CHILD AND ADOLESCENT EFT SERVICES INTAKE

For Office Use:
INKS/MCIS No: _____
Record #: _____
Initials: _____
Date entered: _____

I) CHILD INFORMATION

1. Child's Name: _____ **2. Sex:** o M o F

3. Birth Date: ___/___/___ **4. Social Security No.:** _____-_____-_____

5. Address: _____

6. a. Entitlements: Is the child/adolescent eligible for any of the following entitlements? *(check all that apply)*:

o No Insurance o SSI o IV-E o Adoption Subsidy
o Medicaid o SSDI o Other *(specify)*: _____

Medicaid number: _____

6. b. If not currently enrolled in Medicaid date of application: ____/____/____

7. Private Insurance: _____ _____
(Name of Subscriber) (Company)

8. Legal custody/guardian: _____
Relationship to client: _____

9. Has the child/adolescent been adopted? o Yes o No

II) EDUCATIONAL STATUS

1. IEP Status: *(check one)*

IEP for SED o Need to refer o Unknown
IEP for other reason o Assessed and found ineligible o Not on an IEP
Pending o N/A

2. 504 Status: *(check one)*

504 plan o Need to refer o Unknown
Assessed and found ineligible o Not on an 504
Pending o N/A

III) MENTAL HEALTH AND BEHAVIORAL STATUS

1. DSM-V Diagnoses (Child/Adolescent):

1.a. Primary Diagnostic Code: __ __ __ . __ __

1.b. Disorder Description: _____

2.a. Secondary Diagnostic Code: __ __ __ . __ __

2.b. Disorder Description: _____

3.a. Tertiary Diagnostic Code: __ __ __ . __ __

3.b. Disorder Description: _____

4.a. Diagnostic Code: __ __ __ . __ __

4.b. Disorder Description: _____

5.a. Diagnostic Code: __ __ __ . __ __

5.b. Disorder Description: _____