







MEDICAL CONDITIONS (check all that apply):

C= Current

H= History of

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

Deceased (which one): \_\_\_\_\_ Other: \_\_\_\_\_

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

Name 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?

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There is a family history of (check all that apply):

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|--|--|
| <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:

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**SCHOOL INFORMATION**

Name of Last School Enrolled: \_\_\_\_\_

District: \_\_\_\_\_ Grade: \_\_\_\_\_

Special Education Classification:

Delivery Model:

- 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)

- Resource Room
- Self-Contained Classroom
- Itinerant
- Medical Homebound (Requires a physician's order)
- Homebased (Special Education. Requires an IEP)
- Regular Education

Does the client have a current IEP?     No     Yes-date, county and district completing: \_\_\_\_\_

Does the client have a Section 504 plan?  No     Yes-date: \_\_\_\_\_

Does the client have a history of truancy?  No     Yes

Has the client ever been suspended?  No     Yes-For what? \_\_\_\_\_

Has the client ever been expelled?  No     Yes-For what? \_\_\_\_\_

Name of Last School and District Attended \_\_\_\_\_

IQ/ACHIEVEMENT/ADAPTIVE TESTING

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

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

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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	

**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: \_\_\_\_\_