

Client name:

DOB:

CS Record #:

The Children's Home INQUIRY FOR SERVICES

Winston-Salem Campus
Franklin Campus

Phone: (336) 721-7625
Phone: (828) 349-0345

Fax (336) 728-4355
Fax (828) 349-9685

I. FAMILY INFORMATION

Date of inquiry: _____ Phone call? Y N

Person/agency making application: _____

Relationship to child: _____ Phone #: _____

E-mail address: _____

Services Requested: L II	L III	DT	FC	TFC	OPTX	PSY
ASSESSMENT	OTHER: _____					

CHILD:

Name: _____ Prefers to be called: _____ Age: _____
Last First MI

Date of birth: _____ Sex: _____ Race: _____ SSN: _____

Place of birth: (city) _____ County: _____ Martial Status: _____

State or country: _____ Religious affiliation: _____ Primary language: _____

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"/> secure/locked facility (non-hospital) |
| <input type="checkbox"/> foster home | <input type="checkbox"/> detention |
| <input type="checkbox"/> therapeutic foster home | <input type="checkbox"/> psychiatric hospital |
| <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"/> homeless |
| <input type="checkbox"/> other: _____ | * If Residential Treatment, indicate Level: _____ |

Living conditions described as (circle all that apply):

Sufficient Crowded Chaotic Unsafe Inconsistent

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BIOLOGICAL PARENTS:

Father's name: _____ Address: _____

Phone #: _____ DOB: _____ Date of Death: _____ Marital Status: _____

Email address: _____

Mother's name: _____ Address: _____

Phone #: _____ DOB: _____ Date of Death: _____ Marital Status: _____

E-mail address: _____

Have proceedings been initiated to terminate parental rights for his child?

Mother: Y N Father: Y N; if yes give date(s)-if known: _____

CHILD'S SIBLINGS:

Name	Date of Birth or Age	Relationship	Presently living with	**If a F.C. referral, is there a chance for placement with sibling(s)?

II. CUSTODY

LEGAL GUARDIAN (if other than parent):

****If FC or TxFC referral, are all kinship placements exhausted (placement with siblings or adult relatives?) _____*******

Name of Legal Guardian: _____

Address: _____

Name of Contact Person: _____ E-mail address: _____

Best Phone #: _____ Alternate Phone # _____ Okay to leave mess Y N

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Relationship to child: Step [] Adoptive [] Relative [] Other [] _____

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

III. INSURANCE INFORMATION

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

Private Insurance and Number: _____

Insured's Name: _____

Policy Number: _____ Phone #: _____

Medicaid/NCHC Number: _____ County: _____

SSI? Y N; SSI Applied for? Y N; Initial Denial of SSI? Y N 2nd Denial of SSI? Y N

Other funding sources? _____

If Cl. has private insurance:

- *ask caller to obtain benefits & eligibility for Residential and/ or Day Treatment services*
- *inquire about out-of-network benefits* • *advise caller of co-pay responsibility*
- *If cl. is local and enhanced services sought, please find out if cl. wants to start OP services prior to potential approval for additional services (e.g.: Residential Group Treatment, Foster Care, Tx Foster Care, Day Treatment)*

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IV. SOCIAL HISTORY

Reason for Referral (*circle all that apply: suicidal thoughts, physical aggression, runaway history, level of sexual activity, substance use/abuse, mental health diagnosis(es), low GPA, grade retention*) *Please provide more detail below:*

Child's Strengths (*circle all that apply: average to high self –esteem, affiliates with a religion, prays, achieves good grades in school, has constructive goals for the future, feels loved by family members*) *Please provide more detail below:*

Family's Strengths (*circle all that apply: 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 more detail below:*

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

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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 more detail below:*

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)? *Please provide more detail below:*

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 below:*

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:

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Runaway History

Gone overnight? Yes No Last time? _____

Longest time missing? _____ Alone or with friends? _____

AWOL to unknown areas or to familiar areas? _____

Sexually active or sexually provocative? Yes No

Provide details of any "yes" response:

Aggression toward self, other & property:

Cuts/ burns self, or bangs head? Yes No Recent physical fights? Yes No

Binges, purges over exercises? Yes No Threatens others? Yes No

Breaks objects? 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: _____

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, shopping, gambling, eating, exercising, working)?

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V. MEDICAL/MENTAL HEALTH CARE

Any **recent hospitalizations** for homicidal or suicidal ideations? Yes No

Provide details of any "yes" response:

Any **residential placements**? Yes No

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

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

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?

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What is the permanency plan for this child?

Current Therapist: _____

Phone number: _____ Fax number: _____

E-mail address: _____

Current Psychiatrist: _____

Phone number: _____ Fax number: _____

Community Support Provider/QP Name: _____

Phone number: _____ Fax number: _____

E-mail address: _____

Primary Care Doctor: _____

Phone number: _____ Fax number: _____

Are immunizations current? Yes No

If so, where are the records held? Name of Agency: _____ Contact

Phone: _____ Fax Number: _____

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:

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MEDICATIONS:

Medication Name	Dosage	Frequency	Purpose	Written By

Any recent medication changes: _____

Are psychiatric or other medical services going to be needed? Yes No

DIAGNOSIS

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

Is there a family history of mental illness? Yes No

Provide details of any "yes" response:

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VI. Education Information

Academics

School: _____ Contact Person: _____

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

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? Yes No; How many times?

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

Long term school suspension? Yes No Reason: _____

When will the child be allowed to return? _____

VII. Legal History

Number of past legal charges: _____ On probation? Y N

Any current charges? Y N; (if yes, explain): _____

Up coming court dates? _____

Probation Counselor: _____ Phone number: _____

E-mail address: _____

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Internal Tracking and Staffing Assessment

Referral Source:

Name:

Agency/Organization: _____

Address: _____

Phone number: _____

E-mail address: _____

POSTCARD SENT: Yes No

OUTCOME OF INQUIRY:

Client requests:

Day TX LII LIII Therapeutic Foster Care Traditional Foster

Reynolda Counseling Services Psychiatric Community Support

After an evaluation of the requested service, the Admissions Counselor recommends:

Day TX LII LIII Therapeutic Foster Care Traditional Foster

Reynolda Counseling Services Psychiatric Community Support

Admissions Counselor recommends the anticipated length of stay in service(s): _____

Client staffed with (include date/time staffed and outcome of staffing):

- *BE SURE TO SEND THIS INQUIRY TO RCS AS THE REFERRAL TO OPT (VIA EMAIL)*

Service offered client: Day Treatment

Residential

LII

LIII

Traditional Foster Care

Therapeutic Foster Care

Reynolda Counseling Services

Community Support

TCH Referral offered: No Yes

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Service requested is denied: No Yes

If yes, reason for denial:

Staff Signature: _____ Date: _____
