APPLICATION

INNER ROADS

@Families First, Inc

455 E Main St., Missoula, MT 59802

Making this step on behalf of your family takes time, courage and love and is worthy of respect. Please don't hesitate to contact us with questions to help you decide if our expeditions are the right fit your for child and family. *We also know that time, literacy skills, and technology access can be obstacles to getting this lengthy application to us.* Please contact us via phone or email, or visit us on the 2nd floor of the Missoula Public Library if we can be of assistance.

You can reach us by calling **(406) 721-7690** and asking to speak with the Inner Roads therapist or coordinator.

Your application is entirely confidential, and your honest and thoughtful responses are not only appreciated, but necessary for your child's safety. We may request supporting documentation of all psychological evaluations or treatment history, along with a release to speak to school administrators. We will call you with next steps once we receive your application.

Please send your application electronically to our Program Therapist at **Brie@FamiliesFirstMT.org**, or **fax it to (406)519-0633, attn: Inner Roads**

INNER ROADS
EMPOWERED BY NATURE

APPLICATION

FAMILY INFORMATION

Youth's Name (first, middle, last):____

Date of Birth:____________ Sex:_____ Pronouns:____ Social Security #:______________

Address:______________________________City, State, Zip: ________________________

Hair color:_________ Eye color:_________ Height:___________ Weight:________________

Shoe size:_________ Pant size: ________Shirt size: ___________________________________

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?____________

If separated, who has legal custody* of the child?_______________________

**Include custody agreement in application.*

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

INNER ROADS
EMPOWERED BY NATURE

APPLICATION

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 will 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/skills?_____________________________
Does the youth need assistance in any particular subjects/skills?____________________
List any academic difficulties or learning disabilities:
____
____
Has your child received any special medical or educational accommodations for these difficulties? If so, please describe:
____

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?

____

APPLICATION

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.)?

____

____

Describe 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…**

Turning the corner: YOUR GOALS AND OBJECTIVES

What are your child's strengths?____
____

What are your personal strengths? ____
____

What are your goals for your teen while in this program?
____
____

This intervention relies on the youth graduating into an environment that can sustain positive change that was gained through participation in our program. 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, individualized family therapy camping trips, professional 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.

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

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

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

Placement name:____
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**

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 the start of the expedition.*

Are there known side effects for this youth with any of the medications? If yes, please explain the side effects:____
____
Please explain your teen's history with regards to taking medications (*ie*: *resists, irregular, hordes, distributes*, *etc*):____

Has your teen been placed on or taken off any medications in the last three 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 the expedition. The form used for the physical will be sent to you upon enrollment, and youth may receive this service for free at CostCare in Missoula, MT once enrolled in our program).

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. Let us know if you need this cost covered.

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:____

CLIENT MEDICAL HISTORY (continued)

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

If the youth experiences menstruation, please list any unusual difficulties:
____

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 anything else your child 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 or medical conditions? If so, please provide details below.
_____Covid _____Concussion _____Stuttering ____Rheumatic Fever
_____Scarlet Fever _____Scoliosis _____Thyroid disease_____Tuberculosis _____Ulcers
_____Whooping cough (croup) _____Endometriosis or Cysts _____ Venereal diseases
_____AIDS/HIV Positive _____Anemia (low red blood cell count) _____Anorexia/bulimia
_____Arthritis _____ Back injury _____ Bladder/kidney infection _____Bone condition
_____Chicken Pox _____Constipation or diarrhea _____Convulsions or seizures
_____Dermatitis, eczema _____Diabetes _____Epilepsy _____Pregnancy
_____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: ____
Please give important details about the illnesses or conditions selected above:__________
____
____
____

Is your child up to date on all vaccinations? ___Yes ___No
**Please include records of immunization with this completed application.*

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 teen's therapy sessions provided by clinicians at Inner Roads, please provide the following information:
What is the youth's primary health insurance company? _________________________
Member ID________________________ Group number:_____________Expiration:____
Policy Holder Name_________________ Date of Birth:____________SS#____________
Address:____
Relationship of Policy Holder to child:_______________________________________

By choosing "Yes" and signing below, I am granting Families First, Inc permission to bill the youth's insurance company for professional counseling services provided by 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.

RELEASE OF INFORMATION to Inner Roads @ Families First

Youth's name:_________________________ Date of Birth:______________________

I give Inner Roads @ Families First 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/therapist:____
Mental health agency:____

State agency (Children's Family Services):______________________________________
Case manager:____
Youth court probation officer: ____
Chemical dependency program:____
Other:____
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 name:____

Parent/Guardian signature:________________________________ Date: ____________