FINAL 7-19-18

# UNIVERSAL REFERRAL/ADMISSION PACKET

| AGENCY REQUESTING PLACEMENT: Choose an Agency. | DATE OF REQUEST: TODAY<br>REQUESTED BY: |
|---|---|
| CASE MANAGER: | PHONE #:<br>EMAIL: |
| SUPERVISOR: | PHONE #:<br>EMAIL: |
| CASEWORKER: | PHONE #:<br>EMAIL: |
| PROBATION OFFICER: | PHONE #:<br>EMAIL: |
| ATTORNEY FOR CHILD: | PHONE #:<br>EMAIL: |

| CHILD'S NAME: |
|---|
| CASE NAME: |

REASON CHILD ENTERED CARE: Choose an item.
LEGAL STATUS: ☐ART 10 ☐JD ☐PINS ☐VOL PPG: ☐RTP ☐ADOPTION ☐APPLA
DISCHARGE RESOURCE: Click here to enter text.
TRIBAL AFFILIATION: ☐YES ☐NO IF YES, TRIBAL NAME: Click here to enter text.

| CHILD'S CURRENT LOCATION: | DATE PLACEMENT NEEDED: TODAY |
|---|---|
| REASON FOR CURRENT REQUEST<br>**(Current issues/Behaviors):** | |

| AGE: | DOB: | SEX: |
|---|---|---|
| RELIGION: | RACE: | ETHNICITY: |
| CIN: | SSN: | DATE CERTAIN: TODAY |
| CID: TODAY | DSS CASE #: | RATE: |

LEVEL OF CARE YOU BELIEVE CHILD NEEDS (check one):
☐FH ☐GH ☐RTC ☐RTA ☐DIAGNOSTIC ☐NON-SECURE ☐OCFS

TYPE OF PLACEMENT REQUESTED:

FAMILY SUPPORT CENTER: ☐ LONG TERM: ☐ EMERGENCY: ☐
RESPITE: ☐ (dates needed): VISITING RESOURCE: ☐ (DAYS/FREQUENCY)

| FORMER SCHOOL ATTENDED: Click here to enter text. | GRADE: | IQ: |
|---|---|---|
| CURRENT SCHOOL ATTENDING: | GRADE: | CSE CLASSIFICATION: |
| CURRENT SCHOOL ISSUES: *suspensions, truancies, expulsions, etc:* | | |

**CURRENT VISITATION PLAN**: (*INCLUDE PHONE CONTACT*):

| With Whom | Where | How often | Supervised | |
|---|---|---|---|---|
| Mother | | | YES ☐ | NO ☐ |
| Father | | | YES ☐ | NO ☐ |
| Siblings | | | YES ☐ | NO ☐ |
| Other | | | YES ☐ | NO ☐ |

| ORDER OF PROTECTIONS: | |
|---|---|

DESCRIBE STRENGTHS AND INTERESTS OF THIS CHILD/FAMILY**:**

**PLEASE CHECK ALL APPLICABLE BOXES (at least one box in each section)**

| | PAST | PRESENT | | PAST | PRESENT |
|---|---|---|---|---|---|
| **MEDICAL** | | | **MENTAL HEALTH / DEVELOPMENTAL** | | |
| EMERGENCY MEDICAL CARE REQUIRED | ☐ | ☐ | EMOTIONAL ABUSE/NEGLECT: | ☐ | ☐ |
| EXPOSURE TO CONTAGIOUS DISEASE: | ☐ | ☐ | LEARNING / EDUCATIONAL: | ☐ | ☐ |
| MEDICAL PROBLEMS: | ☐ | ☐ | PHYSICAL ABUSE: | ☐ | ☐ |
| DIETARY RESTRICTIONS: | ☐ | ☐ | SELF INJURIOUS: | ☐ | ☐ |
| ALLERGIES: | ☐ | ☐ | EATING DISORDERS: | ☐ | ☐ |
| PHYSICAL HANDICAP: | ☐ | ☐ | SLEEP DISORDERS: | ☐ | ☐ |
| INFECTIOUS DISEASE: | ☐ | ☐ | HALLUCINATIONS/DELUSIONS: | ☐ | ☐ |
| FAILURE TO THRIVE: | ☐ | ☐ | SUICIDAL: | ☐ | ☐ |
| WELL CHILD | ☐ | ☐ | NO INDICATORS AT THIS TIME | ☐ | ☐ |
| ANY MEDICAL RESTRICTIONS | ☐ | ☐ | | | |
| **BEHAVIORAL CONCERNS** | | | **SEXUALIZED BEHAVIORAL** | | |
| FIRE SETTER | ☐ | ☐ | ACTS OUT SEXUALLY: | ☐ | ☐ |
| ENCOPRESIS | ☐ | ☐ | PERPETRATOR: | ☐ | ☐ |
| STEALS | ☐ | ☐ | SEXUAL ABUSE VICTIM: | ☐ | ☐ |
| HURTS ANIMALS | ☐ | ☐ | GENDER DYSPHORIA | ☐ | ☐ |
| PHYSICALLY AGGRESSIVE | ☐ | ☐ | NO INDICATORS AT THIS TIME | ☐ | ☐ |
| HISTORY OF RUNNING AWAY | ☐ | ☐ | | | |
| SUBSTANCE ABUSE | ☐ | ☐ | **SAFETY & RISK NEEDS** | | |
| ALCOHOL ABUSE | ☐ | ☐ | SEPARATE ROOM NEEDED | ☐ | ☐ |
| IMPULSIVE | ☐ | ☐ | DOOR ALARMS NEEDED | ☐ | ☐ |
| OPPOSITIONAL/DEFIANT | ☐ | ☐ | SAFETY PLAN REQUIRED | ☐ | ☐ |
| LYING/STORY TELLING | ☐ | ☐ | | | |
| PEER ISSUES | ☐ | ☐ | | | |

