youable
Emotional Health

CLIENT REGISTRATION & INSURANCE INFORMATION

Client ID# _____

Date: _____

CLIENT INFORMATION

Please Print

Name _____
Last Name First Name Middle Initial

Address: _____
Street Apt. # City State Zip County

Sex: ☐ M ☐ F Age: _____ Birth Date: _____ Soc. Sec. # _____

Home Phone Number _____ Work Phone Number _____

Email Address: _____

As a Community Mental Health Center and a Rule 29 Clinic, Youable Emotional Health is required to report certain demographic information to the state and Hennepin County. All information is reported anonymously to protect your privacy.

Gross (Yearly) Household Income: ( )$ 0-$10K ( ) $10K-20K ( ) $20K-$29K ( ) 30K-39K ( ) $40K-$49K ( ) $50K-$59K ( )$60K-$69K ( ) $70K-$79K ( ) $80K-$89K ( ) $90K-$99K ( ) $100K-$119K ( ) $120K and Up

Race: ( ) African American ( ) Asian American ( ) Caucasion ( ) Hispanic ( ) Hmong ( ) Multi-Racial ( ) Native American ( ) Pacific Islander ( ) Somali ( ) Sudanese ( ) Other

RESPONSIBLE PARTY

Responsible Party if **Other Than Client**: _____

Address (if different than above): _____

Home Phone Number _____ Work Phone Number _____

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Email Address: _____

PRIMARY INSURANCE

Policy Holder's Name: _____
Last Name First Name Middle Initial

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Address (if different from above) _____
Street City State Zip

Home Phone Number: _____ Work Phone Number: _____

Employer: _____

Insurance Company Name: _____ Effective Date: _____

Insurance ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Policy Holder's Name: _____
Last Name First Name Middle Initial

Birthdate: _____ Soc. Sec. # _____ Relationship to Client: _____

Address (if different from above) _____
Street City State Zip

Home Phone Number: _____ Work Phone Number: _____

Employer: _____

Insurance Company Name: _____ Effective Date: _____

Insurance ID Number: _____ Group Number: _____

PLEASE SEE REVERSE SIDE FOR SIGNATURE AND OTHER INFORMATION

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Client Rights & Privacy Policy

Consistent with the Health Insurance Portability and Accountability Act-HIPAA (1996), I have been provided with a copy of the Notice of Privacy Practices. I have also been provided with a copy of the Client's Rights and Responsibilities, which provides a description of my rights as a recipient of services.

I understand that I may receive another copy of either of these documents at any time and that I may direct any complaints or concerns about the services I received to the Chief Services Officer or Chief Executive Officer.

I understand that Youable Emotional Health encourages me to fully read each of these documents and inform my provider if I have any questions or concerns.

Client/Guardian Acknowledge: ○ Yes ○ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

OP Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy. An important part of keeping our services accessible is having our clients follow through with their financial obligations. Please read this policy carefully prior to agreeing to treatment.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash, check, debit or credit card. While we may be listed as a network provider for your insurance, this is not a guarantee of coverage. Should your insurance company deny a claim, you may be held responsible for the balance due.

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. This assignment can only happen with a client's signed authorization. Clients or their responsible parties are responsible for providing Youable with accurate insurance information and for promptly alerting Youable to any changes in coverage. If the insurance company requires a referral, the client may need to obtain the referral prior to care. Claims not processed by insurance after 60 days become the responsibility of the client unless they are able to get insurance to make payment. However, the terms of this Financial Policy shall be subject to, and applied in accordance with, the terms of any contract we may have with your insurance company.

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage.

Reduced Fees - As a non-profit community mental health provider, we may be able to reduce our fees in certain circumstances. Please request to meet with a representative to determine if you are eligible for reduced fees. Clients who qualify for reduced fees are responsible for paying the agreed upon fee at the time of service.

Missed Appointments - Please provide 24-hour minimum notice to avoid any cancellation charges, as we require 24-business- hours' notice when you cancel an appointment. For example, notify us by 10 a.m. Monday to cancel a 10 a.m. Tuesday appointment; 10 a.m. Friday to cancel a 10 a.m. Monday appointment. A charge of $75 will be applied to your account for ALL appointments missed or canceled with less than 24-business-hours' notice. Charges for "emergency" cancellations will be considered. Late cancel charges are not payable by your insurance and will be your responsibility. Please help us serve you better by keeping scheduled appointments. Clients with two or more unpaid missed appointment fees may be subject to termination of care.

