Springboard COMMUNITY SERVICES
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CLIENT REGISTRATION FORM

Services I am requesting: ☐ Case Management ☐ Medication Management ☐ Counseling ☐ Housing

GENERAL INFORMATION

Legal Name: _____

Name Preference (How would you like to be addressed?): _____

Gender: _____ Pronouns: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated ☐ I Decline to specify

Address: _____

City: _____ State: _____ Zip Code: _____ ☐ Currently homeless/no permanent address

Phone: _____ Type: ☐ Cell ☐ Home ☐ Work

Secondary Contact: _____ Type: ☐ Cell ☐ Home ☐ Work

Email: _____ Language(s) Preference: _____

How should we contact you? (check all that apply) ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Mail ☐ Email

Race: ☐ Black/African-American ☐ White/Caucasian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ American Indian/Alaskan Native ☐ Other: _____ ☐ I Choose Not to Disclose

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ I Choose Not to Disclose

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual
☐ I Choose not to disclose ☐ Other _____

I am a Veteran of the United States Military: ☐ Yes ☐ No

Highest Level of Education Completed: ☐ Some High School ☐ High School Diploma/GED ☐ Associate's ☐ Bachelor's
☐ Master's ☐ Doctorate ☐ Trade/Technical/Vocational ☐ I Choose Not to Disclose

I am Currently: ☐ Employed Full ☐ Employed Part ☐ Unemployed ☐ Full-Time Student ☐ Self-Employed ☐ Retired

Employer/School Information: _____ Phone Number: _____

EMERGENCY CONTACT (Parent or Legal Guardian for Minors)

Name: _____ Relationship: _____

Phone Number: _____ Type: ☐ Cell ☐ Home ☐ Work

SCS will only attempt to notify my Emergency Contact Person in the event of an emergency.

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FAMILY COMPOSITION & HOUSEHOLD INFORMATION

NAME	RELATIONSHIP	D.O.B	SAME RESIDENCE?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

I am Currently the Head of My Household: ☐ Yes ☐ No Household Yearly Income: $ _____

What is your Income Source? (check all that apply) ☐ Employment ☐ TCA ☐ Food Stamps ☐ SSI/SSDI ☐ Other:

Do you feel you earn enough money to meet your family's basic needs such as food, clothing, and shelter? ☐ Yes ☐ No

Are you currently homeless? ☐ Do you have any safety concerns in your current environment? ☐ Yes ☐ No

Are you concerned that you may lose your current housing within the next 14 days? ☐ Yes ☐ No

Do you have access to reliable transportation? ☐ Yes ☐ No Do you have adequate childcare? ☐ Yes ☐ No ☐ N/A

INSURANCE & ACCOUNT GUARANTOR INFORMATION

Do you and/or your family currently have medical insurance? ☐ Yes ☐ No If so, please provide the information below.

If not, are you interested in obtaining medical insurance? ☐ Yes ☐ No

Primary Insurance:	Secondary Insurance:
Name of Insured:	Name of Insured:
Insured's Date of Birth:	Insured's Date of Birth:
Social Security #:	Social Security #:
Relationship to Client:	Relationship to Client:
Employer:	Employer:
Policy #:	Policy #:
Group #:	Group #:

RESPONSIBLE PARTY (Who will be responsible for this account for Insured Services which includes Counseling and Medication Management)

Name: _____ Relationship to Client: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Work Number: _____ Other Contact Number: _____

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HISTORY OF TRAUMA & VICTIMIZATION- We recognize it is difficult to share personal information. The following confidential information is meant to provide us with an understanding of your trauma history and service needs. This information will be used to work with you on creating an individualized plan that addresses your needs.			
☐ Child Abuse and/or Assault	☐ Assault and Battery	☐ Domestic Violence	☐ Gang Violence
☐ Child Sexual Abuse and/ or Assault	☐ Sexual Assault	☐ Teen Dating Violence	☐ Family Violence
☐ Child Pornography	☐ Rape	☐ Stalking/Harassment	☐ Community Violence
☐ Bullying (Physical, Verbal, &/or Cyber)	☐ Motor Vehicle Theft	☐ Human Trafficking Sexual	☐ Human Trafficking Labor
☐ Elder Abuse or Neglect	☐ Fraud	Hate Crime: ☐ Disability ☐ Transgender identify ☐ Sexual Orientation ☐ Race ☐ Religion	
☐ Burglary/Larceny	☐ N/A	☐ Other (Please specify) _____	

