DHR-DFC-1870

DATE OF APPLICATION

____

THERAPEUTIC FOSTER HOME
GROUP HOME, INSTITUTION, OR RESIDENTIAL TREATMENT
APPLICATION FOR ADMISSION

PERSON MAKING REFERRAL ______________________ CONTACT TELEPHONE # ______________

ADDRESS ____

CHILD____ DOB __________ AGE ____ SEX ____ RACE ___
First Middle Last

REASON FOR REFERRAL: ____

____

HEIGHT _____ WEIGHT _____ EYE COLOR _____ HAIR COLOR _____ SOC. SEC. # ______________

LEGAL STATUS: DEPENDENT _____ CHINS _____ DELINQUENT _____ OTHER ______________

LEGAL CUSTODIAN: ____

ADDRESS: ____

MEDICAL HISTORY:

CHECK IF CHILD HAS HAD:

_____ MEASLES _____ MUMPS _____ CHICKEN POX _____ SCARLET FEVER _____ WHOOPING COUGH

_____ TB SKIN TEST DATE ____________ WHERE ________________________ RESULTS________

_____ SICKLE CELL ANEMIA TEST DATE ________ WHERE ____________________ RESULTS ________

PRESCRIBED MEDICATIONS CHILD CURRENTLY TAKES ______________________________

HOSPITALIZATIONS:

NAME OF HOSPITAL DATE ADMITTED DOCTOR REASON FOR ADMISSION

____

____

____

DESCRIBE ANY PHYSICAL, MEDICAL, DEVELOPMENTAL OR PSYCHOLOGICAL PROBLEMS THAT WILL REQUIRE SPECIAL ATTENTION IN CARING FOR THIS CHILD:

____

____

____

CHECK IF CHILD HAS EVER HAD A PROBLEM WITH:

_____ HEAD _____ HEARING _____ VISION _____ MOUTH _____ LEARNING _____ SWALLOWING

_____ NECK _____ HEART _____ LUNGS _____ URINARY _____ TALKING _____ BREATHING

_____ FEET _____ BACK _____ SKIN _____ RECTUM _____ WALKING _____ CHEWING

_____ HANDS _____ ABDOMEN _____ NOSE _____ GENITALIA _____ CRAWLING _____ OTHER

_____ ARMS _____ LEGS _____ THROAT _____ ALLERGIES _____ SITTING

IF CHECKED, PLEASE EXPLAIN:

____

____

____

EDUCATION:

CURRENT/LAST ATTENDED SCHOOL ______________________________ GRADE ________

ADDRESS ______________________________ PHONE ________

IF SPECIAL EDUCATION, CHECK AS APPROPRIATE: _____ LD _____ EF _____ EMR

HAS CHILD BEEN TESTED: _____ DATE _____ WHERE ______________________________

CHECK APPLICABLE SCHOOL PROBLEMS:

_____ PEER PROBLEMS _____ AGGRESSION TOWARD PERSONS _____ AGGRESSION TOWARD PROPERTY

_____ TRUANT/SCHOOL AVOIDANT _____ PROBLEMS WITH TEACHERS _____ UNDERACHIEVER

_____ UNDERSOCIALIZED _____ THEFT _____ OTHER (SPECIFY) ______________________________

PARENTAL/FAMILY INFORMATION:

PARENTS' MARITAL STATUS: _____ MAR _____ SEP _____ DIV _____ WID _____ NEVER MARRIED

FATHER: DOB ______________ SOC. SEC. # ______________ LIVING _____ DECEASED _____

IF DECEASED, DATE AND CAUSE OF DEATH: ______________________________

NAME ______________________________

ADDRESS ______________________________ PHONE ______________

PLACE OF EMPLOYMENT ______________________________

PRESENT SPOUSE (COHABITING?) ______________________________

GENERAL HEALTH ______________ DATE OF LAST CONTACT WITH AGENCY ______________

MOTHER: DOB ______________ SOC. SEC. # ______________ LIVING _____ DECEASED _____

IF DECEASED, DATE AND CAUSE OF DEATH: ______________________________

NAME ______________________________

ADDRESS ______________________________ PHONE ______________

PLACE OF EMPLOYMENT ______________________________

PRESENT SPOUSE (COHABITING?) ______________________________

GENERAL HEALTH ______________ DATE OF LAST CONTACT WITH AGENCY ______________

SIBLINGS:

NAME	SEX	AGE	ADDRESS & PHONE

PLEASE ATTACH IN NARRATIVE FORM A SOCIAL SUMMARY THAT COVERS AT LEAST THE FOLLOWING:

1. PRENATAL CARE (LENGTH OF PREGNANCY, DURATION OF LABOR, COMPLICATION, ETC.)
2. CURRENT LIVING SITUATION AND WHY CHANGE IN PLACEMENT IS BEING SOUGHT.
3. PLACEMENT HISTORY, LENGTH IN CARE AT EACH HOME/FACILITY AND WHY MOVED.
4. CHILD'S ACTING-OUT BEHAVIORS, BEING VERY SPECIFIC.
5. CHILD'S STRENGTHS AND NEEDS.
6. CHILD'S INTERESTS, TALENTS, SPECIAL SKILLS.
7. PARENTAL HISTORY AND FAMILY DYNAMICS. INCLUDE PARENTAL STRENGTHS AND NEEDS, SIGNIFICANT OTHERS AND THEIR ROLES, MENTAL ILLNESS, PHYSICAL DISABILITIES, INCARCERATIONS, SUBSTANCE ABUSE, ETC
8. REUNIFICATION ATTEMPS WITH PARENTS/RELATIVES.
9. RESTRICTIONS ON VISITATION, TELEPHONE, AND MAIL ACCESS.
10. CASE PLAN AND TIME FRAMES.

OTHER:

ATTACH RECENT COPY OF MEDICAL, PSYCHOLOGICAL, SOCIAL SECURITY CARD, CERTIFICATE OF IMMUNIZATIONS, AND BIRTH CERTIFICATE.

Certification of Need for Services:
Non-Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name | Recipient Medicaid Number

Date of Birth | Race | Sex | County of Residence

Facility Name and Address | Planned Admission Date

PHYSICIAN CERTIFICATION:

1. I am not employed or reimbursed by the facility.
2. I have competence in diagnosis and treatment of mental illness.
3. I have knowledge of the patient's situation.
4. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
5. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
6. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Printed Name of Physician | Physician Signature | Phone Number | Date

Physician Address | License Number

Printed Name of Other Team Member | Signature | Phone Number | Date

Printed Name of Other Team Member | Signature | Phone Number | Date