LifeSkills

PROJECT SAFE SPACE/CANS REFERRAL

CLIENT NAME: _____ **SSN:** _____ **DATE:** _____

Birthdate _____ **Age**_____ **Gender** ☐ **Male** ☐ **Female**

Billing Address _____

City _____ **State** _____ **Zip** _____

Guardian_____ **Phone #** _____

Foster Parent_____ **Phone #**_____ **Alt #** _____

Address:_____

Reason for Referral_____

_____

Highest Grade Completed: _____ **Primary Language:**_____

If you are here for Substance Use Issues: Are you pregnant? ☐ **Yes** ☐ **No**

I.V. Drug Use? ☐ **Yes** ☐ **No**

Type of Insurance: (*please check all that apply*) ***(Please show your card(s) to the front desk)***

☐ No coverage ☐ Medicare ☐ KY Medicaid if *so, is your Medicaid through one of the following?*

☐ Humana CareSource ☐ AETNA ☐ WellCare ☐ Passport ☐ Anthem Medicaid ☐ UNITED

☐ EAP, specify employer: _____

☐ Private insurance company: _____

Policyholders Name: _____ **Policyholders Birthdate:**_____

Identification No:_____ **Policyholders Social Security No:**_____