Request for Services

Independence Center

21 Church Street, Waterbury CT 06702
Phone: 203-756-5772, Fax: 203-756-9744

Name: _____ Social Security #: _____

What is your goal or motivation for attending the Independence Center? (880 character limit)

_____

_____

_____

_____

Home phone #: _____ Cell Phone #: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Race:_____ Ethnicity(Hispanic/Non): _____ Religion:_____

Veteran? ☐ Yes ☐ No Start Date: _____ End Date: _____

Date of Birth: _____ ☐ Male ☐ Female

Primary Language: _____ Other Language(s): _____

Conservator of Person? ☐ Yes ☐ No

Name: _____ Phone: _____

Applicant Name: _____

Insurance:

☐ Medicaid (T.19, Husky, LIA):

Policy/card number: _____ Expiration Date: _____

☐ Medicare

Policy/card number: _____ Expiration Date: _____

☐ Veteran Benefits

Policy/card number: _____ Expiration Date: _____

☐ Other Insurance

Policy/card number: _____ Expiration Date: _____

Monthly Income Source:

Work: _____ SSI: _____ SSDI: _____ SNAP: _____

Other (type/amount): _____

Have you ever been arrested and/or convicted of a crime? ☐ Yes ☐ No If yes, how long ago?
Please explain the situation. (680 character limit)

_____

_____

_____

Do you have any legal charges pending? ☐ Yes ☐ No If yes, Please explain (385 character limit):

_____

_____

Applicant Name: _____

Please check appropriate income range based on number of individuals living in household:

	# IN HOUSEHOLD		INCOME RANGE		INCOME RANGE	
Single Adult		1	$0-$11,880	☐	$11,881-$26,088	☐
Married Couple		2	$0-$16,020	☐	$16,021-$34,812	☐
1 Adult, 1 Child		2	$0-$16,020	☐	$16,021-$44,238	☐
1 Adult 2 Children		3	$0-$20,160	☐	$20,161-$45,215	☐
1 Adult, 3 Children		4	$0-$24,300	☐	$24,301-$46,119	☐
1 Adult, 4 Children		5	$0-$28,440	☐	$28,441-$47,041	☐
2 Adults, 2 Children		4	$0-$24,300	☐	$24,301-$73,716	☐
2 Adults, 3 Children		5	$0-$28,440	☐	$28,441-$75,190	☐
2 Adults, 4 Children		6	$0-$32,580	☐	$32,581-$76,694	☐
Other	#:		$			

If "Other", please indicate number in household:

Adults: _____ Children: _____

Are you in mental health treatment at this time?

☐ NO ☐ YES (if yes, please list below)

Name of Provider (Clinician, Therapist, Psychiatrist, etc.)	Type of Service (Individual Therapy, Med management, Group Therapy, etc.)

Additional Services Received (If applicable):

Type of Service	Contact Name	Agency Name	Phone number
Case Manager			
Residential Provider			

I wish to be considered for services.

I understand that Mental Health Connecticut Independence Center may gather additional information regarding my mental health history (if applicable).

Applicant Signature: _____ Date: _____

Conservator Signature (if applicable): _____ Date: _____

Part 2 - To Be Completed By Referring Clinician

Current Diagnoses:

Diagnoses	Name of Condition with ICD-10 Code
Behavioral Health	
Medical	
Psycho-Social & Environmental	
MGAF (current)	

Does the Client currently use medication for the treatment of a mental illness? Yes ☐ No ☐

If "Yes", please list: _____

_____

Does the Client currently use street drugs or alcohol? ☐ Yes ☐ No

If yes, what type(s): _____

_____

Risk Assessment (please check appropriate box):

Behavior	None	Current	Past 60 Days	Past Year
Suicidal/danger to self	☐	☐	☐	☐
Homicidal/danger to others	☐	☐	☐	☐
Alcohol/drug abuse	☐	☐	☐	☐
At risk sexual behavior	☐	☐	☐	☐
Serious Assault to others (high risk)	☐	☐	☐	☐
Serious Assault to others (low risk)	☐	☐	☐	☐
Anti-social or criminal behavior	☐	☐	☐	☐
Arson attempt/threat	☐	☐	☐	☐
Access to firearms	☐	☐	☐	☐

Comments regarding above (215 character limit):_____

_____

_____

Applicant Name: _____

Behavioral Health & Substance Abuse Treatment History:

Provider (Current/ Most recent first)	Type (Inpatient/Residential)	Reason for Admission	Dates of Treatment

Please confirm before submitting:

☐ Most recent psych eval and comprehensive are attached. If not available, current clinical record is attached.

☐ Release of information from clinical provider to Mental Health Connecticut is complete and attached.

☐ This paperwork is complete. No known information is missing.

Clinician Printed Name: _____ Title: _____

Signature: _____ Date: _____

Agency Name: _____ Phone: _____

Please Fax Completed Request to: 203-756-9744

Applicant Name: _____