WV FSRS

Family Support & Rehabilitation Services

WVFSRS ENROLLMENT REFERRAL FORM

CLIENT DEMOGRAPHICS		
CLIENT NAME:		
DOB:	**SS#/Gov. ID#:**	**Med ID#:**
Address:		
County of Residence:	**Address Type:** ☐ BILLING ☐ HOME ☐ HOMELESS ☐ MAILING ☐ LAST PREVIOUSLY KNOWN ☐ WORK ☐ UNKNOWN	**Type of Residence:** ☐ PRIVATE ☐ RESIDENCE ☐ HOMELESS ☐ INSTITUTION *(i.e., hospital, jail)* ☐ OTHER *(specify)*: __________ __________ __________
Home Phone #:	**Alternate #:**	*Does the client provide permission to leave a voicemail on identified #?* ☐ YES ☐ NO
Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ LIVING TOGETHER	**# Of Minor Children:** **# Of other dependents:**	**Religious Preference:** ☐ PROTESTANT ☐ CATHOLIC ☐ JEWISH ☐ ISLAMIC ☐ OTHER ☐ AGNOSTIC OR ATHEIST ☐ PREFER NOT TO ANSWER
GENDER: ☐ MALE ☐ FEMALE ☐ TRANSGENDER IDENTIFIES AS A MALE ☐ TRANSGENDER IDENTIFIES AS A FEMALE ☐ TRANSGENDER UNKNOWN ☐ PREFER NOT TO ANSWER	**ETHNICITY:** ☐ PUERTO RICAN ☐ MEXICAN ☐ CUBAN ☐ OTHER SPECIFIC HISPANIC ☐ NOT OF HISPANIC ORIGIN ☐ HISPANIC-SPECIFIC ORIGIN UNKNOWN ☐ UNKNOWN	**RACE:** ☐ ALASKA NATIVE ☐ AMERICAN INDIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN ☐ OTHER SINGLE RACE ☐ TWO OR MORE RACES ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ OTHER

PRIORITY POPULATION INFORMATION		
☐ Pregnant woman who injects drugs	☐ Pregnant woman who uses substances	☐ Person who injects drugs
☐ Overdose Survivor	☐ Veteran	

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INSURANCE INFORMATION	
MEMBER NAME *(As it appears on card):*	**MEMBER ID #:**
INSURANCE COMPANY (Name):	**Customer Service #** *(located on back of card)*:

REFERRAL INFORMATION	
REFERRAL REASON *(i.e. MH, SUD, Co-Occurring issues, requesting PRSS services, requesting counseling)*:	
REFERRAL SOURCE: ☐ SELF ☐ COUNTY-MH/ID PROGRAM ☐ COUNTY DRUG/ALCOHOL COURT ☐ CRIMINAL JUSTICE SYSTEM *(Probation/Parole)* ☐ COMMUNITY PROVIDER ☐ DRUG/ALCOHOL PROVIDER ☐ EMPLOYER ☐ FAMILY/FRIENDS/PARAMOUR ☐ HEALTHCARE PROVIDER ☐ HOSPITAL ☐ OTHER: ________________	
REFERRING AGENCY *(Name/Address):*	
REFERRED BY *(Name)*:	TITLE:
PHONE #:	EXT.:

Client Signature *(If applicable):*	**Date:**
Person Completing Form Signature/Credentials:	**Date:**

*****By signing this document, you confirm that all information is correct to the best of your knowledge. By signing this document, you confirm that client has been notified that their information was provided for the purpose to enroll into a Licensed Behavioral Health Center (LBHC), WV Family Support & Rehabilitation Services (WVFSRS).*

WVFSRS, 214 8th Street, Parkersburg, WV 26101 (304) 917-0021

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