MEDICAL/PHYSICAL HEALTH INFORMATION

Do you have a Primary Care Provider (PCP)? ☐ Yes ☐ No

PCP Name: _____ Phone: _____

Do you have a preferred pharmacy? ☐ Yes ☐ No

Name: _____ Phone: _____

Are you currently pregnant? ☐ Yes ☐ No

Do you have a physical disability? ☐ Yes ☐ No - If yes, please list: _____

Do you have any medical conditions or concerns SCS staff and providers should be aware of? ☐ Yes ☐ No If yes, please list:

_____

MENTAL HEALTH & SUBSATANCE USE INFORMATION

Are you currently enrolled in outpatient mental health services? ☐ Yes ☐ No

Check all that apply: ☐ Therapy/Counseling ☐ Medication Management ☐ Intensive Outpatient ☐ PRP

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No - If yes, list diagnosis and approximate date:

_____

Have you ever been admitted to an inpatient psychiatric facility for treatment? ☐ Yes ☐ No - If yes, please list when, where, and the approximate dates of treatment: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day or week? _____

In the past, or do you now use a substance? ☐ Yes ☐ No If yes, what substance(s) and how often?

_____

Are there any addictions like alcohol, substance use or something else you would like help to quit ☐ Yes ☐ No If yes, what is it? _____

LEGAL INFORMATION

Do you have any pending legal concerns that SCS staff and providers should be aware of? ☐ Yes ☐ No

Are you required to register as a sex offender? ☐ Yes ☐ No Are you currently on probation or parole? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No Do you have an advanced directive? ☐ Yes ☐ No

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SERVICE NEEDS & SUPPORTS			
☐ Crisis Intervention	☐ Counseling	☐ Positive Youth Development Life Skills	☐ LGBTQIA+ Services
☐ Eviction Prevention/Utilities Assistance	☐ Medication Management	☐ Academic Enrichment/Support	☐ Intimate Partner Violence Support
☐ Homelessness/Housing Support	☐ Grief/Loss Support	☐ Employment Services	☐ HIV/AIDS Supportive Services
☐ Assistance Obtaining Food	☐ Family Mediation	☐ Family Violence Support	☐ Substance Use Support
☐ Assistance obtaining health insurance, food stamps and/or TCA	☐ Anger Management	☐ Court Ordered Services	☐ Other: _____

SERVICE GOALS & NEEDS **(In your own words, please tell us what you would like to gain from services at Springboard.)**

IMPORTANT DOCUMENTS:

Please select all documents that you have in your possession:

☐ Photo ID ☐ Social Security Card ☐ Birth Certificate ☐ Insurance Card ☐ Paystubs ☐ W2/1099 Forms ☐ Lease/Mortgage

Let us know how you heard about Springboard Community Services

☐ Recommendation from Friend ☐ Recommendation from a Provider ☐ Flyer ☐ Social Media (Twitter, Facebook, etc.)

☐ Radio ☐ Local Ad ☐ Insurance Co. _____ ☐ Other (Please Specify) _____

CERTIFICATION & SIGNATURES

I authorize the release of any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such care to the third party payors and/or health providers. I authorize and request my insurance company to pay directly to the provider's group insurance benefits otherwise payable to me. I understand and agree that, regardless of my insurance status, I am ultimately financially responsible for all charges whether or not paid by insurance, all services rendered on my behalf or on the behalf of my dependents. I understand that is my responsibility to provide SCS with appropriate and current insurance information and to notify SCS immediately upon any change in my insurance coverage – to ensure efficient claims, billing and payment.

I agree to pay any costs incurred in collecting any unpaid balance due to SCS including collection fees, court costs, and or attorney fees. I understand that payments made will be applied to any unpaid balance owed to SCS including deductibles, copays, no show fees, and or late cancellation fees.

I understand that payments for office visits are due at the time services are rendered unless prior arrangements have been made with SCS. Additionally, I understand any applicable no show or late cancellation fees will be billed to me, not my insurance company. And further, the office reserves the right not to accept future checks if any checks have been returned previously.

I, _____, certify that the information provided in this application is true and accurate, as of the date indicated by my signature. If my information changes, I will notify Springboard as soon as possible.

Client Signature: _____ Date: _____

SCS Staff Signature: _____ Date: _____