Welcome

To better serve you, please read and complete this form

Phone Number: (617) 684-6209
Fax Number: (617) 249- 0408
Email: familiasoutpatientintake@casaesperanza.org

1. Today's Date:		
2. Full Name:	**3. Do you go by any other names/nicknames:** □ Yes: _____ □ No	
4. Date of Birth:		
5. Address:		
Number & Street/Apt #	City:	State/Zip:
6. Phone:	**7. Email:**	
8. Mental Health Diagnosis: _____		
9. Language Capacity: _____		
10. Substance of choice current or past: □ Alcohol □ Cocaine □ Crack □ Heroin □ Marijuana Other: _____	Date of First Substance Used:	Date of Last Use:
11. Referral Information Referral Reason: _____ Referral Source: □ Self Referral □ Provider □ Other:_____ *If provider, please indicate:* Name:_____ Organization:_____ Phone:_____ Email:_____		
12. Health Insurance Information (*Check all that apply*): □ No Health Insurance □ Medicaid/Mass Health (*Indicate Health Insurance Plan):* _____ □ Application Pending □ Private Insurance □ Medicare □ OT- State Subsidy (*eg. Commonwealth Care, Health Safety Net)* □ Other: _____ Insurance Co.: _____ Policy Name: _____ Policy Number: _____ Group #: _____ Policy Start Date: _____		