



APPLICATION FOR SERVICE / INTAKE

Application For: ☐ Therapeutic Foster Care ☐ Family Foster Care ☐ Residential Child Care

FROM (person completing application): _____

Approving Person/Agency: *(person approving application and name of agency he/she represents)* _____

This complete application, with supporting documentation, provides the information necessary to decide whether to admit the child. If the child is admitted, the documents relating specifically to admission will be required. If additional space is needed for any question, add an extra sheet or write on the back of the application (be sure to give question number for reference).

Supporting Documentation Checklist

Exams

- | | |
|---|--|
| <input type="checkbox"/> *Physical Exam | Date (Current): ____ / ____ / ____
Date (Scheduled): ____ / ____ / ____ |
| <input type="checkbox"/> *Dental Exam | Date (Current): ____ / ____ / ____
Date (Scheduled): ____ / ____ / ____ |
| <input type="checkbox"/> *Vision Exam | Date (Current): ____ / ____ / ____
Date (Scheduled): ____ / ____ / ____ |

Medical

- | | |
|---|--------------------------|
| <input type="checkbox"/> Physician/Diagnostic Report | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *Psych Medication Evaluation (within 6 months) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> <i>Consent for Administering Non-Prescription Meds</i> | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *Immunization Card/Records | Date: ____ / ____ / ____ |

Education

- | | |
|--|--------------------------|
| <input type="checkbox"/> *IEP (within 12 months) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *School Report Card (most recent) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *School Transcript | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *Court Order (placing youth in custody) | Date: ____ / ____ / ____ |

Psychological/Psychosocial

- | | |
|--|--------------------------|
| <input type="checkbox"/> Psychological Testing (within 12 months) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *CCA (within 30 days) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *PCP (Word version needed as well) | Date: ____ / ____ / ____ |
| <input type="checkbox"/> *CALOCUS (within 30 days) | Date: ____ / ____ / ____ |

Placement

- | | |
|---|--------------------------|
| <input type="checkbox"/> *Placement Letter | Date: ____ / ____ / ____ |
| <input type="checkbox"/> <i>Out-of-Home Family Services Agreement</i> | Date: ____ / ____ / ____ |

Records

- ☐ *Birth Certificate
- ☐ *Social Security Card
- ☐ *Medicaid Card

I. FAMILY INFORMATION

CHILD:

1. Full Name: _____
2. Prefers to be called: _____
3. Date of Birth (dd/mm/yyyy): ____ / ____ / ____
Verified? ☐ Yes ☐ N
4. Sex: ☐ Male ☐ Female
5. Race/Ethnicity: _____
6. Place of Birth (city): _____ (county): _____
7. (state or country): _____
8. Social Security Number: ____ - ____ - ____
9. Currently Living With: ☐ Biological Parents ☐ Relative ☐ Foster Family
☐ Other (Specify): _____

BIOLOGICAL PARENTS:

Father's Full Name: _____

1. Date of Birth (dd/mm/yyyy): ____ / ____ / ____
2. Date of Death (dd/mm/yyyy): ____ / ____ / ____ (if applicable)
3. Social Security Number: ____ - ____ - ____
4. Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
5. Marital Status: _____
6. Race/Ethnicity: _____
7. Religion: _____

Mother's Full Name: _____

1. Date of Birth (dd/mm/yyyy): ____ / ____ / ____
2. Date of Death (dd/mm/yyyy): ____ / ____ / ____ (if applicable)
3. Social Security Number: ____ - ____ - ____
4. Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
5. Marital Status: _____
6. Race/Ethnicity: _____
7. Religion: _____

CURRENT PARENTAL RELATIONSHIPS:

Parental Rights

Have proceedings been initiated to terminate parental rights for this child's mother or father?