If you have any questions regarding our fees and your financial obligations, contact our billing department at 651-352-6357 or by email at headwaybilling@tnthbs.com.

My initials below are authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Youable Emotional Health. I acknowledge that I have read, understand and agree to the above Financial Policy.

Client/Guardian Consents: ○ Yes ○ No

Client/Guardian Initials: _____

/

Headway
Emotional Health

Corporate Office
612 861 1675 | info@headway.org
6425 Nicollet Avenue South | Richfield MN 55423
headway.org

OP Consent for Treatment COVID

I give my consent to participate in in-person mental health treatment or related services through Youable Emotional Health amidst the COVID-19 "stay safe order" and social distancing recommendations.

I understand that I am at risk of exposure to COVID-19 by participating in in-person sessions.

I understand that if I am experiencing COVID-19 like symptoms or if my temperature is above 100.4F at the time of my appointment that I will be asked to reschedule my appointment or switch my appointment to a telehealth or telephone appointment.
I understand that Youable recommends me to wash my hands or use hand sanitizer when I enter the building, wear a mask, practice social distancing both in the lobby and within my provider's office, and practice good hygiene precautions.

Client/Guardian Consents: ◯ Yes ◯ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Informed Consent for a Minor

Programs:

I give my consent for my minor child/adolescent to participate in the following mental health treatment or related services through Youable Emotional Health. I understand that staff employed directly through Youable Emotional Health will provide this treatment.

- ☐ Children's Mental Health Targeted Case Management
- ☐ Day Treatment
- ☐ Family Spirit
- ☐ Healthy Families
- ☐ Medication Management
- ☐ Outpatient Therapy
- ☐ Plus
- ☐ Psychological Testing
- ☐ School-Based Outpatient Therapy
- ☐ Truancy
- ☐ Youth Diversion

Copy of Custody/Court Document Provided:

I understand that in order to authorize consent for treatment for my minor child/adolescent I must have either sole or joint legal custody. I understand that if I am divorced or separated from the other parent of my minor child/adolescent that I need to provide a copy of the most recent custody decree that establishes custody rights of me and the other parent or otherwise demonstrates that I have the right to authorize treatment for my child/adolescent.

◯ N/A ◯ No ◯ Yes

Acknowledgment of Disclosure of Minor's Treatment Information to Parents:

Therapy is most effective when a trusting relationship exists between the provider and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to us without your child's agreement. This is not the case if your child is in serious and immediate danger of harm. If your provider feels that your child is in such danger, the provider will communicate this information to you.

The Client Rights and Responsibilities Brochure has more information about respecting the confidential relationship between your minor child/adolescent and their service provider.

◯ Yes ◯ No

Acknowledgment of Disclosure of Minor's Treatment Records to Parents:

Although the laws of Minnesota may give parents the right to see any written records your provider keeps about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with their provider, and you agree not to request access to your child's written treatment records.

◯ Yes ◯ No

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation:

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although your provider's responsibility to your child may require them helping to address conflicts between the child's parents, their role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena their records or ask your provider to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing their opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring your provider's testimony, even though they will not do so unless legally compelled. If your provider is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, your provider will provide information as needed, if appropriate releases are signed or a court order is provided, but your provider will not make any recommendation about the final decision(s). Furthermore, if your provider is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for their participation agrees to reimburse Youable at the rate of $175 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

○ Yes ○ No

Acknowledgment of Withdrawing Consent:

I understand that I may decline a specific treatment and may withdraw my consent for the treatment of my minor child/adolescent at any time, for any reason. I understand that withdrawing consent would end my minor child/adolescent's ability to continue to receive services.

○ Yes ○ No

Receipt of Clients Rights and Responsibilities for Minors:

I understand that the Client Rights and Responsibilities Brochure has specific information about the Rights of Minors.

My signature below confirms that I have read and understand these rights and agree to abide by them.

