

# SAULT TRIBE YOUTH FACILITY INTAKE FORM (PLEASE PRINT CLEARLY).

1130 North State Street St. Ignace, MI 49781

Phone: (906) 643-0941 Fax: (906) 643-6340

## Instructions:

- Fill out Intake Form in its entirety.
  - Fax to Sault Tribe Youth Facility (906) 643-6340
  - Call Facility indicating that you have sent fax. (906) 643-0941
  - Upon review, an officer will call you back in a timely manner.
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Name: \_\_\_\_\_ Arrival Date/Time: \_\_\_\_\_

Referring Court/Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Probation Officer/Caseworker: \_\_\_\_\_

CONTACT NUMBER: \_\_\_\_\_ COURT WARD: \_\_\_\_\_ or ACT 150: \_\_\_\_\_

\*SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

SEX: ( ) Male ( ) Female HGT: \_\_\_\_\_ WGT: \_\_\_\_\_ HAIR: \_\_\_\_\_ EYES: \_\_\_\_\_

## REASON FOR CURRENT COURT INVOLVEMENT:

1. Specific Charge(s) \_\_\_\_\_

2. Previous Offenses: \_\_\_\_\_

3. Previous Placements (including mental health placements): \_\_\_\_\_

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LENGTH OF STAY. (MUST HAVE A RELEASE DATE ON COURT ORDER OR PLACEMENT WILL BE DENIED):

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Fathers Name: \_\_\_\_\_ Mothers Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/State: \_\_\_\_\_ City/State: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Ever Attempted Suicide: ( ) YES ( ) NO

Aggressive/ Assaultive Behavior: ( ) YES ( ) NO

Other Behavioral/ Emotional Concerns: \_\_\_\_\_

Previous School Attended: \_\_\_\_\_

Grade Level: \_\_\_\_\_ Special Ed/IEP: ( ) YES ( ) NO

Medical Insurance Provider: \_\_\_\_\_ ID#: \_\_\_\_\_

(Include copy of insurance card both sides).

- If resident is placed longer than 30 days and is on Medicaid, the county/worker is responsible for paying for medications. *Initial:* \_\_\_\_\_

Medical Problems/Disabilities \_\_\_\_\_

**ALLERGIES:**

Bee stings: ( ) YES ( ) NO

Food: \_\_\_\_\_

Current medications & dosages:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CHRONIC CONDITIONS:**

Asthma: ( ) YES ( ) NO

Diabetes: ( ) YES ( ) NO

Seizure Disorder: ( ) YES ( ) NO

Mental Health & other conditions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Approved Visitors/Telephone Contacts:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**On-Call Information for HBH Related ER Visits. (Must have this information).**

**1. Case Worker**

- Name:
- Phone Number:
- On-Call Dates:

**2. Probation Officer**

- Name:
- Phone Number:
- On-Call Dates:

**3. Additional Contact (If Applicable)**

- Name:
- Phone Number:
- On-Call Dates:

**4. Additional Contact (If Applicable)**

- Name:
- Phone Number:
- On-Call Dates:

Please initial all areas below: (5)

**Court Orders:**

- All court orders **must specify a release date** and obtain approval from either a Lead Officer or the officer on duty before a resident can be accepted by Sault Tribe Youth Facility. **Initial:** \_\_\_\_\_

**Transportation:**

- Sault Tribe Youth Facility DOES NOT provide transportation for residents other than doctor appts to Mackinac Straits Hospital and Sault Tribal Health Center in St. Ignace. It is the responsibility of the placement agency to arrange and manage for all other transportation needs. All court appts are done through ZOOM at Sault Tribe Youth Facility, no transportation is required. **Initial** \_\_\_\_\_

**EMERGENCY ROOM VISITS:**

- In the event that an emergency room visit related to Hiawatha Behavioral Health is necessary, the placement agency is responsible for transporting the resident to the ER and remain with the resident until released. On-call contact information for case workers and probation officers must be available at all times. Sault Tribe Youth Facility must be notified of any changes to on-call personnel promptly. **Initial** \_\_\_\_\_

**UNEXPECTED RESIDENT DEPARTURE:**

- In the event the youth needs to be returned to the referring county because of such issues as limited bed space, extreme medical needs, suicidal watch with one-on-one care, and/or extreme volatile behaviors etc., The Sault Tribe Youth Facility will give a 48 hour notice to the referring county to find alternative placement. **Initial:** \_\_\_\_\_

**FORM SUBMISSION:**

- **This updated form must be completed in its entirety. Incomplete forms with any blank fields will not be accepted and may delay the placement process. This form was revised on 10-28-24 and only this form will be accepted for intake, all previous forms are invalid.** **Initial** \_\_\_\_\_

Time & date faxed to facility: \_\_\_\_\_

Form submitted by (print name): \_\_\_\_\_