JOHNSON COUNTY KANSAS Mental Health

Adolescent Center for Treatment (ACT)
6440 Nieman Rd, Shawnee, KS 66203
Ph: 913-782-0283 / Fx: 913-782-0609
Website: www.mentalhealth.jocogov.org
Email: ACT@jocogov.org

SUD EVALUATION INFORMATION

Complete this form and provide copies of the documents listed below, **prior to the scheduled assessment.** They can be returned by fax to 913-782-0609 or by photo/scan/email to ACT@jocogov.org.

Client Name: (First Middle Last) _____ **DOB:** _____ **SSN#:** _____

Client Phone #: _____ **Client Email#:** _____

Provide the Following Copies of Documents (prior to admission)

- ☐ **Social Security Card (client)**
- ☐ **Birth Certificate (client)**
- ☐ **Client ID (if available) / Parent/Guardian ID (required)**
- ☐ **Proof of Income (Adjusted Gross Income)** Enter Amt of Income $ _____
- ☐ **Proof of Residency (JOCO resident only - utility bill, rent agreement, etc.)**
- ☐ **School District Referral Letter (if applicable)**
- ☐ **Funding** ☐ School ☐ Aetna ☐ Sunflower ☐ United ☐ Grant
- ☐ **Medicaid Card/ID#** _____
- ☐ **Private Insurance Card/ID# (front and back) if applicable**
- ☐ **Release of Information (ROI) for Private Insurance (Signed by client and parent)**
- ☐ **Guardianship Papers/Power of Attorney (if applicable)**

Please Print Clearly:

PARENTAL CONTACTS:

Primary Parental Contact Name _____ **Relationship** _____
Address/City/State/Zip _____ **Primary Phone** _____
Email **SSN#** **DOB#**

Secondary Parental Contact Name _____ **Relationship** _____
Address/City/State/Zip _____ **Primary Phone** _____
Email **SSN#** **DOB#**

PRIVATE INSURANCE INFO:

Primary Private Ins Company _____ **Member/ID#** _____ **Ins Holder Name/Relationship** _____
Ins Holder SSN# **Ins Holder DOB** **Ins Holder Phone**

STATE CUSTODY

State Custody Agency (KDOC/CINC): _____ **Case Mgr Name:** _____
Address: _____ **Direct Phone#** _____
Office Phone# _____ **Fax#** _____ **Emerg/Aftr Hr #** _____
Case Mgr Email

LEGAL INVOLVEMENT (DIVERSION, PROBATION, COURT SERVICES, COMMUNITY CORRECTIONS, ISP, PENDING CHARGES):

Legal Officer Name _____ **Direct Phone** _____
Check One ☐ Pending Chgs ☐ Diversion ☐ Prob/Court Serv ☐ Comm Corr/ISP **Fax#** _____
County **Email**

SCHOOL INFORMATION

School Name **Current Grade** **Status:** IEP/504 Plan Dropped Out

Allergies (medications/food/environmental)		Current Medications		Chronic/Current Medical Conditions	