Application for Adolescent Outpatient Treatment

Filling out the Application:
Please complete each section of this Application. Indicate "NA" or "Unknown" throughout as applicable. Complete application will be processed quicker. Incomplete applications will require follow-up phone calls from Eckert Staff. If you have any questions or need assistance regarding completing this inquiry, please contact Eckert Staff at 701-609-5305.

Submitting the Applications:
If you need help filling out this application, please contact Eckert Staff. This application and supporting documents may be submitted by email to outpatient@eckertyouth.com

- You are encouraged to follow-up via phone or email to confirm your information has been received and verify if any additional documents will be needed.
- You will receive a response acknowledging receipt of your inquiry within 24 hours.

Additional Documentation:

Items required for Admission:

- Completed Eligibility Application
- Necessary Releases of Information and Informed Consent
- Assessment to determine appropriate level of care
- Previous assessments and/or collateral information may be requested
- A signed Treatment, Payment, and Healthcare Operations (TPO) consent will be required prior to conducting an assessment or billing insurance.

If a referring agency is submitting this application, a valid Release of Information compliant with 42 CFR Part 2 must be included to allow discussion of substance use disorder information. If proper authorization is not included, Eckert may only communicate information permitted by applicable law until authorization is received. If available, please attach written documentation of applicant's integrated mental health and substance abuse intake, diagnosis, and recommendations from a qualified mental health professional from within the last year.

NOTE: **Minor Consent for Substance Use Disorder Information:**
In accordance with North Dakota law and 42 CFR Part 2, youth age 14 and older must sign a Release of Information for disclosure of their substance use disorder treatment records unless otherwise authorized by court order or applicable law. Legal custody status may impact who is authorized to sign. Supporting documentation may be required.

Consent:
Completion of this application authorizes Eckert Youth Homes Admissions Staff to review the submitted information for eligibility determination only. This application does not authorize treatment, billing, or disclosure of information to third parties. Separate Treatment, Payment, and Healthcare Operations (TPO) consent and/or Release of Information forms will be required prior to services being provided.

This application may contain information protected under federal confidentiality laws including HIPAA and 42 CFR Part 2. Federal law prohibits unauthorized redisclosure of information identifying an individual as having or having had a substance use disorder except as permitted by written consent or applicable law.

Referral Information		
Name of the person filling out this application:		
Agency:	Contact Phone Number:	Contact Email Address:
Relationship to the Youth or Self-Referral:		
Are you legally authorized to approve medical or treatment decisions for this youth? ☐ Yes ☐ No ☐ Not sure If yes, please explain your role (parent, legal guardian, CPS, DJS, court-appointed decision maker, etc.):		
Is the youth / guardians aware of this application?		
Signature:	Date:	

I hereby certify that the above statements are true and correct to the best of my knowledge.

Eligibility:

- Ages 14-17, males and females (Ages above or below this range will be looked at on a case by case basis)
- North Dakota resident
- Preference given to pregnant youth and youth with IV substance use
- Meets diagnostic criteria for a diagnosable mental health condition as outlined in the DSM
- Meets specifications in each of the ASAM dimensions required for the recommended level of care

START OF THE APPLICATION

Are you seeking services for	☐	Substance Use Disorder	☐ Mental Health	☐ Unsure

Section A: High Risk Screen

1. Pregnancy
Is the youth currently pregnant? ☐ Yes ☐ No
If yes, please explain current prenatal care and length of pregnancy:

2. IV Substance Use
Does the youth have a history of IV substance use? ☐ Yes ☐ No ☐ Unknown
If yes, please explain the type and frequency of IV substance use, and the last known date of use:

3. Substance Use
What substances is the youth using?
How often does the youth use?
How much does the youth use?
Has the youth ever overdosed? If so, how many times?

Section B: Demographic and Home Information

4. Demographics		
Youth name:		Gender ☐ Male ☐ Female ☐ Transgender
Date of Birth:	Age:	Social Security Number:
Youth's Phone Number (if available):		Youth's email address (if available):
School Youth Attends:		Grade Youth is in:

Mother's Name:	Mother's phone number:
Mother's Address	Mother's email:
Father's Name:	Father's phone number:
Father's Address:	Father's email:
Other Guardian/ Family Name and Relationship:	Phone Number:
Address:	Email:

3. Home Residence			
Current Residence Address or Other Placement Address and Information (If currently in a difference setting)			
Address:	City:	State:	ZIP code:
Describe home environment who the youth lives with:			

Applicant's Other Placement Address and Information (If currently in a different setting):			
Agency or foster home name:	Telephone Number:	Fax:	
Address:	City:	State:	Zip:
Agency of Foster home Contact Person and Information:			

Section C: Referral Information

4. Referral Narrative
Description of reason for referral:
What services has the youth received in the past year?

Section D: Medical History

5. Medical History			
Are there any known current or past Medical Problems?	☐ Yes	☐ No	☐ Unknown
If yes, please explain: Does the youth have any disabilities?	☐ Yes	☐ No	☐ Unknown
If yes, please explain:			
Is the youth currently on any Medications?	☐ Yes	☐ No	☐ Unknown
If yes, please provide drug name, length of use, dosage and purpose:			

Section D: Billing Information

6. Coverage Type
What type of health coverage does the youth have? ☐ Medicaid ☐ BCBS ☐ Sanford ☐ Other Insurance ☐ No Coverage
Other Comments:

Coverage Information
Primary Insurance

Third Party Insurance Company Name:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Name of Policy Holder and Relationship to Youth:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Policy Number			

Secondary Insurance

Third Party Insurance Company Name:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Name of Policy Holder and Relationship to Youth:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Policy Number:			

Submission of this application does not guarantee admission or coverage of services.

END OF APPLICATION