Kansas Department for Aging and Disability Services

UNIVERSAL PACKET

SERVICE ENTRY AUTHORIZATIONS

Client Name _____ Client ID# _____DOB _____

Initial when applicable	Authorization	Explanation
	Exceptions of Confidentiality	**By signing below and initialing, the client indicates his/her understanding that providers at this agency may communicate with supervisors or other staff within the Community Mental Health Center without a release of information to provide the client with quality services. In addition, information about the client can be shared if he/she threatens to harm self or someone else or as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.**
	Authorization to communicate with placement provider	**By signing below and initialing, the client indicates his/her understanding that staff from the Community Mental Health Center has consent to initiate communication for the purpose of coordinating and scheduling timely mental health services with the client's placement provider.**
	Authorization to assign payment and release information	**By signing below and initialing, the client consents to treatment and agrees to assign payment directly to the CMHC for the benefits otherwise payable to client but not to exceed the balance due to of the CMHC's regular charges for this period of service. A photocopy of this authorization shall be considered as effective and valid as the original. The client also authorizes the release of information that pertains to the client's condition and the services delivered (including any treatment for alcohol or drug abuse) as necessary in processing health insurance and/or Title XIX claims. This consent shall be valid for the period of time required to allow complete processing of the client's claims for reimbursement. The consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.**
	Sharing pharmacy and lab information	**If medications should be prescribed or laboratory tests required as part of my treatment, I hereby give consent to release my name to the pharmacy or indigent program so that I may obtain medications and to assist in filling and managing prescriptions for me. The client also gives consent to release information for the purpose of obtaining laboratory results that are needed as part of the client's treatment.**

TO BE COMPLETED AT FIRST FACE TO FACE MEETING WITH THERAPIST

	Disclosure of licensure information	**By signing below and initialing, the client indicates that the licensure of the provider has been disclosed to the client as follows _____. Individuals with these qualifications are not authorized to practice medicine or prescribe drugs. This agency does employ staff credentialed to prescribe medications and the client may request a referral for that service.**

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Legal Custodian Signature _____ Date _____

Consent for Mental Health Treatment
for Child/Youth in Foster Care or Juvenile Justice System

By signing below, you are authorizing the designated Community Mental Health Center (CMHC) to provide the minor child named below with mental health and/or substance abuse services, which may include individual counseling, group therapy, psychiatric evaluation, medication services (including prescribing medications), and/or other related services. These services will be provided by the CMHC in accordance with appropriate state and federal laws.

By signing below, you agree that you are the legal guardian of the child listed below and that you authorize the CMHC to provide mental health and/or substance abuse services. Those services may include individual counseling, group therapy, psychiatric evaluation, medication services, and/or other related services. These services will be provided in accordance with the appropriate state and federal laws. You understand that this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. By signing below, you are granting permission for your child to participate in activities/programs, including transportation to and from these activities. You understand that this may involve transportation to locations external to the agency, by staff, representatives and/or volunteers.

By signing below, you confirm that you have received a copy of your rights as a client and have received an explanation of these rights if you have requested one.

By signing below, you agree that you have been offered a copy of The Notice of Privacy Practices.

I, _____ (Print Name of Guardian or Legally Authorized Agency Representative) do hereby consent for _____(Print Name of Child/Youth) to receive mental health services as listed above) at _____ (Print Name of CMHC).

Name of Child/Youth: _____ Date of Birth: _____/___/_____
Child/Youth's Social Security Number: _____
Name of Parent/Relative, Guardian or Foster Parent in whose home this child/youth will be residing:
_____
Phone Number for Parent/Relative, Guardian or Foster Parent: _____

Street Address where child/youth will be residing while in treatment: _____

City, State, Zip code: _____

Name of Guardian and/or Legally Authorized Agency Representative responsible for child/youth:

_____

Phone Number for Guardian and/or Legally Authorized Agency Representative Office Number_____

