The purpose of this intake form is to prepare for the initial Transition House consultation and save time during the session.

Please complete and return the form before the scheduled appointment using one of the following options:

Today's Date:_____

My intake will be submitted by:

☐ **Email:**
callingonbeth@gmail.com

☐ **Mail:**
Transition House c/o Olney Post Office
Post Office 776
Olney, MD 20830

☐ Receive bill and pay on-line

Name of person completing this form: _____

Relationship to client being referred: _____

Referring Party Information

Home Phone: _____

Mobile Phone: _____

Email: _____

Preferred number to reach you:

☐ Home Phone ☐ Cell Phone ☐ Email

Address: _____

City: _____ State:_____ Zip:_____

Are you the Authorized Representative to speak on behalf of client?

☐ Yes ☐. No

Explain: _____

Power of Attorney

Medical ☐ Yes ☐ No

Financial ☐ Yes ☐ No

Trustee ☐ Yes ☐ No

Name of Attorney: _____

Authorized Representative ☐ Yes ☐ No

Guardian ☐ Yes ☐ No

Explain: _____

I will be responsible for paying House Calls $250 intake fee and future appointments.
☐ Yes ☐ No

If No, who is? _____

Relationship to Client _____ Initials _____

If No, provide Information on the person who will be paying the bill. Skip if same

Payee _____

Preferred number to reach payee:

☐ Home Phone ☐ Cell Phone ☐ Email

Address: _____

City: _____ State: _____ Zip: _____

How were you referred to House Calls?

☐ Organization or Website Search

☐ Advertisement: (Where) _____

☐ Friend/Relative: (Name) _____

☐ Professional (Name) _____

INFORMATION ABOUT THE PERSON NEEDING ASSISTANCE (Client)

Name of Client:_____

Client's Age: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Preferred number to reach client:

☐ Home Phone ☐ Cell Phone ☐ Email

Address: _____

City: _____State:_____Zip:_____

Best days for an initial consult:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
☐ AM ☐ PM ☐ Anytime ☐ Requested Time: _____

NOTE: If the client will be resistant, it is better to meet with you alone the first time to develop a plan for connecting with the client.

Check most comfortable meeting place:

Place	**Check**	**Comment**
Restaurant	☐	
Coffee shop	☐	
Library	☐	
Relative's Home	☐	
Client's Home	☐	
School	☐	
Work	☐	

What does this client need help with and what do you want to accomplish at the first intake meeting?

_____

_____

_____

_____

Check categories of need:

		Comment
Accommodations	☐	
Advocacy	☐	
Addiction	☐	
Case Management	☐	
Community Resources	☐	
Counseling (specify if online)	☐	
Coaching	☐	
DeClutter/Organization	☐	
Discharge Planning	☐	
Doctor Referrals	☐	
Elderly Issues	☐	
Education Special Needs	☐	
Exposure Therapy	☐	
Family Issues	☐	
Homecare	☐	
Housing Referrals	☐	
Medicaid	☐	
Recreational	☐	
Recovery Coach	☐	
Risk Assessment	☐	
Social Security	☐	
Transition to Assisted Living	☐	
Other (please explain)	☐	

What are your expectations and what has been done in the past?

_____

_____

_____

Signature: _____

☐ **I agree to all terms of this document.**

STOP HERE AS THE REST OF THE INTAKE CAN BE DONE DURING YOUR CONSULTATION.

CLIENT'S FAMILY INFORMATION

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Spouse: _____

Marital Status: _____

Children: # _____

Names_____/_____/_____/_____

Elaborate:_____

Does client live alone or who does he/she live with?

Explain_____

Relevant Information About Family Dynamics:

_____

_____

Client is assisted in the following areas by:

☐ Financial: _____

☐ Emotional:_____

Strengths of Client:

_____

Limitations of Client:

_____

Client's Recreational Routine: Loner, very social, active or what is a typical day like/week like?

_____

_____

_____

RELEVANT MEDICAL INFORMATION

MEDICAL
Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

PSYCHIATRIST
Psychiatrist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

SOCIAL WORKER OR PSYCHOLOGIST
Social Worker or Psychologist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

List all medications:

_____

_____

How often are these medications monitored? _____

RECENT HOSPITALIZATION(if applicable)
Name of hospital(s): _____

Dates hospitalized: _____

What behavior necessitated hospitalization?

_____

What has been done in the past in an attempt to help with this issue?

_____

Memorandum of Agreement

The fee for an initial consultation with Evan Taff, Owner and Operations Coordinator is $250 an hour ($45 for each 15 minutes over the hour) and a $25 travel fee (if within Montgomery County). Outside Montgomery County, IRS business travel mileage will apply. ☐ **Agree**

NOTE: Additional fees apply if you are requesting the Owner, Beth Albaneze CTRS CPRP, ($350 per hour, plus travel fee $25 if within Montgomery County). ☐ **Agree**

Travel exceeding the Montgomery County radius is based on current IRS rates per mile. ☐ **Agree**

Payment is due immediately after the consultation session unless otherwise negotiated with Transition House specialist in advance. *Transition House accepts payments through PayPal. **Cancellation with less than 24 hours notice requires payment of the full fee. ☐ **Agree**

Any phone calls, emails, activity expenditure, texting, referrals, and/or advocacy work after the initial consultation, will be billed at an hourly rate (outlined above). We will give you advance notice if this is routine/necessary. ☐ **Agree**

Terms of Agreement form will be completed by Transition House specialist _____ and remitted to the person paying the bill for signature before services start . ☐ **Agree**

The plan for services agreed upon will be emailed to select member(s) of the team working with the client and one family member/friend/lawyer will need to act on behalf of the client as a representative and share the information with others if permitted to do so. (if not the client). ☐ **Agree**

Additional fees may apply if Transition House is requested to create multiple action plans, perform any other services and/or discuss the plan with more than one client representative. ☐ **Agree**

Agreement to Pay Bill:

I agree to pay for my intake consultation immediately after the session and will pay immediately after all further services are rendered.

If Transition House has not received payment before the end of the month that the service was provided, I understand a late fee will apply until payment is paid in full**.** ☐ **Agree**

Name of Person Paying Bill:

Permission Given to Transition House, LLC and _____ to communicate with other parties relevant to the client's rehabilitation goals and objectives. At all times confidentiality will be respected unless there is imminent harm, bodily injury or abuse. We are not a crisis service and defer to the family or relevant community resources to intervene**.** ☐ **Agree**

Email Privacy Statement: In general, email communications are not secure. Please check here for your informed consent to communicate through these channels.

NOTE: If you choose not to proceed and check the above box, we will assume you will print this Intake (or download the pdf Intake Form to send in advance or bring with you). ☐ **Agree**

I am aware of the risks associated with sending emails or other channels. ☐ **Agree**

Please type your electronic signature to give your consent for email correspondence. I hereby agree to be bound by this agreement and am aware that if by choose an electronic signature it is enforceable as if it were handwritten

Signature _____ Date_____

This verifies that I give my written consent to bill me for any of the above related expenditures including legal fees, court costs and collection expenses involved for breach of contract. ☐ **Agree**

Transition House Representative: _____ Date _____

FOR OFFICE USE: ----------

NOTES: