Client ID_____
For Office Use Only

SOUTHWEST MS
MENTAL HEALTH COMPLEX
REGION XI
A Clear Path to Wellness and Recovery

P. O. Box 786 • McComb, MS 39649 • (601) 684-2173

You must complete a Pre-Intake Assessment Form to receive services from our facility. Also, you will be required to return the following required information personally to our office before an intake appointment can be made for you. PLEASE do not attempt to fax or email these forms.

Required Information for Adults:

1. Proof of all household income OR the income of the person who supports you.
2. Proof of insurance, if you have insurance.
3. Proof of residency.
4, Any prescription medication(s) that you are currently taking.
5. Current Photo I.D.
6. Social Security Card

Required Information for Children:

1. Proof of all household income OR the income of the person who supports the family
2. Proof of child's insurance, if they have insurance.
3. Proof of residency.
4, Any prescription medication(s) that the child is currently taking.
5. Current Photo I.D of parent/guardian
6. Social Security Card of child
7. Birth Certificate for child
8. Any divorce or custody paperwork for child

We cannot open your case without this information. If you arrive without it, we will have to reschedule your appointment for your intake to be completed.

Payment (if any) will be due prior to receiving services. **Payment is accepted in forms of cash, personal check, money orders, and credit cards.** You should be prepared to pay for 1-1/2 hours of service. With proof of income and other information, the front office staff will be able to provide you with the amount of your payment, if any, prior to your appointment.

If you do not arrive for your scheduled appointment within ten minutes of your scheduled time, we will assume that you chose to not initiate a record and your Pre-Intake package, along with any other information you provided, will be destroyed.

Telehealth Services are also available on a daily basis, with extended hours on Tuesday and Thursday, 5:00 pm - 7:00 pm. Telehealth appointments must be pre-scheduled.

If you have any additional questions or concerns, please contact our office between the hours of

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8:00 am - 5:00 pm, Monday thru Friday at (601) 684-2173.

Southwest Mississippi Mental Health Complex

Client Data Entry Packet

Initial Contact Date: _____**Date of Intake/Admission:**_____

Social Security Number:_____ **Date of Birth**:_____

Name: _____
Last First Middle Maiden Name Suffix

Physical Address: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone(s) Home: _____**Work:** _____**Cell:** _____

County of Residence: _____

Mailing Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____

Gender: ___Female ___Male ___Other ___Unknown ___Transgender

Ethnicity: ___Alaskan Native (Aleut, Eskimo, Indian) ___ American Indian ___Asian
___Black/African American ___Native Hawaiian/Pacific Islander
___White/Caucasian ___ Other Race ___Unknown or N/A

Hispanic Origin: ___Cuban ___Mexican ___Not of Hispanic Origin
___Other Specific Hispanic ___Puerto Rican ___Unknown Or N/A

Citizenship: ___United States Citizen ___ Non United States Citizen

Marital Status: ___Single (Never Married/Married Annulled) ____Married
___Separated ___Divorced ___Widowed ___Unknown

Veteran Status: ___Yes ___No ___Unknown

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Legal Status: Involuntary (court ordered): _____Voluntary (self or guardian): _____

Initial Contact: _____By Appointment _____Walk-in _____ Phone _____Other
How were you referred to SMMHC: _____
(Please include referral source, relationship and name of family member (if applicable)
Please state any precipitating event that led you to this admission:

_____ None	_____ Non-compliance with Treatment
_____Accident	_____Occupational Loss
_____Developmental Challenge	_____Physical Illness
_____Emotional/Social Loss	_____Physical Loss
_____Exacerbation of Chronic Discord	_____Substance Abuse
_____Other (explain):_____	

Living Arrangement: ___ Lives Alone

___Lives w/Parents ___Lives w/Children

___Lives w/Spouse ___Lives w/Other Relatives

___Homeless ___Lives w/Friends ___Other

Residential Arrangement:

___Private Residence (House/Apt) ___Other Independent (Rooming House/Dorm)

___Homeless/Shelter ___Institution ___Community Program

___Correctional Facility ___Other ___Foster Care

___Residential Care ___Crisis Residence ___Nursing Home

___Children's Residential Treatment ___Boarding House ___Family Foster Care

___Hospital ___Friend ___Not Available/Unknown

**Correctional Inmate must have Residential Arrangement = Correctional Facility and Living Arrangement = Lives with non-relatives

Educational Level: ____ Highest Grade Completed (0-12) ___High School Graduate

___GED ___Pre-School/Kindergarten ___Special Education

___Tech/Trade School ___1 year College ___2 years College

___3 years College ___Associate Degree ___Bachelor's Degree

___Graduate School ___Master's Degree ___Post Graduate School

___Doctorate ___Unknown ___Never Attended

Employment Status ___Employed Full time ___Part Time

___Employed-Active military duty ___Seasonal/Migrant Worker

___Unemployed-Seeking work ___Unemployed-Not seeking work

___Homemaker ____ Student/under 17 ___Student/over 17

___Retired ___Disabled ___Correctional Inmate**

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School Attendance (last three months) ___Attending School Regularly: 5 Days or Less Absent
___Not Attending School Regularly: 6 Day or More Absent ___ Home Schooled
___Not Available ___ Not Applicable

Family Income: Annual $_____ # Living on Income:_____

Primary Source of Household Income: ___wages/salary ___public assistance
___retirement/pension ___disability income ___other ___unknown ___none

Primary Source of Household Payment: ___None ___Personal Resources
___Service Contract ___Blue Cross/Blue Shield ___CHAMPUS
___Other Commercial Health Insurance ___Medicare ___Medicaid
___VA ___Workmen's Compensation ___ Other Public (government resources)
___CHIP ___ Other Source of Payment ___Unknown

Is Client Indigent: ____Yes ____ No

Is Client Pregnant: ____ Yes Due Date: _____
____ No ____ Not Applicable ____ Unknown

Is Client HIV Positive: ____Yes ____ No ____ Unknown

Responsible Party Record:
Relationship to Client:_____
Responsible Party Name: _____
Prefix Last First Middle Suffix
Address:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone(s): Home:_____ Work:_____ Cell:_____
Social Security Number:_____ Employer:_____

Emergency Contact Record:

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Name:_____

Relationship to you:_____

Address:_____

Address:_____

City _____ State _____ Zip Code_____

Phone(s): Home:_____ Work:_____ Cell:_____

Relationship:_____

Please list allergies, if any, including the reaction:

_____

_____

_____

_____

Physician's Name: _____

Do you have a Primary Care Physician? _____ Yes _____ No

Address _____

City _____State _____Zip Code_____

Phone: _____ Date Last Seen: _____

Do you have a Preferred Hospital? _____ Yes _____ No

Hospital Name: _____

CURRENT MEDICATIONS: **(**Please list ALL known and/or reported medications you are currently taking regardless of type or purpose to include over-the-counter (OTC) medications (use back of page if necessary)

Name of Medication	**Dose**	**Route**	**Frequency**	**Prescribing Doctor**