# 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) (Child's date of birth) (Parent(s) name) (Telephone number)

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

$500.00 per day for CORE Unit
$275.00 per day for Secure Unit
$225.00 per day for Shelter Unit **Please circle one**

_____
(County name)

pharmaceutical expenses as well as extra staff for suicide watches, medical transport, and facility staff duties,

if the juvenile is hospitalized, and property damage.

Medical Condition Report / Special instructions: _____

_____

_____

_____

_____

_____

Authorizing Agent: _____

Billing Address: _____

_____

_____

_____