



Date: _____

Minor Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Client Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date _____ / _____ / _____ Social Security Number _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____ Home phone _____

Parent/Guardian's Cell phone _____ Email _____

Who referred client? _____

Is there pending / expected court involvement: custody, placement, parental rights, CPS? Y NIs the client seeking counseling due to a court order or criminal charges? Y N**May we:** Call Leave a message Text None **Prefer:** Cell Home**Gender**

- Male
- Female
- Non-binary/3rd gender
- Prefer to self-describe
- Prefer not to say

Sexual Orientation

- Straight/Heterosexual
- Gay, Lesbian, or Queer
- Bisexual
- Prefer to self-describe
- Prefer not to say

Do you identify as transgender?

- Yes
- No
- Prefer not to say

Preferred Pronouns: She/Her/Hers He/Him/His They/Them/ Their Other _____**Racial/Ethnic identity:** African American Asian American Native American
 Pacific Islander White/Caucasian Other _____**Are you Hispanic/Latino** Yes No**Emergency Contact:** Name _____ Contact number _____

Relationship to the client _____

Household Income: Household Income: 0-,9999 10,000-19,999 20,000-29,999 30,000-39,999
 40,000-49,999 50,000-59,999 60,000-69,999 70,000-79,999 80,000-89,999 90,000-100,000
 100,000+ Refused

Education: Current grade _____ School _____ Problems at school? Y N

If yes, please explain _____

What services does child receive from school? _____

Religion/Denominational preference _____ Congregation (if any) _____

Insurance Information

Primary Insurance Name: _____

Secondary Insurance Name: _____

Phone Number of Insurance: _____

Phone number of Insurance: _____

Policy Holder Name: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder Date of Birth: _____

Insurance ID: _____

Insurance ID: _____

Insurance Group Number: _____

Insurance Group Number: _____

Family Information:

Parents: Married Cohabitating Never Married Separated Divorced

Mother _____ Full Custody Joint Custody No Rights Other

Father _____ Full Custody Joint Custody No Rights Other

If other, please explain: _____

Is there a legal document outlining custody? Y N (**copy required prior to client being seen**)

Is the minor in the care of a guardian or conservator? Y N If yes, who? _____

What is this person's relationship to the child? _____

Is there a legal document detailing this? Y N (**copy required prior to client being seen**)

Siblings: How many? _____ I am the: Oldest In the Middle Youngest Only Child

Sibling Ages _____

List everyone living in the home with the client (name & relationship) _____

Has the client or anyone in the client's family experienced abuse or neglect? Y N

Is the client currently experiencing abuse or neglect? Y N

Check all that the client is experiencing

<input type="checkbox"/> ADHD	<input type="checkbox"/> Guilt feelings	<input type="checkbox"/> Problems with concentration
<input type="checkbox"/> Anger	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Problems with memory
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irrational fears	<input type="checkbox"/> Problems with sleep
<input type="checkbox"/> Avoid open spaces	<input type="checkbox"/> Irritability	<input type="checkbox"/> Rage
<input type="checkbox"/> Behavioral problems	<input type="checkbox"/> Isolating/withdrawn	<input type="checkbox"/> Relationship to children
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Lack of activities	<input type="checkbox"/> Relationship to parents
<input type="checkbox"/> Chronic fear	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Relationship to significant other
<input type="checkbox"/> Compulsions	<input type="checkbox"/> Loss of faith in God	<input type="checkbox"/> Religious doubts
<input type="checkbox"/> Conflicts at work	<input type="checkbox"/> Loss of hope	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Decreased energy/fatigue	<input type="checkbox"/> Loss of meaning in life	<input type="checkbox"/> Self-injury
<input type="checkbox"/> Decreased pleasure	<input type="checkbox"/> Muscle tension	<input type="checkbox"/> Sexual orientation
<input type="checkbox"/> Delusions	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Other/Explain below	<input type="checkbox"/> Significant weight change
<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Stress
<input type="checkbox"/> Excessive worry	<input type="checkbox"/> Phobias	<input type="checkbox"/> Substance use problems
<input type="checkbox"/> Feel like I'm losing control	<input type="checkbox"/> Plans to harm self	<input type="checkbox"/> Thoughts of death
<input type="checkbox"/> Feelings of worthlessness	<input type="checkbox"/> Plans to harming others	<input type="checkbox"/> Thoughts of harming others
<input type="checkbox"/> Gender identity issues	<input type="checkbox"/> Problems due to abuse/trauma	<input type="checkbox"/> Thoughts of suicide
<input type="checkbox"/> Grief	<input type="checkbox"/> Problems in school	

Mental Health

Has the client experienced mental health problems before? Y N If yes, explain _____

Does the client have a family history of mental health problems? Y N

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

Y N If yes, when andwhere? _____

Has the client ever been hospitalized or received inpatient treatment for mentalhealth issues? Y N If yes, when and where? _____

Substance Use History

Does the client drink alcohol? Y N On average, how many drinks do you have? _____ per _____
quantity & type
day/week/month

Does the client use drugs (illegal drugs, recreational drugs, drugs not prescribed to client or used in excess of how they are prescribed)? Y N If yes, whichones? _____

How often? _____ per _____
quantity & drug
day/week/month IV drug use? Y N

Has the client ever been treated (counseling, therapy, psychiatrist, medication) for a drug or alcohol problem?

