APPLICATION
Part I

INNER ROADS, INC.
Empowered by Nature

Thank you for your interest in the Inner Roads. Making this step on behalf of your family takes courage and love and is worthy of respect. Please complete all sections of the Application Part I. Your honest and thoughtful responses are appreciated.

Your application is entirely confidential. Please provide supporting documentation of any and all psychological evaluations, inpatient or outpatient discharge summaries, and any other mental health history documentation. Once we receive your Application Part I, we will call to schedule an intake interview for both you and your child. Please send your application electronically to info@InnerRoadsMT.org.

I look forward to talking with you soon. Please call with any questions.
Sincerely,

Brie Shulman, LCPC
Therapist at Inner Roads, Inc.
Brie.Shulman@innerroadsMT.org
(585) 330-0780

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FAMILY INFORMATION

Youth's Name (first, middle, last):_____
Date of Birth:_____ Gender: _____Social Security #:_____
Address:_____City, State, Zip: _____
Hair color:_____ Eye color:_____ Height:_____ Weight:_____
Shoe size:_____ Pant size: _____Shirt size: _____
Please attach a current photo to this application

Parent/Guardian's Name (Primary contact): _____
Relationship to youth (biological, adoptive, step-parent, etc):_____
Quality of youth's relationship to this person (good, fair, poor):_____
Mailing Address:_____City, State, Zip:_____
Home Phone:_____Work Phone:_____
Email:_____

Parent/Guardian's Name:_____
Relationship to youth (biological, adoptive, step-parent, etc):_____
(Quality of youth's relationship to this person (good, fair, poor):_____
Mailing Address:_____City, State, Zip:_____
Home Phone:_____Work Phone:_____
Email:_____

List all siblings of the youth: Name, Age, Current Residence, Biological/Adopted/Step, Quality of youth's relationship to sibling (good, fair, poor):_____
_____
_____

MARITAL STATUS
Are parents divorced/separated?_____ If yes, when?_____
Are either of the parents deceased? _____ If yes, when?_____
Who has legal custody of the child?_____
Who has physical custody of the child?_____
Who does the child live with?_____
Can the non-custodial parent have access to information about the child's treatment?
____YES ____ NO
Will the non-custodial parent be involved in the program?
____YES ____ NO

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EMERGENCY CONTACT INFORMATION: *(Other than parents)*
Name:_____ Relationship to youth:_____
Mailing Address:_____City, State, Zip:_____
Home Phone:_____Work Phone:_____
Email:_____

If legal custody belongs to one parent, please provide current custody agreement with this application.

FAMILY BACKGROUND
Birthplace of the youth (city, state):_____ Ethnicity of youth:_____
Is your son/daughter adopted? If yes, what age?_____
Religion of youth:_____
Religion of parent:_____
Does the applicant have any special needs related to religion, nationality, race, ethnic identity, or sexual orientation? _____
_____
Other cultural information you would like us to know:
_____
_____

FAMILY INCOME
If you are interested in applying for the sliding fee scale, please provide the following information:
Annual Income of household:_____Number of Dependents:_____
We may ask to verify your family's income with the most recent complete federal tax return (1040).

ACADEMIC AND SOCIAL HISTORY

What school does the youth currently attend?_____
Highest grade completed:_____Youth's current GPA:_____
Does the youth excel in any particular subjects?_____
Does the youth need assistance in any particular subjects?_____
List any academic difficulties or learning disabilities:
_____
_____
Has she/he received any special medical or educational accommodations for these difficulties?
If so, please describe: _____

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How does the youth typically spend free time?

_____

How does the youth relate to peers?

_____

How does the youth tend to deal with conflict?

_____

EMOTIONAL & BEHAVIORAL CONCERNS

Current behavioral concerns of the applicant.

Is your child currently diagnosed with, or being treated for, a psychological or mental health disorder? *If yes, please describe:*

_____

_____

Has the youth ever experienced or exhibited any of the following?

For all YES answers, please provide specific details, including dates. ***Please note*** *that saying YES does not disqualify your child from receiving our services, but informs of us of individualized treatment needs.*

Significant trauma or loss at any point in his or her life?

