

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral:

Date Placement Needed:

Type of Referral:

- Group Care Intensive Services Low Management (DSS Only)
 Group Care Independent Living Services
 Shelter Services Runaway Homeless:

Referring Agency:

- COC DDSN DJJ DMH DSS DSS-MTS
 Other:

If client is in DSS custody, has the ISCEDC team approved placement? Yes No

Case Manager's Name:

Phone Number:

Fax Number:

Address:

CLIENT INFORMATION

Client's Name:

Alias/Nickname:

Social Security Number:

Date of Birth:

Age:

Gender:

Race:

Height:

Weight:

Religious Affiliation: Protestant Catholic Muslim Jewish
 None Other:

Legal Custodian:

Relationship to Client:

Address:

Telephone Number:

Distinguishing Features (i.e. scars, tattoos, birthmarks, etc.):

Hobbies:

Strengths: Strong Family Base On Grade-Level Good Socialization Skills
(check all that apply) Appropriate Reading Level Good Verbal Skills
 Good Personal Hygiene Appropriate Coping Skills Level
 Average/Above IQ Other

Reason for Referral:

CLIENT'S CURRENT PLACEMENT:

Type of Facility:

- High Management Moderate Management Supervised Independent Living
 Intensive Crisis Care Residential Treatment Therapeutic Foster Care
 Temporary De-escalation Care Other:

Number of Previous Placements: 0-3 4-6 7-10 More than 10

Placement History (Please list all placements including psychiatric hospitalizations.
Attach additional page(s) if necessary).

Placement	Dates (from/to)	Reason for Discharge

CURRENT BEHAVIORAL PROBLEMS/WEAKNESSES (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Aggressive (Verbally) | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Antisocial Behavior |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arson | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Below Grade Level | <input type="checkbox"/> Cruelty to Animals | <input type="checkbox"/> Delusional |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Destroys Property | <input type="checkbox"/> Difficulty with Authority |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Functionally Illiterate |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Loss/Grief Difficulties | <input type="checkbox"/> Low IQ/Mental Retardation |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Oppositional/Defiant | <input type="checkbox"/> Parental Neglect Issues |
| <input type="checkbox"/> Phobic Reactions/Behavior | <input type="checkbox"/> Physical Disability: | <input type="checkbox"/> Poor Coping Skills |
| <input type="checkbox"/> Poor Personal Hygiene | <input type="checkbox"/> Problems at School | <input type="checkbox"/> Poor Reality Orientation |
| <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Sexually Acts Out | <input type="checkbox"/> Running Away |
| <input type="checkbox"/> Self-Destructive Behavior | <input type="checkbox"/> Suicidal Gestures | <input type="checkbox"/> Sexually Provocative |
| <input type="checkbox"/> Sibling Related Difficulty | <input type="checkbox"/> Truancy | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Other | <input type="checkbox"/> Unruly/Ungovernable |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Other |

Client has been a victim of (check all that apply):

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: |

MEDICAL INFORMATION

DSM IV-DIAGNOSIS:

	<u>Diagnosis</u>	<u>Date Given</u>	<u>Source</u>
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			

MEDICATIONS (list all current medications, dosages, and instructions):

Medication Name	Dosage	Instructions
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MEDICAL CONDITIONS (check all that apply): C=Current H=History of

Anemia C H Anorexia C H Asthma C H Bulimia C H
 Burns C H Chicken Pox C H Convulsions C H Eczema C H
 Enuresis C H Encopresis C H Fainting C H Hay Fever C H
 Headaches C H HIV/AIDS C H Lice C H Measles C H
 Mumps C H Pink Eye C H Ringworm C H Seizures C H
 Sinusitis C H Sore Throat C H STD(s) C H Tuberculosis C H

C H Other: _____

C H Other: _____

C H Other: _____

Date of last Physical Exam: Dental Exam: Eye Exam:

Dental Appliances: Yes No Contacts/Glasses: Yes No

Allergies:

Special Dietary Needs:

Medicaid Number:

