 Today’s date: 11/3/23

**IACCT Inquiry Form**

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| **PERSON MAKING THE INQUIRY** |
| Name:        | Referral Source/Agency:       |
| Phone Number:        | Email address:       |
| Alternate Contact Person:       |
| ***\*(Disclaimer: Legal Guardian should be aware of any Inquiry made to IACCT)*** |
| Phone Number:        | Email address:       | Relationship to Youth:        |
| **YOUTH INFORMATION** |
| Name:       | Date of Birth:       | Medicaid Number (if known):       |
| Youth’s Address:       |
| LEGAL GUARDIAN INFORMATION |
| Name of Legal Guardian(s):        | Phone Number of Legal Guardian:       |
| Does Legal Guardian require interpreter? [ ]  Yes [ ]  No  | Language:       |
| Legal Guardian’s Locality (city or county):        |
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| Is the youth in foster care? [ ]  Yes [ ]  No*\*If yes, please provide the name and contact number for the DSS guardian:*        |
| Is this youth currently involved with their local Family Assessment and Planning Team (FAPT): [ ]  Yes [ ]  No*\*If Yes, please provide the name and number for the FAPT contact:*       |
| Briefly, what is the reason for this Inquiry?       |
| What other services or treatment prior to this Inquiry has been attempted?      |
| Is the youth currently in a psychiatric or substance use inpatient facility?       |
| Where does youth currently reside?       |