|  |  |
| --- | --- |
| Date | Date of Acceptance (to be completed by DCF) |
| Parent/Guardian Name | Link # (to be completed by DCF) |
| Address |
| Telephone Number – Home:  | Work:  |
| Referral Source |
| Reason for Request for Voluntary Services |
| Parents are expected to use their own insurance if it is available. |
| Are services being sought because private insurance will not cover costs of treatment? [ ]  Yes [ ]  No |
| Are services being sought because Medicaid will not cover costs of treatment? [ ]  Yes [ ]  No |

|  |
| --- |
| **IDENTIFYING DATA** |
| Child’s Name | Address |
| Sex: [ ]  Male [ ]  Female | Race:  |
| Social Security Number | DOB | Place of Birth |
| Is Child Adopted? [ ]  Yes [ ]  No | Is Child a DCF Adopted Child? [ ]  Yes [ ]  No |
| Present Grade:  | Most Recent I.Q.:  |
| Date of Last Physical: | Diagnosis (if known): |
| Name of Person Who Diagnosed | Date of Diagnosis |
| Significant Health Problems |
| Medication |
| Type | Dosage | Reason Prescribed | How Long Prescribed |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **PLACEMENTS OR HOSPITALIZATIONS** |
| Location | Date Placed | Reason Placed | Date Discharged | Reason Discharged |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **FAMILY AND COMMUNITY CAPACITY TO MEET THESE NEEDS** |
| Willingness of Family to be Involved in Treatment |
| List current and previous services to family member |
| Person Receiving Services | Type of Service | Service Provider | Dates of Service |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |
| List anticipated problems or roadblocks to the success of in-home services |

|  |
| --- |
| **Child Being Referred** |
| Developmental History |
| Birth Weight:  |
| Please indicate age for the following: | Crawling: | Toilet Training: |
| Walking: | First Stood With Help: |
| Talking: | First Stood Alone: |
|  |
| Does child have a history of the following: | High temperatures | [ ]  Yes [ ]  No |
| Enuresis | [ ]  Yes [ ]  No |
| Encopresis | [ ]  Yes [ ]  No |
| Convulsions | [ ]  Yes [ ]  No |
| Allergies/dietary needs | [ ]  Yes [ ]  No |
|  |  |  |
| Please list all significant childhood diseases |

|  |
| --- |
| Educational History |
| Current History | Town of Nexus |
| School Contact | Address |
| [ ]  Regular Education | [ ]  Special Education | [ ]  Disability Category |
| Date of last Planning and Placement Team (PPT) | Date of most current Psychological Evaluation |
| Schools Attended | From/To Dates | Contact |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| Comments on school behavior, attitude, etc. |
|  |
| Educational / Vocational goals |
| Interests / Hobbies |
| List child’s special interests and/or hobbies |

|  |
| --- |
| **FAMILY BACKGROUND** |
| List the name(s) of all persons living in child’s residence |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |
| Primary Language Spoken by Caregivers:  |
| Housing: Years at current address:  |
| If less than one year, previous address |

|  |
| --- |
|  |
| Significant others (include relatives and friends) |
| Name: |  |  | Name: |  |  |
| Address: |  |  | Address: |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Relationship:  |  Relationship:  |

|  |
| --- |
| **FINANCIAL INFORMATION** |
| Does the family receive: | TANF [ ]  Yes [ ]  No | Food Stamps [ ]  Yes [ ]  No | WIC [ ]  Yes [ ]  No |
| Other assistance:  |
| Medicaid [ ]  Yes [ ]  No | Medicaid Number: |
| Is the family/child covered by private insurance? | [ ]  Yes [ ]  No |
| If yes, name of insurance:  | Policy Number:  |
| Physician/Clinic:  | Phone Number: |
| Dentist: | Phone Number:  |

|  |
| --- |
| **SIBLINGS** |
| 1. | Name | DOB | Sex [ ]  Male [ ]  Female |
|  | Birthplace:  | Social Security Number:  |
|  | Address: |
|  |
| 2. | Name | DOB | Sex [ ]  Male [ ]  Female |
|  | Birthplace:  | Social Security Number:  |
|  | Address: |
|  |
| 3. | Name | DOB | Sex [ ]  Male [ ]  Female |
|  | Birthplace: | Social Security Number:  |
|  | Address: |
|  |
| 4. | Name | DOB | Sex [ ]  Male [ ]  Female |
|  | Birthplace:  | Social Security Number:  |
|  | Address: |

|  |
| --- |
| **PARENTS / GUARDIAN** |
| Primary Caregiver Name: | Secondary Caregiver Name: |
| Relationship: | Relationship: |
| DOB: | DOB: |
| Place of Birth: | Place of Birth: |
| Social Security Number: | Social Security Number: |
| Address:  | Address:  |
| Home Phone Number: | Home Phone Number: |
| Work Phone Number: | Work Phone Number: |
| Employer: | Employer: |
| Okay to call at work? [ ]  Yes [ ]  No | Okay to call at work? [ ]  Yes [ ]  No |
| Work Schedule: | Work Schedule: |
| Education (last grade completed): | Education (last grade completed): |
| Medical Information – List all health problems/special needs.(Also include any substance abuse or mental health issues) | Medical Information – List all health problems/special needs.(Also include any substance abuse or mental health issues) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |
| Have you used any other names? [ ]  Yes [ ]  No (If so, please list them) | Have you used any other names? [ ]  Yes [ ]  No (If so, please list them) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |
| Relationship with child being referred: | Relationship with child being referred: |

**Application for Services – Consent for Treatment/Services**

 I understand that by submitting this application for Voluntary Services, I am consenting to the provision of in-home

mental health services for my child/youth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and family. I further understand that my

child/youth may require out-of-home care and that I will be asked to sign a “Permission to Place” form at that time.

 In addition, I understand that our family’s continued eligibility for these services is dependent upon our ongoing

involvement in and participation with the agreed upon treatment plan.

|  |
| --- |
| **SIGNATURES** |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
| Parent |  | Date |
|  |  |  |
|  |  |  |
|  |  |  |
| Parent |  | Date |
|  |  |  |
|  |  |  |
|  |  |  |
| Youth (age fourteen or older) |  | Date |
|  |  |  |
|  |  |  |
|  |  |  |
| Social Worker |  | Date |

**Checklist for Submission of Materials**

**Voluntary Services Application**

|  |  |
| --- | --- |
| [ ]  | Educational Records / Current Report Card |
| [ ]  | Psychological Evaluation |
| [ ]  | Psychiatric Evaluation |
| [ ]  | Copy of Social Security Card |
| [ ]  | Copy of Birth Certificate |
| [ ]  | Medical Records / Information (if applicable) |
| [ ]  | Signed Release of Information Forms |
| [ ]  | Verification of Supplemental Security Income (SSI) (if applicable) |
| [ ]  | Completed DCF-550, Title IV-E / Title XIX Application |
| [ ]  | Record of Immunizations |
| [ ]  | Alien Registration Card (Green Card) (if applicable) |
| [ ]  | Copy of Most Recent 1040 |
| [ ]  | Adoption Subsidy Agreement (if applicable) |
| [ ]  | Trust Fund Information (if applicable) |