ACT, 920 W Spruce, St Olathe, KS 66061 Ph: 913-715-7600 Fax: 913-782-0609
Website: http://mentalhealth.jocogov.org/htpages/act.shtml (Full Handbook) Email: ACT@jocogov.org

Paperwork Needed for Adolescent Drug/Alcohol Assessment

Adolescent Center for Treatment (ACT) is a drug and alcohol treatment program for ages 12-18.

The following information and documents must be provided **prior to the scheduled assessment date**, by camera photo/scan/email to Wanda.Ray@jocogov.org or ACT@jocogov.org OR by fax: 913-782-0609.

Please Print Clearly

Client's Name:
Involved Parent(s)/Guardian(s) – Include Name, Relationship, Phone(s) and Email
Primary/Residential :
Secondary:

Proof of Citizenship (one or both of the following)	
☐ Social Security Card *(number must be provided)*	SSN#:
☐ Birth Certificate	

Proof of Residency (one of the following)
☐ Driver's License/State ID *(client and/or parent/guardian)*
☐ School ID (client)
☐ Utility Bill *(parent/guardian)*

Proof of Insurance (all that apply) **Copy of front/back of card(s)**				
☐ KanCare (Medicaid) card:	☐ Amerigroup	☐ Sunflower	☐ United	ID#:
☐ Primary Private Insurance ID#:			☐ Secondary Private Insurance ID#*:*	
Company Name:			Company Name:	
Primary Insurance Holder's Name #1:			Secondary Insurance Holder's Name:	
Primary SSN#::			Secondary Holder's SSN#:	

Proof of Adjusted Gross Income *(required only if seeking (AAPS) state grant OR for Johnson County – reduced fee only)*
☐ Tax Return or W2 form or Paycheck stubs or letter from agency/person regarding lack of income.

Allergies-Medical
☐ Allergies to: Medication(s) / Food / Environmental **LIST:**
☐ Current Medication(s) **LIST:**
☐ Medical Conditions (Chronic or current) **LIST**:

Important Contact Information *(Please print clearly)*		
Primary Care Physician Name:		
Practice or Agency Name:		
Phone:		
Emergency Contact Name *(other than parent/guardian)*:		
Phone:		**Relationship:**
Legal Officer or KDOC/DCF-Case Manager Name *Include (KVC/St Francis Case Manager (If applicable)*		
County or Agency:		
Email:		
Phone/Fax:	**Phone:**	**Fax:**
After Hours # (Foster Care/KDOC Case Mgr):		

Requested School Drug/Alcohol Assessment Letter
☐ Copy of the Olathe or Blue Valley School District request for assessment and arrangement for payment statement

Assessment Payment (*only applicable to full fee and Johnson County reduced fee clients or School Assessment)*
☐ Check, Cash or Credit/Debit Card