

## SERVICE APPLICATION

Name:			
First	Middle Initial	Last	
Date of Birth:		SSN:	
Address:			
City:		State:	Zip Code:
Home Phone:		Cell Phone:	
Email:			
How did you hear about COVA?: <input type="checkbox"/> Self <input type="checkbox"/> CMHC <input type="checkbox"/> ORSC <input type="checkbox"/> Other (specify):			
List professional supports below (psychiatrist, therapists, physician, case manager, etc.):			
Name and Title	Agency Name Address, Phone and Email	Consent for Release of Information	
		Yes	No
Diagnosis/Disability:			
Date of last appointment with mental health provider:			
Date of next appointment with mental health provider:			
Are you taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, list types of medication below:			
Medication	Dosage	Purpose	
Do you take medication(s) as prescribed?: <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify):		<b>Ethnic Group:</b> <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Somalian <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Other (specify):	
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		<b>Living arrangements:</b> <input type="checkbox"/> Own Home/Apt. <input type="checkbox"/> Group Home <input type="checkbox"/> Friend's Home/Apt. <input type="checkbox"/> Homeless <input type="checkbox"/> Relative's Home/Apt. <input type="checkbox"/> Supervised Living <input type="checkbox"/> Other (specify):	
Number of dependents:		Highest level of education:	
Diploma/GED: <input type="checkbox"/> Yes <input type="checkbox"/> No		Degree:	
Monthly income:		Source (e.g., wages, SSI, SSDI):	
Health insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Other (specify):			
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		History of incarceration: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Emergency contact:</b> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>First</span> <span>Middle Initial</span> <span>Last</span> </div>			
Relationship:		Phone:	
<b>Guardian name:</b> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>First</span> <span>Middle Initial</span> <span>Last</span> </div>			
Phone:			

<b>FOR AGENCY USE ONLY:</b>	
<b>Potential Payor Sources:</b> <input type="checkbox"/> Columbus City Schools <input type="checkbox"/> Concord/Medicaid <input type="checkbox"/> Del/Mor MH & Recovery Services Board <input type="checkbox"/> Franklin County ADAMH Board <input type="checkbox"/> Franklin County Children's Services <input type="checkbox"/> Ohio Rehabilitation Services Commission <input type="checkbox"/> Private Pay <input type="checkbox"/> WIPA <input type="checkbox"/> YMCA <input type="checkbox"/> Other(specify):	<b>Disposition:</b> <input type="checkbox"/> Assessment <input type="checkbox"/> BVR Referral <input type="checkbox"/> Benefits Consult <input type="checkbox"/> Concord <input type="checkbox"/> Del/Mor Employment <input type="checkbox"/> Pathways <input type="checkbox"/> YMCA <input type="checkbox"/> Youth Services <input type="checkbox"/> Chose Not to Continue <input type="checkbox"/> Referral to Another Community Resource <input type="checkbox"/> Ineligible: <input type="radio"/> Non-SMD <input type="radio"/> No Payor Source <input type="radio"/> No Disability <input type="radio"/> Other (specify):

COVA Staff: \_\_\_\_\_ Date: \_\_\_\_\_