Cell Phone Number: _____ Agency Name: _____

Signature of Guardian or Legally Authorized Agency Representative: _____

Date: _____

Signature of Witness: _____ Date: _____

Signature of Child/Youth: _____ Date: _____

(Age 13 or older for Mental Health Treatment and 14 or older for Substance Abuse Treatment)

PLACEMENT PROVIDER

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: _____ Date of Birth: ____/____/____ Age: _____
Social Security Number: _____ Medicaid ID: _____ MCO: _____
Or Third Party Insurance: _____

I _____, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: _____ Telephone Number: _____
Address of Office: _____ Fax Number: _____
City, State, Zip: _____ Email Address: _____

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: _____Provider Name of Applicable: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Fax Number: _____ Email Address: _____

☐	Entry/ Admission Report	☐	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
☐	Admission Evaluation Plan	☐	Discharge Summary/Report
☐	Case Plan/Treatment Plan	☐	HIV Testing, HIV Status, AIDS, TB or Hepatitis
☐	Diagnosis/Prognosis	☐	Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
☐	Psychological Evaluation Report & Recommendations	☐	Educational and/or Special Education Reports
☐	Psychiatric Evaluation Report	☐	Verbal Communication
☐	Case Consultations	☐	Other
☐	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)_____

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _____
NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: _____ Date: _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Person Authorized to Sign: _____

Relationship to Child/Youth: _____
Address and Phone Number: _____

C. Signature of Witness: _____ Date: _____

* NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment Information, and HIV/AIDS (or other communicable disease) Information.

PRIMARY HEALTH PROVIDER

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: _____ Date of Birth: ____/____/____ Age: _____
Social Security Number: _____ Medicaid ID: _____ MCO: _____
Or Third Party Insurance: _____

I _____, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: _____ Telephone Number: _____
Address of Office: _____ Fax Number: _____
City, State, Zip: _____ Email Address: _____

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: _____Provider Name of Applicable: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Fax Number: _____ Email Address: _____

☐	Entry/ Admission Report	☐	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
☐	Admission Evaluation Plan	☐	Discharge Summary/Report
☐	Case Plan/Treatment Plan	☐	HIV Testing, HIV Status, AIDS, TB or Hepatitis
☐	Diagnosis/Prognosis	☐	Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
☐	Psychological Evaluation Report & Recommendations	☐	Educational and/or Special Education Reports
☐	Psychiatric Evaluation Report	☐	Verbal Communication
☐	Case Consultations	☐	Other
☐	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)_____

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _____
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B. Signature of either party is acceptable:

Signature of Patient: _____ Date: _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Person Authorized to Sign: _____

Relationship to Child/Youth: _____
Address and Phone Number: _____

C. Signature of Witness: _____ Date: _____

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SCHOOL

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: _____ Date of Birth: ____/____/____ Age: _____
Social Security Number: _____ Medicaid ID: _____ MCO: _____
Or Third Party Insurance: _____

I _____, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: _____ Telephone Number: _____
Address of Office: _____ Fax Number: _____
City, State, Zip: _____ Email Address: _____

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: _____Provider Name of Applicable: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Fax Number: _____ Email Address: _____

☐	Entry/ Admission Report	☐	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
☐	Admission Evaluation Plan	☐	Discharge Summary/Report
☐	Case Plan/Treatment Plan	☐	HIV Testing, HIV Status, AIDS, TB or Hepatitis
☐	Diagnosis/Prognosis	☐	Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
☐	Psychological Evaluation Report & Recommendations	☐	Educational and/or Special Education Reports
☐	Psychiatric Evaluation Report	☐	Verbal Communication
☐	Case Consultations	☐	Other
☐	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)_____

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _____
NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

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B. Signature of either party is acceptable:

Signature of Patient: _____ Date: _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Person Authorized to Sign: _____

Relationship to Child/Youth: _____
Address and Phone Number: _____

C. Signature of Witness: _____ Date: _____

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FOSTER CARE CONTRACTOR

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: _____ Date of Birth: ____/____/____ Age: _____
Social Security Number: _____ Medicaid ID: _____ MCO: _____
Or Third Party Insurance: _____