○ Yes ○ No

Guardian Name: _____

Guardian Consents : ○ Yes ○ No

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

OP Consent for Treatment

I give my consent to participate in Mental Health Treatment or related services through Youable Emotional Health. I understand that staff employed directly through Youable Emotional Health will provide this treatment.

This consent may include services such as evaluations, therapy, medication management or testing (if indicated).

I understand that I may decline a specific treatment and may withdraw my consent to treatment at any time, for any reason.

I understand that withdrawing consent would end my ability to continue to receive services.

All clients and/or their families will be involved in the design of a treatment plan with their service provider.

I consent and agree to being involved in the treatment planning process.

Client/Guardian Acknowledge: ◯ Yes ◯ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Supervision Notice

The Minnesota State Department of Human Services, BlueCross & BlueShield as well as United Behavioral Health/Medica all have a supervision requirement to which we must alert you.

Until a therapist has their own billing number, or until a therapist has an independent license to practice, they must be supervised by a therapist who is enrolled in the insurance plan for which you are covered. If a therapist being supervised relevant to this rule provides your care, we must inform you and have you acknowledge with your signature that you have been so advised.

Youable Emotional Health believes in the importance of furthering the profession of Social Workers, Psychologists and/or Marriage and Family Therapists. We provide highly supervised internships that meet the requirements of the state, the professional licensing boards, as well as the standards set by your insurance company.

Know that Youable Emotional Health hires only therapists who are licensed by the State of Minnesota to provide therapy. Having a State License means your therapist holds a Master's Degree. Further, they completed over 2,000 hours of supervised clinical experience just to be eligible to take the state licensing exam. Youable hires therapists who have many years of experience well after they have passed their state licensing exam. You can feel assured that the therapist to whom you are assigned is highly competent and is an approved provider for many other insurance companies. Both their licensure and experience make them eligible to participate in this new agreement.

Client/Guardian Acknowledge:
I have been advised of this supervisory arrangement and acknowledge being informed by my initials below.

○ Yes ○ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Coordination With Primary Care Provider

It is considered best practice for therapists to have communication with medical providers to coordinate care for clients. However, communication between Youable and your medical provider is voluntary. Please indicate below if you would like Youable to be in contact with your medical provider. If you indicated "Yes" you will be prompted to complete a release of information for Youable Emotional Health to consult with your primary medical doctor or psychiatrist.

Coordinate with PCP? ○ Yes ○ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Telehealth Consent

Telehealth services are covered under the same privacy standards and rights as face-to-face, or in-office, sessions. Telehealth services involve the use of HIPAA compliant, live, two-way interaction between the client and provider using audio-visual technology for the delivery of mental health services to and from remote locations. These interactive systems are compliant with current privacy regulation.

By signing this consent form:

-I consent to receive services at Youable by means of telehealth technology.

-I understand that I will not physically be in the same room as my telehealth provider.

-I understand that while the session is conducted via HIPAA compliant software, factors in my own environment (others present, privacy of the location) may affect the confidentiality of my sessions. It is in my best interest to be in a location that is private and in which I can stay focused on my treatment during the appointment time.

-I understand that it is important to hold telehealth sessions in a safe and private environment that allows for focusing on my care. If my provider believes the environment is not safe or not private (ie. In a public place, operating a vehicle, multiple distractions, etc.) the session will be rescheduled.

-I will agree to provide my specific location and contact phone number at the start of each appointment. Should a session be interrupted or disconnected for any reason, I agree to wait for my provider to make contact to reconnect and will accept the call or invitation to rejoin the session. Failure to reconnect may result in notification of emergency services as necessary, dependent on the situation.

-I understand that all documentation and storage of my protected health information will take place in the electronic health record utilized by Youable.

-I understand that either my telehealth provider or I can discontinue the visit if the telehealth services are not adequate for my situation.

-I understand that I will be informed if individuals other than my telehealth provider are present in the room at the time of service, and appointments will be managed in a similar manner as in-clinic appointments.

-I understand that my provider can terminate telehealth services if they determine that I would receive a greater benefit from in-clinic services. My provider will assist me in locating the appropriate resources and/or making the transition to in-clinic services.

