



CRISIS INTAKE
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 HUMAN SERVICE CENTERS
 SFN 1543 (6-2024)

*In compliance with the Federal Privacy Act of 1974, disclose of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

CLIENT INFORMATION

Legal Name (First, Middle Initial, Last)		Date of Birth	
Preferred Name(s)		* Social Security Number	
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Telephone Number	Primary Language	
<input type="checkbox"/> Mailing Address <input type="checkbox"/> Physical Address			
Address		City	State ZIP Code

INSURANCE INFORMATION

Do you currently have health insurance?

Yes

Company Name

* Policy Number | * Group Number

** To collect if information is available*

No - Would they like someone to assist them in applying?

Yes
 No

EMERGENCY CONTACT

Is this contact a parent/legal representative? Yes No

Name

Relationship | Telephone Number

Address | City | State | ZIP Code