_____

_____

_____

Psychotic episode or hallucinations?

_____

Gang activity?

_____

Arson/fire setting?

_____

Eating disorders, large weight gains or losses?

_____

Suicidal discussion, threat or attempt?

_____

Self abuse/cutting/scratching?

_____

Assault/aggressive behavior? Has the youth ever been charged with any form of assault?

_____

Runaway? Sexual activity?

_____

Has the youth ever committed, been charged with, or convicted of a sexual offense?

_____

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Has the youth ever experienced or exhibited any of the following? *(continued)*

Physical, sexual, emotional abuse or neglect?

_____

Drug/alcohol/tobacco use?

_____

Expelled or withdrawn from school?.

_____

Cruelty towards animals?

_____

How does the youth express anger (At school, at home, etc.)?

_____

_____

Have there been any physical confrontations between parents and child, or child and siblings?

_____

_____

Does he/she exhibit low self-esteem or lack confidence? How so?

_____

_____

Is there a history of mental health issues and/or treatment in youth's family?
If so: who, what, and when.

_____

_____

_____

Is there a history of alcohol or drug abuse in youth's family? *If so: who, what, and when.*

_____

_____

What specific events precipitated enrollment to this program, and what are your major concerns? _____

_____

_____

Does the youth have a history of involvement with the juvenile justice system?_____
Offenses/present status/assigned probation officer: _____

_____

Next: **GOALS! Getting on the right track…**

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Turning the corner: YOUR GOALS AND OBJECTIVES

What are your child's strengths? _____
_____

What are your personal strengths?_____
_____

What are your goals for your son or daughter while in this program? _____
_____
_____

This intervention relies on the youth graduating into an environment that can sustain his or her positive change. With that in mind, what are your goals for yourself and your family?

_____
_____
_____

What types of support are you interested in receiving as the youth's guardian? Examples include: Free parenting workshops, in-home family therapy, individual counseling or medical support for yourself, couples counseling, grief counseling, readings and online resources, etc:

_____
_____

Thank you for your willingness and dedication to helping your child and family grow in a happier, healthier, and safer direction. The following requested information allows us to understand your child's emotional and physical needs by collaborating with previous providers to combine professional knowledge.

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TREATMENT HISTORY

Please list the most recent placement or intervention first. These may be therapeutic or non-therapeutic, including but not limited to: hospitalization, treatment program, school intervention program, foster home, and shelter. *Please include outpatient therapy.*

Placement name:____
Reason:____
Therapist/Psychiatrist/Psychologist:____
Dates of service/frequency of visits:____
Phone: ______________________Address:____
Reason for termination:____
Evaluations that were done:____

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Reason:____
Therapist/Psychiatrist/Psychologist:____
Dates of service/frequency of visits:____
Phone: ______________________Address:____
Reason for termination:____
Evaluations that were done:____

Please include evaluations and discharge summary from therapeutic placements with the application.

Next: **Medical History**

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CLIENT MEDICAL HISTORY

Please list any current or previous significant health problems affecting the applicant:
_____
_____
_____

Youth's current medications (please include dosage/frequency):
_____
_____
**Please note that you will need to supply refills to the program for continued medications prior to enrollment.*

Are there known side effects for this youth with any of the medications? Yes No
If yes, please explain the side effects:_____
_____

Please explain your son/daughter's history with regards to taking medications *(ie: resists, irregular, hordes, distributes, etc)*:_____

Has your child been placed on or taken off any medications in the last six months? __Yes __No
If yes, please explain types and circumstances:_____
_____

Physician's name:_____ Name of medical office:_____
Phone:_____ Address: _____
Date of last physical exam:_____
(A physical must be completed no more than 30 days prior to enrollment. The form used for the physical will be sent to you in Application Part II).

Youth's psychiatrist or medication prescriber, if different: _____
Phone:_____ Address: _____

Does the youth wear glasses or contacts? ____Yes ____No
If yes, please note that contacts are not appropriate for our outdoor program, and glasses will need to be ordered as necessary.

