MH 224A
Revised 10/29/09

CLIENT FACE SHEET

Note: Shaded/Bolded fields must be completed on individuals prior to Triage.
The remainder of the fields must be completed prior to opening an Episode.

***See Client Face Sheet Codes Table for a listing of codes/definitions for the field.**
**** Field is NOT entered into the IS; information gathering only.**

CLIENT DATA			CLIENT I.D.#
Last Name:			
First Name:		**Middle Name:**	
AKA/Maiden Last Name:			
AKA First Name:		**Middle Name:**	
SSN:	**Mother's Maiden Name:**		
Gender: Male ☐ Female ☐ Other ☐ Unknown ☐		**DOB:**	**Age:**
English Speaking: Yes ☐ No ☐	*Primary Lang:	*Preferred Lang:	*Ethnicity:
*If Hispanic, Indicate Origin:	*If American Indian/Alaska Native, Indicate Tribe:		
*Education Level :	*Level of Care:	*Conservatorship:	
*Handicap:	*Marital Status:	*APR:	Veteran: Yes ☐ No ☐
*Living Arrangement:	*Employment Status:	Date of Death: _____	
****Are there children in the home? Yes ☐ No ☐**	****Dependent(s) in the home? Yes ☐ No ☐**		
****Insurance: Medi-Cal ☐ Medicare ☐ Indigent ☐ Private/Other ☐ _____ Unknown ☐**			

CLIENT ADDRESS			
Transient/Homeless: Yes ☐ No ☐	***Time Homeless:**		
Address:			
Second Line:			
City:	*State:	Zip:	*County:
Phone (Home):	****(Cell)**		**(Work)**
Address Memo:			

EMERGENCY CONTACTS	DO NOT CONTACT EMERGENCY CONTACTS EXCEPT IN EMERGENCY SITUATIONS WHICH HAVE BEEN CLEARLY DOCUMENTED		
Name:		*Contact Type:	
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	
Name:		*Contact Type:	
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	

Complete only if the Client's Child is enrolled in FSP			
Child's Name:		Contact Type: **Child Enrolled in FSP**	
Address:	City:	State:	Zip:
DMH I.D.#	Phone:	Email:	

SFPR and PRIMARY CONTACT	
SFPR Name:	Provider Number:
Primary Contact Name:	Provider Number:

BIRTH INFORMATION		
Indicate Client Birth Name (If different than the name listed in Client Data)		
Last Name:	First Name:	Middle Name:
Birth County:	Birth State:	Birth Country (If born outside US):
Mother's First Name:		

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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