STATE OF FLORIDA
SUBSTANCE ABUSE & MENTAL HEALTH
DEMOGRAGHIC FORM

(* Mandatory Fields) (Reference: Chapter 4, DCF Pam 155-2)

Client's Name:

1. *CONTRACTOR IDENTIFIER: ___ ___ - ___ ___ ___ ___ ___ ___ ___ Federal Tax Identification number	Page 4 - 4
2. *CLIENT SSN: ___ ___ ___ ___ ___ ___ ___ ___ The SSN must be 9 digits without dashes. It cannot start with 000 or 999. If unavailable use Pseudo-social. Instructions in SAMH Pamphlet	Page 4 – 4
3. CLIENT ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 4 - 4
4. *LAST NAME. (Up to 35 characters)**:**	Page 4 - 4
5. *FIRST NAME. (Up to 35 characters)**:**	Page 4 - 4
6. *MIDDLE NAME. (Up to 14 characters)**:**	Page 4 - 4
7. SUFFIX. (Up to 10 characters)**:**	Page 4 - 4
8. *DATE OF BIRTH: __ __ __ __ __ __ __ __ FORMAT: YYYYMMDD	Page 4 – 4
9. *GENDER: ___ ☐ 1 – Male ☐ 2 – Female	Page 4 – 4
10. *RACE: ___ ☐ 1 – White ☐ 5 – Alaskan Native ☐ 2 – Black ☐ 7 - Asian ☐ 3 – American Indian ☐ 8 – Native Hawaiian or Other Pacific Islander ☐ 4 – Other ☐ 9 – Multi-Racial	Page 4 – 4
11. *ETHNICITY: ___ ☐ 1 – Puerto Rican ☐ 5 – Haitian ☐ 2 – Mexican ☐ 6 – None of the Above ☐ 3 – Cuban ☐ 7 – Mexican American ☐ 4 – Other Hispanic ☐ 8 – Spanish/Latino	Page 4 – 5
12. *PREGNANCY TRIMESTER: ___ ☐ 1 - 1-3 Months ☐ 3 - 7-9 Months ☐ 5 - Unknown ☐ 2 - 4-6 Months ☐ 4 - Not Pregnant or male	Page 4 -4
13. *ADMISSION TYPE: ___ ☐ 1 - Voluntary Competent ☐ 3 - Involuntary Competent ☐ 2 - Voluntary Incompetent ☐ 4 - Involuntary Incompetent	Page 4 - 5
14. *DRUG COURT ORDERED: ___ ☐ 0 – No ☐ 1- Yes	Page 4 - 5
15. *INVOLVED IN CHILD WELFARE: ___ ☐ 0 – No ☐ 1 – Yes	Page 4 - 5
16. PROVIDER INFORMATION: _	Page 4 - 5

17. *PROVIDER ID: ___ ___ **-** ___ ___ ___ ___ ___ ___ ___	Page 4 - 5
18. CONTRACTOR NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 4 - 5
19. PROVIDER NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 4 - 5
Signature: _____ Date: _____/_____/_____	