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| **REQUEST FOR BERKS COUNTY FUNDED SERVICE(S)-All of the below fields are requested to be completed. If the consumer wishes to remain anonymous, please complete as many fields as possible.** | |
| **Name of Referred Individual (First, last and middle name):** Click here to enter text. | |
| **Date of Birth (mm/dd/yy):** Click here to enter text. | **Social Security Number:** |
| **Address (Street/ city/state and zip code):** Click here to enter text. | |
| **Date of SAP Assessment (mm/dd/yy):** Click here to enter a date. **Date of Collateral Contact/CC (mm/dd/yy):** Click here to enter a date.    **# of Assessment Units provided (1 unit = 15 minutes):** Click here to enter text. **# of CC Units provided (1 unit = 15 minutes):** Click here to enter text.  **SAP Provider’s Name (add) -** Click here to enter text. | |  |
| **School District Name (No selection/please add) -** |  |
| **Individual’s Diagnostic Impression (based on ICD 10 codes), if known:** Click here to enter text. | |
| **Electronic Version- Form Completion**: Please select the applicable option for each category.  **Manual Version: Form Completion**: Please mark the applicable option for each category. NOTE: **Primary language must be typed into the text field if using the electronic version or handwritten on the form if completing it manually.** | |
| **Primary Language (No selection/please add) - Gender -** Male  Female | |
| **Race -** American Indian  Asian/Pacific Islander  Black  Native Hawaiian  White  Other/Not Volunteered | |
| **Ethnicity -** Hispanic or Latino  Not Hispanic or Latino  Unknown | |
|  | |
| **Citizenship –** Illegal Alien  Permanente Alien  Refugee  Refugee Minor  Temp. Alien  US Citizen | |
| **Marital Status –** Divorced  Divorced/Receiving Spousal Support  Married/Not Separated  Never Married  Remarried  Separated  Widow/Widower | |
| **Veteran Status –** Active Military Discharged  National Guard/Reserve  Non-Veteran  Veteran | |
| **Living Situation –** Assisted Living Residence  Children Residence  Cluster Sharing Living Arrangement  Community Home (MR)  Community Residential Rehabilitation Correction/Detention  D/A  Domiciliary Care  Family Living  Friend’s Home  Group Home  Homeless  ICF/ORC  LTSR  MAX CRR  Nursing Home/Facility  Other  Other Indep. Living  Own Residence  Personal Care Home  PCH – Specialized/Enhanced  Private ICF/MR  Relative’s Home  State MH Hospital  State-Operated ICF/MR  Supported Living  Temporary Shelter | |
| **Vocational/Education Status –** Competitive Employment: Full Time  Part Time  Meaningful Activity: Other  Retired  Seeking Employment  Volunteer  No Activity  Other  Training/Education (Student)  Unknown  Work Program: Other  Sheltered Employment  Sheltered Workshop | |
| **Employment –** Disabled  Full Time  Homemaker  Institutional  Other  Part Time  Retired  Student  Unemployed  Unknown | |
| **Education –** 0-5 Years Completed  10-12 Years Completed  13 Years Completed  6-9 Years Completed  Preschool  Unknown | |
| **PLEASE email this form to** SAM's Adm. Dept. c/o **Cyndi Behney at: cbehney@sam-inc.org**. Rvsd. 8 28 18 | |