Shasta County Mental Health

Access Team
2640 Breslauer Way, Redding CA 96001
(Phone) 530-225-5252 (Fax) 530-225-3870

Start Time:
Date:
Staff Name:

Initial Contact

- ☐ Phone
- ☐ Walk In
- ☐ Fax
- ☐ Agency Referral (Name)

- ☐ Parent/Guardian Name:
- ☐ Other Authorized Rep (Specify)

Has client received services here before?

☐ No ☐ Yes (Chart #) Year:

Client Service Information

Individual needing services:

Name:
Address:

Mailing address if different from above:

Address:

Nearest friend or relative:

Name:
Phone: Cell:

DOB: ☐ M ☐ F
Primary Language/Ethnicity:

-Youth Only-

Name and address of parent or guardian:

Name:
Address:
Relation to Child:
Phone: Cell:

School: Grade:

Receiving IEP-Related Special Ed Services? ☐ Yes ☐ No

Eligibility Information

Shasta County Resident? ☐ Yes ☐ No
Medi-Cal? ☐ Yes ☐ No

Medi-Cal Co of Responsibility if not Shasta:
Number: Confirmed:

☐ Medicare ☐ Parole (DOJ) ☐ Victim Witness ☐ VA/CHAMPUS ☐ Self-Pay
☐ Healthy Families ☐ Probation

Access Team Client Data Form

Client:
Chart # DOB:

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Additional Information

Client:	
Chart #	DOB:

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v--Youth Only--v

Does child reside with a parent? ☐ Yes ☐ No

If yes, are parents: ☐ Married ☐ Never Married ☐ Divorced

If divorced, legal custody of child is held by:

☐ Joint Legal ☐ Sole legal ☐ Joint Physical ☐ Sole Physical

If applicable, copy of intake order is: ☐ Requested ☐ Obtained Date received:

If legal authority to consent is based on court order (e.g., guardianship, juvenile court, etc), copy of order is:

☐ Requested ☐ Obtained Date received:

If child does not reside with a parent, who has legal authority to consent to treatment?

Basis of legal authority is:

☐ 300 Defendant ☐ 600 Ward ☐ Legal Guardianship

☐ Other Explain:

Caregiver Authorization affidavit executed on: File copy received on:

Other agency and/or clinician involved in family? ☐ Yes ☐ No

If yes, list agency, name, contact and phone #:

Name: Contact: Phone:

Name: Contact: Phone:

Name: Contact: Phone:

^--Youth Only--^

Staff Tracking

UMDAP completed? ☐ Yes ☐ No

☐ Signed ☐ Needs signature

☐ Episode open

☐ Established client ID/chart

End Time:

Date:

Clinical Staff Name:

Forwarded to (Access Team Clinician):

Print Form

Access Team Client Data Form

Client:

Chart # DOB: