

Personal Information

Client's Full Name Social Security Number

Date of Birth Place of Birth Sex Male Female

Height Weight Religious Preference:

Are services attended? Yes No

Ethnicity

Caucasian African American Asian Hispanic Biracial

Native American Other

Current Placement Information

Current Placement

Home/Legal Guardians Therapeutic Foster Care Residential Hospital

Detention Shelter Other

Current Placement Address

Current Placement Contact

Name

Telephone

Fax

Family and/or Caretakers

Mother Father

Stepmother Stepfather

Foster Parent Grandparent

Other (include relationship)

Immediate Family Information

Sibling's Name	Date of Birth	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Others Living in the Home

Contact Information

Legal Guardian

Biological Parent Adoptive Parent Relative Social Services Agency

Local Educational Agency Community Services Board Placing Agency

Juvenile Justice Other

Legal Guardian's Name and Address		Home Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>
Occupation	<input type="text"/>	Fax Number	<input type="text"/>
		Email	<input type="text"/>

Mother's Name and Address <input type="radio"/> Not Applicable		Home Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>
Occupation	<input type="text"/>	Fax Number	<input type="text"/>
		Email	<input type="text"/>

Father's Name and Address <input type="radio"/> Not Applicable		Home Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>
Occupation	<input type="text"/>	Fax Number	<input type="text"/>
		Email	<input type="text"/>

Social Services' Address <input type="radio"/> Not Applicable		Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Alternate Telephone	<input type="text"/>
Contact	<input type="text"/>	Mobile	<input type="text"/>
Title	<input type="text"/>	Fax Number	<input type="text"/>
		Email	<input type="text"/>

School's Address <input type="radio"/> Not Applicable		Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Alternate Telephone	<input type="text"/>
Contact	<input type="text"/>	Mobile	<input type="text"/>
Title	<input type="text"/>	Fax Number	<input type="text"/>
		Email	<input type="text"/>

Community Services Board's Address <input type="radio"/> Not Applicable		Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Alternate Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>
Contact	<input type="text"/>	Fax Number	<input type="text"/>
Title	<input type="text"/>	Email	<input type="text"/>

Probation/Court Services Address		Work Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Alternate Telephone	<input type="text"/>
<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>
Contact	<input type="text"/>	Fax Number	<input type="text"/>
Title	<input type="text"/>	Email	<input type="text"/>

Emergency Contact Information

Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>
Primary Emergency Contact		Secondary Emergency Contact	
Name	<input type="text"/>	Name	<input type="text"/>
Home Phone	<input type="text"/>	Home Phone	<input type="text"/>
Work Phone	<input type="text"/>	Work Phone	<input type="text"/>
Address	<input type="text"/>		<input type="text"/>
	<input type="text"/>		<input type="text"/>

Insurance Information

Insurance Company Name	<input type="text"/>	ID/Policy Number	<input type="text"/>
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Does this individual have secondary insurance?

Yes (If "yes" list the policy and ID number)

No

Billing - Who will be responsible for medical bills not covered by Insurance?

Name	<input type="text"/>	Employer	<input type="text"/>
Address	<input type="text"/>	Home Phone	<input type="text"/>
	<input type="text"/>	Work Phone	<input type="text"/>

Medical Contact Information

Physician	<input type="text"/>	Telephone	<input type="text"/>
Date of Last Physical	<input type="text"/>	Fax Number	<input type="text"/>
Dentist	<input type="text"/>	Telephone	<input type="text"/>
Date of Last Exam	<input type="text"/>	Fax Number	<input type="text"/>
Psychiatrist	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Fax Number	<input type="text"/>
Neurologist	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Fax Number	<input type="text"/>
Other	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Fax Number	<input type="text"/>
Other	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Fax Number	<input type="text"/>

Medical Information

Diagnosis (Most Recent):

Axis I

Axis II

Axis III

Axis IV

GAF: Current Last Year

Current Medications

Medication	Dosage	Time	Target Symptoms
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If the applicant is allergic to any medications, list them along with symptoms.

Medications Applicant is Allergic to:	Symptoms of Allergies
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Other Allergies: (Please list symptoms too)

The following information is considered part of the referral process and should be forwarded along with the application.

- Social History
- Educational Evaluations (e.g., Speech/Language, Occupational Therapy, etc.)
- IEP, ISP, CSP and/or IP
- Physical and Medical Health History
- Immunization Record
- Dental Examination Report
- Social Security Card (copy)
- Birth Certificate (copy)
- Medicaid Card/Insurance Card (copy)
- Most recent Psychological
- Most recent Psychiatric
- Most recent Treatment Plan from Current Placement (if applicable)
- Discharge Summary from Previous Placements/Hospitalizations (if applicable)

Placement History

Name Admission Date Discharge Date

Residential Foster Care Shelter Hospital Detention Other

Telephone Fax

Was Placement Successful? Yes No

If Placement was not successful, list reason(s):

Name Admission Date Discharge Date

Residential Foster Care Shelter Hospital Detention Other

Telephone Fax

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