1 - Office	4 - Home	8 - Correctional Facility	11 - Faith-based	14 - Client's Job Site	17 - Non-Traditional	20 - Telehealth
2 - Field	5 - School	9 - Inpatient	12 - Health Care	15 - Adult Residential	18 - Other	21 - Unknown
3 - Phone	6 - Satellite Clinic	10 - Homeless	13 - Age-Specific	16 - Mobile Service	19 - Childrens Residential	

DATE: BILLING TIME: LOCATION: SERVICE TYPE: **ASSESSMENT**

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE").
(complete on first or second visit; may be completed by LPHA or non-LPHA)

RESOURCE NEEDS (appropriate to client's desires and culture)

INCOME: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

FOOD: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

HOUSING: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

MEDICAL CARE: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

EDUCATION: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

WORK/VOLUNTEER WORK/PREPARATION FOR WORK: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

CHILDCARE: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

TRANSPORTATION: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

LEGAL ADVICE: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

IMMIGRATION ASSISTANCE: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

OTHER _____: ☐ No need Describe need and recommendation/plan: _____

_____ ☐ Client declines help at this time

Date: _____ Provider Signature: _____ Provider Printed Name: _____

Date: _____ Client Signature: _____ Client Printed Name: _____

CLIENT RESOURCE EVALUATION
San Bernardino County
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM: