South Dakota Department of Social Services

DIVISION OF BEHAVIORAL HEALTH
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Hardship Consideration (Calendar Year 2026)

PERSONAL INFORMATION

CLIENT NAME: DOB: CID #:

ADDRESS:

CITY/STATE: ZIP:

PARENT/GUARDIAN/REPRESENTATTIVE (if applicable):

ADDRESS (if different from above):

SERVICES

Will the client be receiving **Substance Use Disorder Treatment** services?

Select the type of **SUD** service from the dropdown box:

Will the client be receiving **Gambling** services?

Will the client be receiving **Mental Health** services?

Select the type of **MH** service from the dropdown box:

CYF or **CARE:** Number of units per month: Duration of services:

IMMINENT RISK OR EMERGENCY

Is there **imminent risk** of hospitalization, residential placement, or out of home placement? Is there potential for involvement/increased involvement of other systems (i.e., law enforcement, CPS, UJS, DOC)?

Is there an **emergency** (i.e., suicidal, acutely psychotic, demonstrates potential relapse or co-occurring disorder) that can be treated in a community setting?

I hereby attest that this information is true and correct.

Behavioral Health Representative: _____ Date: _____