YOUTH SERVICES APPLICATION

Date of Application:_____ Referring Agency/Level of Care:_____

Referring Staff/CM:_____ Supervisor: _____

Staff/CM's email address:_____ Staff/CM's phone:_____

CaLOCUS ID:_____

Referred Level of Care: ☐Res Level 1 ☐SIPP ☐CAT

Applicant Demographic Information		
Name:	DOB:	Gender
Current Address:		
Phone:	Other Contact Info:	SS#:
Guardian's Name:		
Relationship to Youth:	Phone:	

Diagnosis (please list all- DSM V): _____

Prescribed Medication: _____

_____

Current Legal Status: ☐None ☐DJJ Involvement ☐Child Welfare Involved

Assigned Judge:_____ Next court date:_____

Current living arrangements: ☐Parents ☐Foster Care ☐Family/Friend ☐ Group home

☐Department of Juvenile Justice ☐Independent housing

☐ Residential Program _____ ☐ Other Relative _____

Applicant language preference: ☐English ☐Spanish ☐Creole ☐Other:_____

Previous Treatment: _____

_____

Income: ☐None ☐SSI ☐Employed ☐Other Amount: _____

Insurance: ☐None ☐Medicaid #: _____

Please email this form, a copy of the Eligibility Verification print out, and the signed Confidentiality Release to Carisk Behavioral Health at advocacy.bbhc@concordiabh.com in Broward or fax to (786) 533-2618 for initial authorization.

_____

Referring Staff Signature Print name Date