



# PROJECT COPE - INTAKE INFORMATION

**CLIENT DATA:**

**TODAY'S DATE:** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male Female Cellular Phone(\_\_\_\_\_) \_\_\_\_\_

Ethnicity/Culture \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Have you ever received services from Project COPE previously? Yes No**

**Who referred you to Project COPE? (If other than yourself, please include all requested information.)**

Self or family Private Referral Court/Probation DSS Other

If court referred - Which court \_\_\_\_\_ Probation Officer \_\_\_\_\_

If DSS referred - Which DSS office \_\_\_\_\_ Case Worker \_\_\_\_\_

If other, please specify \_\_\_\_\_

**For what services have you been referred to Project COPE (please read through all categories and check the appropriate line(s))**

**Adolescent Services:**

Outpatient Counseling and Education Services Evaluation Treatment Substance Abuse  
Adolescent Anger Management

**Adult Services:**

Outpatient Counseling and Education Services Evaluation Treatment Substance Abuse

Driving Under the Influence Programs:

Driver Alcohol Education (24D First Offender OUI Program)

Second Offender Aftercare Program (SOAP, Multiple OUI Offense Program)

Interpersonal Violence Program (Certified Batterer's Intervention Program)

General Violence Program (Anger Management Program)

Employee Assistance Program (please specify) \_\_\_\_\_

Other (please specify) \_\_\_\_\_

**If court or DSS involved, please answer the following questions (otherwise skip to the next section):**

What were the charges that resulted in your involvement with the court/DSS? \_\_\_\_\_

What is the current status of your case? Case Pending? ( Yes No) \_\_\_\_\_

Have you been referred to Project COPE as a condition of Probation/Parole? ( Yes No)

Have you been referred to Project COPE as a condition of your DSS Service Plan? ( Yes No)

**INSURANCE INFORMATION (Not Applicable for DUI or Violence Intervention programs)**

Do you currently have health insurance?                      Yes    No (If no, sign below and skip to the next section.)

Do you have Medicare?                      Yes    No                      Medicare Number \_\_\_\_\_

Do you have Medicaid?                      Yes    No                      Mass Health # \_\_\_\_\_

RID # \_\_\_\_\_ Sequence # \_\_\_\_\_

If Private Insurance:    Name of Insurance Company \_\_\_\_\_

Policy or Group Number \_\_\_\_\_

Telephone # for benefit information \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Social Security # of Policy Holder \_\_\_\_\_

Relationship of client to insured \_\_\_\_\_

**I understand that I am responsible for all charges not reimbursed by other parties.**

***Client Signature*** \_\_\_\_\_

**EMPLOYMENT HISTORY**

Currently Employed:    Yes    No    Employer \_\_\_\_\_ Annual Income \_\_\_\_\_

**FOR OFFICE USE ONLY:**

***Amount of Deposit paid with application:*** \_\_\_\_\_

**Check** appropriate Program:                      **OP**                      **OP-Adol.**                      **DAE**                      **MOP**                      **IVP**  
**GVP**                      **WAG**                      **EAP**  
**OTHER** \_\_\_\_\_

Appointment Date \_\_\_\_\_ Appointment Time: \_\_\_\_\_ AM \_\_\_\_\_ PM

If no appointment was given, please explain: \_\_\_\_\_

Assigned Clinician \_\_\_\_\_

**For Clinician Use Only:**

MIS Number \_\_\_\_\_ File Number \_\_\_\_\_

Diagnosis \_\_\_\_\_

Principle Code \_\_\_\_\_

Date of Interview \_\_\_\_\_

Clinician Signature \_\_\_\_\_

(Please initial)  
Date of 1<sup>st</sup> NS \_\_\_\_\_ w/ \_\_\_\_\_  
Date of 2<sup>nd</sup> NS \_\_\_\_\_ w/ \_\_\_\_\_  
Date of 3<sup>rd</sup> NS \_\_\_\_\_ w/ \_\_\_\_\_