IDAHO DEPARTMENT OF JUVENILE CORRECTIONS

# JUVENILE JUSTICE SUBSTANCE USE DISORDER

## Authorization Form

**Client's Legal Name:** _____

**Social Security Number:** _____

**Date of Birth:** _____

**Gender: Select**

**Street Address:** _____

**City, State, Zip:** _____

**Phone Number:** _____

**Release of Information Completed?** ☐ **Yes** ☐ **No**

**Parent/Guardian Name**: _____

**Type of Funding**

☐ JJ SUDS

☐ Medicaid #_____

Supervising County: _____

Supervising Tribe: _____

IJOS/CMS/Other #: _____

JPO Name: _____

JPO Phone: _____

AUTHORIZATION DATE Start: _____ End: _____

| TREATMENT SERVICE | PROVIDER | LOCATION | UNITS/DAYS APPROVED |
|---|---|---|---|
| Assessment | | | |
| Level I-Outpatient | | | |
| Level II-Intensive Outpatient | | | |
| Level III.5-Residential | | | |
| Case Management | | | |
| Child Care | | | |
| Drug Testing | | | |
| Life Skills | | | |
| Recovery Coaching | | | |
| Safe and Sober Housing | | | |
| Staffing | | | |
| Transitional Housing | | | |
| Transportation | | | |
| Other: | | | |

AUTHORIZING PARTY

| | |
|---|---|
| Print Name: | Phone: |
| Signature: | Date: |
| Comments: | |