Client/Guardian Consents: ○ Yes ○ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Covid 19 Screening

1: Do you currently have a cough or trouble breathing unrelated to a pre-existing condition

○ Yes ○ No

2: Are you currently experiencing two or more of the following:

☐ None
☐ Chills
☐ Headache
☐ Muscle pain that is not injury related
☐ New loss of taste or smell
☐ Sore Throat

3: Have you been in close contact with anyone who is being quarantined for COVID-19 within the last 14 days?

○ Yes ○ No

4: Have you been in close contact with anyone who thinks they have been exposed to COVID-19 within the last 14 days?

○ Yes ○ No

5: Have you been in close contact with anyone who is experiencing COVID-19 like illnesses (shortness of breath, cough, fever, etc.) within the last 14 days?

○ Yes ○ No

Youable Emotional Health Staff Use Only

Client Temp over 100.4F? ○ Yes ○ No

If a client answers yes to any of the above questions OR if their temperature registers above 100.4F, inform the client that they are not able to attend an in-person appointment today. Offer telehealth or telephone appointment from vehicle/home.

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

OP Client Contact Consent Form

I give my consent for Youable Emotional Health to contact me via voicemail, text message, and/or email message to remind me of an upcoming appointment or to alert me to an appointment cancellation due to inclement weather or provider illness. This will also be used to provide me things like our client satisfaction surveys.

I understand that by accepting a voicemail, text message, and/or email message appointment confirmation that the message will not be encrypted. The confirmation will include the following information: Patient's first name, agency name and location, date and time of appointment.

Phone/Voicemail/Email

Voicemail/Text Message: ☐ Text Msg ☐ Voicemail ☐ Neither

Phone Number: _____ _____ _____

Email Confirmation? ○ Yes ○ No

Agency Mailing List? ○ Yes ○ No

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH ROI Brooklyn Center

Authorization to Obtain/Release Health Information

Street 1:
Street 2:
APT/Suite:
City:
State/Province:
Zip:
Zip + 4:
Phone Number:

Authorizes

Youable Emotional Health Services
5910 Shingle Creek Pkwy, Suite 250 Brooklyn Center, MN 55430

ATTN:
Phone:
Fax:
Authorization: Select Authorization
Organization/Provider Name:
Street Address:
City:
State:
Zip Code:
Phone:
Fax:

Specify the information to be obtained and/or released:

- ○ Specific Information / Records
- ○ Entire Record, Excluding Billing Records
- ○ Entire Record, Including Billing Records

Specific Records:

- ☐ Billing Records/Statements
- ☐ Chemical Dependency Evaluation/Treatment
- ☐ Diagnosis & Treatment Plan
- ☐ Diagnostic Assessment
- ☐ Discharge Summary
- ☐ Education Records
- ☐ HIV History
- ☐ Medical/Physical History
- ☐ Medication Records
- ☐ Other
- ☐ Prior Treatment Records
- ☐ Progress Notes
- ☐ Progress Review
- ☐ Psychiatric Assessment
- ☐ Psychological Testing Assessment

Purpose of Information Disclosure:

- ☐ Coordination of Care
- ☐ Communication Regarding Legal Issues
- ☐ Insurance Payment
- ☐ Third Party Authorization and Payment
- ☐ Other

Other:

Expiration

This authorization, unless specified below, expires 1 year from date of signature.

Start Date:

End Date:

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Youable Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy / fax of this authorization will be treated in the same manner as an original.

Further, I realize that Youable Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Youable Emotional Health Services is released from any and all liability resulting from re-disclosure.

If you are the client's legal representative, please attach a copy of the document that gives you the authority to act as the legal representative.

You are entitled to a copy of this document.

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH ROI Richfield

Authorization to Obtain/Release Health Information

Street 1:
Street 2:
APT/Suite:
City:
State/Province:
Zip:
Zip + 4:
Phone Number:

Authorizes

Youable Emotional Health Services
6425 Nicollet Ave South
Richfield, MN 55423

ATTN:
Phone:
Fax:
Authorization: Select Authorizaton

Organization/Provider Name:
Street Address:
City:
State:
Zip Code:
Phone:
Fax:

Specify the information to be obtained and/or released:

- ○ Specific Information / Records
- ○ Entire Record, Excluding Billing Records
- ○ Entire Record, Including Billing Records

