ARKANSAS NATIONAL GUARD
YOUTH CHALLENGE PROGRAM
Camp Joseph T. Robinson
North Little Rock, Arkansas 72199-9600
(501) 212-5565 / 800-814-8453

MENTAL FUNCTIONAL CAPACITY ASSESSMENT

The Arkansas National Guard Youth ChalleNGe Program is a highly structured military style behavior modification program. We do not provide any type of mental health services. In addition, our participants are not allowed to leave our campus during the residential phase (5 ½ months). Because of these restrictions, we are relying on your professional opinion to help us evaluate the applicant for entry into our program. It is our desire not to prevent any mental services that are conducive for the improvement of any mental condition. Please visit our website for more program details: www.aryouthchallenge.com.

Please answer the following questions about your patient's mental health impairment(s) and how his or her ability to attend the ARYC is affected by the impairment. Your answers should be based on the evidence in the patient's file and on your personal contact with and observations of the patient.

APPLICANT'S NAME: ____

TYPE OF COUNSELING OR MENTAL HEALTH THERAPY: __________________________________

DIAGNOSIS:____

____

DATE TREATMENT BEGAN: ____________________ DATE TREATMENT ENDED:____________________

1. Is the patient compliant with treatment? Yes | No
2. Do you believe the patient can tolerate normal levels of stress? Yes | No
3. Has patient been diagnosed cutting or self-harming? Yes | No

   If yes, please explain the triggers and location of cutting or self-harm ______________________

   ____

   ____

   ____

4. PLEASE LIST PRESCRIBED MEDICATIONS

   ____

   ____

   ____

   ____

"We Support Second Chances"

5. If accepted for enrollment in the Youth Challenge Program, would you provide medications upon entry into the program and any additional prescription refills needed upon request for the duration of the 5 ½ month program: Yes | No

   If No, please explain: ____

   ____

6. Do you believe the patient can manage in a military style environment for 22 weeks without therapeutic intervention? Yes / No

   If No, please explain: ____

   ____

   (Note: Any continuation of treatment during residential phase will be pending approval from YC Medical staff)

COUNSELOR'S/THERAPIST NAME:____

CREDENTIALS: ____

SIGNATURE: ____DATE: _________________________

CLINIC / FACILITY / OFFICE:____

PHONE ______________________________________ EMAIL ____________________________________

ADDRESS:

____

____

____