



Phone 419-589-5511 Fax 419-589-7381

### ADMISSION APPLICATION

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Application \_\_\_\_\_

45 day assessment program: \_\_\_\_\_ or Residential program: \_\_\_\_\_

#### **Program Mission:**

The mission of Foundations for Living (FFL) is to provide an environment of safety where youth feel empowered to heal the wounds of the past and build a foundation of hope for the future.

Please read through the information in this packet if you are considering making a referral to Foundations. We will do everything possible to assist you in assessing needed services.

Foundations provides treatment for those females and males ages 12-18 who experience a variety of emotional, mental, and behavioral disturbances.

#### **Admission Policy:**

It is the policy of Foundations to carefully review all written material submitted for consideration for admission of all potential residents. The material is reviewed by the Director of Intake and the CEO as needed for appropriateness of placement. Foundations is committed to accepting referrals on a non-discriminatory basis on the basis of race, color religion, sex, sexual orientation, national origin, age, physical and mental disability. Individualized treatment planning enables admission acceptance of a wide range residential. In the event that Foundations For Living is unable to accommodate an admission referral indicative of a severe mental or physical disability (e.g.: extremely fragile medical condition or extremely low IQ), referrals are made to appropriate treatment settings as part of the Universal Health Services National Referral Network, KidLink, with the permission of the referring agency.

#### **Indicators of the Need for Residential Treatment and/or Rehabilitation**

- The following is a list of potential indicators of the need for residential care. The list is not meant to be exhaustive nor should any one indicator by itself necessarily justify the need for this level of care. A decision needs to be made by a Multidisciplinary Treatment Team with a thorough assessment of each adolescents strengths, available resources, as well as dysfunction.
  - Behavior that constitutes a danger to self or others (but does not meet the criteria for acute care) that the family, foster home, and/or community cannot manage.
  - Chronic behavior problems such as aggression, running away or truancy.
  - Chronic substance abuse that cannot be controlled through outpatient treatment.
  - Diagnosed mental illness that requires consistent, on-going treatment in a secure environment.
  - Individual needs a step-down from psychiatric hospitalization, detention, or other more restrictive environment, before transitioning to independent living, foster care, or back with family members.

**Admission Procedure**

If accepted into the program, the following documents must be received prior to admission. If not received and the child is entering the 45 day assessment program, the length of stay may be lengthened.

- \_\_\_ Family Case Plan
- \_\_\_ Detailed Social History
- \_\_\_ Recent Physical Examinations
- \_\_\_ Immunization Records
- \_\_\_ Medicaid Card
- \_\_\_ Accurate and Current list of Medications
- \_\_\_ Private Health Insurance Card (copy of front and back)
- \_\_\_ History of youth involvement in the juvenile justice system
- \_\_\_ Treatment history over past 12 months
- \_\_\_ Educational Information to include: IEPs, MFEs, ETRs, reports cards and/or transcripts, and a court order identifying the school district responsible for payment
- \_\_\_ Personality/Psychological Assessments
- \_\_\_ Official/Legal Custody Documents
- \_\_\_ Medical History
- \_\_\_ Birth Certificate
- \_\_\_ Social Security Card

**Referring Agency Information**

Caseworker Name: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Referring Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Reason for referral: \_\_\_\_\_

**Youth's Personal Information**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ U.S. Citizen: Yes or NO  
Height \_\_\_\_\_ Weight: \_\_\_\_\_ Hair color \_\_\_\_\_ Eye Color \_\_\_\_\_  
Race/Ethnicity: \_\_\_\_\_ Religious Preference: \_\_\_\_\_  
Distinguishing Marks, Scars, Tattoos or piercings (including ears): \_\_\_\_\_  
Address of Primary Residence: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Lived With Whom: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Current Grade Level: \_\_\_\_\_ Full Scale IQ: \_\_\_\_\_ AWOL risk? Yes or NO

**Family Information**

Legal Guardian: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell #: \_\_\_\_\_

Birth Mother: \_\_\_\_\_ Custody:  Yes  No  Joint

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

Include in treatment plan:  Yes  No

Birth Father: \_\_\_\_\_ Custody:  Yes  No  Joint

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

Include in treatment plan:  Yes  No

Were Parents Married?  Yes  No  Unknown  Divorced

If parents were not married was paternity legally established?  Yes  No

Are there other siblings in the home?  Yes  No If yes, how many and ages?

