

Client name: _____ DOB: _____ CS Record #: _____

TCH INQUIRY FOR SERVICES

I. FAMILY INFORMATION

Date of inquiry _____ Phone call? [] Yes [] No
Person/agency making application _____
Relationship to child _____ Phone _____
E-mail address _____

Service Requested:			
L III _____	L II (Prog) _____	TFC _____	Trad FC _____
ReStart _____	DT _____	PRTF _____	Gray/OH _____

Name _____
Last First MI
Preferred Name _____ SSN _____
Birth date _____ Age _____ Sex _____
Primary language _____ Race _____
Birthplace: (city, state) _____ County _____
Religious affiliation _____

LIVING SITUATION PRIOR TO SERVICES: (check one)

- | | |
|---|--|
| <input type="checkbox"/> at home (biological, extended, adoptive) | <input type="checkbox"/> camp program |
| <input type="checkbox"/> child lives on own | <input type="checkbox"/> homeless |
| <input type="checkbox"/> foster home | <input type="checkbox"/> secure/locked facility (non-hospital) |
| <input type="checkbox"/> therapeutic foster home | <input type="checkbox"/> detention |
| <input type="checkbox"/> independent living program | <input type="checkbox"/> youth development center |
| * <input type="checkbox"/> small group home (less than 4 clients) | <input type="checkbox"/> prison/jail |
| * <input type="checkbox"/> large group home (5 or more clients) | <input type="checkbox"/> psychiatric hospital |
| <input type="checkbox"/> other: _____ | * If Residential Treatment, indicate Level: _____ |

Living conditions described as (check all that apply):

[X] Sufficient [] Crowded [] Chaotic [] Unsafe [] Inconsistent

DIAGNOSIS

AXIS	CODE	TYPE	DESCRIPTION
AXIS I			
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			

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II. CUSTODY

LEGAL GUARDIAN (if other than parent):

Name of Legal Guardian: _____

Address: _____

Name of contact person: _____ Best Phone #: _____

VPA Agreement, if _____

Email: _____ DSS? _____

Relationship to Child: _____ Ok to leave message: _____

Legal status confirmed? _____ Is child aware of adoption? _____ Adoption date: _____

Does legal guardian have reliable transportation? No transportation

III. INSURANCE INFORMATION

- *Be sure to list ALL insurance providers, for example, Medicaid and BXBS*

Private Insurance and Number: _____

Insured's Name: _____

Policy #: _____ Phone # _____

Medicaid/NCHC Number: _____ County: _____

SSI? []Yes []No; SSI Applied for? []Yes []No; Initial Denial of SSI? []Yes []No;
2nd Denial of SSI? []Yes []No Other funding sources? _____

Current Provider Information:

Has the cl had a recent psychological assessment? []Yes []No If yes what date?

Community Support Provider/ QP Name: _____

Fax #: _____ Phone #: _____

Email address : _____ PCP Received? _____

Need to Request Records? _____ Date Requested: _____

Therapist Name: _____ Phone #: _____

Email address : _____ Fax #: _____

Need to Request Records? _____ Date Requested: _____

Psychiatrist Name: _____ Phone #: _____

Email address : _____ Fax #: _____

Need to Request Records? _____ Date Requested: _____

Primary Care Doctor: _____ Phone #: _____

Fax #: _____

Need to Request Records? _____ Date Requested: _____

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Dental Provider: _____ Phone #: _____
Fax #: _____

Need to Request Records? _____ Date Requested: _____

Are immunizations current? [] Yes [] No
If so, where are the records held? Name of Agency: _____
Contact Phone: _____ Fax Number: _____

Are psychiatric or other medical services going to be transferred? [] Yes [] No
If so, which? _____

BIOLOGICAL PARENTS: Father:

Name: _____ Phone #: _____
Address: _____
Email: _____
DOB: _____ Race: _____ Religion: _____ Marital Status: _____

Mother:

Name: _____ Phone #: _____
Address: _____
Email: _____
DOB: _____ Race: _____ Religion: _____ Marital Status: _____

Have proceedings been initiated to terminate parental rights for his child?
Mother: [] Yes [x] No **Father:** [] Yes [x] No; *if yes date(s)-if known:* _____

CHILD'S SIBLINGS and OTHER RELATIVES:

Name	DOB/ Age	Relationship	Address	Phone #

List other significant relationships or previous marriages? (duration, children, age of client)

List all of the current members of the client's household (if they are not currently in residential placement)?

What is the permanency plan for this child? Is there a chance for placement with sibling(s)?
**If FC or TxFC referral, are all kinship placements exhausted (placement with siblings ,adult relatives?) **

IV. SOCIAL HISTORY

Reason for Referral (suicidal thoughts, physical aggression, runaway history, level of sexual activity, substance use/abuse, mental health diagnosis, grade retention)

Please provide more detail:

Safety

Suicidal

Suicidal thoughts? Yes No
Suicidal plans? Yes No
Attempts? Yes No
Family hx of? Yes No

Homicidal

Thoughts of killing others? Yes No
Plans to kill others? Yes No
Attempts? Yes No
Family hx of? Yes No

Provide details of any "yes" response: _____

Runaway History

Gone overnight? Yes No
Longest time missing? _____
AWOL to unknown areas or to familiar areas? _____

Last time? _____
Alone or with friends? _____

Provide details of any "yes" response:

Aggression toward self, other & property:

Cuts/ burns self, or bangs head? Yes No
Binges, purges over exercises? Yes No
Breaks objects? Yes No
Sexually active or sexually provocative? Yes No

Recent physical fights? Yes No
Threatens others? Yes No
Accomplished or attempted Yes No
sexual assaults?

Provide details of any "yes" response: _____

Drugs/alcohol

Has client used drugs or alcohol? Yes No Last incidence of use: _____
Has client had drug/alcohol treatment? Yes No
Does anyone in the family have a history of drug or alcohol abuse and/or treatment? Yes No
Please provide details of any "yes" response including contact information for treatment providers:

Other addictive behaviors (sex, eating, exercising)? _____

Describe the client's motivation for use? _____

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Child's Strengths (positive self –esteem, spiritual, achieves good grades, has constructive goals for the future, feels loved) **Please provide detail:**

Family's Strengths (parents / LG's are involved in client's life, parents / LG's have high expectations for completing high school and college, parents/ LG's are accessible and/or supervise client's activities) **Please provide detail:** _____

Support Systems for Child (natural support: mentors, church, etc. or professional support: Community Support, school social worker, etc) **Please provide detail:** _____

Family Relational Issues/ Parents Expected Involvement in Treatment? _____

Is there any history of domestic violence within the family? Substantiated allegations of child abuse (physical and/or sexual)? Neglect? Exploitation? History of or current child abuse suspected (physical and/or sexual?) History of DSS involvement? Current open case with DSS? **Please provide detail:**

If youth is in DSS custody: reason child was removed from home: _____

Has child suffered a traumatic event of any kind (loss of loved one by death, abandonment, incarceration; life-changing residence change(s); separation from nuclear or extended family members; rape; victim of sexually inappropriate act by peer, sibling, non-family member; natural disaster; witness to a violent crime; homicide of family member or friend; motor vehicle accident; major illness)? (specify ages & alleged perpetrator) **Please provide more detail:** _____

Developmental Milestones on time (babbling/talking before age 3, walking by age 2, responds to name/directions, uses objects correctly, imitates behavior of others)? **Please provide more detail:**

Describe the client's peer relationships: _____

Is there a family history of mental illness? [] Yes [] No Received Treatment? [] Yes [] No
Provide details of any "yes" response: _____

V. MEDICAL/MENTAL HEALTH CARE

Any **recent hospitalizations** for homicidal or suicidal ideations? [] Yes [] No
Provide details of any "yes" response, including dates/location of all hospitalizations or hospital discharge summaries:

Any **residential placements (including foster placements)**? [] Yes [] No

Name of Caregiver(s)	Address	Dates of care	Successful D/C (Y / N)

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What is child's ability to live and be treated within a group residential setting? *Please provide detailed response below:* _____

Intensive In Home treatment programs? [] Yes [] No *Provide details of any "yes" response:*

Any limitations in the area of Activities of Daily Living (ADL's) and/or Independent Living Skills?
[] Yes [] No *Provide details of any "yes" response:*

What **other types** of treatment used/tried?

MEDICATIONS:

Medication Name	Dosage	Frequency	Purpose	Written By

Any recent medication changes: _____

Any significant health issues or medical conditions (e.g.: allergies, cancer, diabetes, asthma, STD, TB)? [] Yes [] No

Provide details of any "yes" response including medical specialist's name and contact information:

Physical Stature

Height: _____ Weight: _____

VI. Education Information

School: _____ Contact Person: _____

Assigned School Grade: _____ In which grade(s) has the child been retained: _____

Current classes (is performance below, above or average):

How many high school credits earned thus far?

What is the client's favorite Subject? _____

Educational Setting: Regular Class: [] ; Special Education: [] ; IQ score/range: _____

Does the child receive any type of *special services* from school (IEP)? [] Yes [] No

If yes: [] LD [] BED self cont [] BED mainstream [] OHI [] ADHD

Has the client been suspended from school? [X] Yes [] No; How many times? _____

ISS: _____ OSS: _____ For what reason(s): _____

Long term school suspension? [] Yes [] No Date the child can return? _____

Reason: _____

IEP Requested? [] Yes [] No Date: _____ Date Received/Reviewed? _____

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VII. Legal History

DJJ involvement? Yes No

If yes, please specify :

Is treatment court-ordered? Yes No

Charges: _____

- Adjudicated Delinquent Disposition Pending
- Adjudicated Undisciplined Disposition Pending
- Commitment
- Court Counselor Consultation
- Deferred Prosecution
- Diversion Plan/Contract
- Petition filed
- Post release supervision
- Probation
- Protective supervision

Up coming court dates? _____

Probation Counselor: _____

Phone number: _____

E-mail address: _____

**** If you are requesting Emergency Shelter services and your child is NOT currently receiving mental health and/or substance abuse services, would you like a *Free Mental Health and Substance Abuse Screening* for your child? Y N Yes No
(If yes, staff will contact Tonia Glasco at 728-4373)**

Additional information: _____

Duration of contact: _____

Staff Signature

Date

