

**Idaho Department of Juvenile Corrections  
Mental Health Program Application**

| Juvenile Information  |                                |  |
|-----------------------|--------------------------------|--|
| Name of Juvenile:     | County:                        | IJS or County ID Number:   |
| Date of Request       | Juvenile's Birth Date:         | Does Juvenile meet Rule 19:<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| Date of latest Arrest | Date of Screening Team Review: | Has the court ordered an assessment and treatment under 20-511A or 20-520(l): <input type="checkbox"/> YES <input type="checkbox"/> NO |

| Probation Information     |        |        |      |
|---------------------------|--------|--------|------|
| Probation Officer's Name: | Email: | Phone: | Fax: |
| Supervisor's Name:        | Email: | Phone: | Fax: |

| Diagnosis Information    |                    |
|--------------------------|--------------------|
| Mental Health Diagnosis: |                    |
| Diagnosing Practitioner: | Date of Diagnosis: |

| Screening Information                      |               |                                |
|--|---------------|--------------------------------|
| CAFAS or CANS Score:<br><i>Attach copy</i> | Completed by: | CAFAS or CANS Completion date: |
| YLS/CMI Score:<br><i>Attach copy</i>       | Completed by: | YLS/CMI Completion date:       |

| Requested Services                                  |                     |             |
|---|---------------------|-------------|
| <b>A. Evidence-Based Treatment (best practice):</b> |                     |             |
| Unit Cost:  | Total Units:        | Total Cost: |
| Requested Start Date:                               | Requested End Date: | Frequency:  |
| Provider: (attach provider certification)           |                     |             |
| <b>B. Evidence-Based Treatment (best practice):</b> |                     |             |
| Unit Cost:  | Total Units:        | Total Cost: |
| Requested Start Date:                               | Requested End Date: | Frequency:  |
| Provider: (attach provider certification)           |                     |             |



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### Mental Health Program Case Plan

|                   |         |                           |
|-------------------|---------|---------------------------|
| Name of Juvenile: | County: | IJOS or County ID Number: |
|-------------------|---------|---------------------------|

**Screening Team**

|         |  |
|---------|--|
| Member: | Role:<br>Parent                              |
| Member: | Role:<br>Probation Officer                   |
| Member: | Role:<br>Licensed Mental Health Professional |
| Member: | Role:  |
| Member: | Role:  |
| Member: | Role:  |

Overview – Please complete a brief background on the juvenile

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**Community Safety**

|                                 |  |
|---------------------------------|--|
| Goal:                           |  |
| Empirically Supported Approach: |  |
| Provider:                       |  |

**Family**

|                                 |  |
|---------------------------------|--|
| Goal:                           |  |
| Empirically Supported Approach: |  |
| Provider:                       |  |

**Education / Employment**

|                                 |  |
|---------------------------------|--|
| Goal:                           |  |
| Empirically Supported Approach: |  |
| Provider:                       |  |

**Peer Relations**

|                                 |  |
|---------------------------------|--|
| Goal:                           |  |
| Empirically Supported Approach: |  |
| Provider:                       |  |

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| Substance Use  |   |
|--|---|
| Goal:  |   |
| Empirically Supported Approach:                        |   |
| Provider:  |   |
| Leisure / Recreation                                   |   |
| Goal:  |   |
| Empirically Supported Approach:                        |   |
| Provider:  |   |
| Mental Health  |   |
| Goal:  |   |
| Empirically Supported Approach:                        |   |
| Provider:  |   |
| Long Term Mental Health Services                       |   |
| Provider:<br>(IDHW; Medicaid; Private Insurance, etc.) |   |
| Date of Application to Provider:                       |   |
| Contact Person from Provider                           | <i>Name / Address / Phone / Fax / Email</i> |
| Accountability to Victim (s)                           |   |
| Goal:  |   |
| Empirically Supported Approach:                        |   |
| Supervision:   |   |

*To ensure the mental health program fills gaps in comprehensive case plans, please complete each section of this case plan regardless of the funding source or provider. Plans that do not include information for each domain will not be approved.*

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**Provider Certification**

|                   |         |                           |
|-------------------|---------|---------------------------|
| Name of Juvenile: | County: | IJOS or County ID Number: |
|-------------------|---------|---------------------------|

|  |           |                     |
|--|-----------|---------------------|
| Evidence-Based Treatment(best practice):   |           |                     |
| Source(s) of Best Practice Endorsement: (ie. SAMHSA, OJJDP, etc.)  |           |                     |
| Protocol for Model Fidelity:   |           |                     |
| Start Date:  | End Date: | Frequency:          |
| Contact Person:  | Phone:    | Fax:                |
| Business Name and Address  |           | Tax ID or SS Number |
| Name of Chief Executive Officer:   |           |                     |
| Signature _____ Date: _____  |           |                     |
| <p><i>Signature certifies that treatment listed above will be provided with fidelity using the protocols noted for quality assurance and provider agrees to reviews by IDJC staff or contractors; and</i></p> <p><i>Certifies that the placement can be made on the requested start date and the length of the requested treatment is consistent with the project period in the application from the county; and</i></p> <p><i>Provider agrees to abide by all program guidelines and provide the referring probation department with monthly status reports on all juveniles placed through the program; and</i></p> <p><i>Provider understands that the service agreement is between the County and the provider and while IDJC will process payments to providers once reimbursement forms are received from the County, payments are based upon reports being current and IDJC can not pay late fees, interest, or other chargers not related to direct services for the identified juvenile including no-show appointments.</i></p> |           |                     |