SD EForm - 1770 V6 Complete and use the button at the end to print for mailing. HELP

HARDSHIP CONSIDERATION (Calendar Year 2017)

Instructions
To be completed by the Behavioral Health Provider. All "yes" answers must include a detailed explanation.

Personal Information *(Please Print)*

CID #:

Consumer Name: _____
(First) *(MI)* *(Last)*

Address: _____ _____ _____ _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

Check type of service: ☐ Substance Use Services ☐ Gambling ☐ CARE ☐ CYF ☐ IMPACT ☐ MH Outpatient

☐ **YES** ☐ **NO** Will **CARE** services exceed two or more units per month? Please indicate the number of units per month and the duration for which services will continue.

☐ **YES** ☐ **NO** Will **CYF** services exceed eight or more units per month? Please indicate the number of units per month and the duration for which services will continue.

☐ **YES** ☐ **NO** Is there an imminent risk of hospitalization, residential placement, or out of home placement? Is there potential for involvement/increased involvement with other systems (e.g., law enforcement, CPS, UJS, DOC)? Please explain.

☐ **YES** ☐ **NO** Is there an emergency situation (e.g., suicidal, acutely psychotic, demonstrates potential relapse, or co-occurring disorder) that can be treated in a community setting? Please explain.

I hereby attest that this information is true and correct.

_____

Signature (Behavioral Health Representative) Date

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