



## Infant and Early Childhood Mental Health Enrollment Form

This form can be used by IECMH providers to summarize information that is required for enrollment in the IECMH program. Providers must submit this information into the IECMH invoice portal to complete the enrollment process.

Please Print

|                                                                                                                                                                                                             |          |                     |                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|----------------|
| Client's First Name                                                                                                                                                                                         |          | Client's Last Name  |                |
| Client's Date of Birth                                                                                                                                                                                      |          |                     |                |
| Month                                                                                                                                                                                                       | Day      | Year                |                |
| Client's Sex:<br>Male      Female                                                                                                                                                                           |          |                     |                |
| Client's Address 1:                                                                                                                                                                                         |          | Client's Address 2: |                |
| Client's City:                                                                                                                                                                                              |          | Client's Zip Code:  |                |
| Client's Race/Ethnicity:<br>American Indian or Alaska Native      Asian      Black or African American      Hispanic<br>Middle Eastern or North African      Native Hawaiian or Pacific Islander      White |          |                     |                |
| Please indicate if child is in legal custody of the following (this is not the foster parent). *                                                                                                            |          |                     |                |
| Parent      Relative      DCFS (specify county): _____                                                                                                                                                      |          |                     |                |
| Community Services Board (specify county): _____                                                                                                                                                            |          |                     |                |
| Other (specify): _____                                                                                                                                                                                      |          |                     |                |
| *Please ensure this information corresponds with the details provided on the Residency Verification form to ensure consistency and accuracy across documents.                                               |          |                     |                |
| Primary Caregiver's Name                                                                                                                                                                                    |          |                     |                |
| First Name                                                                                                                                                                                                  |          | Last Name           |                |
| Primary's Caregiver's Date of Birth                                                                                                                                                                         |          |                     |                |
| Month                                                                                                                                                                                                       | Day      | Year                |                |
| Has Cuyahoga County Residency Been Verified Through the Residency Form?      Yes      No                                                                                                                    |          |                     |                |
| Type of Insurance:                                                                                                                                                                                          | Medicaid | Private Insurance   | CHIP      None |