ACT, 920 W Spruce, St Olathe, KS 66061 Ph: 913-715-7600 Fax: 913-782-0609
Website: http://mentalhealth.jocogov.org/htpages/act.shtml (Full Handbook) Email: ACT@jocogov.org

Paperwork Needed for ACT Admission

Length of Stay Our residential program is designed for a 28 day stay. Any variance in the length of stay is based upon review of individual needs and progress in treatment by our clinical staff.

The following information and documents must be provided **prior to the scheduled admission date**, by fax: 913-782-0609 OR by scan/email or camera picture/email to Wanda.Ray@jocogov.org or ACT@jocogov.org

Please Print Clearly

Client's Name:	
Involved Parent(s)/Guardian(s) – Include Name, Relationship, Phone(s) and Email	
Primary/Residential :	
Secondary:	
Proof of Citizenship (one or both of the following)	
Social Security Card *(number must be provided)*	SSN#:
Birth Certificate	

Proof of Residency (one of the following)
☐ Driver's License/State ID *(client and/or parent/guardian)*
☐ School ID (client)
☐ Utility Bill *(parent/guardian)*

Proof of Insurance (all that apply) **Copy of front/back of card(s)** Complete attached form for Priv Insurance ONLY	
☐ KanCare (Medicaid) card: ☐ Amerigroup ☐ Sunflower ☐ United ID#:	
☐ Primary Private Insurance ID#:	☐ Secondary Private Insurance ID#:
Company Name:	Company Name:
Primary Insurance Holder's Name #1:	Secondary Insurance Holder's Name:
Primary SSN#::	Secondary Holder's SSN#:

Consent to Medical Care Form *(ONLY from DCF/Foster Care Agency or KDOC Case Manager)*
Consent to Medical Care Form

Proof of Adjusted Gross Income *(required only if seeking (AAPS) state grant OR for Johnson County – reduced fee only)*
☐ Tax Return or W2 form or Paycheck stubs or letter from agency/person regarding lack of income.

Immunization records/ TB Results / Allergies-Medical	
☐ Immunization/Shot Record	☐ Tuberculin (TB) results within last 6 months (if applicable):
☐ Allergies to: Medication(s) / Food / Environmental **LIST:**	
☐ Current Medication(s) **LIST:**	
☐ Medical Conditions (Chronic or current) **LIST:**	

Important Contact Information *(Please print clearly)*		
Primary Care Physician Name:		
Practice or Agency Name:		
Phone:		
Emergency Contact Name *(other than parent/guardian)*:		
Phone:		**Relationship:**
Legal Officer or KDOC/DCF-Case Manager Name *Include (KVC/St Francis Case Manager (If applicable)*		
County or Agency:		
Email:		
Phone/Fax:	**Phone:**	**Fax:**
After Hours # (Foster Care/KDOC Case Mgr):		

Admission Payment (*only applicable to full fee and Johnson County reduced fee clients)*
☐ Check, Cash or Credit/Debit Card

JOHNSON COUNTY KANSAS
Mental Health