

Face Sheet

Community Counseling Services

Rev 01/17

Case Name _____

Case ID# _____

Date _____

- New**
- Readmit**
- Change**
- Annual Review**

Admission Date _____ Intake Status _____ Admission Type _____

Annual Review Date _____ Original Intake Date _____

Case Name: _____

Alias: _____

Maiden Name: _____

Address: _____

City _____ State _____ Zip _____

Home# _____ Cell# _____

Date of Birth _____ SS# _____

Age _____ Gender _____ Race _____ Pregnant _____

Hispanic Origin _____ Marital _____ Legal Status _____

Admission Referral _____
(if referral is 01, 02, 03 must fill out referral organization)

Admission Referral Organization Code _____

County of Residence _____ Location of Case File _____

Veteran Status _____

Education Level _____

School Name _____

Intake Status

- 1 New
- 2 Readmit
- 3 Eval Only

Admission Type

- 1 Primary
- 2 Collateral
- 3 Unregistered

Gender

- F - Female
- M - Male
- U - Unknown

Hispanic Origin

- C - Cuban
- M - Mexican
- N - Not of Hispanic
- O - Other Hispanic
- P - Puerto Rican
- U - Unknown

Race

- A - Asian
- B - Black/African American
- I - Native American Indian
- K - Alaskan Native
- M - Reporting Multiple Race
- Other-Other Race
- P - Native Hawaiian/Other Pac
- W White/Caucasian
- U - Unknown/Not Applicable

Pregnant

- Y- Yes N- No
- X- N/A (male)
- U - Unknown

Marital

- D-Divorced
- M-Now Married
- P-Single - Separated
- S-Single - Never Married
- U-Unknown
- W-Widowed

Admission Referral

- 01 DMH psychiatric hospital
- 02 Other MS CMHC
- 03 DMH IDD facility
- 04 Private psychiatric hospital
- 05 Other MH care provider
- 06 Other IDD care provider
- 07 Other A&D care provider
- 08 General hospital/health care
- 09 Self
- 10 Family/Friend
- 11 School/educational agency
- 12 Employer/EAP
- 13 Police/Sheiff
- 14 Court/Correctional facility
- 15 Probation/Parole
- 16 Self Help Program
- 17 Vocational rehab/job placement
- 18 Nursing home (non-DMH)
- 19 Boarding home
- 20 Group home (non-DMH)
- 21 Other social services agency
- 97 Other
- 98 Unknown
- 99 None

Legal Status

- 1 Voluntary (Referral)
- 2 Involuntary - civil (psych)
- 3 Involuntary - civil (chemical)
- 4 Involuntary - youth court
- 5 Involuntary - criminal
- 6 Involuntary - revoked outpatient
- 7 Other legal status
- 9 Treatment ordered (prob/parol)

Referral Organization

- 101 Region 1 Mental Health Ctr
- 102 Region 2 Mental Health Ctr
- 103 Region 3 Mental Health Ctr
- 104 Region 4 Mental Health Ctr
- 106 Region 6 Mental Health Ctr
- 108 Region 8 Mental Health Ctr
- 109 Region 9 Mental Health Ctr
- 110 Region10 Mental Health Ctr
- 111 Region 11 Mental Health Ctr
- 112 Region 12 Mental Health Ctr
- 113 Region 13 Mental Health Ctr
- 114 Region 14 Mental Health Ctr
- 115 Region 15 Mental Health Ctr
- 201 Miss. State Hospital
- 202 East Miss. State Hospital
- 203 North MS State Hospital
- 301 North Miss. Regional Center
- 302 Hudspeth Regional Center
- 303 Boswell Regional Center
- 304 Ellisville State School
- 305 South Miss. Regional Center
- 306 Juvenile Rehab. Facility
- 700 Private providers

INITIALS: _____

County of Residence

- 10-Choctaw
- 13-Clay
- 44-Lowndes
- 52-Noxubee
- 53-Oktibbeha
- 78-Webster
- 80-Winston
- 99-Out of State
- Other _____

Location of Case File

- 1 Choctaw/Ackerman
- 2 Clay/West Point
- 3 Noxubee/Macon
- 4 Lowndes/Columbus
- 5 Oktibbeha/Starkville
- 6 Webster/Eupora
- 7 Winston/Louisville
- 8 PACH/SUD Facilities

Education Level

- 01 -12 First - Twelfth Grade
- 13 GED
- 14 Technical/Trade school
- 15 Some College, no degree
- 16 Associate Degree
- 17 Bachelor's Degree
- 18 Master's Degree
- 19 Ph.D.
- 51 Preschool/Kindergarten
- 52 Special Education
- 98 Unknown
- 99 Never attended school

