

**APPLICATION FOR RESIDENTIAL, INTENSIVE IN-HOME, FAMILY GROUP
DECISION-MAKING AND PARTNERSHIPS SERVICES**

**THIS APPLICATION MUST BE FILLED OUT AS COMPLETELY AS
POSSIBLE**

**IF THIS APPLICATION HAS BEEN COMPLETED WITHIN THE LAST YEAR
AND REQUIRES ONLY AN UPDATE PLEASE ATTACH A BRIEF NARRATIVE
TO THIS APPLICATION**

By completing this application I understand that its contents may be shared with agencies involved in services. I have completed & attached the multi-agency release of information for this purpose (SFN 970).

PARENT/GUARDIAN: _____
(Signature)

CUSTODIAN: _____
(Signature)

Please check the box (es) for which service you are making an application:

- Partnerships (multi-agency needs)
- Family Group Decision-Making
- Intensive In-home Services

Residential

- PATH
- Group Home _____
- Residential Child Care Facility (RCCF) _____
- Psychiatric Residential Treatment Facility (PRTF) _____

REFERRAL REASONS (please check up to TWO Primary reasons per family unit)

- Referred by Child & Family Team/Wraparound Process
- Early Intervention
- Services Required
- Services Recommended

- Reunification
- Juvenile Court/DJS
- Prevent Adoption Disruption
- Social Service Case Management
- Other: _____

Referral Reason Narrative (option)

REFERRAL CONCERNS/RISK FACTORS (Please check up to TWO primary risks per family)

- Child Abuse/Neglect
- Substance Abuse
- Serious Mental Health Issues
- Law Violations/Domestic Violence/Incarcerations (Adults)
- Rule Violations/Status Offense/Delinquency (Youth)
- Prior Placement History of Child/ren
- Physical/Developmental Disability (Child or Adult)
- Parent/Child Conflict/Family Discord
- Joblessness/Financial/Housing
- Educational
- Other: _____

Explanation of above checked areas:

The Risk of Placement without Services Imminent High Moderate
 Low

Immediate Safety Concerns: _____

REFERRAL INFORMATION

DATE OF REFERRAL: _____ COMPLETED BY: _____
(Signature)

LEGAL CUSTODIAN: _____

AGENCY NAME & ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

COURT ORDER DATE: _____

COUNTY OF FINANCIAL RESPONSIBILITY: _____

TRIBAL AFFILIATION: _____

TRIBAL ENROLLMENT NUMBER: _____

IF NOT ENROLLED, IS CHILD ENROLLABLE? (Y) _____ (N) _____

NAME OF DESIRED FACILITY FOR PLACEMENT: _____

Please indicate N/A or Unknown throughout this form as applicable.

CLIENT'S NAME: _____ DOB: _____ AGE: _____

PLACE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

GENDER: _____ SSN: _____

RACE: _____ RELIGION: _____

CHILD ADOPTED: (Y) _____ (N) _____

CULTURE: (customs, traditions, heritage, ancestry, etc.)

CURRENT RESIDENCE OR PLACEMENT OF YOUTH: (i.e. Foster Home, Parental Home)

Name of Foster Parent(s)/Facility: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

MEDICAID ELIGIBLE: YES {} NO {} UNKNOWN {}

MEDICAID (MA) #: _____ COUNTY ISSUING MA#: _____

RECIPIENT LIABILITY: YES {} NO {} UNKNOWN {}

ESTIMATED RECIPIENT LIABILITY/AVERAGE PER MONTH \$ _____

WHO WILL SECURE THE LETTER FROM THE PHYSICIAN RECOMMENDING SERVICES FOR INTENSIVE IN-HOME? THERAPIST COUNTY WORKER

TITLE IV-E ELIGIBLE: YES NO UNKNOWN

EMERGENCY ASSISTANCE (EA) ELIGIBLE: YES NO UNKNOWN

SSI ELIGIBLE: YES NO UNKNOWN

SSDI ELIGIBLE: YES NO UNKNOWN

THIRD PARTY INSURANCE COMPANY NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

POLICY HOLDER'S NAME: _____

ADDRESS: _____

POLICY NUMBER: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

DESCRIPTION OF PRESENT TREATMENT ISSUES including current symptoms/behaviors, severity and nature of all preceding treatment issues:

