# APPLICATION FOR SERVICES

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

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

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

Street Address, City, State, ZIP

Mailing Address, City State, ZIP

Cell Phone #: Office Phone #

E-mail

**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

Cell Phone #: Office Phone #

E-mail

**Presenting Concerns / Crisis (i.e. behavior):**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

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

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

□ □ Substance Use Assessment/TX \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Therapeutic Group Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Day Treatment/Youth Partial Hospital \_\_\_\_\_\_\_\_\_\_ □ □ CSCT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

□ □ Youth Case Management \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Acute Hospital / Residential (PRTF) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Check Services Requested:**

□ Mental Health Assessment □ Youth Mentoring (CBPRS/FSA) □ Supervised Visits

□ Substance Use Assessment □ Youth Case Management □ Day Treatment

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

□ Substance Use Treatment □ Therapeutic Foster Care □ Therapeutic Group Home

□ Chafee Foster Care Independence Program (Billings Only)

**Other Needs:**

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

**Insurance:** Does the youth have: ❑Medicaid/HMK Plus ❑CHIP/HMK ❑Private Insurance ❑No Insurance

**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