# Mental Health Clearance and Authorization Instructions

**Dear Parent/Guardian/Applicant:**

If the youth/applicant has received counseling within the past 18 months, you are required to obtain a Mental Health Clearance from your mental health care provider. In addition, an Authorization to Disclose Information must be completed, signed, and uploaded to the Job ChalleNGe Student Portal. The Job ChalleNGe program needs the Authorization to Disclose Information before they can receive, share or discuss any Mental Health Information with your Provider. If the applicant is over 18, they may complete this Authorization otherwise both a parent/ guardian and the applicant must sign the Authorization.

Print out these forms, complete and sign the Authorization to Disclose Information and upload to your Job ChalleNGE Student Portal. Bring the blank Mental Health Clearance form to your mental health care provider. The mental health care provider should complete the Mental Health Clearance form and submit it directly to the Job ChalleNGe program. It is possible that the Mental Health Care Provider requires their own Authorization to Disclose Information. Please note, this is in addition to the Job ChalleNGe requirement and does not take the place of the Job ChalleNGe Authorization to Disclose Information form.

# Michigan Job ChalleNGe Academy
**2501 26th Street., BLDG 2900**
**Augusta, Michigan 49012**

## AUTHORIZATION TO DISCLOSE INFORMATION

_____ _____
Applicant's Name Date of Birth

I,_____, hereby authorize _____
(Parent/Guardian) (Name of Mental Health Provider/Organization)

_____to exchange/release the following
(Address)

information with Michigan Job ChalleNGe Program
(Name of Person /Organization)

2501 26th Street, Bldg 2900, Augusta, MI 49012
(Address) (State and Zip Code)

__X__Verbal Exchange of Information __X__ Send Information to __X__ Obtain Information From

## SPECIFIC INFORMATION TO BE DISCLOSED:

Time frame of records needed: **2021 - CURRENT**

_____School Record _____Mental Health Background _____Physician / Health Care Provider

_____Progress Notes/ Discharge Summary _____Medications _____Case Management Services

_____Hospital Records/ Lab Results _____Mental Health Therapist/Provider _____Legal

__X__Michigan Job ChalleNGe Program Mental Health Summary (attached)

**Any Information not to be released:**_____

**Reason for Disclosure: POSSIBLE ADMITTANCE TO MICHIGAN JOB CHALLENGE PROGRAM**

This Authorization will expire one year from date of client signature unless specified:_____. I understand that my records are protected by State and Federal Confidentiality Rules and cannot be disclosed without my written authorization unless release is required by other regulations. I also understand that I may revoke this authorization at any time in writing except to the extent that action has already been taken. I understand that medical information may include records, if any, on psychology, social work, and information about alcohol, drug abuse, HIV, AIDS, and ARC may be released as permitted by law. I understand that treatment, enrollment or eligibility for services will not be conditioned on signing this authorization. I understand there is a possibility the protected health information may be re-disclosed by the recipient of the information and no longer protected by Privacy Rules.

_____ _____
Applicant's Signature Date of Signature

_____ _____
Signature of Parent/Guardian/Legal Representative Date of Signature

**NOTE TO RECEIVING AGENCY:** This information has been disclosed to you from records protected by law. An individual receiving information made confidential shall disclose the information to others only to the extent consistent with the authorized purpose for which it was obtained. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

To be completed by parent/guardian and applicant, if under 18 years of age. 18 year old applicants may sign for themselves.

# MENTAL HEALTH CLEARANCE

***ATTN: Applicant – Take this form to your Mental Health Provider to complete.***

**Client:**

**Date of Services: Start:** **End:**

**Frequency of Visits: Daily:☐** **Weekly:☐** **Monthly:☐**

**Diagnosis: (DSM Code & Diagnosis)**

## Services Rendered:

☐Initial Evaluation
☐Family Psychotherapy
☐Anger Management
☐Individual Psychotherapy
☐Group Therapy
☐Substance Abuse Therapy

## Behavior:

☐Open
☐Defensive
☐Manipulative
☐Impulsive
☐Guarded
☐Oppositional
☐Impaired
☐Tearful
☐Withdrawn
☐Hostile
☐Threatening
☐Self-Harm

## Mood/Affect:

☐Flat
☐Anxious
☐Angry
☐Depressed
☐Fearful
☐Labile
☐Manic
☐Irritable
☐Incongruent

## Signs/Symptoms of Abuse:

☐Sexual ☐Physical ☐Psychological ☐Neglect

## Progress:

☐Exceptional
☐Steady
☐Good
☐Slow
☐Stable
☐Regressing

## Current Psychotropic Medication:

Med: _____ Med:_____ Med: _____
Dose:_____ Dose:_____ Dose:_____

Med:_____ Med:_____ Med:_____
Dose: _____ Dose: _____ Dose:_____

**Treatment Goals for Individual:**

**Additional Pertinent Information:**

**WITHIN THE 6 MONTHS, HAS PATIENT BEEN:**

**Hospitalized for mental health related issue(s):** ☐Yes ☐No

**Must submit discharge paperwork to be complete**

**Mental Health outpatient treatment:** ☐Yes ☐No

**Please explain**

**Residential Treatment Facility: Must provide** ☐Yes ☐No

**discharge paperwork to be complete**

**Self-harm:** ☐Yes ☐No

**Attempted Suicide:** ☐Yes ☐No

**Suicide Ideation:** ☐Yes ☐No

If yes, please check the ones that apply:

- ☐Preoccupation Suicidal Ideation
- ☐Previous Attempt(s)
- ☐Impulsiveness
- ☐Available Means
- ☐Hostile Intent
- ☐History of Violence
- ☐Ideation History
- ☐Current Ideation
- ☐Viable Plan
- ☐Settling of Affairs
- ☐Previous Intimidation
- ☐Current Intent

**For each box checked, please explain each one below:**

**Please note: This is not a therapeutic program. It is military-like, stressful, structured environment.**

**Do you feel that would be successful at MJCP?** ☐Yes ☐No
**Please explain,**

**Do you feel that** **should attend the MJCP?** ☐Yes ☐No
**Please explain,**

**Printed Name** **Organization** **Title**

**Phone Number** **Signature** **Date**

**Confidential Notice:** This document is confidential and contains client information and property of the Michigan Job ChalleNGe Program Counselor Department. Neither this document nor any of the information contained herein may be reproduced or disclosed under any circumstances without the express written permission of The Michigan Job ChalleNGe Program Counselor Department. Please be aware that disclosure, copying, distribution or use of this document and the information contained therein is strictly prohibited.

**Email completed form to: GetmanL@michigan.gov**