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 make a determination to 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:_____

Frequency of treatment (weekly / bi-weekly / monthly) _____

Date of last appointment: _____

1. Is the patient compliant with treatment? Yes | No
2. Does is the patient have the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness. Yes | No
3. Does the patient have the ability to tolerate normal levels of stress? Yes | No
4. Do you believe the patient can manage in this military style environment for 22 weeks without in-person therapeutic intervention? Yes | No
5. If No Please Explain: _____
   _____
6. 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

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7. Has patient been diagnosed cutting or self-harming? Yes | No
8. If yes, please explain the triggers and location of cutting or self-harm _____
   _____
   _____
   _____

9. PLEASE LIST MEDICATIONS
   _____
   _____
   _____
   _____
   _____

10. Will you provide bi-weekly Tele-Health therapy for client during the 5, ½ month program: Yes | No

    If yes, what platform do you utilize? Check One - Zoom | FaceTime | Phone

    If no, are you willing to refer the client to a local provider during the residential portion of this program: Yes | No

COUNSELOR'S/THERAPIST NAME:_____

CREDENTIALS: _____

SIGNATURE: _____DATE: _____

CLINIC / FACILITY / OFFICE:_____

PHONE _____ EMAIL _____

ADDRESS:

_____

_____

_____