I _____, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: _____ Telephone Number: _____
Address of Office: _____ Fax Number: _____
City, State, Zip: _____ Email Address: _____

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: _____Provider Name of Applicable: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Fax Number: _____ Email Address: _____

☐	Entry/ Admission Report	☐	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
☐	Admission Evaluation Plan	☐	Discharge Summary/Report
☐	Case Plan/Treatment Plan	☐	HIV Testing, HIV Status, AIDS, TB or Hepatitis
☐	Diagnosis/Prognosis	☐	Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
☐	Psychological Evaluation Report & Recommendations	☐	Educational and/or Special Education Reports
☐	Psychiatric Evaluation Report	☐	Verbal Communication
☐	Case Consultations	☐	Other
☐	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)_____

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _____
NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: _____ Date: _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Person Authorized to Sign: _____

Relationship to Child/Youth: _____
Address and Phone Number: _____

C. Signature of Witness: _____ Date: _____

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's Full Name: _____ **Date of Birth:** ____/____/____ Age: _____

Social Security Number: _____ **Medicaid ID:** _____ **MCO:** Choose...

ThirdParty Ins: _____

I _____ hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: _____ Telephone Number: _____

Address of Office: _____ Fax Number: _____

City, State, Zip: _____ E-mail Address: _____

☐ **To Disclose To AND/OR** ☐ **To Obtain From**

Name of Agency: _____ Provider Name if Applicable: _____

Address: _____ City, State, Zip: _____

Telephone Number: _____ Fax Number: _____ E-mail Address: _____

☐	Entry/ Admission Report	☐	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
☐	Admission Evaluation Plan	☐	Discharge Summary/Report
☐	Case Plan/Treatment Plan	☐	HIV Testing, HIV Status, AIDS, TB or Hepatitis
☐	Diagnosis/Prognosis	☐	Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
☐	Psychological Evaluation Report & Recommendations	☐	Educational and/or Special Education Reports
☐	Psychiatric Evaluation Report	☐	Verbal Communication
☐	Case Consultations	☐	Other
☐	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here: _____

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify) _____

*I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year. _____

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B. Signature of either party is acceptable:

Signature of Patient _____ Date _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian _____ Date _____

Printed Name of Person Authorized to Sign _____

Relationship to Child/Youth _____

Address and Phone # _____

C. Signature of Witness _____ Date _____

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Foster Care or Juvenile Justice Mental Health Referral

Original: ☐ Yes ☐ No Date: _____

Update: ☐ Yes ☐ No Date: _____

Child/Youth Name: _____Date of Birth: _____/_____/_____

Alias Name (Birth Name if Adopted): _____

Placement Provider Name: _____Phone:_____

Address (where residing): _____Phone: _____

City, State, Zip: _____Social Security #: _____

County of Court Jurisdiction: _____

Name of Child Welfare or KDOC-JS Management Provider Designee legally authorized to consent for treatment: _____

Role: _____

Address, City and State: _____

Work Phone: _____ Cell Phone: _____

Sex	Race	Ethnicity	Eligibility for SSI or SSDI
☐ Male	☐ American Indian or Alaska Native	☐ Hispanic or Latino	☐ Not applicable
☐ Female	☐ Asian	☐ Not Hispanic or Latino	☐ Eligible and Receiving Payment
	☐ Black or African American		☐ Eligible but not Receiving Payment
	☐ Native Hawaiian or other Pacific Islander		☐ Potentially Eligible
	☐ White		☐ Determined to be Ineligible by Review & Decision
	☐ Other		☐ Determination Decision on Appeal

Education

Name of School:_____ **Present Grade:_____**

Special Education Services: ☐ Yes ☐ No

Most grades are currently: ☐ A ☐ B ☐ C ☐ D ☐ F

INSURANCE INFORMATION

Primary Insurance Company Name: _____(Includes Medicaid/Medicare)

ID#: _____Subscriber: _____DOB:_____

Subscriber SSN: _____ Subscriber Employer:_____

Secondary Insurance Company Name: _____(Includes Medicaid/Medicare)