\_\_\_\_\_

**School Information**

Most recent school attended: \_\_\_\_\_

Address: \_\_\_\_\_ Most recent grade completed: \_\_\_\_

List all previous school districts in which the child resided (including out of home placements) \_\_\_\_\_

\_\_\_\_\_

School Attendance:  Excellent  Average  Poor

Previous grade retentions: \_\_\_\_\_

Suspensions/expulsions (dates/reasons): \_\_\_\_\_

\_\_\_\_\_

SPEC ED:  Yes  No IEP:  Yes  No (Please remember to send a copy of IEP)

Educational assessment history:

\_\_\_\_\_

\_\_\_\_\_

Other academic/school concerns (including performance/behavioral problems due to AoD use): \_\_\_\_\_

\_\_\_\_\_

Barriers to learning:  None Reported  Inability to read  Other \_\_\_\_\_

\_\_\_\_\_

**Placement History (please list prior placements in order starting with most recent)**

Name	Location	Dates
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the child, currently or in the past: **(Please provide explanation and dates in space provided)**

<input type="checkbox"/> Had suicidal ideations/attempts	
<input type="checkbox"/> Had homicidal ideations/attempts	
<input type="checkbox"/> Have a history of assaulting other	
<input type="checkbox"/> Have a history of running away	
<input type="checkbox"/> Have a history of flashbacks or triggers related to abuse	
<input type="checkbox"/> Have a history of accidents, such as injuries, falls, etc...	
<input type="checkbox"/> Have a past or current medical condition	
<input type="checkbox"/> Adjudicated sexual offender	
<input type="checkbox"/> Past or current sexual acting out behaviors and/or sexual preoccupation	
<input type="checkbox"/> Illegal drug use/abuse in the past 12 months	
<input type="checkbox"/> Non-prescription drug abuse in the past 12 months	
<input type="checkbox"/> Prescription drug abuse in the past 12 months	
<input type="checkbox"/> Abuse of other substances in the past 12 months	

**Drug/Substance/Alcohol Use:**

Age of First Use \_\_\_\_\_ Date of Last Use \_\_\_\_\_  
 Frequency of Use \_\_\_\_\_ Amount \_\_\_\_\_ Method \_\_\_\_\_  
 Has a toxicology screen be completed?  
 Not Indicated    No    Yes      If yes, date& results: \_\_\_\_\_

**Pertinent Developmental History (please describe issues/concerns in space provided)**

Mother's pregnancy history: \_\_\_\_\_  
 \_\_\_\_\_  
 Infancy (age 0-1): \_\_\_\_\_  
 \_\_\_\_\_  
 Preschool (age 2-4): \_\_\_\_\_  
 \_\_\_\_\_  
 Childhood (age 5-12): \_\_\_\_\_  
 \_\_\_\_\_  
 Adolescent (age 13-17): \_\_\_\_\_  
 \_\_\_\_\_  
 Pertinent Sexual Issues/Concerns: \_\_\_\_\_  
 \_\_\_\_\_  
 Peer relationships/social functioning: \_\_\_\_\_  
 \_\_\_\_\_

**Mental Health Treatment (please list agency/facility; dates; clinicians; reasons)**

Was the Child Adopted? Yes or No \_\_\_\_\_ If Yes, Age at Time of Adoption: \_\_\_\_\_

Psychiatric Diagnosis and Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Outpatient treatment: \_\_\_\_\_  
\_\_\_\_\_

Psychiatric Hospitalization: \_\_\_\_\_  
\_\_\_\_\_

**AoD Treatment (please give dates and locations):**  None Reported  Outpatient

Inpatient  Residential  Detox  Other \_\_\_\_\_  
\_\_\_\_\_

**History of Abuse, Neglect, Violence:**

No self-reported history of abuse, neglect violence

If there is a history please indicate below if client was the Victim (V) and/or Perpetrator (P) and if it was reported)

**Physical Neglect:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Physical Abuse:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Emotional Abuse:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Domestic Abuse:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Elder Abuse:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Community Violence:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

**Sexual Abuse/Molestation:** V P **Reported:** Y N **To Whom:** \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

**Family Environment/Relationships:**

*Parent-Child Relationship(s): Identify – P=Primary S=Secondary Household B=Both*

Parent-Child Conflict: \_\_\_\_\_None-Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe

Parent Supervision/Monitoring of Child: \_\_\_Always \_\_\_Usually \_\_\_Inconsistently \_\_\_Rarely

Cooperation Between Parents Regarding Child: \_\_\_Always \_\_\_Usually \_\_\_Inconsistently \_\_\_Rarely

Parent Positive Activities with Child: \_\_\_Frequent \_\_\_Occasional \_\_\_Infrequent

Parent Satisfaction with Relationship: \_\_\_Satisfied \_\_\_Neutral \_\_\_Dissatisfied

Child Satisfaction with Relationship: \_\_\_Satisfied \_\_\_Neutral \_\_\_Dissatisfied

Comment on Parent-Child Relationships (describe further if needed): \_\_\_\_\_  
\_\_\_\_\_

*Sibling-Child (Client) Relationship(s):*  No siblings *P = Primary S = Secondary Household*

Child-Sibling(s) Conflict: \_\_\_\_\_None-Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe

Sibling(s) Positive Activities with Child: \_\_\_\_\_Frequent \_\_\_\_\_Occasional \_\_\_\_\_Infrequent

Sibling(s) Satisfaction with Relationship: \_\_\_\_\_Satisfied \_\_\_\_\_Neutral \_\_\_\_\_Dissatisfied

Child Satisfaction with Relationship: \_\_\_\_\_Satisfied \_\_\_\_\_Neutral \_\_\_\_\_Dissatisfied

Comment on Sibling-Child Relationships (describe further if needed): \_\_\_\_\_

**Other Family Concerns:**

Family Member Alcohol Abuse: \_\_\_\_\_

Family Member Substance Abuse: \_\_\_\_\_

Family Member Mental Health: \_\_\_\_\_

Family Member Health Problems: \_\_\_\_\_

Family Member Disability: \_\_\_\_\_

Family Member Legal Issues: \_\_\_\_\_

Family Financial Concerns: \_\_\_\_\_

Other (describe): \_\_\_\_\_

Comment on Other Family Concerns (specify problems that impact client's needs): \_\_\_\_\_

Foundations For Living does its best to ensure the safety and well being of all residents. To ensure this safety, we need to have an understanding of the child's current environment. **Does this child currently have access to weapons, lethal medications and/or other means of self harm in the home? If yes, please describe:** \_\_\_\_\_

**Court Information**

Current legal status:  None  Probation  Detention  Awaiting Charge  AoD Related  
 Court ordered to treatment

History of Legal Charges:  Yes  No If yes, check one:  Status Offense  Delinquency

Upcoming Court Date/Time: \_\_\_\_\_ Charge: \_\_\_\_\_

Juvenile Court involvement (related to child abuse/neglect/dependency):  Current  Past

Name/Phone # Probation officer (if applicable): \_\_\_\_\_

Name/Phone # GAL and/or CASA (if applicable): \_\_\_\_\_

**Medical Information**

Has Medicaid/IV-E Medicaid been established?  Yes  No

Medicaid #: \_\_\_\_\_

Allergies (include food, meds, animals, environmental): \_\_\_\_\_

Has the child ever been diagnosed with any of the following?:

<input type="checkbox"/> Asthma <input type="checkbox"/> Bladder/Kidney Infection <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Convulsions Last Episode: <input type="checkbox"/> Diabetes (attach current schedule) <input type="checkbox"/> Heart Disorder Last EKG: <input type="checkbox"/> Heart Murmur Last EKG:	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV Positive/AIDS <input type="checkbox"/> Meningitis <input type="checkbox"/> Mononucleosis <input type="checkbox"/> MRSA (attach treatment utilized) <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Problem with joints	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Sickle Cell trait <input type="checkbox"/> Syphilis <input type="checkbox"/> Tuberculosis Last PD: Treated: Tx Completed (attach TX utilized) <input type="checkbox"/> Ulcers
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Does the child have any other illness/physical ailment/disability not mentioned above? \_\_\_\_\_

**Individual Responsible for Medical Authorization:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Daytime Phone Number: \_\_\_\_\_

**Emergency Contact Information:**

Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

**Additional Information**

What are the goals for this child while in treatment? \_\_\_\_\_

What is the step-down plan for this child (if known at this time)? \_\_\_\_\_

Is the child aware that he/she is coming to Foundations For Living?  Yes  No

What is your county's clothing requirement? Do the children need to return with a certain amount of clothing? How do we handle outgrown/out-of-season clothing?

If not stated in master contract, does the county provide clothing vouchers for the child when needed?

Yes  No