

HARDSHIP CONSIDERATION (Calendar Year 2017)

Instructions

To be completed by the Behavioral Health Provider. All "yes" answers must include a detailed explanation.

Personal Information

(Please Print)

CID #: _____

Consumer Name: _____
(First) (MI) (Last)

Address: _____ Ph. #: _____
(Street) (City) (State) (Zip)

Parent/Guardian or Representative (if applicable): _____

Address (if different from above): _____

Check type of service: Substance Use Services Gambling CARE CYF IMPACT MH Outpatient

YES NO Will **CARE** services exceed two or more units per month? Please indicate the number of units per month and the duration for which services will continue.

YES NO Will **CYF** services exceed eight or more units per month? Please indicate the number of units per month and the duration for which services will continue.

YES NO Is there an imminent risk of hospitalization, residential placement, or out of home placement? Is there potential for involvement/increased involvement with other systems (e.g., law enforcement, CPS, UJS, DOC)? Please explain.

YES NO Is there an emergency situation (e.g., suicidal, acutely psychotic, demonstrates potential relapse, or co-occurring disorder) that can be treated in a community setting? Please explain.

I hereby attest that this information is true and correct.

Signature (Behavioral Health Representative)

Date