THE TWELVE OF OHIO, INC.
619 TREMONT AVE. S.W.
MASSILLON, OHIO 44647
330-837-3555 888-513-8706

APPLICATION FOR SERVICES AND PERMISSION FOR TREATMENT

YOUTH NAME: _____ DOB: _____

SSN#: _____-_____-_____ CUSTODIAL AGENCY: _____

In making application for services and treatment for the above named youth, I hereby authorize The Twelve of Ohio, Inc. to provide such services as are necessary for the care and protection of the above named youth and to provide such evaluation and treatment.

Mental Health Assessment ☐ Group Counseling ☐
Counseling ☐ Community Psychiatric Support Treatment ☐

In the event of an emergency or a situation involving danger to self or others, the youth and all necessary information will be transported to the appropriate care setting, as deemed appropriate by The Twelve of Ohio, Inc.

I, the guardian of the youth, and the above named youth, have received an explanation of the benefits and risk of both authorizing and not authorizing treatment services and understand that I have the right to not authorize treatment services. I and the above named youth have been told the consequences of refusal of treatment and alternative approaches to treatment have been discussed.

This permission to treat may be revoked at any time upon signed notification of parent/legal guardian/custodian.

I, _____ , am the legal guardian/custodian for the above named youth. I have the legal authority to give consent for the provision of services and treatment by The Twelve of Ohio, Inc.

_____ _____
Youth Name Date

_____ _____
Legal Guardian / Custodian Date

_____ _____
The Twelve of Ohio, Inc. Representative Date

(Rev-6/16/2010)