Youth Dynamics

APPLICATION FOR SERVICES

Youth Name:	DOB: / /	SSN:
Legal Gender ☐Male ☐Female ☐Declined to Specify	**Gender Identity** ☐Male ☐Female ☐Transgender Female/male-to-female (MTF) ☐Transgender Male/female-to-male (FTM) ☐Genderqueer/neither exclusively male nor female ☐Other ☐Declined to Specify	
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify	**Race** ☐White ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Two or more races ☐Declined to Specify	

Legal Guardian Name: _____ Relationship: ☐Mother ☐Father ☐Agency: _____ ☐ Other _____
Street Address, City, State, ZIP_____
Mailing Address, City State, ZIP_____
Cell Phone #:_____ Office Phone # _____
E-mail _____

Parent/Caregiver Name: _____ Relationship: ☐Mother ☐Father ☐ Other _____
☐same as above
Street Address, City, State, ZIP_____
Mailing Address, City State, ZIP_____
Cell Phone #:_____ Office Phone # _____
E-mail _____

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

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

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

_____

Current Medications Name/Dosage: _____

Check services previously received or currently receiving and list 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 Tx/Youth Partial Hospital_____	☐	☐	CSCT _____
☐	☐	Youth Case Management_____	☐	☐	Acute Hospital/Residential (PRTF) _____

Check Services Requested

☐Mental Health Assessment	☐Youth Mentoring (CBPRS/FSA)	☐Therapeutic Group Home
☐Substance Use Assessment	☐Youth Case Management	☐Day Treatment
☐Substance Use Treatment	☐Therapeutic Foster Care	☐Parent Education/Home Support (HSS/FST)
☐Therapy	☐Medication Management	☐Supervised Visits

Other Needs: ☐Housing Assistance ☐Financial Assistance/Food Stamps ☐Medical ☐Dental ☐Other_____

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 ☐ Social Media ☐Website ☐Doctor ☐Other _____

_____ _____
Legal Guardian Signature / Date Legal Guardian Signature / Date