



### 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 for attending the Independence Center?

\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

Insurance (policy/card number): \_\_\_\_\_

Medicaid (T.19, Husky, LIA) Medicare Veteran Benefits

Other Insurance (name & number): \_\_\_\_\_

Applicant Name: \_\_\_\_\_



Income from 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.

\_\_\_\_\_

\_\_\_\_\_

Do you have any legal charges pending?  Yes  No If yes, Please explain:

\_\_\_\_\_

|                      | # 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                |                |              |  |                   |  |
| Not Verified         |                |              |  |                   |  |

Are you in treatment at this time?

NO  YES (if yes, please list below)

| Name of Provider | Type of Service |
|------------------|-----------------|
|                  |                 |
|                  |                 |
|                  |                 |

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                    |      |         |              |           |

Behavioral Health & Substance Abuse Treatment History:

| Provider<br>(Current/<br>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**