HARDSHIP CONSIDERATION (Calendar Year 2021)

Personal Information *(Please Print)*

CID #: ____________________

Client Name: ____
(First) *(MI)* *(Last)*

Address: ____ Ph. #: ________________
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):____________________________________

Address (if different from above): ____________________________________

☐ **YES** ☐ **NO** Will the client be receiving **Substance Use Disorder Treatment Services**?
☐ **YES** ☐ **NO** Will the client be receiving **Gambling Services**?

Check type of SUD and/or gambling service: ☐ 0.5 Early Intervention ☐ 1.0 Outpatient
☐ 2.1 IOP ☐ 3.1 Residential ☐ 3.2 Detoxification ☐ 3.7 Inpatient ☐ Adult EBP ☐ MRT

Check type of MH service: ☐ CARE ☐ CYF ☐ IMPACT ☐ MH Outpatient (Non-SMI/Non-SED)

CYF or CARE: Indicate the number of units per month and the duration for which services will continue.

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Imminent Risk or Emergency:
☐ **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.

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

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I hereby attest that this information is true and correct.

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Signature (Behavioral Health Representative) Date