

CONSENT FOR MINOR

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

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

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).

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.

SELF SUFFICIENT: (To be completed by the client) This minor is self-sufficient as exhibited by being able to declare all of the following (Cal Fam Code 6922).

- I am 15 years of age or older, having been born on _____ (birthdate).
- I am living at the address given on admission for services which is apart from the home/residence of my parents or legal guardian.
- I am managing my own financial affairs indicated by the financial information provided by me on admission for services.
- I understand that I am financially responsible for the charges for my mental health services and I may not disaffirm this consent because I am a minor.

Signature of Client

Date

NEED FOR MENTAL HEALTH SERVICES: (To be completed by an Authorized Mental Health Discipline-AMHD). This minor is in need of mental health services. I certify that **each** of the following **four** requirements are met (Cal Fam Code 6924).

1. The client is 12 or older and mature enough to participate intelligently in the services provided.

2. The client meets one of the following:

- there is danger of serious physical or mental harm if participation is not permitted
- there is alleged incest or child abuse

3. The client's parent(s)/guardian(s):

- were contacted on _____ by _____
- were not contacted because _____

4. The client's parent(s)/guardians(s)

- are currently involved in the services provided
- do not want or are unwilling to participate in the treatment
- are not appropriate to participation in the services provided

Note: The client WILL NOT be prescribed psychiatric medications without his/her parent/guardian signing the *Consent for Services form*.

AMHD Signature and Discipline

Date

REQUEST FOR MENTAL HEALTH SERVICES: (To be completed by an Authorized Mental Health Discipline-AMHD). This minor is mature enough to participate in mental health treatment. I certify that **each** of the below **three** criteria are met and that **services will not be claimed to Medi-Cal** (Health & Safety Code 124260). **Services provided to a client who meets only these criteria may NEVER be claimed to Medi-Cal; alternate funding must be available.**

1. The client is 12 or older and mature enough to participate intelligently in the services provided.

2. The client's parent(s)/guardian(s):

- were contacted on _____ by _____
- were not contacted because _____

3. The client's parent(s)/guardians(s)

- are currently involved in the services provided
- do not want or are unwilling to participate in the treatment
- are not appropriate to participation in the services provided

Note: The client WILL NOT be prescribed psychiatric medications without his/her parent/guardian signing the *Consent for Services form*.

AMHD Signature and Discipline

Date

CONSENT FOR MINOR

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

REQUEST FOR SUBSTANCE USE SERVICES: This minor is mature enough to participate in substance use treatment. I certify that the following requirement is met (Cal. Fam Code 6929(b)).

1. The client is 12 or older and mature enough to participate intelligently in the services provided.

Signature and Discipline

Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

IBHIS#:

Agency: Didi Hirsch M.H.S.

Provider #: