Community Mental Health for Central Michigan

Youth Intervention Participation Form

Youth Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Insurance: ☐ **Yes** ☐ **No** **Insurance Name:** _____

Grade: _____ **Does the youth have an IEP?** ☐ **Yes** ☐ **No**

Race/Ethnicity: _____

Youth's Identified Gender: ☐ **Male** ☐ **Female** ☐ **Unspecified/Non-Binary** ☐ **Other:**_____

Is youth currently receiving mental health services? ☐ **Yes** ☐ **No** **If so, where?** _____

PARENT/GUARDIAN CONSENT – MUST be signed prior to referral being submitted

- I have been given a description of the Youth Intervention Program and have requested to participate in the program.
- I understand that I may be referred to other resources in the community for services.
- I authorize Community Mental Health for Central Michigan, YIS, to perform a screening to identify signs of mental/emotional disturbance, distress, substance abuse issues, and patterns of problem behavior.
- I understand this authorization will expire one year from the date of my signature below or upon termination of services.
- I authorize my child to be seen at school without my presence.

I authorize the Youth Intervention Specialist to exchange information to/from:

School Name: _____ **Other:** _____

I give permission for the YIS to contact me via ☐ **phone** ☐ **mail** ☐ **email** ☐ **text**

_____ _____ _____

Parent/Guardian Signature **Relationship to Youth** Date

_____ _____

Parent/Guardian Printed Name Parent/Guardian Email (optional)

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_____ _____

Youth Name Date