Youth and Parent/Guardian Acknowledgement Form

As parent/guardian/caregiver of _____, I/we acknowledge that I/we have read and fully understand the Children's Behavioral Health Service my/our child is being referred for. I/We understand the following about the service and agree to a referral being submitted on our behalf:

I/We understand that that HCT, RCS, Specialized RCS, MST, MST-PSB and FFT are services that will be coming to our home and that CRCF is an out of home treatment that my child would be admitted to. (check the service you are interested in):

☐ **Home and Community Treatment (HCT):** Average of 10 hours per week for youth age 0-21. Initial_____

☐ **Rehabilitative and Community Services (RCS):** Average of 17 hours per week for youth age 0-21. Initial_____

☐ **Specialized Rehabilitative and Community Services (Specialized RCS)**: Average 22 hours of work with the family a week. Initial____

☐ **Multisystemic Therapy (MST):** Average 10 hours per week for youth age 11-17. Initial_____

☐ **Multisystemic Therapy for Problem Sexual Behavior (MST-PSB):** Average 3 sessions per week for youth age 10-17. Initial_____

☐ **Functional Family Therapy (FFT):** Average 1-3 sessions per week for youth age 10-17. Initial_____

☐ **Children's Residential CARE FACILITY (CRCF):** Average admission is 3 to 6 months. Caregivers should plan to participate in weekly family therapy and regular visitation at the program and at home. Initial_____

I/We understand that this service is for my/our entire family to learn ways to support our child/youth. I/We agree to participate in this service with our child/youth. If youth is in foster care, foster parents agree to participate. Initials_____

I/We have reviewed the information sheet and understand the service I/we are requesting. Initials_____

I/We understand that if I/we are choosing to wait for a specific provider of the service my/our child is being referred for may increase the time it takes to obtain the service. Initials_____

I/We agree to keep my contact information updated with my/our case manager who will then make sure my/our information is updated with Kepro. If I/we do not have a case manager, I/we will notify Kepro by calling provider relations at 1-866-521-0027. Initials_____

I/We agree to let my/our case manager know if I/we no longer need/want this service to make sure other families who need the service can get it. If I/we do not have a case manager, I/we will notify Kepro by calling provider relations at 1-866-521-0027. Initials_____

_____ _____

Print Guardian Name Print Guardian Name

_____ _____

Guardian Signature Date Guardian Signature Date

_____ _____

Print Youth Name (as appropriate) Youth Signature (as appropriate) Date

*Keep a copy for your records