Caring Services Inc.
caringservices.org

Initial Eligibility Screening

Date: _____ Time Arrived:_____ Time Seen:_____

Basic Information

Name _____ DOB_____ SSN_____

Street Address _____

City _____County _____ Phone _____

Gender _____ Race _____ Veteran _____ Education Level _____

Emergency Contact _____ Phone _____

How were you referred to Caring Services?

☐ Self ☐ Friends/Family ☐ Treatment Center
☐ TASC ☐ Drug Treatment Court ☐ Mental Health Court
☐ Other:

What services are you seeking?

☐Transitional Housing ☐Outpatient Treatment (OP or IOP) ☐DUI Assessment or Treatment
☐ Other:

Other agency involvement: _____

Emergent and Legal Information

What is your current living arrangement?

☐Homeless Sheltered ☐Homeless Unsheltered ☐Living w/ family or friends
☐Private Residence ☐ Treatment Center ☐Incarcerated
☐ Other:

Are you employed? _____ Annual Income _____

Are you on probation/post-release? _____ List Pending Court Dates: _____

Are you a registered sex offender? ☐ Yes ☐ No Legal Guardian: ☐ Self ☐ Other

Medical Information

Do you have insurance/Medicaid? ____ If yes, please list policy number _____

If Medicaid, please list county of Medicaid _____ Currently Pregnant? ☐Yes ☐No

Children under 18, in your care _____

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Do you have any allergies? _____ If yes, please list _____

Please list any mental health or physical health concerns _____

_____

Current Medications ☐None	Dosage	Frequency

Substance Use Information

Substance	Age of 1st use	Primary Route	Typical Amount of Use	Last Use

Treatment History_____

_____

Clinician Notes: _____

_____

_____ COVID Vaccine ☐Yes ☐No Medicaid verified: ☐

Appropriate for services? ☐Yes Enrollment Date: _____

☐No Referred to: _____

Follow-up: _____

☐Client declined services/referral

_____ _____

Clinician Signature Date