Y N If yes, when and where? _____

Completed successfully? Y N

Has the client ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

Y N If yes, when and where? _____

Completed successfully? Y N

Medical History of Client

Pediatrician _____

List any physical illness or symptoms the client is having at this time _____

List major surgeries or illnesses _____

List current medications (include dosages and physician prescribing) _____

 **Custody or guardianship paperwork is required (if applicable) prior to a minor client being seen for services.**

Telehealth/TeleCounseling

Telehealth/Telecounseling refers to diagnosis, consultation, billing, client education, and professional education/training delivered via electronic technology. This allows clinicians at West Texas Counseling & Guidance to connect with clients using interactive video/audio data communication. One benefit is that the client and clinician can engage in services without physically being in the same location. This can be beneficial if the client moves to a different location or is unable to meet in person for appointments. It can also serve as an opportunity for treatment that may not be accessible for the client in their location.

Some of the WTCG therapists practice both face to face and telecounseling means for appointments, please visit with the receptionists to determine if these options are available to you. On occasion, appointments may be switched between the two types of sessions if appropriate and both parties have the capacity.

Crisis Management Plan:

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individuals for additional assistance:

1) Personal Contact: _____

Phone Number(s): _____

2) Personal Contact: _____

Phone Number(s): _____

3) Professional Contact: _____

Phone Number(s): _____

I understand if deemed necessary, my therapist may request a Welfare Check to be completed, contact local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with WTCG staff.

Acknowledgement of these forms

The information written on this packet is accurate, to the best of my knowledge.

Signature of Parent / Guardian / Client

Date



No Shows, Cancellations, & Payment for Services

Client Name: _____

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message with our answering service is fine, even on weekends. The time you called will be posted with the message. If you do not give 24 hours' notice before cancelling your appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to schedule with another therapist or moved to the WTCG wait list for services. Clients may also be charged a **\$50 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than \$50 per session, the fee will be your usual session charge. Those seen without a session fee will be charged \$5 per missed session.

Clients with certain insurances cannot be billed the missed appointment fee - Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

Certain insurances may not reimburse for some services offered at WTCG; in the event that insurance does not reimburse for a service provided and the client does not qualify for one of several client assistance programs at WTCG, the client will be held responsible for payment for that service.

Counselor Discretion: The counselor may choose to continue to see the client without requiring same-day appointments. The counselor may also waive the \$50 fee.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation. Due to the counselors maintaining a set schedule:

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

Court appearance: In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for the costs involved in producing the records and the therapist's normal **hourly rate of \$104.00** for giving that testimony. If a clinician is required to travel to a court location out of town, per diem and mileage are additional costs that you will be responsible for. Such payments are to be made prior to the time the services are rendered by the therapist.

By signing this agreement, I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

Signature of Parent / Guardian / Client

Date

Signature of WTCG Staff

Date



Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction. I am making an informed decision, free of any coercion, to engage in psychotherapeutic/counseling/clinical social work services, and for purpose of research to have my non identifiable information used. If I would like to withdraw my non-identifiable information from data collection and evaluation, I must submit this request in writing to reception@wtcg.us. I understand that I will not be denied services based on my withdrawal from data collection.

If deemed necessary or appropriate to participate in telecounseling services at West Texas Counseling & Guidance, I agree to the Informed Consent for Telehealth/Telecounseling provided in the Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices. I have the opportunity to discuss the telehealth policies with my therapist and ask any questions I may have in regard to telecounseling services prior to participation.

