Please email completed form to info@shiningstarlv.com

Or fax to 702-522-9336.

If you have any questions, call **702-882-STAR**

Shining Star
Community Services

Client Intake Form

Client Name: _____

DOB: _____ _____**Male** _____**Female**

Medicaid #: _____

Client is in the custody of: _____**Parent** _____**State** _____**Agency**

Legal Guardian Name: _____

Legal Guardian Phone Number: _____

Supervisor Name (DFS only): _____

Parent/Foster Parent Name: _____

Parent/Foster Parent Phone Number(s): _____

Client Home Address: _____

City: _____ **State:** _____

School: _____ **Grade:** _____

Has client received services (Therapy/BST/PSR/Etc.) in the last 6 months? ___**Yes** ____**No** ____**Unknown**

Agency Name: _____

Service(s) Received: _____

What service(s) are you seeking for client? : _____

Additional Information:

_____

_____

Created 7/31/13