Medical Insurance Policy Carrier Number (s), Holder:

FAMILY INFORMATION

Biological Mother's Name:

Address:

Telephone Number:

Race: Educational Level (if known):

Criminal Record: Yes No

Biological Father's Name:

Address:

Telephone Number:

Race: Educational Level (if known):

Criminal Record: Yes No

Are the Biological Parents: Married Separated Divorced

Have Parental Rights Been Terminated? No Yes, date:

Name of Siblings:

Placement:

FAMILY CONTACT

Significant Family Member(s) and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

OTHER APPROVED CONTACTS

Significant Family Member(s) and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

Are there any special conditions/restrictions for home visits or furloughs?
 There is a family history of (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Criminal Activity |
| <input type="checkbox"/> Inappropriate Sexual Behavior | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Treatment Disruption | <input type="checkbox"/> Other: |

Brief family history on education, behavior, development, adoption, psychosocial, legal (arson, stealing, sexual, burglary, and assault), parent's psychiatric history, etc.

SCHOOL INFORMATION

Name of Last School Enrolled:
 District:

Grade:

Special Education Classification:

- Learning Disabled
- Emotionally Disturbed
- Educable Mentally Disabled
- Trainable Mentally Disabled
- Other Health Impairment
- Speech or Language Impairment
- Profoundly mentally Disabled
- Hearing Impairment
- Visual Impairment
- Multiple Disabilities
- Orthopedic Impairment
- Deafness
- Deafness-Blindness
- Autism
- Traumatic Brain Injury
- None (Regular Education)

Delivery Model:

- Resource Room
- Self-Contained Classroom
- Itinerant
- Medical Homebound
- Home based (special education)
- Regular Education

Does the client have a current IEP? No Yes-date:
 Does the client have a Section 504 plan? No Yes-date:
 Does the client have a history of truancy? No Yes-date:
 Has the client ever been suspended? No Yes-For What?
 Has the client ever been expelled? No Yes-For What?
 Name of School/District?

IQ/ACHIEVEMENT/ADAPTIVE TESTING

<u>Name of Test:</u>	<u>Date:</u>	<u>Given By:</u>	<u>Scores and Range</u> <u>(e.g. Low Average,</u> <u>etc.)</u>

EMOTIONAL/BEHAVIORAL FUNCTIONING (Findings from psychological assessments)

AGENCY/COURT INVOLVEMENT

AGENCIES CURRENTLY INVOLVED WITH CLIENT

CCRS COC DDSN DJJ DMH DSS DSS-MTS
 Voc. Rehab Other:

Has the client ever been to court? No Yes-type of court and outcome:

Does the client have pending charges? No Yes-list charges:

Is placement court ordered? No Yes – attach copy of the order

TREATMENT GOALS

Client's Goals	
Family's Goals (if Applicable)	
Agency's Goals	
Educational Goals	

Permanency Plan:

**ADMISSION REQUIREMENTS CHECKLIST
(TO BE FORWARDED IF CLIENT IS ACCEPTED FOR PLACEMENT)**

The referring agency will make every reasonable effort to supply the items listed in the Admission Requirements Checklist if the client is accepted for placement. If more information than is provided in the Children's Services Referral Application is required to determine client eligibility for admission, the provider agency should request in writing the additional information from the referring agency.

**Admission Requirements Checklist
(if accepted for Placement)**

Medical Exam	
Most Recent Treatment Plan	
Current Medicaid/Insurance Card	
Medical Necessity Form	
254 Authorization Form	
Most Recent Psychological/Psychiatric Evaluation(s)	
Previous Placement Discharge Summary(ies)	
Individual Education Plan (if applicable)	
Copy of Birth Certificate	
Copy of Social Security Card	
Immunization Records	
Completed Consent Forms (Program should Forward to referring agency prior to admission)	
Copies of Court Orders	
Signed Homebound Form (if applicable)	
Pre-Admission Assessment (if applicable)	

Name of Person Making Application:

Relationship to Client:

Telephone:

Address:

Signature

Date

Signature

Date

Signature

Date