Mother: ☐ Yes ☐ No

If yes, give the date of the final order terminating parental rights: _____

Father: ☐ Yes ☐ No

If yes, give the date of the final order terminating parental rights: _____

Adoptions

Has this child been adopted? ☐ Yes ☐ No

If yes, give date(s) of the final adoption order(s): _____

Caregivers:

The person(s), if not biological parents, who will be working in a parental capacity with child while in care

1. Full Name: _____

Relationship to Child: ☐ Step ☐ Adoptive ☐ Other (Specify): _____

Date of Birth (dd/mm/yyyy): ____ / ____ / ____

Social Security Number: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

2. Full Name: _____

Relationship to Youth: ☐ Step ☐ Adoptive ☐ Other (Specify): _____

Date of Birth (dd/mm/yyyy): ____ / ____ / ____

Social Security Number: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

YOUTH'S SIBLINGS: *(Include all half siblings, step siblings, adoptive siblings)*

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Relationship to Youth: ☐ Sister ☐ Brother ☐ Other (Specify): _____

Presently Living With: _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Relationship to Youth: ☐ Sister ☐ Brother ☐ Other (Specify): _____

Presently Living With: _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Relationship to Youth: ☐ Sister ☐ Brother ☐ Other (Specify): _____

Presently Living With: _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Relationship to Youth: ☐ Sister ☐ Brother ☐ Other (Specify): _____

Presently Living With: _____

OTHER RELATIVES:

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Relationship: _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Relationship: _____

Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Relationship: _____

II. CUSTODY

Name of Legal Custodian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Name of Contact Person: _____

Phone Number: _____ Email: _____

Is a Voluntary Placement Agreement or is a CARS Agreement in effect? ☐ Yes ☐ No

If yes, give expiration date: ____ / ____ / ____

III. MEDICAL/DEVELOPMENTAL HISTORY

Are there any problems which will require special attention in caring for this youth? ☐ Yes ☐ No

Include brief description of each problem checked

☐ Physical ☐ Medical ☐ Developmental ☐ Psychological

Name of Primary Care Physician (PCP): _____

Practice/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

List any medications this child/youth is now taking, and for what condition(s):

ALL current medications need to come with the youth in order to admit!

Medication	Dosage	Regimen	Condition	Date Prescribed
<i>e.g. Concerta</i>	<i>36 mg</i>	<i>QAM</i>	<i>ADHD</i>	<i>10/01/2020</i>

(Attach additional sheet if needed)

Name of Prescribing Physician (if other than PCP): _____

Date of last physical exam: ____ / ____ / ____ Next medical appointment: ____ / ____ / ____

Please attach copy of most recent physical or other pertinent physician report/ diagnostic information

List any serious illness, injury, hospitalization, surgery, or traumatic event (seizures, asthmas, allergies etc):

Name of Dentist: _____

Practice/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Date of last dental exam: ____ / ____ / ____ Next dental appointment: ____ / ____ / ____

Please attach copy of any other pertinent report

Vision Problems: ☐ Yes ☐ No Glasses: ☐ Yes ☐ No

Date of last eye exam: ____ / ____ / ____ Results: _____

Date of next eye appointment: ____ / ____ / ____

Hearing problems: ☐ Yes or ☐ No Age detected: _____

Tubes in Ear ☐ Yes or ☐ No Date: ____ / ____ / ____

Any type of hearing devices/implants: Type/ Date: _____; ____ / ____ / ____

Date of last hearing exam: ____ / ____ / ____ Next exam appointment: ____ / ____ / ____

DEVELOPMENTAL HISTORY:

Please describe any complication, or other information during the mother's pregnancy (i.e., diabetes, high blood pressure, toxemia, substance use, etc.): _____

Milestone	Age
Sat alone/ unaided	_____
Walked alone	_____
Put words together	_____

Milestone	Age
Crawled	_____
Spoke first word	_____
Toilet trained	_____

Do you have any concerns about the youth/child's development? If yes, please explain:

IV. EDUCATIONAL INFORMATION

(If this form is completed between school terms, please give the information pertaining to the previous school year. If assistance is needed in completing the form, please consult the child's school.)

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

(Attach copy of the child's report card for the latest reporting period)

School performance this year is: ☐ better than ☐ equal to, or ☐ poorer than previous year

Education setting: ☐ Regular Class ☐ Special Education ☐ Other (Specify): _____

Has child been classified as special needs? ☐ Yes ☐ No

If yes specify classification(s): _____

Child's appointed Surrogate Parent Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Name of Current/last school attended: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

School Transcript: Attached: ☐ Yes ☐ No Promised by date: ____ / ____ / ____

Latest Evaluation Information:

Achievement Evaluation (ex: Woodcock Johnsbm etc.)

Date: ____ / ____ / ____ Assessment/Test: _____

Results: _____

Psychological Evaluation (ex: WISC-III, etc.)

