# APPLICATION FOR SERVICES

**Youth Name** **DOB** / / **Age** **SSN** \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

**Legal Gender** □ M □ F **Gender Orientation** □ M □ F

**Legal Guardian Name:**  Relationship: 🞏Mother 🞏Father 🞏Agency: \_\_\_\_\_\_\_\_\_ 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian Name:**  Relationship: 🞏Mother 🞏Father 🞏Agency: \_\_\_\_\_\_\_\_\_ 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_

Is there a court order or court ordered parenting plan? 🞏 Yes 🞏 No If **Yes**, please provide a copy.

Street Address, City, State, ZIP

Mailing Address, City State, ZIP

Phone #: Name/Cell# Name/Cell#

**Presenting Problem / Crisis (i.e. behavior and concerns):**

**Check services previously received or currently receiving and provide provider name:**

**Past Present Past Present**

□ □ Crisis Diversion Placement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Youth Mentoring (CBPRS/FSA) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Mental Health Assessment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Supervised Visits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Individual Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Parent Education/Home Support (HSS/FST) \_\_\_\_\_\_\_\_\_\_\_

□ □ Family Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Day Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Medication Management \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Therapeutic Foster Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Substance Abuse Assessment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Therapeutic Group Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Substance Abuse Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Youth Partial Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ CSCT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Residential (PRTF) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Youth Case Management \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Acute Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications Name/Dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check services being requested:**

□ Crisis Diversion Placement □ Substance Abuse Assessment □ Supervised Visits

□ Mental Health Assessment □ Substance Abuse Treatment □ Day Treatment

□ Individual Therapy □ Youth Case Management □ Therapeutic Foster Care

□ Family Therapy □ Youth Mentoring (CBPRS/FSA) □ Therapeutic Group Home

□ Medication Management □ Parent Education/Home Support (HSS/FST)

**Other Needs:**

□ Housing Assistance □ Financial Assistance □ Food Stamps □ Medical □ Dental □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:**

Does the youth have: ❑Medicaid/HMK Plus ❑CHIP/HMK ❑Private Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑No Coverage

**Support System:** Are there any other family members or professionals who should be involved in the youth’s treatment □ Yes □ No If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Youth Dynamics?** □ Friend/Family □ Facebook □ Website □ Instagram □ Primary Care Doctor □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Signature / Date Legal Guardian Signature / Date