Form A

ESU 2 Payer of Last Resort Application for Mental Health Services

Completed by Referring School System

Child Information

Last Name _____ First Name _____ M.I._____
Other Name(s) Used_____
Date of Birth (Month/Day/Year) _____ Grade _____
Home Address Street_____
Apt. No. _____ City_____
State_____ ZIP _____

Parent/Guardian Information

Last Name _____ First Name _____ M.I._____
Other Name(s) Used_____
email _____
Address Street_____
Apt. No. _____ City_____
State_____ ZIP _____
Phone Primary Phone (_____) _____ Secondary Phone (_____) _____
Can we leave a message? Yes No

School District Information

District Contact Person _____ Position _____
Phone Number _____ email _____
School District _____ County _____ Region 4 5 6

Reason for Therapeutic Need **Referral Source** Student School Parent

Please provide a short description

_____
_____
_____
_____

Barriers to receiving treatment

_____
_____
_____
_____

Strategies Implemented with the Student in need of Mental Health Services

☐ Tier 1 Strategies Attempted/Receiving

_____
_____

☐ Tier 2 Interventions Attempted/Receiving

_____
_____
_____

☐ Tier 3 Interventions Attempted/Receiving

_____
_____

Please attach any additional necessary information to this application and send it to your Mental Health Coordinator.

Request of Location for Therapy School Provider's Office

Agency and Therapist Requested for Service

Agency Name _____ Therapist Name _____