



Facility: \_\_\_\_\_ Entry Date: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Inquiry Date: \_\_\_\_\_

Application Date: \_\_\_\_\_ Interview Date: \_\_\_\_\_ Placement Date: \_\_\_\_\_

Emergency Shelter  Group Home  Foster Home

DEMOGRAPHIC INFORMATION

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Child Living With: \_\_\_\_\_

Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ State of Residence: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Gender:  Male  Female Race: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

CASE / BACKGROUND INFORMATION

Placement is  DSS  Private  
(custodial parent or DSS caseworker)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_

Email: \_\_\_\_\_

Caseworker's Phone: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Supervisor's Phone: \_\_\_\_\_

On-call Phone: \_\_\_\_\_

Other Agencies Involved: \_\_\_\_\_

PLAN OF CARE

- Plan under Development  Return to Parent
- Long-Term Foster Care  Long-Term Group Care
- Independent Living  Live With Relative
- Adoption
- Child Adopted Date: \_\_\_\_\_
- Child Released for Adoption Date: \_\_\_\_\_
- Other: \_\_\_\_\_

REASON FOR PLACEMENT

- Emergency Removal from Family of Origin
- Disruption from Foster Home/Group Home
- Transfer from another Emergency Shelter
- Runaway
- Preparation for Independence
- Other: \_\_\_\_\_

Is this the least restrictive placement?

yes  no

REASON FOR REMOVAL FROM FAMILY OF ORIGIN

- Threat of Harm  Abandonment
- Physical Abuse  Sexual Abuse
- Medical Neglect  Physical Neglect
- Educational Neglect  Lack of Supervision
- Parents Incarcerated
- Family Dysfunction
- Breakdown of Parent / Child Relationship

FOR OFFICE USE ONLY	<input type="checkbox"/> new admission	<input type="checkbox"/> re-admission	<input type="checkbox"/> transfer	Intake Staff: _____
<input type="checkbox"/> Boys' Shelter	<input type="checkbox"/> Children's Home	Intake Date: _____	Time: _____	Transfer Date: _____
Financial Support \$ _____	<input type="checkbox"/> DSS Board	<input type="checkbox"/> Social Security	<input type="checkbox"/> DSS Contract	<input type="checkbox"/> Family

PERMANENCY PLANNING

Goals for Family / Child: \_\_\_\_\_

Expected Time Frame: \_\_\_\_\_ Services Required: \_\_\_\_\_

CONTACT INFORMATION

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Siblings: \_\_\_\_\_ Other: \_\_\_\_\_

Phone Calls Permitted To / From: \_\_\_\_\_

Visitation Permitted With: \_\_\_\_\_

Visitation Type:  Supervised  Unsupervised  Campus Visits  Home Visits  Mail  Email

Contact is Prohibited With: \_\_\_\_\_

HEALTH INFORMATION (please check all that apply)

- Lice  Acid Reflux  Scabies
- Enuresis  Sexually Transmitted Disease  Bruises, welts, abrasions
- Anemia  Drug / Alcohol Use  Malnourishment
- Drug-exposed baby (crack, etc.)  Diabetic  Fetal Alcohol Syndrome
- Physical Limitations/Disabilities  AIDS / HIV  Speech Needs
- Ringworm  Burns  Developmentally delayed
- Sleeping Disorders: \_\_\_\_\_ *(speech, emotionally, etc.)*

Other—specify: \_\_\_\_\_

Are Immunizations/shots current?  Yes  No Copy of shot record provided?  Yes  No

Date of last Physical: \_\_\_\_\_ Dental: \_\_\_\_\_ Hearing: \_\_\_\_\_ Vision: \_\_\_\_\_

Wears:  Braces  Appliance  Hearing Aid  Glasses

Pre-set appointments? \_\_\_\_\_ Mental Health Therapist: \_\_\_\_\_

Is child taking any medications?  Yes  No (if yes, please list below)

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time Frame: \_\_\_\_\_ Purpose: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time Frame: \_\_\_\_\_ Purpose: \_\_\_\_\_

Allergies:  Foods  Medications  Insects  Other If yes, specify: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Response: \_\_\_\_\_

If infant, specify type of formula: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

\_\_\_\_\_

Signature of Responsible Party