Family Service Program Intake Form

Your answers to the following questions are confidential and will help us understand the diversity of who we are serving.

Name:_____ Date: _____

Phone Number:_____

Address:_____City:_____ ___State:_

Zip Code:_____ Email Address (Optional): _____

Consumer Name (Family Member/Loved One):_____Age:_____

Your Relationship to the Consumer: _____

Name of Agency That Referred You to Our Program:_____

In Case of an Onsite Medical Emergency, Please Provide the Following:

Emergency Contact Name:_____

Phone:_____

1. What is your age group?

- ◯ 0-15 y/o
- ◯ 16-25 y/o
- ◯ Prefer not to answer
- ◯ 26-59 y/o
- ◯ 60+ y/o

2. What sex were you assigned on your original birth certificate?

- ◯ Male
- ◯ Female
- ◯ Other: _____
- ◯ Prefer not to answer

3. What is your gender identity? Select one that best describes you:

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer
- ◯ Questioning/unsure of gender identity
- ◯ Another gender identity: _____
- ◯ Prefer not to answer

4. What is your sexual orientation identity? Select one that best describes you:

- ◯ Heterosexual/Straight
- ◯ Gay or Lesbian
- ◯ Bisexual/Pansexual/Sexually Fluid
- ◯ Queer
- ◯ Questioning/unsure of sexual orientation
- ◯ Another sexual orientation: _____
- ◯ Prefer not to answer

5. What is your primary language?

- ◯ English
- ◯ Other:_____
- ◯ Spanish
- ◯ Prefer not to answer

6. What is your race? Please select all that apply:

- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ African American/African/Black
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White/Caucasian
- ◯ Other
- ◯ More than one race
- ◯ Prefer not to answer

7. What is your ethnicity? Please select all that apply:

- ◯ Caribbean
- ◯ Central American
- ◯ Mexican/Mexican-American/Chicano
- ◯ Puerto Rican
- ◯ South American
- ◯ African
- ◯ Asian Indian/South Asian
- ◯ Cambodian
- ◯ Chinese
- ◯ Eastern European
- ◯ European
- ◯ Filipino
- ◯ Japanese
- ◯ Korean
- ◯ Middle Eastern
- ◯ Vietnamese
- ◯ Other ethnicity: _____
- ◯ Multi-ethnic
- ◯ Prefer not to answer

8. Are you a veteran?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

9. Are you experiencing homelessness?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

10. Do you have any disability? If yes, please select all that apply.

(A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.)

- ◯ No, I do not have any of these disabilities
- ◯ Difficulty Seeing
- ◯ Difficulty hearing or having speech understood
- ◯ Learning Disability
- ◯ Developmental Disability
- ◯ Dementia
- ◯ Physical Mobility
- ◯ Chronic Health Condition
- ◯ Other Disability: _____
- ◯ Prefer not to answer

Would you like to be added to our mailing list (Newsletter)?:

- ☐ No
- ☐ Yes

Would you like to be able to correspond with staff via text or email? (If yes, please sign the 2nd page Notice of Privacy Practices to release permissions):

- ☐ Yes
- ☐ No

I understand that the services I receive through TMHA programs are completely confidential and provided free of cost through Mental Health Services Act funding and private donations.

_____ _____

Signature Date

If you would like a Family Services Staff Member to be able to reach you through text or email, please fill out the following optional section:

Client's Cell Phone Number

Cell Phone Carrier

Client Email Address

The following providers may exchange health related information with me via text message and email:

Family Services Staff Members: Vivian Soul, Fernando Vasquez, Maria Perez, Zandra Alfaro-Olea, Mayra Valencia, MelanieDavenport, Ana O'Sullivan, Shawn Ison.

NOTE:
Signing this document authorizes the exchange of health information between client and provider via text messaging and via e-mail.

Please read all of the cautions below:

- Communication by text and/or e-mail may not be secure and private. Understanding this risk, you are voluntarily requesting this form of communication.
- If your situation is important or time-sensitive and needs immediate attention, do not rely on text message or e-mail. Electronic communications will only be returned during business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. (excluding holidays). If you have sent an electronic message to your provider and have not had a response within 48 hours, please contact your provider by phone.
- Communication by text will be limited to scheduling and logistics only. If communication is initiated, which includes clinical information, TMHA Staff is responsible for switching to in- person or phone (voice) discussion.
- Electronic communication will not be used for crisis services or to communicate clinical information.
  If you are having a crisis, Call 911 or call TMHA hotline at (800) 783-0607.
- If you change your phone number or e-mail address, you must notify the Health Agency.

I request and authorize the San Luis Obispo County Department of Behavioral Health or the Santa Barbara County Department of Behavioral Wellness to exchange limited information with me about my healthcare via text messaging and e-mail. I have read and understand this Request and Authorization to Share Information via Electronic Means between Provider and Client.

Print Client Name

Client or Legal Representative Signature

Date