Veteran Status

- Y Yes
- N No
- U Unknown

Client Name _____ Case# _____

EMERGENCY CONTACT

Emergency Contact Name _____

Emergency Relationship _____ Number: _____

Sec Emergency Contact Name _____

Emergency Relationship _____ Number: _____

Living arrangement _____

Type of Residence _____

Employment Status _____

Case# _____

Living Arrangements

- 1 Lives alone
- 2 Lives w. Relatives
- 3 Lives w. non-relatives

Employment

- 01 EMPLOYED - Full Time
- 02 EMPLOYED - Part Time
- 03 EMPLOYED - Active Military
- 04 SEASONAL/Migrant Wrkr
- 05 UNEMPLOYED - seeking wrk
- 06 UNEMPLOYED - not seeking
- 07 HOMEMAKER
- 08 FTS - Student under 17
- 09 RETIRED
- 10 DISABLED
- 11 CORRECTIONAL INMATE
- 97 OTHER

Type of Res.

- 1 Private residence
- 2 Rooming (House/Dormitory)
- 3 Homeless
- 4 Institution (MR Facility etc.)
- 5 Community program (Group Home)
- 6 Correctional facilities
- 7 Other
- 8 Foster Home
- 9 Residential Care
- 10 Crisis Residence
- 11 Children's Residential Trxtmnt
- 99 N/A/Unknown

Individual's Employer

Employer Address _____

Employer Phone number _____

Household Annual Income Amount _____

Number of Dependents _____

Primary Source of Household Income _____

Expected Principal Source of Payment _____

Medicaid Eligibility _____

Medicaid Eligibility Type _____

SSI/SSDI Eligibility _____

Payer #1 _____ Payer #2 _____ Payer #3 _____

A&D Self Pay Fee Amount \$ _____

Responsible Party Info: Self

Name _____

Address _____

City _____

State _____

Zip _____

Number _____

Relationship _____

Primary Source-Household

- 1 Wages/salary
- 2 Public Assistance
- 3 Retirement/Pension
- 4 Disability income
- 7 Other
- 8 Unknown
- 9 None

Expected Source - Payment

- 01 None
- 02 Personal resources
- 03 Service contract
- 04 Blue cross/Blue shield
- 05 Champus
- 06 Other Commercial health INS
- 07 Medicare (Title XVII)
- 08 Medicaid (Title XIX)
- 09 VA (Veteran's Admin)
- 10 Workmen's compn
- 11 Other Public(Govt)source
- 12 Chips (Childrens Health Ins)
- 97 Other source of payment
- 98 Unknown

Medicaid Eligibility Type

- NA Not applicable
- COL Cost Of Living
- CWS CWS Foster Care/Adoption Asst
- DAC Disabled Adult Child -DAC
- LTH Long Term Hospital, SSI Elg Ho
- NH1 Nursing Home, under 300 FPL
- NH2 NH, Eligible at Home
- PFC Proctected Foster Care, Child
- QMB Qualified Medicare Beneficiary
- SSI SSI Individual
- HCBS HCBS
- HMSW Healthier MS Waiver Only
- IV-E IV-E Foster care/Adoption asst
- MEDA Medical Assistance-Intact Fam
- PREG Pregnant Women and Children
- PSSI Protected SSI Child
- QWDI Qualified Working Disabled Ind
- SSIR SSI Retro Eligibility
- CHD01 Children age 1-5 income 143%
- CHD06 Children up to Age 6
- CHD19 Child Under Age 19, under 100
- CHILD Child 6-19 under 107FPL income
- DISAC Disabled Child at Home
- EMIMG Emergency Immigrant
- EMSSI Emergency SSI limitations Case
- GRAND Grandfathered Case 1973
- HCBSA HCBS Assisted Living Waiver
- HCBS E HCBS Elderly/Disabled Waiver
- HCBSI HCBS ID/DD Waiver
- HCBSL HCBS Independent Living Waiver
- MCANC Mississippi Can-Cenpatico
- MCANO Mississippi Can-Optum
- PCOMC PARENTS/CARTRKS OF MINOR
- SWGBD Swing Bed, SSI Elg Home
- TBISC TBI/SCI Waiver(Tram Brain)
- WID50 Widower(er) 50+ yrs
- WID60 Widower(er) 60+ yrs
- WMRDD Waive Mental Ret Dev Dis
- WRDIS Working Disabled

Medicaid Eligibility

- 1 Eligible and receiving payment
- 2 Eligible not receiving payment
- 3 Potentially eligible (review)
- 4 Determined as ineligible
- 8 Unknown
- 9 Not applicable

