

<i>County Use Only</i>	
AVATAR Case #:	_____
Admit Date:	_____
Program Code:	_____ <input type="checkbox"/> MH <input type="checkbox"/> CWS

### CLIENT SERVICES INFORMATION SHEET (CSI)

**Instructions:** *May be completed by client, client's representative, clerical support, or practitioner. "Client" is the individual receiving services.*

- Your (Client) Legal Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_
- Birth Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_
- AKA** (other names used): (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_
- Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_ **Mother's First Name:** \_\_\_\_\_
- Place of Birth:** (City) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_ (Country) \_\_\_\_\_
- Sex:**  Male  Female  Other **Identification:**  Valid Driver's License  I.D. State \_\_\_ Number \_\_\_\_\_
- Marital Status:**  Never Married  Married  Divorced  Widowed  Coupled  Separated  Unknown/Not Disclosed
- Address:** (Mailing Address) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_
- Address:** (Physical Address) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_
- Phone 1:** (\_\_\_\_) \_\_\_\_\_ Home Work Cell **Phone 2:** (\_\_\_\_) \_\_\_\_\_ Home Work Cell **E-mail:** \_\_\_\_\_
- Ethnicity:** *Please check or list one.*  
 Mexican/Mexican American  Cuban  Puerto Rican  Other Hispanic/Latino  
 Not Hispanic  Unknown
- Race:** *Please check or list the race(s) that describe your identity the best. (You can check or list up to 5.)*  
 White/Caucasian  Black/African American  American Indian or Alaska Native  
 Other: \_\_\_\_\_
- Primary Language:** *Please check or list one.*  
 English  Spanish  Russian  American Sign Language  Other: \_\_\_\_\_
- Preferred Language:** *I prefer to receive services in the following language:*  
 English  Spanish  Russian  American Sign Language  Other: \_\_\_\_\_
- Would you like any culturally specific services?**  Yes  No  Not sure **If yes, identify the type and describe.**  
 I would like to receive services in my preferred language.  
 I would like to receive services from a provider who is competent in my culture. (Culture can mean race, religion, sexual orientation, or any other group identity that you may have.) What is the culture or group identity:  
 \_\_\_\_\_
- Do you need wheelchair access or other accommodation for a disability?**  No  Yes \_\_\_\_\_

**17. Please list your next of kin and other members of your family/household:**

Name	Relationship to Client	Date of Birth	Social Security No. (if available)	Address (if same, write "same")	Phone No.

- Insurance Coverage:** **Do you have any of the following insurance plans or benefits?** *Check all that apply.*  
 Medi-Cal  Medi-Care Part A \_\_\_ Part B \_\_\_  Healthy Families: \_\_\_\_\_ (plan)  
 No Health Insurance  VA Benefits  Other Health Insurance: \_\_\_\_\_ (plan)
- May we identify our agency if we call:** Your home?  Yes  No Your work?  Yes  No

**Signature of Person Completing:** \_\_\_\_\_ **Date:** \_\_\_\_\_