

HEALTHY TRANSITIONS

ROADS OF INDEPENDENCE



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Youth Council Application

First Name

Last Name

Preferred Name / Pronoun

Birthdate MM/DD/YYYY

Age

Address

City

State

Zip

Email Address

Cell Phone

I Prefer Text Email Both

By signing below you are confirming the following statements apply to you:

- You are between ages 16-25
- You can participate monthly
- You have have experience with mental illness, foster care, criminal justice, homelessness, substance abuse or domestic abuse

Young Adult Signature

Date

Guardian Signature (if under 18)

Date

CID/ROI#

ROI Staff Signature

Date Received