Request for Services - Child

TODAY'S DATE: _____

OFFICE USE ONLY

CLIENT NAME: _____ CHART NUMBER: _____

FORM COMPLETED BY: _____ **RELATION TO CHILD**: _____

CHILD'S LEGAL NAME: _____ **SEX:** ☐ FEMALE ☐ MALE

LAST **FIRST** **MIDDLE NAME**

CHILD'S DATE OF BIRTH: _____ **AGE:** _____ **SOCIAL SECURITY NUMBER:** _____

ADDRESS (CITY / STATE / ZIP): _____

Family Information

PARENT/LEGAL GUARDIAN NAME: _____ **PHONE**: _____

ADDRESS (CITY / STATE / ZIP): _____ **EMAIL:** _____

(☐ Same Address listed for child)

RELATIONSHIP TO CHILD: ☐ Biological mother ☐ Biological father ☐ Step-parent ☐ Legal Guardian ☐ Other: _____

With whom does the child live? ☐ Birth Parent(s) ☐ Adoptive Parents ☐ Foster Parents ☐ Legal Guardian ☐ Other _____

Who has Legal custody of this child? _____

If child lives with anyone other than birth parents or parents are divorced, documentation of legal custody is required prior to or at the time of intake. **Is DHS or OJA currently involved with your child?** ☐ Yes ☐ No

EMERGENCY CONTACT NAME: _____ **PHONE**: _____

RELATIONSHIP TO CHILD: ☐ Biological mother ☐ Biological father ☐ Step-parent ☐ Legal Guardian ☐ Other: _____

Has a member of your family served in the military? ☐ Yes ☐ No

Reason for Seeking Services

PLEASE DESCRIBE PROBLEMS OR CONCERNS RELATED TO SEEKING MENTAL HEALTH SERVICES FOR THIS CHILD:

_____

_____

ARE YOU CONCERNED FOR THIS CHILD'S SAFETY (statements or suspicion of harm to self or others)? ☐ Yes ☐ No

IF YES, DESCRIBE: _____

WAS THIS CHILD EVER ADMITTED INTO AN INPATIENT OR CRISIS UNIT FACILITY? ☐ Yes ☐ No

IF YES, WHEN AND WHERE: _____

WHO REFERRED THE CHILD TO RED ROCK SERVICES?

_____

SERVICES INTERESTED IN FOR CHILD (please check all that apply):

☐ Therapy/Counseling ☐ Systems of Care (SOC)/Wrap-around ☐ Case Management ☐ Medication Clinic ☐ IPIC

☐ I am not sure- I would like more information about services at Red Rock.

PLEASE COMPLETE ALL PAGES

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Household Information

ANNUAL HOUSEHOLD INCOME: _____ **NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD:** _____

Insurance Information

DOES THE CHILD RECEIVE SSI/SSDI BENEFITS? ☐ Yes ☐ No **DOES THE CHILD HAVE HEALTH INSURANCE?** ☐ Yes ☐ No

IF YES, PROVIDE THE NAME OF INSURANCE: _____ **ID NUMBER:** _____

Demographics

CHILD'S RACE (CHECK ALL THAT APPLY): ☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ BLACK / AFRICAN AMERICAN ☐ ASIAN

☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ WHITE/ CAUCASIAN

CHILD'S ETHNICITY: ☐ HISPANIC ORIGIN ☐ NOT OF HISPANIC ORIGIN **PREFERRED LANGUAGE:** ☐ ENGLISH ☐ OTHER(S) _____

Substance Use

DOES THE CHILD USE TOBACCO PRODUCTS? ☐ Yes ☐ No IF YES, HOW MANY PER DAY? _____

DOES THE CHILD USE ALCOHOL OR OTHER DRUGS? ☐ Yes ☐ No IF YES, WHAT SUBSTANCE? _____

AND HOW OFTEN? _____

Medications

DOES THE CHILD TAKE ANY MEDICATIONS? ☐ **Yes** ☐ No **IF YES, COMPLETE BELOW RELATED TO MEDICATIONS**

LIST MEDICATIONS CHILD IS CURRENTLY TAKING (INCLUDE AMOUNT/DOSAGE AND HOW OFTEN):

_____

_____

PRESCRIBER OF MEDICATIONS CHILD IS CURRENTLY TAKING: ☐ Primary Care Physician ☐ Psychiatrist ☐ Other: _____

PHYSICIAN NAME: _____ **AGENCY/CLINIC NAME:** _____

PHONE: _____ **ADDRESS:** _____

Outside Provider(s)

IS THIS CHILD CURRENTLY RECEIVING MENTAL HEALTH SERVICES OUTSIDE OF RED ROCK (e.g. therapy, medication, etc.)?

☐ Yes ☐ No **IF YES, PLEASE IDENTIFY: TYPE OF SERVICE** _____

AGENCY NAME: _____ **PROVIDER NAME:** _____

Education Information

CHILD'S CURRENT SCHOOL: _____ **GRADE LEVEL:** _____

LIST THE NUMBER OF DAYS WITHIN THE LAST 3 MONTHS THE CHILD HAS BEEN:

ABSENT FROM SCHOOL: _____ **SUSPENDED FROM SCHOOL:** _____ **SUSPENDED FROM DAYCARE:** _____

Additional school support (IEP, special education, etc.) _____

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I and/or my parent/guardian consent to have treatment at Red Rock Behavioral Health Services (RR). I authorize RR to use/disclose my health information to obtain payment for the services received. I understand that a bill may be sent to me and/or a third-party payer. I and/or my parent/guardian assign all insurance benefits for which I am eligible to RR. This agreement will remain in effect until revoked by me and/or my parent/guardian in writing, or when all third party claims are satisfied. I understand that I and/or my parent/guardian are financially responsible for all charges. I have read, or had this information read to me, and understand it.

_____ _____

Child's Signature if over age 16 **Date**

_____ _____

Parent/Guardian Signature (If applicable) **Date**