

**PHILADELPHIA BEHAVIORAL HEALTH SYSTEM/Community Behavioral Health**

**CASE OPEN REQUEST FORM**

Date of Submission: \_\_\_\_\_  
Date CBH Received: \_\_\_\_\_

Client Name	CIS#	Soc. Sec.#	Current Telephone Number	Children Only DHS Involvement		Children Only Is Either Parent Incarcerated		Special Education		Living Arrgmt Code	Voc. Educ. Code	Services That Will Be Provided	Requested Case Open Start Date	Prim. Axis I Dx	Sec. Axis I Dx	Priority Group Code
				Yes	No	Yes	No	Yes	No							
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Agency Name/Contact: \_\_\_\_\_  
Fax #: \_\_\_\_\_

CBH Number: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_