

APPLICATION
Part I

INNER ROADS, INC.
Empowered by Nature

Thank you for your interest in 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.

(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: _____

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: _____

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**

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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?

Aspi 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.

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 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) _____

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Other, please specify: _____

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: _____