STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

REQUEST FOR PARENTAL ADMISSION OF A MINOR FOR SEVEN DAYS

(Pursuant to R.4:74-7A(d))

I, _____, the undersigned, at _____
Address

_____, County of _____, State of New Jersey, hereby

make application for the admission of _____ to
Name of Minor

_____ Hospital for the purpose of receiving evaluation

diagnosis, care and treatment. I am requesting admission because:

This person is under 18 years of age.

I am this minor's parent or guardian.

I am <u>not</u> this minor's parent or guardian but have the following relationship to this minor:

_____

I request that the minor be admitted for evaluation and diagnosis of a childhood mental illness for a period not exceeding seven days.

The place or places in which the minor has resided during the ten years immediately preceding the date of this application are as follows:

From Date	To Date	Street Address	City	State	Zip

The following is a full state of the minor's financial ability for self-support or the ability of such person or persons who are chargeable by law with the minor's support:

The names, relationship and address of the adult next of kin are as follows:

Name	Relationship	Street Address	City	State	Zip	Telephone No.

DESCRIPTION OF MINOR

Date of Birth _____ Height _____ Weight _____ Race _____Sex _____ Marital Status _____

Color of Eyes_____ Color of Hair _____ How long has the minor lived in the United States? _____

Occupation _____ Education _____
Highest Grade Completed

Name of Father _____ Living Deceased

Birthplace _____ Social Security # _____

Maiden Name of Mother _____ Living Deceased

Birthplace _____ Social Security # _____

Is the minor receiving any financial benefits? Yes No

If "Yes", specify (Pensions, VA, Social Security, etc.) _____

Does the minor have Medicaid/NJFamilyCare? Yes No

NJ FamilyCare Managed Care Organization: _____

Medicaid ID: _____

Does the minor have private health insurance? Yes No

Health Insurance Company (Blue Cross, etc.) _____

Insurance ID# _____ Name of Subscriber _____

I understand that 48 hours' notice is required for release and that proceedings for involuntary commitment may be commenced by the hospital administration at any time after admission.

Dated:_____ Applicant _____

(Witness) _____

Name and relationship of person responsible for patient on discharge.

Address: _____ City or Town _____

County _____ State _____ Telephone Number _____

Are services being provided by the Division of Child Protection and Permanency?

Yes, in _____ County

No