

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](mailto: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.*

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**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