ILLINOIS DEPARTMENT OF Healthcare and Family Services

Mobile Crisis Response
Crisis Safety Plan Services Authorization

GENERAL INFORMATION				
Youth Name:	**RIN:**	**Date of Birth:**	**Gender:**	**Insurance Coverage:**
Home Address:	**City:**	**State:**	**Zip Code:**	**County:**

Guardianship Status:
☐ Own guardian ☐ Adoptive Parent
☐ Youth in Care ☐ Biological Parent
☐ Other court appointed ☐ Other: _____

Interpreter Services: ☐ N/A
☐ American Sign Language ☐ Spoken Language: _____
☐ TDD/TYY ☐ Other: _____

Parent/Guardian/Caregiver ☐ N/A
Name: _____ **Phone Number:** _____

Parent/Guardian/Caregiver ☐ N/A
Name: _____ **Phone Number:** _____

MEDICAL INFORMATION

Doctor/Primary Care Provider Name: _____ **Doctor/Primary Care Provider Phone Number:** _____

Medication(s): List all current medications below, including prescribed and over the counter medications.

Prescribing Physician: _____ **Prescribing Physician Phone Number:** _____

Medication Name	Dosage and Frequency	Side Effects

Allergies? ☐ Yes *(list below)* ☐ No ☐ Unknown

Clinical Summary, Including Functional Impairment:	Actionable IM-CAT Items:

DSM-5 Diagnosis:		ICD- 10 Diagnosis:		Preventive
Diagnostic Code	DSM-5 Name	Diagnostic Code	ICD-10 Name	
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐

TREATMENT NEEDS

Service Type / Mode / POS	Amount	Frequency	Duration	Agency and Staff Responsible
☐ Crisis Stabilization Services	_____	_____	_____	_____
☐ CI: Triage and Stabilization Site	_____	_____	_____	_____
☐ Other:				

Assessment Appointment Date: _____ **Next Service Date:** _____

Provider: **Provider:**

Signature

LPHA (print name) Signature Date

SAMPLE