COVA

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?: ❒Self ❒CMHC ❒ORSC ❒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? ❒Yes ❒No If so, list types of medication below:	

Medication	Dosage	Purpose

Do you take medication(s) as prescribed?: ❒Yes ❒No

Race: ❒White ❒Hispanic ❒African American ❒Asian ❒ Other (specify):	Ethnic Group: ❒Non-Hispanic/Latino ❒Somalian ❒Cuban ❒Mexican ❒ Other (specify):
Marital Status: ❒Married ❒Divorced ❒Single ❒Widowed ❒Separated	Living arrangements: ❒Own Home/Apt. ❒Group Home ❒Friend's Home/Apt. ❒ Homeless ❒Relative's Home/Apt. ❒Supervised Living ❒Other (specify):
Number of dependents:	Highest level of education:
Diploma/GED: ❒Yes ❒No	Degree:
Monthly income:	Source (e.g., wages, SSI, SSDI):
Health insurance: ❒Yes ❒No	If yes, ❒Medicare ❒Medicaid ❒Private ❒Other (specify):
Veteran: ❒Yes ❒No	History of incarceration: ❒Yes ❒No
Emergency contact: First Middle Initial Last	
Relationship:	Phone:
Guardian name: First Middle Initial Last	
Phone:	

Agency use only

Potential Payor Sources: ❒ Columbus City Schools ❒ Concord/Medicaid ❒ Del/Mor MH & Recovery Services Board ❒ Franklin County ADAMH Board ❒ Franklin County Children's Services ❒ Ohio Rehabilitation Services Commission ❒ Private Pay ❒ WIPA ❒ YMCA ❒ Other(specify):	Disposition: ❒ Assessment ❒ BVR Referral ❒ Benefits Consult ❒ Concord ❒ Del/Mor Employment ❒ Pathways ❒ YMCA ❒ Youth Services ❒ Chose Not to Continue ❒ Referral to Another Community Resource ❒ Ineligible: ❍ Non-SMD ❍ No Payor Source ❍ No Disability ❍ Other (specify):

COVA Staff:_____ Date:_____

Attach COVA Release of Information Form