

**CORA SERVICES STUDENT ASSISTANCE PROGRAM
REQUEST FOR BEHAVIORAL HEALTH NEEDS ASSESSMENT**

Date: _____

School Staff Comp Form: _____

School: _____

Relationship to student: _____

Student Information:

Name: _____

DOB: _____ Age: _____

Address: _____

Phone: cell: _____

home or work: _____

SS#: _____

Zip Code: _____

Grade: _____ Gender: Male ; Female

Insurance: _____

Race: Caucasian ; Black/African Amer ; Asian

ID/Policy #: _____

Amer Indian/Alaskan Native ; Hispanic

Native Hawaiian/Other Pacific Islander ; Unknown

Parent Information:

Parent/Mother's Name: _____

Parent/Father's Name: _____

Address: _____

Address: _____

Phone: (h) _____ (w) _____

Phone: (h) _____ (w) _____

(other) _____

(other) _____

Legally Responsible Adult: (If different from above)

Name: _____

Relationship: _____

Address: _____

Phone: (h) _____ (w) _____

(other) _____

Living Situation:

Student lives with: _____

Presenting Issues: D/A Involved/Suspected D/A Involvement – Family MH Other

Current Interventions In and Out of School: (Includes current MH or D/A treatment through any provider)

Mental Health Services: Mobile Therapy OP MH Services: _____

AOD Treatment Services: OP Tx IOP Other: _____

Other Related Services: _____

Current Meds: _____

Active Court Involvement: _____

IEP: _____



INFORMED CONSENT FOR BEHAVIORAL HEALTH ASSESSMENT @ SCHOOL

I hereby authorize the Student Assistance Program (SAP) assessor from **CORA Services, Inc.** to complete an assessment process for _____.
(Child's name)

This assessment has been recommended by the SAP team at _____ School in order to determine if any behavioral health barriers exist that may affect learning.

This process will include:

- ❖ A clinical interview with the student to determine possible behavioral, mental health and/or substance use issues.

This process may also include (with properly executed consents):

- ❖ An interview/consultation with the parent or guardian
- ❖ A review of school records
- ❖ A consultation with appropriate school personnel
- ❖ Follow up interviews with student

Student Signature: _____
Date: _____
Printed Name: _____

Witness: _____
Date: _____
Printed Name: _____

Authorized Signature: _____
Date: _____
Printed Name: _____
Relationship to Student: _____



RE: _____
DOB: _____

REQUEST FOR CONFIDENTIAL INFORMATION

I, _____ hereby authorize
(Name of client/person authorized to consent for client)

_____ School to release to CORA Services, Inc., the following
information:

- _____ School Attendance Records/Information
- _____ School Behavior Records/Information
- _____ Academic Achievement/Performance Records/Information
- _____

The above information is released for the following purposes only; any other use is forbidden:

- _____ Service Planning/Consultation/Implementation
- _____

I understand that this information will become part of the client's official CORA record. I understand that CORA will destroy all reports and records five years after termination of all services, leaving only a record that service was rendered, unless there is a legitimate reason to maintain these records for a longer period of time.

This consent will expire one year from the date of authorization listed below unless expressly revoked in writing by the client or person authorized to consent for the client.

AUTHORIZED SIGNATURE: _____ **DATE:** _____
Relationship to Client: _____

AUTHORIZED SIGNATURE: _____ **DATE:** _____
Relationship to Client: _____

WITNESS: _____ **DATE:** _____

Client was offered /received a copy of this form. _____