ACCESS MHA Services Request

Name	Last:	First:	Middle:	Maiden/Alias:		
Address	Street:		City:	State:	Zip:	County:
Birthdate:			Age:			

Is it ok to contact by Mail? ❑ Yes ❑ No

Telephone Contacts

Home ( ) —	Mobile ( ) —	Work/Other ( ) —
Permission to Contact: Yes No	Permission to Contact: Yes No	Permission to Contact: Yes No

English Proficiency	Proficient	Limited – Spanish Primary Language	Limited – Other Primary Language
Communication	No Impairment Noted	American Sign Language	Single Words/Gestures
	Is there a need for Assistive technology?	❑ Yes ❑ No	Utilizes Own Language Technology

Reason for your visit: In the area below please check all boxes that include any of the reasons for your visit. You may add any additional information in the space provided.

❑ Thoughts of Harming Self ❑ Thoughts of Harming Others ❑ Crying Spells
❑ Sleeping Problems ❑ Substance Abuse ❑ Recent Hospitalization ❑ Irritability
❑ Anxiety ❑ Sadness

Additional Information regarding the reason(s) for your visit you wish to provide: