

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral:

Date Placement is Needed:

Type of Referral:

- High Management
 Supervised Independent Living
 Residential Treatment Facility
 Temporary De-escalation Care

- Moderate Management
 Intensive Crisis Care
 Therapeutic Foster Care
 Other: Low Management

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(s):

Social Security Number:

Date of Birth:

Age:

Sex:

Race/Ethnicity:

Height:

Weight:

Religious Affiliation:

- None Protestant Catholic Muslim Jewish
 Other:

Place of Birth:

County of Legal Custody:

Legal Custodian:

Relationship to Client:

Address:

Telephone Number:

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

Hobbies:

CURRENT STRENGTHS (check all that apply):

- Strong Family Base On Grade Level Good Socialization Skills
 Appropriate Reading Level Good Verbal Skills Average/Above Normal IQ
 Appropriate Coping Skills Good Personal Hygiene
 Other:

Reason for Referral:

CLIENT'S CURRENT PLACEMENT

Type of Facility:

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

Number of previous placements: 0-3 4-6 7-10 More than 10

PLACEMENT HISTORY (Please list all placement including psychiatric hospitalizations. Attach additional page(s) if necessary).

Placement	Dates (From/To)	Reason for Discharge
	/	
	/	
	/	
	/	
	/	
	/	

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

- Aggressive (Verbally)
- Anxiety
- Below Grade Level Academically
- Developmentally Delayed
- Eating Disorder
- Homeless
- Phobic Reactions/Behavior
- Poor Personal Hygiene
- Poor Social Skills
- Self-Destructive Behavior
- Sibling-Related Difficulty
- Other:
- Alcohol/Drug Abuse
- Arson
- Cruelty to Animals
- Fire-setting
- Hyperactive
- Loss/Grief Difficulties
- Physical Disability:
- Problems at School
- Sexually Acting Out
- Truancy
- Other:
- Antisocial Behavior
- Bedwetting
- Delusional
- Difficulty with Authority
- Impulsive
- Low IQ/Mental Retardation
- Poor Coping Skills
- Poor Reality Orientation
- Running Away
- Sexually Provocative
- Unruly/Ungovernable
- Other:

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

- Neglect
- Physical Abuse
- Sexual Abuse
- Emotional Abuse
- Allegation
- Allegation
- Allegation
- Allegation
- Substantiated; Perpetrator:
- Substantiated; Perpetrator:
- Substantiated; Perpetrator:
- Substantiated; Perpetrator:

MEDICAL INFORMATION

DSM IV-DIAGNOSIS:

	Diagnosis	Date Given	Source
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			

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

Medication Name	Dosage	Instructions

MEDICAL CONDITIONS (check all that apply): C= Current H= Historical

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	STI(s)	<input type="checkbox"/> C <input type="checkbox"/> H	Tuberculosis	<input type="checkbox"/> C <input type="checkbox"/> H

Other (C H):

Other (C H):

Other (C H):

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/Ethnicity:

Educational Level (if known):

Criminal Record: Yes No

Biological Father's Name:

Address:

Telephone Number:

Race/Ethnicity:

Educational Level (if known):

Criminal Record: Yes No

Are the Biological Parents: Married Separated Divorced Deceased (which one(s):)
 Other:

Have Parental Rights Been Terminated? No Yes, date:

Name of Sibling:	Placement:

FAMILY CONTACTS

Name and Relationship to Client	Address	Phone Number	Type of Contact with Client (i.e., phone, letters, face-to-face, etc.)

OTHER APPROVED CONTACTS

Name and Relationship to Client	Address	Phone Number	Type of Contact with Client (i.e., phone, letters, face-to-face, etc.)

Are there any special conditions/restrictions for home visits or furloughs? Yes No
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: Drug and alcohol abuse |

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

SCHOOL INFORMATION

Name of Last School in which Client was Enrolled:

District:

Grade:

Special Education Classification:

Delivery Model:

- | | |
|--|---|
| <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Resource Room |
| <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Self-Contained Classroom |
| <input type="checkbox"/> Educable Mentally Disabled | <input type="checkbox"/> Itinerant |
| <input type="checkbox"/> Trainable Mentally Disabled | <input type="checkbox"/> Medical Homebound |
| <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Home-Based (Special Education) |
| <input type="checkbox"/> Speech or Language Impairment | <input type="checkbox"/> Regular Education |
| <input type="checkbox"/> Profoundly Mentally Disabled | |
| <input type="checkbox"/> Hearing Impairment | |
| <input type="checkbox"/> Visual Impairment | |
| <input type="checkbox"/> Multiple Disabilities | |
| <input type="checkbox"/> Orthopedic Impairment | |
| <input type="checkbox"/> Deafness | |
| <input type="checkbox"/> Blindness | |
| <input type="checkbox"/> Autism | |
| <input type="checkbox"/> Traumatic Brain Injury | |
| <input type="checkbox"/> None (Regular Education Only) | |

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; why?

Has the client ever been expelled? No Yes; why?

Name of School District:

IQ/ACHIEVEMENT/ADAPTIVE TESTING

Name of Test:

Date:

Administered by:

Scores and Range (i.e., Low Averages, Proficient, etc.):

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*

Agency's Goals

Educational Goals

*if applicable

**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 shall request, in writing, the additional information from the referring agency.

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

Name of Person Making Application:

Relationship to Client:

Telephone Number:

Address:

Signature: _____ Date: _____