SSI/SSDI Eligibility

- 1 Eligible and receiving payment
- 2 Eligible not receiving payment
- 3 Potentially eligible (review)
- 4 Determined as ineligible
- 8 Unknown
- 9 Not applicable

Payer Codes

- 001 Self Pay
- 002 Medicaid
- 021Cenpatico
- 022Optum
- 003 Medicare
- 004 Voc. Rehab
- 600 -981 Insurance
- 007 US District Court
- 066 Taylor Machines
- 088 City of West Point
- Other: _____

Client Name _____ **Case#** _____

Medicare# _____ Date of Elig _____ Medicaid# _____ Date of Elig _____

EAP Name: _____

EAP Address: _____

City _____ State _____ Zip _____

INSURANCE/Medicare/Medicaid:

**Make a copy of the front & back of all Medicare, Medicaid and/or Insurance cards*

Prim. Insurance Name _____

Insured Id # _____ Group # _____

Policy Owner _____ SS# _____

Policy Owner Date of Birth _____ Relationship to Client _____

Employer _____ Employer Phone number _____

Employer Address _____

City _____ State _____ Zip _____

Sec. Insurance Name _____

Insured Id # _____ Group # _____

Policy Owner _____ SS# _____

Policy Owner Date of Birth _____ Relationship to Client _____

Employer _____ Employer Phone number _____

Employer Address _____

City _____ State _____ Zip _____

Third Insurance Name _____

Insured Id # _____ Group # _____

Policy Owner _____ SS# _____

Policy Owner Date of Birth _____ Relationship to Client _____

Employer _____ Employer Phone number _____

Employer Address _____

City _____ State _____ Zip _____

INITIALS: _____

Client Name _____

Case# _____

For Clinician Use Only
CLINICAL INFORMATION

Department Code _____

Physical Impairment 1 _____ Physical Impairment 2 _____

Presenting Problem 1 _____ Presenting Problem 2 _____

Presenting Problem 3 _____

Disability Treatment Category _____

Primary Disability/Treatment Category _____

Is Client SMI _____ Is Client SED _____

Y – Yes N – No U - Unknown

Is Client receiving Integrated Treatment? N

Is Client receiving ACT/PACT Treatment? N

Center Physician: _____

Therapist of Record Billing Number _____

Diagnosis - DSM 5 ICD 10

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Department Code

- 002 MH Counselors-Child
- 003 MH Counselors-Adult
- 010 DD Community Support
- 016 Intensive Case Management
- 023 Cady Hill
- 024 Pines-Halfway House
- 027 Aftercare/Outreach
- 028 Men's Three Quarter way House
- 029 IOP
- 035 Women's Three Quarter way
- 039 IOP Adol and Youth
- 056 Structured Intervention
- 062 Children MR Therapy
- 063 Adult MR Therapy
- 065 SYSTEM OF CARE (SOC)CHILD WP
- 072 Children A&D Therapy
- 073 Adult A&D Therapy
- 076 GTA-SOC
- 079 MH4R HOMELESS GRAN
- 082 IOP MH CHILDREN/YOUTH

Physical Impairment

- 01 Deafness and blindness
- 02 Deafness/severe hearing loss
- 03 Blind/severe vision loss
- 04 Non-ambulatory
- 05 Ambulatory only w. assistance
- 06 Unable to communicate verbally
- 07 Traumatic brain injury
- 08 Major medical condition
- 97 Other
- 98 Unknown
- 99 Not applicable

Presenting Problem

- 01 Marital/family problems
- 02 Social/interpersonal
- 03 Coping w. daily roles
- 04 Medical/somatic
- 05 Communication disorders
- 06 Depression/mood disorder
- 07 Attempt/threat/danger suicide
- 08 Alcohol
- 09 Drugs
- 10 Eating disorder
- 11 Thought disorder
- 12 Abuse/assault/rape victim
- 13 Abuse/assault/rape perpetrator
- 14 Involvement w. criminal justice
- 15 Runaway behavior
- 97 Other

Disability Treatment Category

- 1 Mental health
- 2 Intellectual developmental disability
- 3 Substance abuse
- 4 MH/IDD (Dual diagnosis)
- 5 MH/SA (Dual diagnosis)
- 6 IDD/SA (Dual diagnosis)
- 7 MH/IDD/SA (Dual diagnosis)

Primary Disability Category

- 1 Mental Health
- 2 Intellectual developmental disability
- 3 Substance Abuse

DSM 5

ICD 10

7 _____

COMPLETED BY:

Staff Signature _____

Date _____

INITIALS: _____