02 Telehealth Not in Client's Home	10 Telehealth in Client's Home	15 Mobile Unit	27 Outreach Site/Street	52 Psych Facility-Partial Hospitalization	58 Non- Res Opioid Tx Facility
03 School	11 DBH/Contractor Site - Office	16 Temporary Lodging	31 Skilled Nursing Facility	55 Residential Care/ Community Treatment Facility	99 Other Place of Service
04 Homeless Shelter	12 Home	20 Urgent Care Facility	33 Custodial Care Facility	56 Psych Res Tx Center	
09 Jail	14 Group Home	23 Emergency Room - Hospital	51 Inpatient Psychiatric Facility	57 Non-Res SA Tx Facility	

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: