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 IEMCH 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: ◯ Male ◯ Female		
Client's Address 1:	Client's Address 2:	
Client's City:	Client's Zip Code:	
Client's Race/Ethnicity: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Hispanic ◯ 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		