Has the youth ever been hospitalized or undergone surgery? ____Yes ____No
Reason:_____Date:_____

Has the youth ever broken a bone? ____Yes ____No
If yes, which ones:_____

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CLIENT MEDICAL HISTORY *(continued)*

Does the youth have dietary restrictions? ____Yes ____No
If yes, please identify and describe restrictions: _____

If the youth is female, please list any unusual difficulties associated with menstruation:
_____

Does the youth use an inhaler? ____Yes ____No
If yes, please describe when it is needed: _____

Is the applicant allergic to any of the following?
____Aspirin ____Bee or Wasp stings ____Iodine ____Penicillin ____Pets ____Penicillin
____Shellfish ____Sulfa
Please list other food or drugs the applicant is allergic to: _____
If yes to any of the above, what are the reactions? _____
Other allergies/reaction/treatments? (hives, hay fever, eczema, asthma, etc): _____
_____

Has the youth experienced any of the following? If so, at what age?
Bed wetting, age: _____ Nightmares, age:_____ Head banging, age: _____

Please list any strong fears the youth has experienced (darkness, thunder, death) and at what age: _____
_____
_____

Has the youth had any of the following illnesses, diseases or medical problems? If so, please provide details below.
_____Stuttering _____Polio _____Rheumatic Fever _____Scarlet Fever _____Scoliosis
_____Thyroid disease _____Tuberculosis _____Ulcers _____Whooping cough *(croup)*
_____Venereal diseases _____AIDS/HIV Positive _____Anemia *(low red blood cell count)*
_____Anorexia/bulimia _____Arthritis _____Back injury _____Bladder or kidney infection
_____Bone condition _____Chicken Pox _____Constipation or diarrhea
_____Convulsions or seizures _____Dermatitis, eczema _____Diabetes _____Epilepsy
_____Frequent colds/sore throats _____Frequent ear infections _____Headaches/migraines
_____Heart trouble _____Hepatitis _____High blood pressure _____Hyperactivity
_____Knee or ankle injury _____Mononucleosis _____Muscle weakness _____Obesity
_____Pneumonia _____ bronchitis _____Complications with pregnancy/childbirth
_____Sexually Transmitted Infections: *(herpes, gonorrhea, etc)*_____
Other, please specify: _____

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Please give important details about the illnesses or diseases selected above:_____
_____
_____
_____

Is your child up to date on all vaccinations? ___Yes ___No
**Please include records of immunization with this completed application. It is a requirement by Department of Health and Human Services that we have a copy on file.*
Has your child's health practitioner required Hep A or B series? ___Yes ___No
If yes, please provide documentation.

Are there medical problems that run in the family? If so, which ones: _____
_____
_____

INSURANCE INFORMATION

If you would like to us bill your insurance company for your son or daughter's treatment at Inner Roads, please provide the following information:
What is the youth's primary health insurance company? _____
Member ID_____ Group number:_____
Policy Holder Name_____ Date of Birth:_____SS#_____
Address:_____
Relationship of Policy Holder to child:_____

By choosing "Yes" and signing below, I am granting Inner Roads, Inc permission to bill the youth's insurance company for services provided through assessment and/or participation in this program: _____ Yes ____No

Further, I certify that the information I have provided in this application is true, complete and accurate to the best of my knowledge.

Name of person filling out application:_____
Relationship to youth:_____

Signed by (Parent/guardian):_____ Date: _____

Important: Please complete the Release of Information on the last page.

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RELEASE OF INFORMATION to Inner Roads, Inc

Youth's name:_____ Date of Birth:_____

I give Inner Roads, Inc permission to contact the following individuals or agencies for release of any academic, social, medical or psychological information and to exchange information with the individuals or agencies for the purpose of case planning, treatment, and discharge planning. Please list their name and phone number:

Youth therapist:_____
Family therapist:_____
Parent therapist:_____
School district:_____
School counselor:_____
CSCT therapist:_____
Mental health agency:_____
State agency (Children's Family Services):_____
Case manager:_____
Youth court probation officer: _____
Chemical dependency program:_____
Youth program:_____
Physician:_____

I understand the purpose of this release. The authorization will remain in effect until one year from the date below, and I understand that I may revoke my consent at any time.

Parent/Guardian signature:_____ Date: _____