BRIEF DESCRIPTION OF CHILD ABUSE/NEGLECT HISTORY:

CURRENT CONTACT, IF ANY, WITH KNOWN PERPETRATOR(S) OF ABUSE/NEGLECT: YES NO UNKNOWN EXPLAIN:

FAMILY ORIGIN

FATHER'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: (H) _____ (W) _____

EMPLOYED: YES NO OCCUPATION: _____

RACE: _____ AGE: _____ BIRTH DATE: _____

RELIGION: _____ MARITAL STATUS: _____
LEVEL OF EDUCATION: _____
LEVEL OF CONTACT WITH CHILD: ACTIVE INACTIVE UNKNOWN
EXPLAIN: _____

STEPFATHER'S NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: (H) _____ (W) _____

EMPLOYED: YES NO OCCUPATION: _____
RACE: _____ AGE: _____ BIRTH DATE: _____
RELIGION: _____ MARITAL STATUS: _____
LEVEL OF EDUCATION: _____
LEVEL OF CONTACT WITH CHILD: FREQUENT OCCASIONAL RARELY
 NEVER UNKNOWN EXPLAIN: _____

MOTHER'S NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: (H) _____ (W) _____

EMPLOYED: YES NO OCCUPATION: _____
RACE: _____ AGE: _____ BIRTH DATE: _____
RELIGION: _____ MARITAL STATUS: _____
LEVEL OF EDUCATION: _____
LEVEL OF CONTACT WITH CHILD: ACTIVE INACTIVE UNKNOWN
EXPLAIN: _____

STEPMOTHER'S NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: (H) _____ (W) _____

EMPLOYED: YES NO OCCUPATION: _____
RACE: _____ AGE: _____ BIRTH DATE: _____
RELIGION: _____ MARITAL STATUS: _____
LEVEL OF EDUCATION: _____
LEVEL OF CONTACT WITH CHILD: ACTIVE INACTIVE UNKNOWN
EXPLAIN: _____

DOES EITHER PARENT/STEPARENT CURRENTLY HAVE A SIGNIFICANT OTHER LIVING WITH HIM/HER? YES NO IF YES, PLEASE SPECIFY WHICH PARENT, AND IF THE SIGNIFICANT OTHER HAS YOUTH LIVING

WITH HIM/HER IN THE HOME:

SIBLINGS:

NAME	SEX	AGE	ADDRESS	RELATIONSHIP
OTHER SIGNIFICANT PEOPLE IN YOUTH'S LIFE (peers, church, extended family, neighbors, etc.)				

DESCRIPTION OF FAMILY STRENGTHS (accomplishments, coping skills, etc.): _____

DESCRIPTION OF YOUTH STRENGTHS (spiritual, special interests, hobbies, talents, work, recreation, leisure, vocation etc.):

FAMILY HISTORY (Divorce, domestic violence, family dynamics, etc.):

CHILD'S PROBATION OFFICER: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

REASON FOR PROBATION:

DATE PROBATION EXPIRES: _____

GUARDIAN AD LITEM: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

SERVICES

PLEASE PROVIDE A BRIEF DESCRIPTION OF CURRENT AND/OR PAST SERVICES

	START/END DATES	FREQUENCY	FACILITY	OUTCOME
INDIVIDUAL THERAPY				
FAMILY THERAPY				
GROUP THERAPY				
INTENSIVE IN-HOME				

PARENT AIDE				
CASE AIDE				
RESPITE				
PRIOR INPATIENT TREATMENT				
PRIOR OUTPATIENT TREATMENT				
CHEMICAL DEPENDENCY TREATMENT				
OTHER				

DIAGNOSIS

SOURCE AND DATE: _____

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: **Problems with primary support group**
Specify: _____

Problems related to the social environment
Specify: _____

Educational problems
Specify: _____

Occupational problems
Specify: _____

Housing problems
Specify: _____

Economic problems
Specify: _____

Problems with access to Health Care Services
Specify: _____

Problems related to interaction with the legal system
Specify: _____

Other psychosocial and environmental problems
Specify: _____

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE _____
GAF SCALE WITH SUPPORTS _____ **WITHOUT SUPPORTS** _____
CAF SCORE _____ **HAF SCORE** _____

DATE OF RECENT PSYCHIATRIC EVALUATION: _____

KEY FINDINGS:

**SYMPTOMS REQUIRING INPATIENT CARE:
MONTH/YEAR SYMPTOMS STARTED:
MOST RECENT DATE:**

<u>INTERVENTIONS</u> (List below)	<u>EFFECTIVENESS/OUTCOMES</u>
1.	
2.	
3.	
4.	
5.	

