Crossroads Counseling Center, Inc.

Strengthening Individuals and Families

☐ Harrisonburg	☐ Luray	☐ Manassas	☐ Winchester	☐ Winchester OP
Phone: 540.801.0885	Phone: 540.843.2509	Phone: 703.361.1525	Phone: 540.662.7007	Phone: 540.773.3193
Fax: 540.801.8221	Fax: 540.843.2512	Fax: 703.361.3395	Fax: 540.662.1311	Fax: 540.773.4982

REFERRAL/INTAKE APPLICATION

I. Service Type:

☐ IIH ☐ MHSS ☐ TDT ☐ BTS ☐ OP ☐ HB ☐ Substance Abuse _____

☐ ILS-Older Adolescents ☐ ILS-Adults ☐ Mentoring ☐ ASSIST ☐ Parent Mentoring ☐ Life Skills ☐ Anger Management

☐ Other: _____

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

SSN: _____ DOB: _____ Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced

Name of School or Employer: _____

Grade or Occupation: _____

☐ Parent(s) ☐ Foster Parent(s) Name(s): _____

☐ Legal Guardian Name(s): _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

MEDICAID #: _____

II. Presenting Needs/Reason for Referral:

_____

_____

_____

Current/Previous Diagnosis: _____

Past and Current Treatment(s): _____

Current Living Arrangements: _____

Family Functioning: _____

Referral Agency: _____ Contact Person: _____

Phone: _____ FAX: _____ Email: _____

Requested hours of service per week: _____ Requested hours of service per month: _____

FOR OFFICE USE ONLY

Intake entered by: _____ Requested Service Type: _____

Name of Funding Source (agency): _____

Case Disposition: ☐ Admitted to service ☐ On waiting list ☐ Not admitted ☐ Referred to other provider

Date Medicaid Checked: _____ Eligibility Dates: _____ Verification # _____

Medicaid/MCO: _____ Code: _____

Weeks/Units Available: _____ Other Insurance: _____ Copy of Card ☐

Diagnosis Code and Description: _____

LMHP Signature: _____ Date: _____

☐ Sent to Finance Office Date: _____

Transfer of Service/Funding _____