Print Form

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:
_____
_____

<u>FAMILY ORIGIN</u>

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

EMPLOYED: YES ☐ NO ☐ OCCUPATION: _____
RACE: _____ AGE: _____BIRTH DATE: _____

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

DOES EITHER PARENT/STEPPARENT 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:

INTERVENTIONS **EFFECTIVENESS/OUTCOMES**
(List below)

1.
2.
3.
4.
5.

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

INTERVENTIONS **EFFECTIVENESS/OUTCOMES**
(List below)

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. <u>Please attach release of information if applicable.</u>**

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: _____

<u>EDUCATION</u>

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

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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:			

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

<u>Parent or Guardian Consent for FGDM Services</u>:

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

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS