FACE AND STATUS SHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPECIAL HEALTH SERVICES UNIT
SFN 758 (8-2023)

		Date:	
Client's Name: (Last, First, Initial)	Birth Date:	Sex:	Race:
Address: (Street)	City:	State:	Zip Code:

Home Telephone Number:	Work Telephone Number:	Cell Phone Number:
E-Mail Address:		

Primary Insurance Company:	Policy Date: (Month/Day/Year)	Policy Number:	
Address: (Street)	City:	State:	Zip Code:
Insurance Policy Exclusions or Limitations:			
Other Coverage: (Name of Company) ☐ Health ☐ Vision ☐ Dental	Policy Date: (Month/Day/Year)	Policy Number:	
Address: (Street)	City:	State:	Zip Code:
Other Coverage: (Name of Company) ☐ Health ☐ Vision ☐ Dental	Policy Date: (Month/Day/Year)	Policy Number:	
Address: (Street)	City:	State:	Zip Code:

FAMILY MEMBERS (INCLUDING CLIENT)	RELATIONSHIP TO CLIENT	DATE OF BIRTH	GRADE IN SCHOOL OR OCCUPATION	COMMENTS

ON THE FACE SHEET SUBMITTED TO THE STATE OFFICE, PLEASE DO NOT MAKE ENTRIES IN THE FOLLOWING SECTIONS

Diagnostic Effective Date:	Treatment Effective Date:	County:
Date Age 18:	Date Age 21:	Date Reevaluation Due:

Effective Date	Diagnosis Code	
		First Diagnosis:
		Second Diagnosis:
		Third Diagnosis:
		Fourth Diagnosis:
		Fifth Diagnosis:
		Sixth Diagnosis:

Closing Date: (Month/Day/Year)	Reason

DISTRIBUTION: Submit original to SHS. Retain copy for CSSB file.