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)