STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH 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
City or Town

for the admission of _____ to _____ Hospital
Name of Minor

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 not this minor's parent or guardian but have the following relationship to this minor: _____

request that ( ) he ( ) she be admitted for evaluation and diagnosis of a childhood mental illness for a period not exceeding seven (7) days.

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

Street	City	State	Zip	From Date	To Date

The following is a full statement 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, relationships and addresses of adult next of kin are as follows:

Name	Relationship	Street	City	State	Zip	Telephone Number and Area Code

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 benefits? ( )Yes ( )No

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

Health Insurance Company (Blue Cross, etc.)_____

Insurance ID #_____ Name of Subscriber_____

Military Service ( ) Yes ( ) No Dates: From_____ To_____

Type of Discharge_____ VA Claim No._____

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:_____, 20_____ Applicant_____

Witness_____

Name and relationship of person responsible for patient on discharge_____

Address_____ City or Town_____

County_____ State_____ Telephone Number_____
Include area code

Are services being provided by the Division of Youth and Family Services?

( ) Yes, in _____ County

( ) No