**Client ID#**_____ **Date**_____

**Significant Other ID#**_____ **Assessment**_____

## New Health Care Data Form

**NOTE:** Start with the most recent treatment and work backwards.

| Discharge or Treatment date (make note of corresponding question #) | Name and address of treatment facility | Name of doctor PA, or NP (specify Dr., PA, NP) | Reason for treatment & length of stay in nights (day visit = 0) | How much did you or will you pay for this treatment? | Who else is paying for this treatment? | Supplemental Health Care consent obtained |
|---|---|---|---|---|---|---|
| Question # _____ | | | Days _____ | | O HPHC | O YES<br>O REFUSED<br>O N/A |
| Question # _____ | | | Days _____ | | O HPHC | O YES<br>O REFUSED<br>O N/A |
| Question # _____ | | | Days _____ | | O HPHC | O YES<br>O REFUSED<br>O N/A |