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 ____

Services Requested: [ ] L II [ ] L III [ ] DT [ ] FC [ ] TXFC [ ] OPTX

[ ] PSY ASSESSMENT OTHER: ____________________

CHILD:

Name ____
Last First MI

Preferred Name ___________________________ SSN ________________

Birth date _____________ Age ___________ Sex ________________

Primary language __________________________ Race ________________

____________________ County ________________

Religious affiliation ____________

LIVING SITUATION PRIOR TO SERVICES: *(check one)*

[ ] at home (biological, extended, adoptive)	[ ] camp program
[ ] child lives on own	[ ] homeless
[ ] foster home	[ ] secure/locked facility (non-hospital)
[ ] therapeutic foster home	[ ] detention
[ ] independent living program	[ ] youth development center
* [ ] small group home (less than 4 clients)	[ ] prison/jail
* [ ] large group home (5 or more clients)	[ ] psychiatric hospital
[ ] other: ___________	* If Residential Treatment, indicate Level: ________

Living conditions described as (check all that apply):
[ ] Sufficient [ ] Crowded [ ] Chaotic [ ] Unsafe [ ] Inconsistent

Client name: DOB: CS Record #:

II. CUSTODY

LEGAL GUARDIAN

Name of Legal Guardian: ______________________________

Address: ______________________________

Name of contact person: ____________ Best Phone #: ____________

Email: ____________ Alternative Phone: ____________

Relationship to Child: ____________ Ok to leave message: ____________

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

II. 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 #:: ______________________________

III. TREATMENT NEEDS

What is the reason for **out of home placement**?

____
____
____
____
____
____

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:_________

Aggression toward self, other & property:

Cuts/ burns self, or bangs head? [ ]Yes [ ] No
Binges, purges over exercises? [ ]Yes [ ] No
Breaks objects? [ ]Yes [ ] No

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

*Provide details of any "yes" response:*__________

Drugs/alcohol

Has client used drugs or alcohol? [ ]Yes [ ] No Last incidence of use:_________________________

DIAGNOSIS: ____

Completed by: ____________________________________ Date: __________________________