Changing Lives Matter, LLC

Date: _____

Referral Contact Name:_____ Contact Number:_____

Organization:_____ Email:_____

Reason for referral:

SERVICES: ☐ Psychotherapy ☐ Peer Support ☐ SACOT ☐ SAIOP ☐ Court Ordered Classes: Anger Management

☐ Virtual TelePsychiatry ☐ Virtual Med ☐ Comprehensive Assessment ☐ Diagnostic Assessment

☐ Other:_____

CLIENT INFORMATION Gender: Male ☐ Female ☐ ☐ Adult ☐ Adolescent

Name : _____

DOB: _____/_____/_____ SS #: _____-_____-_____ County of Residence: _____

Address: _____

(Current address) City, State Zip Code

Phone Number: _____ Alternate Number: _____

INSURANCE INFORMATION

Medicaid ID: _____ Other Insurance ID:_____

Medicare ID:_____ MRI#:_____

Insurance Type:

☐ Partners Behavioral Health (MCO) Medicaid ☐ AmeriHealth Caritas Medicaid ☐ Carolina Complete Health Medicaid ☐ Healthy Blue Medicaid ☐ United Healthcare Medicaid ☐ WellCare Medicaid ☐ Other:_____

EMERGENCY CONTACT

Emergency Contact Name: _____ Emergency Contact Number: _____

Relationship:_____ Legal Guardian (if adolescent): _____