Today’s Date:

Youth Demographic Information

Full Name:

Current Placement Provider:

Address:

Medicaid (DCN) Number:       Gender Identity:       Preferred Pronouns:

Religious Preference:  Islam  Jewish  Protestant

Catholic  None  Other

Ethnicity:

African/American/Black  Asian  Asian-Pacific Islander  Caucasian/White

Hispanic  Multi-racial  Native American  Unknown/Other

Referral Information

County of Jurisdiction: ­­­­­      Initial Custody Date:

Case Manager:       Agency:

Work Phone:       24 hour contact name and number

Address:

Email: ­­­­­­­­­­­­­­­­­­­­­­

**Guardian Ad Litem (GAL) name**:

Work Phone:       24 hour contact name and number

Address:

Email: ­­­­­­­­­­­­­­­­­­­­­­

**Deputy Juvenile Officer (DJ0)**:

Work Phone:       24 hour contact name and number

Address:

Email: ­­­­­­­­­­­­­­­­­­­­­­

MOTHER INFORMATION

Mother’s name:       Phone number:

Address:

Email Address:       Work Phone

FATHER INFORMATION

Father’s name:       Phone number:

Address:

Email Address:       Work Phone

EDUCATION INFORMATION

School last attended (name and address):

School district:

Current grade: (If school is in session)       Last grade completed/year (If school is not in session):

Does child receive special education services:  Yes  No

If 'Yes,' what are those special education services:

Individualized Educations Plan (IEP):  Yes (If 'yes,' a copy must accompany the admission packet):  No

MEDICAL INFORMATION

Youth’s Physician:       Phone:

Address:

Date of last Physical:       Concerns noted at last physical:

On-going physical health issues:

Has the youth had any of the following:

Heart Condition, if so describe

Headaches - severe  Migraine  Lung issues  Arthritis

HIV/AIDS  Anemia  Hearing problems  Hemophilia

Kidney disease  High Blood pressure  Tuberculosis  Sinus Problems

Need glasses/contacts  Other Eye issues

Cancer, if so describe:

Other serious physical issue, if so describe:

Surgery, if so describe:

Handicap/Disability, if so describe:

Alcohol use, if so describe:

Drug Usage, if so describe:

Hospitalization – for any reason, if so describe:

Allergies:

Medications:

Food:

Environmental:

OBGYN

Youth’s Doctor:       Phone:

Address:

Date last saw OBGYN:

Any concerns:

DENTAL HISTORY

Youth’s dentist:       Phone:

Address:

Date last saw Dentist:

Any concerns:

BEHAVIORAL HEALTH

Has the youth seen a therapist/psychologist in the last 6 months?  Yes  No

Youth’s Therapist:       Phone:

Address:

Date last saw Therapist:

Any concerns:

Attach last Therapy Report

Youth’s Psychologist:       Phone:

Address:

Date last saw Therapist:

Any concerns:

Attach last Psychologist Report

Has the youth seen a Psychiatrist in the last 6 months?  Yes  No

Youth’s psychiatrist:       Phone:

Address:

Date last saw psychiatrist:

Any concerns:

Attach last Report

Has youth been in a drug/alcohol treatment program?  Yes  No

Youth’s Treatment facility:       Phone:

Address:

Dates of treatment:

Any concerns:

Does the Youth have services form the Department of Mental Health?  Yes  No

DMH worker:       Phone:

Address:

**Make sure to submit the following attachments**

* Recent HCY
* Recent Therapy/Psychological
* CS-9
* Recent Court order
* Recent FST agreeing that Transitional Living Scattered sites (TLSS) is an appropriate placement
* Letters of recommendation
* Letter why the Youth believes TLSS would be appropriate

**At intake we will need**

* BC (youth should have an original)
* SS Card (Youth should have an original)