Revised 9/24/2020

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| **RESIDENT INFORMATION** |
| **Child’s Full Name:** | **Male:**  **Female:**  | **Today’s Date:**      |
| Ethnicity:      | Language:      | Religion:      | DOB:       | Age:       |
| Current Placement: Home Acute Facility Foster Care Other:      Address:       |
| Physical Description:        | Discharge Plan:Return home Foster Care Adoption Other:       |
| Ht:       Wt:       |

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| **BIOLOIGCAL PARENT’S INFORMATION**NO KNOWN INFORMATION |
| **BIOLOGICAL Mother’s Information** | **BIOLOGICAL Father’s Information** |
| Name:       | Name:       |
| Address:       | Address:       |
| Phone:       | Cell:       | Phone:       | Cell:       |
| E-Mail:       | E-Mail:       |
| Place of Employment:       | Place of Employment:       |
| Is bio-parent Legal Guardian: Yes: No:Parental Rights Terminated: Yes: No:Is parent involved: Yes: No:Comments:       | Is bio-parent Legal Guardian: Yes: No:Parental Rights Terminated: Yes: No:Is parent involved: Yes: No:Comments:       |

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| **LEGAL GUARDIAN INFORMATION – *If NOT Biological Parent*** |
| Name:        | Phone:       |
| Relationship: DSS Guardian Adoptive Parent Family member Legal Guardian Other:       |
| Agency:       | Cell:       |
| Address:       | E-Mail:       |
| When did the child come into your care?       |
| Is the child adopted? Yes: No: |
| If adopted, When was the child’s adoption finalized?       |

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| **REFERRAL SOURCE INFORMATION** |
| Referral Source: School Parent/Legal Guardian Agency/County Other:       |
| County of Referral:       |
| Agency of Referral Source:       |
| Name and Title (Case Manager, ICC Coordinator, etc.):       |
| Address:       |
| Phone:       | Cell:       | Fax:       | E-Mail:       |

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| **INSURANCE & FUNDING** |
| ***Childhelp will not be responsible for payment of medication costs,*** ***or any medical appointments/procedures that are not covered by*** ***Medicaid or private insurance.******IDENTIFY RESPONSIBLE PARTY for Co-Pays & unpaid Medical Bills:***       |
| Medicaid:  | Title-IV-E:  | CSA:  | Adoption Subsidy: | HMO: | Private Insurance:  | Tricare:  |
| Medicaid Insurance #:      | Social Security #:      |
| Tricare Insurance ID:       | Tricare Phone #:      |
| Private Insurance Company:       | Private Insurance Member #:       |
| Private Insurance Member’s Name:       | DOB:       | Private Ins. Phone #:       |

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| **FOR VIRGINIA REFERRALS**  |
| **I agree to participate in the IACCT Process****Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **IACCT assessment:**  Started Completed recommending RTF |
| Placing Agency/County that is **Funding** Placement/Education:        |
| Address:       | Phone:      | Fax:      |
| CSA Coordinator:       | E-Mail:       |

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| **OTHER INVOLVEMENT *(Step-Parent, Foster Parent, GAL, CASA Worker, etc.)*** |
| Name/Relationship:       | Phone:       |
| Address:       | Fax:       |
| Name/Relationship:       | Phone:       |
| Address:       | Fax:       |

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| **MENTAL HEALTH INFORMATION** |
| Reason for Referral: Long Term Placement Assessment and Diagnostic |
| Abuse History: Physical  |  Sexual  |  Emotional  | Neglect  |  Trauma  |
| Comments regarding abuse history:       |
| Current Mental Health Diagnosis:       |
| Clinical Assessments Requested:       |

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| **EDUCATIONAL INFORMATION** |
| Current Grade:       | Local Ed. Agency (LEA):       | IEP: Yes No  |
| FSIQ:       ( Never Tested) | Child is ( on below above) grade level |
| Related Services (OT, Speech, etc.,):       |
| Current School:       | Contact Person:       |
| Address:       | Phone:       | Fax:       |

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| **CHILD and FAMILY INFORMATION** |
| Legal Involvement: Yes No:  | Child Parent If “yes”, explain:       |
| Probation/Parole Officer:       | Address:       | Phone:       |
| Protective Order in Place: Yes No:  | If “yes”, explain:       |
| Is there Restrictive Contact: Yes No:  | If “yes”, explain:       |
| Does family have reliable transportation to attend Therapy/Treatment/Meetings: Yes No:  |