Date: ____ / ____ / ____ Assessment/Test: _____

Results: _____

Attendance Record (for school year):

Number of days in attendance: _____ Number of excused absences: _____

Number of unexcused absences (suspension, expulsion, truancy, etc): _____

Explain: _____

Strengths & Weaknesses:

Academic strengths: _____

Academic weaknesses: _____

School behavioral strengths: _____

School behavioral weaknesses: _____

Recommended school information pertinent to this application: _____

Recommended educational plan/program (IEP, etc.): _____

Other: Special needs/talents, including extra-curricular activities and interests: _____

* Additional school information pertinent to this application: _____

IV. SOCIAL HISTORY/ ASSESSMENT

The following information will help agency staff understand the child's and family's needs and how best to meet these needs. Please complete **thoroughly** if no other psychosocial-specific assessment documentation is available and attached.

Current Presenting Issues:

(What is going on in the family at this time? Describe the significant events which effect this family and child)

Family Strengths (describe briefly): _____

Family Weaknesses (describe briefly): _____

Child's/Youth's Strengths (describe briefly): _____

Child's/Youth/s Weaknesses (describe briefly): _____

What and/or who make this child:

Glad? _____

Sad? _____

Mad? _____

Fight? _____

Run? _____

From what agencies/professionals has the family sought or been given help? *(Specify services and results)*

Dates	Agency/Professionals	Services	Outcomes

(Attach additional sheet if needed)

Supports: What religious resources/support systems are available to this child and family?

Name: _____

Type of Resource/support: _____

Phone of contact person): _____

Name: _____

Type of Resource/support: _____

Phone of contact person): _____

Name: _____

Type of Resource/support: _____

Phone of contact person): _____

Why must this child now live away from his/her parents? _____

Out-of-Home Placements:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Dates of Care: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Dates of Care: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Dates of Care: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Dates of Care: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Dates of Care: _____

(Attach additional sheet if needed)

Delinquent Behavior: ☐ Yes ☐ No

(If **yes**, attach description including history of core involvement and a copy of any court order currently in effect)

Suicidal Risk: Is this youth suicidal? ☐ Yes ☐ No (If **yes**, attach history with description of attempts)

Current Needs: (Identify the current needs of the child and family to which the agency is asked to respond)

Needs: _____

Agency: _____
Needs: _____
Agency: _____
Needs: _____
Agency: _____

VI. PLANNING

This section requires equal attention to the family and the child in answering the questions. If the child is in DSS custody attach a current copy of the out-of-home family services agreement.

Permanency Plan for child/youth: _____

Is there a current need to revise the permanent plan? ☐ Yes ☐ No

If **yes**, explain: _____

Goals: *State the goals toward which the family and child are working to achieve the permanent plan*

- _____
- _____
- _____

Service Request: *What specific services of the agency are being requested on behalf of this family and youth?*

- _____
- _____
- _____

How will the requested services help the family and child achieve their permanent plan? _____

Identify **in the order of your priority** all agencies to which this application is being made:

1. _____
2. _____
3. _____
4. _____

Give the name/role of other volunteers/professionals assigned to this child (Guardian ad Litem, Child Advocate, Court Counselor, etc.):

Name: _____	Role: _____
Name: _____	Role: _____
Name: _____	Role: _____
Name: _____	Role: _____

VII. SIGNATURE(S)

I (we), the undersigned, hereby apply to the (Name of agency) for services named above on behalf of the named child for whom I (we) hold legal custody and/or placement authority. I (we) certify that the information contained in this application and the attachments is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information pertinent to this application as requested by the agency. I (we) also agree to cooperate with the agency and to support the plan of service to which we mutually agree.

Print Name of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian Date: ____ / ____ / ____

Signature of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian Date: ____ / ____ / ____

Voluntary Placement Agreement:

Name of Agency holding Voluntary Placement Agreement: _____

Print Name of Representative of Agency holding Voluntary Placement Agreement Date: ____ / ____ / ____

Signature of Representative of Agency holding Voluntary Placement Agreement Date: ____ / ____ / ____

CARS Agreement:

Name of Agency with whom CARS Agreement was signed: _____

Print Name Date: ____ / ____ / ____

Signature Date: ____ / ____ / ____

Print Name of Representative of Agency with whom CARS Agreement was signed Date: ____ / ____ / ____

Signature of Representative of Agency with whom CARS Agreement was signed Date: ____ / ____ / ____