 Today’s date: 11/3/23

**IACCT Inquiry Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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): | | | | | | | |
|  | | | | | | | |
| 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? | | | | | | | |