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| **HEALTH and NUTRITION INFORMATION** |
| ***Childhelp reserves the right to*** ***not admit a child who presents with a communicable disease at the time of admission,******unless our Medical Director certifies that our facility is capable of*** ***providing care to the child, without jeopardizing residents and staff.******Please advise the Admissions Department of any Communicable Disease -******(i.e., Flu, Strep, MRSA, Lice, HIV, Hep A, B, or C, etc.) that your child may have prior to admission.*** |
| Current Immunizations: Yes No:  | Orthodontic Braces: Yes No:  | Eye Glasses: Yes No:  |
| Diagnosed Allergies-including drug/food intolerance:       |
| Diagnosed Medical issues:       |
| Any noted Nutritional Problems:       |
| Doctor ordered Therapeutic Diet: Yes No:  |

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| **CURRENT PHYSICIAN INFORMATION** |
| Primary Care Physician Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
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| Psychiatrist Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
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| Dentist Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
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| Other Specialist Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |

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| **DEVELOPMENTAL HISTORY**  NO KNOWN INFORMATION |
| Child born at       months | Child toilet trained at      months |
| Normal delivery: Yes No:  | If “no”, explain:       |
| Complications at birth: Yes No:  | If “yes”, explain:       |
| Concerns with Gross Motor Skills: Yes No:  | If “yes”, explain:       |
| Concerns with Fine Motor Skills: Yes No:  | If “yes”, explain:       |
| Concerns with Speech Development: Yes No:  | If “yes”, explain:       |

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| **OTHER INFORMATION** |
| Likes:       | Dislikes:       |
| Strengths:       |
| Indicators of success at Home/Other placements:       |
| History of Unsubstantiated Claims: Yes No:  | If “yes”, explain:       |
| History of Substance use: Yes No:  | Child Parent If “yes”, explain:       |

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| **SIGNIFICANT BEHAVIOR INFORMATION** |
| Place an X next to behaviors that are occurringIndicate frequency with “Daily”, 4-5 days/wk, 1-2 days/wk, etc. |
| **BEHAVIOR** |  |  **FREQUENCY** |  |  **BEHAVIOR** |  |  **FREQUENCY** |
| Sexually Inappropriate |  |        |  |  Poor Hygiene |  |        |
| Homicidal Ideation |  |        |  |  Fire Setting |  |        |
| Suicidal Ideation |  |        |  |  Self-Harming Behaviors |  |        |
| Temper Outbursts |  |        |  |  Animal Cruelty |  |        |
| Physical Aggression |  |        |  |  Lying |  |        |
| Verbal Aggression |  |        |  |  Property Destruction |  |        |
| Stealing |  |        |  |  Runs Away |  |        |
| Enuresis |  |        |  |  Wanders at Night |  |        |
| Encopresis |  |        |  |  Depressed/Anxious Symptoms |  |        |
| Nightmares |  |        |  |  Oppositional Defiant Behaviors |  |        |

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| **PAST PLACEMENTS (Provide for up to the last year)** |
| **Name of Placement** | **Type of Service/Placement** (i.e. Acute Hospital, Foster care, Residential, etc.) | **Dates of Service**(mm/dd/yy – mm/dd/yy) | **Reason for Removal/Discharge** |
|       |        |        |        |
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| **PAST SERVICES (Provide for up to the last year)** |
| **Name of Agency** | **Type of Service** (i.e. Psychiatric, Outpatient, Family Therapy, Play Therapy, etc.) | **Dates of Service**(mm/dd/yy – mm/dd/yy) | **Reason for Discharge** |
|       |        |        |        |
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| **MEDICATION RECONCILIATION FORM** |
| **Current Medication Name** | **Dosage** | **Schedule** |
|       |       |       |
|       |       |       |
|       |       |       |
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|        |       |       |
| **MEDICATIONS TRIED in the PAST and their EFECTS** |
| **Medication Name** | **Effects** |
|       |       |
|       |       |
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| **For referrals to be considered by the admissions team the following documentation will need to be reviewed:**  |
| Most recent Medical Physical  |  Attached |  Never had one |
| Most recent Grades  |  Attached |  Never attended school |
| Most recent behavior reports (school) |  Attached |  Never attended school |
| Psychiatric evaluation |  Attached |  Never had one |
| Psychological evaluation |  Attached |  Never had one |
| Assessments and Daily progress notes from previous placements |  Attached |  Never had one |

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| **Name of Person Providing Information:**       | **Date:**       |
| **Relationship:**       | **Phone:**       |