

REQUEST FOR SPACE IN THE Western Region Adolescent Services

_____ County requests that the La Crosse County Western Region Adolescent Services hold

(County name)

_____, _____, _____, _____

(Child's name)

(Date of birth)

(Parent(s) name)

(Telephone number)

_____ County acknowledges and agrees to pay to La Crosse County the basic rate of,

(County name)

\$ 350.00 per day for CORE Unit

\$ 210.00 per day for Secure Unit

\$ 170.00 per day for the Shelter Unit

Please circle one

(County name)

pharmaceutical expenses as well as extra staff for suicide watches, medical transport, and guard duties, if the

juvenile is hospitalized, and property damage.

Medical Condition Report / Special instructions: _____

Authorizing Agent: _____

Billing Address: _____
