NEW BEGINNINGS BEHAVIORAL HEALTH SERVICES, LLC
REQUEST FOR SERVICES FORM

Phone: 501.663.1837 Fax: 501.663.1839 **DATE OF REQUEST:**_____

Prospective Client:_____ DOB: _____

☐ Male ☐ Female ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other:_____

Name of person making request:_____

Referral Source:_____ Relationship to Client: _____
(School, Agency, Court, Hospital, Self, etc.)

☐ School-based Referral School: _____Grade:_____

☐ Telephone Call ☐ Walk-in ☐ Voluntary ☐ Court-Ordered ☐ Other: _____

Former NBBHS Client: ☐ Yes ☐ No If yes, reason for discharge:_____

Other Mental Health Provider ☐ Yes ☐ No If yes, name of Provider:_____

Home Address:_____

If a minor, name of parent/guardian:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Living Arrangements: ☐ W/Family ☐ Foster Home ☐ Other _____

Need for Interpretive Services: ☐ Sign Language (ASL) ☐ Language (specify): _____

Other Accommodations:_____

Reason for referral: _____**Best Time to Call:**_____

Services requested:

☐ Outpatient Services Off-Site (school/home based); specify location: _____

☐ Outpatient services (clinic based

Reimbursement Source (copy of cards):

☐ Medicaid ☐ ArKids 1st ☐ Private Insurance ☐ Self Pay

Insurance Name & Policy/ID Number(s):_____

Medicaid #:_____ SS#:_____

Primary Care Physician: _____Last PCP Visit (Month/Year):_____

Person Completing Form:_____ _____
Print Name **Signature** **Date**

OFFICE USE ONLY BELOW THIS LINE

_____ _____
Therapist Assigned **Signature of receiving therapist** **Date**

Attempts to schedule Intake/Barriers:
1.
2.
3.

Intake Appointment date & time:_____

Reason Intake not scheduled:_____