HARDSHIP CONSIDERATION (Calendar Year 2020)

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

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): _____

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

☐ **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 (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