UPPER BAY COUNSELING & SUPPORT SERVICES, INC.
626 Revolution Street
Havre de Grace, MD 21078
Phone: 410-939-8744
Fax: 410-939-8748

APPLICATION FOR SPECIALIZED TRANSITIONAL AGE YOUTH (TAY) SERVICES

Please complete this application and return with supporting documentation to:

Office on Mental Health/ Core Service Agency of Harford County
Attention: Jamie Miller jmiller@harfordmentalhealth.org
125 N. Main Street
Bel Air, Md 21014
Or fax to: 410-803-8732 Phone: 410-803-8726

Please submit supporting clinical documentation (i.e. psychiatric evaluation, psycho-social evaluation, progress notes, or discharge summary) with this application.

CONSENT OT RELEASE INFORMATION FOR SPECIALIZED TAY SERVICES

I give my consent to _____ to release and obtain information from_____ (CSA), regarding this application and other clinical and psycho-social history in order to assess my eligibility for TAY services in the community.
I understand that this information will not be released to any other party without my express written consent. I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.

Applicant's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____
(Recommended if applicant is under 18)

APPLICATION FOR SPECIALIZED TRANSITIONAL AGE YOUTH (TAY) SERVICES

DEMOGRAPHICS

Applicant's Name: _____
(First) (Middle) (Last)
Address: _____
With whom is applicant living? _____
Phone number: _____
Date of birth: ____/____/____ Social Security number: ____-____-_____
Gender (circle): Male/Female Race: _____
Primary Care Physician _____
Does the applicant have children ☐ Yes ☐ No Ages of children: _____

INCOME/ INSURANCE (If individual has private insurance or is uninsured, please list household's monthly income $_____). Please check all that apply.

☐ Medical Assistance #_____
☐ Primary Adult Care MCO_____
☐ Private insurance type_____
☐ Uninsured
☐ Applied for _____ on _____
(Date of application)
☐ MCHIP
☐ SSI
☐ SSDI
☐ Earned Income

REFERRAL SOURCE (referral may be contacted for additional clinical documentation)

Referral Source's Name: _____
Referral Source's Agency: _____
Referral Source's Contact Phone Number: _____
Referral Source's Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to applicant: _____
Phone Number: _____

CLINICAL INFORMATION

Diagnosis

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Diagnosed By: _____ Date of Diagnosis: _____

Impairments related to this disorder have resulted in at least two of the following (please check all that applies):

____Psychiatric Hospitalization
____Behaviors resulting in danger to self or others
____Residential Treatment Center Placement
____ Psychosis
____ Substance Abuse
____ Poor reality testing
____Aggressive Behavior
____ High levels of impulsivity, poor judgment, and/or inability to self protect in the community

Treatment

What PMHS services is applicant currently receiving? Please list type of service
(i.e. case management, PRP, OMHC, etc): _____
Provider name /contact number: _____

Has this individual been identified as a High Cost utilizer of PMHS services? ☐ Yes ☐ No

What substance abuse services is applicant currently receiving?
Please list type of service: _____
Provider name /contact number: _____

Has applicant been in a psychiatric hospital/ER? ☐ Yes ☐ No If yes, please list #: _____ Dates, locations, and length of stays: _____
_____
Has applicant been in an inpatient facility for substance abuse tx./ detox. ☐ Yes ☐ No
If yes, please list #: ____ Dates, locations, and length of stays: _____
_____

Has the applicant been prescribed psychotropic medications? ☐ Yes ☐ No
If yes, please list type, dosage, and frequency: _____
_____

Has applicant been in other out of home placements? ☐ Yes ☐ No # RTC stays _____
If yes, please indicate type and dates of placement:

- ☐ Foster Care/Treatment Foster Care _____
- ☐ Group Home _____
- ☐ Residential Treatment Center (RTC) _____
- ☐ Residential Substance Abuse Treatment Facility _____
- ☐ Juvenile Commitment Facility _____

Please list other agencies involved ☐ DSS ☐ DDA ☐ LEA ☐ DJS ☐ DORS

Education/ Employment:

Is applicant currently enrolled in school? ☐ Yes ☐ No
If yes, please provide name of school: _____
Highest grade completed _____
Has the applicant ever been in Special Education ☐ Yes ☐ No
Has the applicant ever been competitively employed? ☐ Yes ☐ No
Is the applicant currently competitively employed ? ☐ Yes ☐ No
If yes, please list name of employer : _____ Job title : _____
Hours worked per week : _____ Wage per hour : _____

Referral signature: _____ Date: _____

For Office Use Only:
CSA approves referral ☐ Yes ☐ No
If no, describe reason for denial:
_____

CSA signature: _____ Date: _____

09/10/11