Signature of Parent / Guardian / Client

Date

Signature of WTCG Staff

Date

*****For Clients over the age of 12 years*****
Patient Health Questionnaire- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle your answer)		Not at all	Several days	More than half the days	Nearly every day
		0	1	2	3
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
Trouble falling or staying asleep, or sleeping too much					
Feeling tired or having little energy					
Poor appetite or overeating					
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down					
7. Trouble concentrating on things, such as reading the newspaper or watching television					
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual					
9. Thoughts that you would be better off dead or of hurting yourself in some way					

FOR OFFICE CODING

— 0+ — + — + —

=Total Score: —

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

*****For Clients over the age of 12 years*****

General Anxiety Disorder (GAD-7)

NAME

DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all sure	Several days	Over half the days	Nearly every day
<ul style="list-style-type: none"> • Feeling nervous, anxious, or on edge 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Not being able to stop or control worrying 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Worrying too much about different things 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Trouble relaxing 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Being so restless that it's hard to sit still 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Becoming easily annoyed or Irritable 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<ul style="list-style-type: none"> • Feeling afraid as if something awful might happen 		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>					
TOTAL SCORE (add your column scores)					
		Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

PCL-5 with Criterion A

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

Yes
 No

How did you experience it?

It happened to me directly
 I witnessed it
 I learned about it happening to a close family member or close friend
 I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
 Other, please describe

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

Accident or violence
 Natural causes
 Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
2. Repeated, disturbing dreams of the stressful experience?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
4. Feeling very upset when something reminded you of the stressful experience?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
8. Trouble remembering important parts of the stressful experience?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
12. Loss of interest in activities that you used to enjoy?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
13. Feeling distant or cut off from other people?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
15. Irritable behavior, angry outbursts, or acting aggressively?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
16. Taking too many risks or doing things that could cause you harm?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
17. Being "superalert" or watchful or on guard?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
18. Feeling jumpy or easily startled?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
19. Having difficulty concentrating?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
20. Trouble falling or staying asleep?	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Columbia-Suicide Severity Rating Scale

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Past month	
Ask questions that are bolded and <u>underlined</u> . Ask Questions 1 and 2		YES	NO
1	<p>Wish to be Dead: <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</p>	<input type="radio"/>	<input type="radio"/>
2	<p>Suicidal Thoughts: <u>Have you actually had any thoughts of killing yourself?</u> General non-specific thoughts of wanting to end one's life/commit suicide, "<i>I've thought about killing myself</i>" without general thoughts of ways to kill oneself/associated methods, intent, or plan.</p>	<input type="radio"/>	<input type="radio"/>
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3	<p>Suicidal Thoughts with Method (without Specific Plan or Intent to Act): <u>Have you been thinking about how you might kill yourself?</u> Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. <i>"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."</i></p>	<input type="radio"/>	<input type="radio"/>
4	<p>Suicidal Intent (without Specific Plan): <u>Have you had these thoughts and had some intention of acting on them?</u> Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to <i>"I have the thoughts but I definitely will not do anything about them."</i></p>	<input type="radio"/>	<input type="radio"/>
5	<p>Suicide Intent with Specific Plan: <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</p>	<input type="radio"/>	<input type="radio"/>
6	<p>Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</p> <p>If YES: <u>How long ago did you do any of these?</u></p> <p><input type="radio"/> Over a year ago? <input type="radio"/> Between 3 months and a year ago? <input type="radio"/> Within the last 3 months?</p>	<input type="radio"/>	<input type="radio"/>
Total:			

Date: _____

Military Program Eligibility Form

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's First Name _____ Last Name _____

1. Has the client ever served in the U.S. Military? Y N

What is your current military status?

- Active Duty
- Prior Service
- National Guard/Reserves

2. Is the client related to any of the following who have ever served/or are currently in the U.S. military? Y N

- Spouse
- Parent

If you answered no to questions 1 or 2, you do not have to continue this form.

3. Please fill out the below for yourself the veteran sponsor's information:

a. Dates of service: from _____ to _____

b. Service Connected Disability Y N

c. Rank Enlisted Officer Warrant Officer

d. Branch Navy Marine Army Coast Guard Air Force Space Force

Eligibility of military or dependent status established by following documentation

Individuals requesting services and claiming eligibility must provide documentation before they will be seen under a grant. Please see the example of documents below needed to verify eligibility. If an individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding.

Veterans

- DD Form 214, Certificate of Release or Discharge from Active Duty
- NGB-22, National Guard Report of Separation and Record of Service
- NA Form 13038, Certification of Military Service
- Department of Veterans Affairs (VA) official letter or disability letter
- E-Benefits summary letter
- Uniform Services Identification Card
- State of Texas Issued Driver License with Veteran designation
- Certificate verifying Active Duty Status from Department of Defense Manpower Data Center (ONLY –currently serving active duty)

Family Member

- Uniform Services Identification Card
- Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Birth Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Adoption Certificate - Must have one of the above with sponsors' proof of Veteran Status

Surviving Spouse

- Uniform Services Identification Card
- Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Death Certificate - Must have one of the above with sponsors' proof of Veteran Status

Copy of eligibility documents provided and included in chart

Alert has been created in chart stating “needs military documentation”.

Staff Member _____ **Date** _____