The Seventy Times Seven Wellness Mission

2107 N Charles St* Baltimore MD 21218 * 410-624-5037(office) * 800-405-6914 (fax)

Client Information:

Client Name: _____ Phone #: _____
Current Address:_____
Date of Birth: _____ SS#_____
Medicaid? ___yes ____no
Medicaid number _____

Presenting problem and/or most recent mental health diagnosis:

By signing below I am confirming my request that 70X7WM link the client listed above to one of their mental health service provider partners for individual mental health therapy.

This form was completed by:

Name: _____ Date: _____

Phone: _____ Fax: _____

Address: _____

Email address: _____

Fax this form to 800-405-6914 Attn: Intake Coordinator or send to INFO@70X7WM.COM

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