ID#: _____Subscriber: _____DOB:_____

Subscriber SSN: _____ Subscriber Employer:_____

Tertiary Insurance Company Name: _____(Includes Medicaid/Medicare)

ID#: _____Subscriber: _____DOB:_____

Subscriber SSN: _____ Subscriber Employer:_____

CUSTODY STATUS

(Please select the current residential setting by placing an "X" before the selection)

☐	**1**	Child in KDOC-JS custody and lives at home	☐	**5**	Child is under DCF supervision, but not in their custody
☐	**2**	Child in KDOC-JS custody and out of home placement	☐	**6**	Child is under supervision of KDOC-JS, but not in their custody
☐	**3**	Child is in DCF custody and lives at home	☐	**7**	No KDOC-JS or DCF involvement
☐	**4**	Child is in DCF custody and out of home placement			

EDUCATIONAL PLACEMENT

(Please select the current educational placement by placing an "X" before the selection)

☐	**1**	Not applicable (not listed below)	☐	**13**	Not in school (GED)
☐	**2**	Institutional instruction: e.g. psych. Hospital, detention	☐	**14**	Not in school (expelled)
☐	**3**	Residential School	☐	**15**	Not in school (drop-out)
☐	**4**	Home-based instruction from school district	☐	**16**	Preschool
☐	**6**	Special Ed Classroom	☐	**17**	Other
☐	**7**	Regular classroom with Special Ed. Services or Consultation	☐	**18**	Alternative Education placement with Intensive Psychosocial
☐	**9**	Regular classroom (100% of the day, no Special Ed.)	☐	**19**	Not in school-Summer Break
☐	**10**	Home Schooling not provided by the school district	☐	**20**	Therapeutic Services in Preschool Children
☐	**11**	Not in school (suspended)	☐	**21**	Enrolled in Post Secondary Education (Technical School, College, Professional Development such as Cosmetology)
☐	**12**	Not in school (graduated)			

Are there currently any particular educational concerns? _____

_____

_____

RESIDENTIAL SETTING

(Please select the current educational placement by placing an "X" before the selection)

☐	**1**	Jail/Detention	☐	**8**	Emergency Shelter
☐	**2**	State Hospital	☐	**9**	Therapeutic Foster Care
☐	**3**	Inpatient Psychiatric Unit	☐	**10**	Foster Home
☐	**4**	Crisis Resolution/Stabilization Unit	☐	**11**	Temporarily living with a relative or family friend
☐	**5**	Drug/Alcohol Treatment Center	☐	**12**	Home of parent(s); Biological, Adoptive, or Legal
☐	**6**	Residential Treatment (PRTF)	☐	**13**	Independent Living
☐	**7**	Group Home (YRC)	☐	**14**	Homeless

JUVENILE JUSTICE & LAW ENFORCEMENT

(Please report the number of each category based on the previous 30 days)

	Total number of arrests		# of adjudicated misdemeanors
	# of adjudicated felonies for property crimes		# of law enforcement contacts (face-to-face contact not resulting in arrest)
	# of adjudicated felonies for crimes against persons		# of adjudicated felonies not property or persons
		☐	Not applicable

Does the child/youth have any pending or current charges? If yes, explain: _____

_____

_____

Does the child/youth have a No Run Order? ☐ Yes ☐ No ☐ Unknown

Recent History of Present Situation

Please describe the problems you are concerned about regarding this child/youth:

_____

_____

_____

What mental health symptoms or behaviors is the child/youth currently demonstrating?

