CHILD OUTPATIENT MEDICAID INFORMATION FORM

CHILD'S MEDICAID #: ______________________ DATE: ______________________

CHILD'S INFORMATION (*Please list legal name as shown on Medicaid Card*)

Child's Name: ______________________

Address: ______________________

City: ____________ State: ______ Zip: ________-______

Home Phone: ____________

Birthdate: ____/____/______ Male: ______ Female: ______

Child's Social Security #: _____/_____/_______

Parent/Guardian

Name: ______________________

Address: ______________________

City: ____________ State: ______ Zip: ________-______

Home Phone: ____________ Work Phone: ____________

Cell Phone: ______________________

Relationship: ______________________

PRIMARY REFERRAL:

- ☐ Self
- ☐ Family/Friend
- ☐ Physician or medical facility
- ☐ Social or community agency
- ☐ Educational system)
- ☐ Courts, law enforcement, correctional agency
- ☐ Private psychiatric/mental health program
- ☐ Public psychiatric/mental health program
- ☐ Clergy
- ☐ Private practice mental health professional
- ☐ Other persons or organizations
- ☐ Unknown

RESIDENTIAL ARRANGEMENTS:

- ☐ Private Residence/Apartment
- ☐ Other Institution
- ☐ Child Foster Care
- ☐ Other Residential Facility

MARITAL STATUS: ☐ Single Never Married

VETERAN STATUS: ☐ No

EMPLOYMENT STATUS: ☐ Not in work force/student/pre-school

REQUIRED LANGUAGE TO BE SPOKEN DURING THERAPY:

☐ ENGL	English	☐ NAVJO	Native American Navajo
☐ ASL	Am Sign Language	☐ UTE	Native American UTE
☐ ARAB	Arabic	☐ RUSSN	Russian
☐ BOSN	Bosnian	☐ SAMOA	Samoan
☐ CAMB	Cambodian	☐ SERB	Serbian
☐ CHINA	Chinese	☐ SOMAL	Somalian
☐ CROAT	Croatian	☐ SPNSH	Spanish
☐ FARSI	Farsi	☐ SWAHL	Swahili
☐ FRNCH	French	☐ TIBET	Tibetan
☐ GREEK	Greek	☐ TONGA	Tongan
☐ GRMN	German	☐ VIETN	Vietnamese
☐ ITALN	Italian	☐ ZULU	Zulu
☐ JAPAN	Japanese	☐ SUDAN	Sudanese
☐ KURD	Kurdish	☐ HINDI	Hindi
☐ LAOTN	Laotian	☐ PORT	Portuguese

HANDICAPS OR IMPAIRMENTS:

- ☐ None
- ☐ Deafness/Severe Hearing Loss
- ☐ Development Mental Retardation
- ☐ Non-Ambulation/or Severe
- ☐ 0rganically Based/Express Communication
- ☐ Moderate/Severe Medical
- ☐ Blind/or Severe Hearing Loss

PATIENT'S RACE:

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other Single Race
- ☐ Alaska Native
- ☐ Pacific Islander
- ☐ Two or more races
- ☐ Unknown

HISPANIC/SPANISH ORIGIN:

- ☐ Not of Hispanic Origin
- ☐ Mexican/Mexican American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic

EDUCATION TYPE – CURRENT:

- ☐ Currently Regular Education
- ☐ Currently Special Education
- ☐ Not Currently Enrolled

EDUCATION COMPLETED:

- ☐ P Preschool
- ☐ K Kindergarten
- ☐ 01 1st Grade
- ☐ 02 2nd Grade
- ☐ 03 3rd Grade
- ☐ N Never Attended

PREVIOUS MENTAL HEALTH:

- ☐ Yes
- ☐ No
- ☐ Psychiatric Hospital
- ☐ This mental health agency

HOUSEHOLD INFORMATON

MONTHLY INCOME: ____________ # OF DEPENDENTS: ____________ # IN HOUSEHOLD: ____________

PRIMARY SOURCE OF INCOME:

- ☐ Employment/Wages
- ☐ Public Assistance
- ☐ Social Security Benefits
- ☐ Unemployment
- ☐ Workman's Compensation
- ☐ Alimony/Child Support
- ☐ None
- ☐ Other

MEDICAID ☐ YES ☐ NO MEDICAID #: ____________

OTHER INSURANCE INFORMATION:

INSURANCE CO: ____________ GROUP#: ____________

POLICY #: ____________

INSURED'S NAME:: ____________ INSURED'S BIRTHDATE: ___/___/___

Member Acknowledgement Form

I, ________________________________, hereby acknowledge that
I Name of Consumer
I have received a Medicaid Member Handbook and Provider Directory (either in the mail or from my provider). I understand that the purpose of the handbook is to ensure I have information about my benefits, rights and responsibilities. The handbook also provides information on how to receive covered services, access to emergency services, transportation, and how choose a provider. The handbook also addresses procedures for filing grievances and appeals.

I also understand that if I have been treated unfairly or discriminated against for any reason, I may file a complaint by contacting Optum Salt Lake County at:
1-877-370-8953

My provider has reviewed the materials with me and answered my questions.

____
Printed Member Name

______________________________ ______________
Parent/Legal Guardian Signature Date

______________________________ ______________
Interpreter's Signature Date