COLONIAL INTERMEDIATE UNIT 20
6 Danforth Drive ~ Easton, PA 18045-7899
(610) 252-5550 ~ Fax (610) 515-6501

Resolve Behavioral Health Services

Interagency Client Admission Form

Client Information:

Date of Request:_____

Client Last Name: _____

Client First Name: _____ Middle Initial _____

Date of Birth: _____ Gender: Male ☐ Female ☐ Other ☐ _____

Client Social Security Number: _____

Penn Data Number: _____

Ethnicity:	Asian/Pacific Islander	☐	
	Black/African American	☐	
	Caucasian/White	☐	
	Hispanic	☐	
	Multiracial	☐	
	Native American/Alaskan	☐	
	Other	☐	_____
Primary Language:	English	☐	
	Spanish	☐	
	Asian	☐	
	Japanese	☐	
	Vietnamese	☐	
	Other	☐	_____
Residence Location:	Rural	☐	
	Suburban	☐	
	Urban	☐	
Client Lives With:	Birth Parent(s)	☐	
	Relatives	☐	
	Adoptive Parents	☐	
	Foster Parents	☐	
	Friends	☐	
	Group Home	☐	
	Institution	☐	_____
	Emancipated	☐	

PA Secure ID Number: _____

COLONIAL INTERMEDIATE UNIT 20
6 Danforth Drive ~ Easton, PA 18045-7899
(610) 252-5550 ~ Fax (610) 515-6501

Resolve Behavioral Health Services

Interagency Client Admission Form

Client Residence: (where child sleeps)

Last Name: _____

First Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Email Address: _____

Relationship:

Biological Mother	☐	
Biological Father	☐	
Stepmother	☐	
Stepfather	☐	
Adoptive Mother	☐	
Adoptive Father	☐	
Foster Mother	☐	
Foster Father	☐	
Aunt	☐	
Uncle	☐	
Grandmother	☐	
Grandfather	☐	
Agency	☐	_____
Institution	☐	_____
Other	☐	_____

Guardian's County of Residence: _____

Current School District: _____

School Currently Attending: _____

Grade: _____

COLONIAL INTERMEDIATE UNIT 20
6 Danforth Drive ~ Easton, PA 18045-7899
(610) 252-5550 ~ Fax (610) 515-6501

Resolve Behavioral Health Services

Interagency Client Admission Form

Education/Insurance:

Referring Agent: _____

Referring Agent Phone Number: _____

Is child currently in a special program or receiving special services: No ☐ Yes ☐

If yes, what program or service? _____

If CIU20 program, specific program/location: _____

Person/Agency with Custodial & Legal Rights: _____

Person/Agency with Educational Rights: _____

Programs being considered: (check one)

ES ☐ PHP ☐ Alt Ed ☐ P50 ☐ Informational ☐ Other ☐ _____

Is there any request for special location where service would be provided? No ☐ Yes ☐
If Yes, where? _____

Psychiatric Evaluation completed: No ☐ Yes ☐ Evaluation Date: _____

Psychiatric Evaluation done by: _____

Primary Care Physician Name: _____

Recent Physical Examination Date: _____ No recent exam ☐
(needed for placement in PHP)

Does client have Medical Assistance? No ☐ Yes ☐ Card No. _____

Private Third Party Insurance: No ☐ Yes ☐ Name of Insurance: _____
Insurance Company Contact Number: _____

Persons being invited by Referring Agent:

----------**FOR OFFICE USE ONLY**----------

Meeting Date: _____ Meeting Time: _____