_____

_____

_____

_____

_____

How long have you been concerned about this child/youth? _____

Family history of mental illness? □ Yes □ No □ Unknown (e.g. depression, schizophrenia, etc)

If yes, explain: _____

Family history of substance abuse? □ Yes □ No □ Unknown

If yes, explain: _____

History of family suicidal, homicidal, or self-injurious behavior? □ Yes □ No □ Unknown

If yes, explain: _____

History of child/youth suicidal, homicidal, or self-injurious behaviors? □ Yes □ No □ Unknown

If yes, explain: _____

Has this child/youth ever been sexually abused? □ Yes □ No □ Unknown

If yes, by whom? What is the relationship to the perpetrator? _____

_____

_____

Has this child/youth ever been physically abused? □ Yes □ No □ Unknown

If yes, by whom? What is the relationship to the perpetrator? _____

_____

_____

Has this child/youth ever been neglected? □ Yes □ No □ Unknown

If yes, explain: _____

Is there a history of child/youth trauma? □ Yes □ No □ Unknown

If yes, explain: _____

_____

_____

Please list all members of the family-of-origin and give related information

Name	Relationship to Child/Youth	Legal Guardian	Age	Residence
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		

Who is child/youth closest to in his/her family? ____

What do you consider to be this child/youth's strengths? ___________________________________

Please describe mother's health during pregnancy with this child/youth:________________________

Any pregnancy problems? □ Yes □ No □ Unknown

If yes, explain: ____

Were there any health problems during infancy or early childhood? □ Yes □ No □ Unknown

If yes, explain: ____

Are there any developmental issues? (walking, talking, potty training, etc.) □ Yes □ No □ Unknown

If yes, explain: ____

Does the child/youth have any I/DD issues? □ Yes □ No □ Unknown

If yes:

Is the child on the I/DD Wait list? □ Yes □ No □ Unknown
If so, what CDDO are they connected to? _____
Is the child on the I/DD Waiver? □ Yes □ No □ Unknown
If so, Please sign a ROI for the I/DD case manager
Is the child on the Autism Waiver? □ Yes □ No □ Unknown
If so, Please sign a ROI for that Autism provider

Medical Information

Is this child/youth currently experiencing any illness or physical complaints? □ Yes □ No □ Unknown
If yes, explain: _____
Please list all prescription medications this child/youth is **currently** taking and dosage:
_____
_____
Name of Physician who prescribed these: _____
Please list all prescription medications this child/youth has taken in the **past six months:**
_____
_____
Please list all current over-the-counter medications or herbal preparations this child/youth is taking (kind and quantity): _____
_____
What medications has this child/youth **previously** taken for psychiatric conditions?
_____

Please list all drug allergies and adverse reactions this child/youth has had to medications:

Name of Drug: Type of Adverse Reactions:

_____ _____
_____ _____
_____ _____
_____ _____
Please list all other non-medication allergies: _____

_____

Please list all PREVIOUS mental health and/or substance use disorder treatment this child/youth has received:

Facility	**Location Type of Care (Inpatient, Outpatient, Substance Use)**	**Month and Year**
_____		From _____ to _____
_____		From _____ to _____
_____		From _____ to _____

Please list prior and present mental health diagnoses: _____
_____

Is the child/youth on the SED Waiver? If so, through which Community Mental Health Center? _____
_____

Recommendations based on the initial assessment will be made by the QMHP. Services necessary to meet the needs of the client may include:

- Case Management
- Home Based Family Therapy
- Psychosocial Group
- Attendant Care
- Individual Therapy
- Psychiatric-Medication Services
- Parent Support
- SED Waiver-Parent Support
- Family Therapy

Have you or others ever been concerned about this child/youth's drinking or drug use? □ Yes □ No
If yes, explain: _____
_____

Why is this child/youth in custody? _____

Number of Foster Care placements since the child/youth entered DCF custody:_____

How long in the current placement? _____

In an emergency, who can we notify? Name: _____ Relationship: _____

Street Address: _____ Home Phone: _____

City: _____State: _____Zip:_____ Business Phone: _____

Form Completed by: _____ Date: _____

Consent to Photograph

I am the Legal Guardian / Custodial parent of (please print) _____.
I hereby give my permission for him / her to be photographed solely for identification purposes.

_____ _____
Legally Authorized Agency Representative Signature **Date**

For Office Use Only:
Reviewed By: _____ Initials for Additions: _____ Date: _____