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| **Person Served Information** | |
| **Person Served Name:** | **Avatar ID Number:** |

Please select the appropriate section. One section MUST be completed**.**

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| **EMANCIPATED: (To be completed by staff)** This minor has been declared emancipated from his/her parent/guardian by the courts and has been issued an identification card by the Department of Motor Vehicles (Cal Fam Code 7120). A copy of the identification card must be filed with this form. |
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| **ACTIVE DUTY WITH ARMED FORCES: (To be completed by staff)** This minor must be currently serving in the US Armed Forces. A copy of his/her military ID must be filed with this form (Cal Fam Code 7002). |
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| **MARRIED: (To be completed by staff)** This minor is or has been married (Cal Fam Code 7002). A copy of the marriage certificate must be filed with this form. |
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| **REQUEST FOR SUD SERVICES: (To be completed by a professional person\*)** This minor is mature enough to participate in SUD treatment. I certify that **each** of the below **three** criteria are met and that **services will not be claimed to Medi-Cal (**Cal Fam Code 6929). Services provided to a minor who meet these criteria may NEVER be claimed to Medi-Cal; alternate funding must be available.   1. The minor is 12 years of age or older and mature enough to participate intelligently in the services provided. 2. The minor’s parent(s)/guardian(s):    * + Were contacted on by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      + Were not contacted because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. The minor’s parent(s)/guardians(s):    * + Are currently involved in the services provided      + Do not want or are unwilling to participate in the treatment or are not appropriate to participate in the services provided   NOTE: The minor WILL NOT be prescribed medications without his/her parent/guardian signing the *Consent for Treatment*.  Signature of professional person\* and licensure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \**Professional person is an LPHA* |