Four Feathers Counseling
hope for generations

New Medicaid Client Information

Intake Date: _____ Ind Fam Group Case Mgt

Therapist: _____

Client Name: _____

ID#: _____ DX 1: _____ DX 2: _____

Additional Questions for Authorization:

Client receiving disability? (circle) Yes No

Advanced Directive? (circle) Yes No

Medical Conditions? (circle) None Asthma/COPD Cancer Cardiovascular
Chronic Pain Dementia Diabetes Obesity

Date client contacted for appointment: _____

Date client *offered* initial appointment: _____

If *offered* outside of 7 days reason: No appt available Practice full to new clients

Office closed/holiday/vacation Other: _____

Social Elements Impacting Diagnosis

Circle all that apply:

None	Problem w/primary support group	Problems related to social environment
Educational Problems	Housing (not homeless)	Homelessness

Financial Problems	Occupational problems	Unknown
Problem w/access to healthcare	Other psychosocial & environmental	
Legal Problems		

Social Security Number (SSN) of insured (if available): _____

Client Phone: _____ Client Email: _____

Client Address: _____

If Medicaid card is available include copy with fax. Please understand it is not always possible to read ID number on fax so always write it on the form. This form may be emailed if preferred.
Fax: 1-866-262-6521 or email: csupernault@fourfeatherscounseling.com