Funding Profile

Section A: Client Profile

01.Legal First Name:	02.Legal Middle Name:	03.Legal Last Name:	04.Alias/Nickname:

05.Suffix:	06.E-mail Address:	07.Gender:	08.DOB	09.SS#:

10. Is Client an Idaho Resident?:	11.Primary Mailing Address (include Apt/Trlr #):

12.City:	13.State:	14.Zip Code:	15.Primary Contact #:

16.Ethnicity:	17.Race:	18.Special Needs:	19.Veteran Status:

20. County of Residence:	21. Pregnant:	22. If Pregnant, Due Date:	23.Past IV Drug Use:

24. Presenting Problem:	25. County of Supervision:

26. Does Client Have Medicaid or Medicare:	27 .If Medicaid, does client have a Medicaid SUD treatment plan:

☐ Child Care: ______________________ ☐ Transportation: ______________________

☐ Life Skills: ______________________ ☐ Safe & Sober Housing: ______________________

☐ Education: ______________________ ☐ Staffing: ______________________

☐ Medical Needs ______________________ ☐ Detox: ______________________

☐ Residential ______________________ ☐ Halfway House: ______________________

☐ Basic Housing Essentials (only for Mental Health Court referrals) ______________________

Section B: Military Information

1. For which branch of the US forces are you on active duty or the dependent of someone on active duty?

Military Branch:	Status:

2. Are you Active Guard or Active Duty for Special Work in the Guard or Reserves or the dependent of someone Active Guard or Active Duty for Special Work in the Guard or Reserves?

Military Reserve Branches:	Status:	State:

3. Of which branch(es) of the armed forces are you a veteran?

Military Branches:

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4. Have you served or are you the dependent of someone who served in a combat theater of operation? If so, please indicate how many deployments.

Combat Theaters:	Status:	# of deployments:

5. Have you been screened for Traumatic Brain Injury? ______________________________
6. If yes, have you been diagnosed with a Traumatic Brain Injury?______________________________
7. Have you been screened for Post-Traumatic Stress Disorder? ______________________________
8. If yes, have you been diagnosed with Post-Traumatic Stress Disorder? ______________________________

Section C: Collateral Contact

01.Person's Name:	02.Relationship to Client:	03.Phone #:

Section D: Referral Information:

01.Referral Name (print name):	02.Referral Contact #:	03. Referral Email:	04.Referral Type:

05. Level of Care:	06. Provider Name:	07. Site/City:
08. Level of Care:	09. Provider Name:	10. Site/City:
11. Level of Care:	12. Provider Name:	13. Site/City:
14. Level of Care:	15. Provider Name:	16. Site/City:

Section E: Financial Information (all dollar amounts should be for the prior month)

01.Monthly Gross Income:	02.# in Family:	03. Does the client have insurance?:	04.Court Ordered Obligations:
05.Dependent Support:	06.Child Care:	07.Medical Expenses:	08.Transportation
09.Extraordinary Rehabilitative Expenses:		10.State and Federal Tax Payments:	11.Total Monthly Deductions:

CLIENT AFFIRMATION: I affirm that the above financial information statements made herein are true and correct to the best of my knowledge. I understand that any false statements of material fact could result in disqualification and/or civil action. I understand that I may be asked to provide verification of my statements of income, statements of expenses and dependents.

Client Signature:______________________________ **Date:** ______________________________

Referral/Witness Signature:______________________________ **Date:** ______________________________