



# Request for Intake Form

Application Date: \_\_\_\_\_

Received by: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about CMHA? \_\_\_\_\_

\_\_\_\_\_

How can CMHA assist you? \_\_\_\_\_

\_\_\_\_\_

Are you connected to Mental Health Services?    Yes \_\_\_\_    No \_\_\_\_

Do we have permission to contact your service provider (doctor, mental health worker, etc.)?

Yes \_\_\_\_    No \_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*A staff member will be contacting you within 10 business days to arrange an intake appointment.