Specific Records:

- ☐ Billing Records/Statements
- ☐ Chemical Dependency Evaluation/Treatment
- ☐ Diagnosis & Treatment Plan
- ☐ Diagnostic Assessment
- ☐ Discharge Summary
- ☐ Education Records
- ☐ HIV History
- ☐ Medical/Physical History
- ☐ Medication Records
- ☐ Other
- ☐ Prior Treatment Records
- ☐ Progress Notes
- ☐ Progress Review
- ☐ Psychiatric Assessment
- ☐ Psychological Testing Assessment

Purpose of Information Disclosure:

- ☐ Coordination of Care
- ☐ Communication Regarding Legal Issues
- ☐ Insurance Payment
- ☐ Third Party Authorization and Payment
- ☐ Other

Other:

Expiration

This authorization, unless specified below, expires 1 year from date of signature.

Start Date:

End Date:

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Youable Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy / fax of this authorization will be treated in the same manner as an original.

Further, I realize that Youable Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Youable Emotional Health Services is released from any and all liability resulting from re-disclosure.

If you are the client's legal representative, please attach a copy of the document that gives you the authority to act as the legal representative.

You are entitled to a copy of this document.

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Media Consent

I authorize the staff of Youable Emotional Health Services to make and use the following (please check all types of media that the client/parent/guardian authorizes by this consent):

Media Types:

- ☐ Art Projects
- ☐ Photography
- ☐ Video
- ☐ Audio
- ☐ Testimonials
- ☐ Other:

I understand that the above recording, pictures, slides, videotape, art projects, or testimonials will be used for the following purposes:

-Display of art projects within Headway's physical locations.
-Use or display by Youable for professional development, internal staff education, and/or quality control purposes.
-Use by Youable for public relations and/or marketing purposes in various ways including but not limited to print, website, video, and/or audio, news, or information stories.

I understand that I may revoke this consent at any time by notifying the Youable CEO or designee in person or writing (email or letter). I understand that my decision to revoke consent will not have any effect on use of the material before Youable received revocation.

Photographs will not be used by Youable for web based, print, or electronic marketing without additional permission from the client and/or client's parent or guardian.

Photographs will not be displayed at the Youable location where my child receives his or her primary services, and will not be displayed with student names or dates of time in our programs.

No material will be copied and all material will be erased and discarded upon client discharge and will not be placed in client's permanent file.

This release expires 12 months after signing. Material used during the authorized period may remain in use by Youable following the expiration of this release. Once the release expires, there will be no new use(s) of the material.

I am aware that I may refuse to sign this release. I understand that my treatment or my child's treatment or continued treatment at Youable is in no way affected by whether or not I sign this authorization.

Answer: I consent to the media types selected above ◯ Yes ◯ No

Client/Guardian Initials: _____

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Safety Contract

I understand the safety concerns expressed by my Youable provider and have created the safety plan below with them.

I understand: ◯ Yes ◯ No

Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing

Max: 500 characters.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems (without contacting another person (relaxation technique, physical activity)

Max: 500 characters.

Step 3: People and social settings that provide distraction

Max: 500 characters.

Step 4: People whom I can ask for help

Max: 500 characters.

Step 5: Making the environment safe

Max: 500 characters.

In addition to following the steps outlining in this safety plan, I agree to not engage in any self-destructive, risk taking, or life-threatening behavior toward others or myself. If I have difficulty managing my symptoms, thoughts, or impulses, I will contact my Youable Services' provider and/or one of the emergency resource contacts provided to me.
I agree that if I am in an unsafe environment, I get frustrated or overwhelmed with caring for those in my care or myself, or if a family member becomes in danger, threatens to harm themselves or someone else I will contact one of the resources provided to me for assistance.

Youable Provider Name:

Phone Number:

Client Initials:

Provider Initials:

Guardian Initials: (if applicable)

/

6425 Nicollet Ave Richfield, MN 55423
612-861-1675
www.youable.health

YEH Application for Reduced Services

Do you have health insurance? ○ Yes ○ No

Gross yearly income:

Number of dependants: Including yourself

Comments:

Max: 500 characters.

Please provide a copy of your most recent Income Tax form or W2. This must be included with your application to be considered.