker must complete initial consents prior to intake. Please contact intake coordinator in reference to this process

8967 Yellow Brick Road 1114 Benfield Blvd, Suite G 5740 Executive Drive, Suite 220 12501 Prosperity Drive Suite 3-235
Rosedale, MD 21237 Millersville, MD 21108 Catonsville, MD 21228 Silver Spring, MD 20904