

BEHAVIORAL HEALTH APPLICATION FOR SERVICES

San Luis Obispo Behavioral Health Department		<input type="checkbox"/> DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805)-781- 4275 FAX (805) 781-1227		<input type="checkbox"/> MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177		
REFERRAL Who referred you? (check as many as apply)	<input type="checkbox"/> Self <input type="checkbox"/> School <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Friends	<input type="checkbox"/> DUI <input type="checkbox"/> Jail <input type="checkbox"/> Medical/Physician <input type="checkbox"/> Medical Hospital <input type="checkbox"/> Child Welfare Services <input type="checkbox"/> Social Services	<input type="checkbox"/> Court <input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Prop 36 Court <input checked="" type="checkbox"/> Adult Felony Drug Ct. <input checked="" type="checkbox"/> Post Release Comm. AB109	<input type="checkbox"/> Mobile Crisis <input type="checkbox"/> Private Mental Health Practice <input type="checkbox"/> County Mental Health <input type="checkbox"/> Other Psychiatric Hospital <input type="checkbox"/> Vocational Rehab <input type="checkbox"/> SAFE	<input type="checkbox"/> OTHER specify:	
	<input type="checkbox"/> OTHER specify:		<input type="checkbox"/> OTHER specify:		<input type="checkbox"/> OTHER specify:	
Applicant Name (First, Middle, last, Jr. Sr., I or II)						
Applicant First Name as it appears on Birth Certificate						
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		Date of Birth		Date of Birth is <input type="checkbox"/> Actual <input type="checkbox"/> Estimated		
Applicant Street Address		SLO CO. JAIL		City	State	
Mailing Address (if different than above)				City	State	
Home/Message Phone N/A		Cell Phone N/A		<input type="checkbox"/> OK to leave message? N/A		
Email Address N/A						
Driver's License Number		Driver's License State		Social Security Number		
Reason no SSN given						
BIRTHPLACE	<input type="checkbox"/> SLO County	Other CA COUNTY- Specify		Other STATE Specify		
Other COUNTRY Specify						
MARITAL STATUS	Applicants MOTHER'S FIRST Name?		<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner			
RACE ETHNICITY	Are you of Hispanic or Latin origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> White	<input type="checkbox"/> Other Hispanic	<input type="checkbox"/> Laotian	<input type="checkbox"/> Guamanian	
		<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Alaskan Native	
		<input type="checkbox"/> Native American	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	
		<input type="checkbox"/> Mexican/American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Asian Indian	
		<input type="checkbox"/> Latin American	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Mixed Race	
Other Race Specify:						
LANGUAGE	PRIMARY LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (Specify)		<input type="checkbox"/> Services needed in language other than English			
PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (Specify)						
WORK	<input type="checkbox"/> Employed full-time (35 hrs or more per wk)		<input type="checkbox"/> Unemployed (looking for work)		<input checked="" type="checkbox"/> Not in labor force (not looking for work)	
<input type="checkbox"/> Part time (less than 35 hrs per wk)		<input type="checkbox"/> Unemployed (not looking for work)		Not working because (reason)? INCARCERATED		
LIVING ARRANGEMENTS	<input type="checkbox"/> House/Apt/Mobile Home		<input type="checkbox"/> Homeless in transition		<input type="checkbox"/> Drug Residential Rehab	
<input type="checkbox"/> SRO Hotel, Motel/Rooming House		<input type="checkbox"/> Homeless no County residence		<input type="checkbox"/> Group Qtrs. dormitory, barracks, camp		
<input type="checkbox"/> Friend/Other		<input type="checkbox"/> Group Home		<input checked="" type="checkbox"/> Correctional Facility Adult		
				<input type="checkbox"/> Sober Living Environment		
				<input type="checkbox"/> Other		
APPLICANTS FAMILY	Is applicant PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No		DUE DATE:		Number of Applicants Children 0-5 Years	
	Has applicant had or currently has an open Child Welfare Services case? <input type="checkbox"/> Yes <input type="checkbox"/> No				Number of Applicants Children 6-17 Years	
	Number of dependent adults applicant cares for 50% of the time		0		Number of children under 17 applicant cares for 50% of the time	
				0		
EDUCATION	Highest Grade Completed		Vocational Program <input type="checkbox"/> Yes <input type="checkbox"/> No		Current School Name	
	Specify Degree		Specify Vocational Program		School District of Residence	
DISABILITY	<input type="checkbox"/> 1 Hearing <input type="checkbox"/> 2 Visual <input type="checkbox"/> 3 Mobility <input type="checkbox"/> 4 Speech <input type="checkbox"/> 6 Health <input type="checkbox"/> 7 Developmentally Disabled <input type="checkbox"/> 8 Other(not drug or alcohol) <input type="checkbox"/> 12 Mental <input type="checkbox"/> NONE					
MILITARY	Are you a Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer			Do you have a military connected disability <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have VA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, VA Claim Number		
Other Names Used	First		Middle		Last	
EMERGENCY CONTACT	Name		Phone		Work Phone	
	Address				Relationship to Applicant	
LEGAL INFO	Probation Contact Name & Phone #		Court Case #		Social Worker's Name & Phone #	
	Parole Contact Name & Phone #		CDC Number #		Other/Conservatorship/JuvCourt300/601/602	
FINANCIAL	What is your monthly family income? 0		How many people live on your income including you? 0			
	MediCal? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		MediCal/CIN Number (eg. 123456789A)			
	Medicare Number		Private Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No			
SUSPENDED						
CLIENT NAME:		DATE		CLIENT NUMBER		