**CHRONIC BEHAVIORS:
MONTH/YEAR BEHAVIORS STARTED:
MOST RECENT DATE:**

<u>INTERVENTIONS</u> (List below)	<u>EFFECTIVENESS/OUTCOMES</u>
1.	
2.	
3.	
4.	
5.	

**DRUG/ALCOHOL USE:
TYPE OF SUBSTANCES:
AGE FIRST USED:
AGE REGULAR USE:
DATE LAST USED: AMOUNT:
RATE OF USE PAST 6 MONTHS:
(List below)**

- 1.
- 2.
- 3.
- 4.

5.

FAMILY SUPPORT SYSTEM:

PERSON:

RELATIONSHIP:

DESCRIPTION OF SUPPORT:

INVOLVEMENT IN TREATMENT:

SUPPORT LEVEL:

(List Below)

- 1.
- 2.
- 3.
- 4.
- 5.

LABORATORY TESTS:

LAB TYPE:

DATE COMPLETED :

FINDINGS:

******FOR PARTNERSHIPS/INTENSIVE IN-HOME/RESIDENTIAL SERVICES-
PLEASE ATTACH WRITTEN DOCUMENTATION OF CHILD'S DIAGNOSIS
AND GAF SCORE FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL
FROM WITHIN THE LAST YEAR.**

**PLACEMENT HISTORY (most current first, Family Foster Care, Therapeutic
Foster Care, PRTF, RCCF, Inpatient, Relative Care)**

PROVIDER NAME/ ADDRESS	ENTRY DATE	REASON FOR PLACEMENT	TX PLAN COMPLETED (Y) or (N)	DISCHARGE DATE	OUTCOME

HISTORY OF YOUTH'S BEHAVIOR/TREATMENT (MAY DESCRIBE YOUTH'S BEHAVIOR/TREATMENT IN AN ATTACHED NARRATIVE AND/OR COMPLETE SECTION BELOW)

1. DESTRUCTIVENESS (include fire-setting): _____

2. AGGRESSIVENESS: _____

3. SEXUAL OFFENDING: _____

4. RELATIONSHIP WITH PEERS/CLASSMATES: _____

5. RELATIONSHIP WITH ADULTS: _____

6. RELATIONSHIP WITH AUTHORITY/TEACHERS/COUNSELORS: _____

7. HARM TO SELF (cutting, burning, etc):

8. DANGER/VIOLENCE TO OTHERS (include animals):

9. EATING AND SLEEPING HABITS (eating and sleeping disorder symptoms):

10. DANGER TO SELF/SUICIDE ATTEMPTS/IDEATION (YOUTH):

11. MENTAL ILLNESS HISTORY (family): _____

12. PIERCING/TATTOOS (WITHOUT PARENTAL CONSENT):

13. HISTORY OF SEXUALITY (sexually active, STD's, pregnancy, etc.):

14. ALCOHOL/DRUG USAGE, INCLUDING SMOKING, HUFFING (Youth):

*** NOTE: For youth ages 14 and above, a release of information must be signed by the youth only for release of drug and alcohol treatment records. Parents/guardians are not able to access the youth's records without signed permission by the youth. Please attach release of information if applicable.

15. ALCOHOL AND DRUG USAGE, INCLUDING SMOKING, HUFFING
(Parental/Other Family Members):

Has client been assessed for Fetal Alcohol Syndrome/Fetal Alcohol
Effects? Yes {} No {}

If yes, what were the results? _____

16. LEGAL HISTORY: _____

RUNAWAY RISK/HISTORY _____

DESCRIBE ANY RESTITUTION/COMMUNITY SERVICE: _____

(HRS) _____ DATE (S): _____ AMOUNT: \$ _____

17. OTHER: _____

EDUCATION

HOME SCHOOL DISTRICT: _____

CURRENT SCHOOL ATTENDING: _____

SUPERINTENDENT'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SCHOOL CONTACT: _____
ADDRESS: _____
TELEPHONE NUMBER: _____ FAX NUMBER: _____

PRESENT GRADE LEVEL: ___ LAST GRADE COMPLETED: ___ GED: ___

RECEIVING SPECIAL EDUCATION: Yes {} No {} IEP: Yes {} No {}
CATEGORY: LD ___ ED ___ SPEECH/LANUAGE ___ 504 ___ OTHER ___
SPECIAL EDUCATION DISTRICT: _____
ADDRESS: _____
TELEPHONE NUMBER: _____ FAX NUMBER: _____

GED: Yes {} No {} DATE: _____
VERBAL IQ SCORE: _____ PERFORMANCE IQ : _____
FULL SCALE IQ: _____ DATE: _____
DATE OF COGNITIVE EVAL: _____ TYPE OF IEP: _____
CURRENT ED IEP DATE: _____
EDUCATIONAL STRENGTHS, INTERESTS, AND
ACHIEVEMENTS: _____

EDUCATIONAL DEVELOPMENT (History of learning / perceptual problems,
sensory deficits, dyslexia, etc.):

ATTENDANCE HISTORY (punctuality, approximate number of excused and
unexcused absences, etc.):

PAST YEAR AND PRESENT YEAR PERFORMANCE (average grades):

HAS SCHOOL BEEN INFORMED OF REFERRAL: YES {} NO {}

INDEPENDENT LIVING COORDINATOR
NAME: _____

TELEPHONE NUMBER: _____

**END OF PARTNERSHIPS APPLICATION
PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**

**PLEASE CONTINUE APPLICATION PROCESS FOR RESIDENTIAL/
INTENSIVE IN-HOME & FAMILY GROUP DECISION-MAKING**

MEDICAL HISTORY

1. KNOWN MEDICAL PROBLEMS/DISABILITIES/HEAD INJURIES (include allergies: medications, food, insects etc.: _____

2. MEDICATIONS (current):

Drug Name	Dosage	Purpose	Dates Used	Frequency of checks	Precautions

Medications within last year:

IMMUNIZATION RECORD MUST BE PROVIDED TO THE FACILITY

DOCTOR'S NAME	CLINIC/ADDRESS	PHONE NUMBER	LAST EXAM
FAMILY DOCTOR:			
DENTIST:			
OPTOMETRIST:			
PSYCHOLOGIST:			

PSYCHIATRIST:			
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LEVEL OF ENGAGEMENT/INVOLVEMENT

YOUTH'S MOTIVATION/STAGE OF READINESS AND ENGAGEMENT/INVOLVEMENT IN TREATMENT (referral's perception of youth's cooperation):

FAMILY'S ENGAGEMENT/INVOLVEMENT IN TREATMENT (referral's perception of family's cooperation): _____

POST-DISCHARGE PLAN

IF THIS YOUTH IS ACCEPTED, WHAT IS THE PLAN FOLLOWING DISCHARGE? _____

END OF RESIDENTIAL SERVICES & INTENSIVE IN-HOME SERVICES APPLICATION

CONTINUE TO COMPLETE THE FOLLOWING SECTION FOR FAMILY GROUP DECISION-MAKING SERVICES

FAMILY GROUP DECISION-MAKING SERVICES

Has the family agreed to participate in Family Group Decision-Making meeting? Yes {} No {}

What is the GOAL/PURPOSE of Family Group Decision-Making meeting?

Has the family agreed to the GOAL/PURPOSE of meeting? Yes {} No {}

Does the family have any cultural or language needs? Yes {} No {} If yes, please explain:

Persons to be invited to the conference (Family, Friends, Service Providers)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP TO CHILD/PARENT

Parent or Guardian Consent for FGDM Services:

I, _____ consent that the other people invited to participate in the Family Group Decision-Making Conference may hear information about me and my child (ren). I specifically authorize the County Social Services Agency, other service providers, family members and other conference participants to share information about me with the Conference Facilitator, so that the facilitator can be fully informed. I also consent to the Social Services staff and the facilitator sharing and exchanging information with the other conference participants.

Name: (Please Print) _____
 Address: _____
 Telephone: _____

 Authorizing Agency Representative Signature

 Date

 Parent (s)/Guardian Signature

 Date

 Youth (over 14 years of age) Signature

 Date

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