IF ANY OF THE ABOVE BEHAVIORS ARE CHECKED, PLEASE ASSESS AND DESCRIBE BEHAVIORS AND DESCRIBE CHILD'S NEEDS, AS WELL AS TIMEFRAME ASSOCIATED WITH BEHAVIORS.

| **CANVASSING NEEDS:** (for Foster Homes only) | YES | NO |
|---|---|---|
| SIBLING PLACEMENT | ☐ | ☐ |
| TWO PARENT HOUSEHOLD | ☐ | ☐ |
| SINGLE PARENT ONLY (male or female) | ☐ | ☐ |
| OLDER CHILDREN ONLY | ☐ | ☐ |
| YOUNGER CHILDREN ONLY | ☐ | ☐ |
| NO CHILDREN | ☐ | ☐ |
| ETHNICITY: Specify: | | |
| NATIVE AFFILIATION: | | |
| ANIMALS: Specify- Fears/Allergies/ Aggressive towards | ☐ | ☐ |
| OTHER (e.g. needs specific school district) | ☐ | ☐ |

| SPECIFIC FOSTER HOME REQUESTS OR REQUIREMENTS: |
|---|

**PLEASE PROVIDE PRIOR PLACEMENT HISTORY** (attach movement/placement form)
*Are there any reasons why prior foster parents should not be contacted?* _____

## *IF AGENCY ACCEPTS PLACEMENT PLEASE COMPLETE THE FOLLOWING:

**CURRENT HEALTH INFORMATION**

| Primary Care Physician: | Address: |
|---|---|
| Office: | Phone: |

| Dentist: | Address: |
|---|---|
| Office: | Phone: |

| Mental Health: | Address: |
|---|---|
| Office: | Phone: |

| Prescribing Psychiatrist: | Address: |
|---|---|
| Office: | Phone: |

**DSM V DIAGNOSES:**

| | Code | Description |
|---|---|---|
| Axis I | | |
| | | |
| | | |
| Axis II | | |
| | | |
| Axis III | | |
| | | |
| Current GAF | | |
| Diagnosis Prescribed By | | |

**MEDICATIONS**

| MEDICATION | DOSE | DIAGNOSIS | PRESCRIBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY INFORMATION**

| SIBLINGS | LOCATION | IN PLACEMENT | CARETAKER |
|---|---|---|---|
| | | | NAME:<br>PHONE: |
| | | | NAME:<br>PHONE: |
| | | | NAME:<br>PHONE: |
| | | | NAME:<br>PHONE: |

PLACE TOGETHER ☐ YES ☐ NO (*IF NO, STATE WHY NOT*) _____

FATHER'S NAME: (Last) (First) (M) ADDRESS: PHONE:
EMPLOYED/FINANCIAL SUPPORT: AGE: MARITAL STATUS:

| SERVICES RECEIVED: | | | |
|---|---|---|---|
| SERVICE GOAL | SERVICE PROVIDER | PROGRESS/BARRIERS | |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt:: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt:: |

MOTHER'S NAME: (Last) (First) (M) ADDRESS: PHONE:
EMPLOYED/FINANCIAL SUPPORT: AGE: MARITAL STATUS:
*MOTHER'S MAIDEN NAME*:

| SERVICES RECEIVED: | | | |
|---|---|---|---|
| SERVICE GOAL | SERVICE PROVIDER | PROGRESS/BARRIERS | |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt:: |
| | Ph#: | | ☐Referred<br>☐Engaged<br>☐Not engaged<br>Last Appt:: |

## OTHER FAMILY MEMBERS OR INTERESTED PARTIES

NAMES ADDRESSES & PHONE #'S RELATIONSHIP

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.
4. Click here to enter text.

**NAME OF AGENCY: Click here to enter text.**

**IS AGENCY ABLE/WILLING TO ACCEPT THIS CHILD? YES ☐ NO ☐**

**IF NOT, A REJECTION IS DETERMINED BASED ON:** Choose an item.

**IF NOT, WHAT ACCOMMODATIONS WOULD BE REQUIRED FOR SUCCESSFUL PLACEMENT OF THIS CHILD:** Click here to enter text.

## ADDITIONAL MATERIALS FOR NON-EMERGENCY REFERRAL

*Copies of the following documents are needed prior to placement (**If applicable**). If items are not available at the time of placement please submit what you have and then the remaining documentation as soon as possible.*

☐ Initial FASP and 2 most recent FASPs

☐ Child's IEP and any school reports

☐ Child's most recent report card

☐ Child & family psychosocial

☐ Child's most recent psychiatric & psychological reports

☐ Previous placement discharge summaries

☐ Transition Plans

☐ Bridges to Health Detailed Service Plan

☐ Bridges to Health Individualized Health Plan (IHP)

☐ Care Coordination Detailed Service Plan

*COPIES OF THE FOLLOWING DOCUMENTS ARE NEEDED **PRIOR TO PLACEMENT**, IF MATCH IS MADE:*

☐ Birth certificate

☐ Social security card

☐ Medicaid card/third party insurance card

☐ Various LDSS/voluntary agency consents/releases (medical care, travel, etc.)

☐ Rate confirmation letter; clothing voucher confirmation

☐ Court orders

☐ Child's IL assessment

☐ Child's medical information (immunization records, HIV risk assessment & capacity to consent, etc)