DCF – 787 (12/2017)

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| General Information (USE THE **TAB BUTTON** TO MOVE TO THE NEXT TEXT BOX) |
| Area Office/Referrer:  | Date Completed:      |
| AO DMHAS Liaison:       | Phone #:       |

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| DCF Contact Information |
| SW:        | #:       |
| SWS:        | #:        |
| PS:        | #:       |

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| Client Information (**FN**= first name of the client/**LN** = last name of the client) |
| **FN**:  | **LN**:  | DOB:        | Age:        | Gender:  |
| Case ID:        | Person ID:        | Ethnicity:   | Language: -Enter Primary- |

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| Social Security Information |
| SSN:        | Receiving SSI:   | SSI Application completed:  |

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| Commitment/Guardian Information |
| Legal Status:  |
| Legal Guardian Name:        | Phone #:       |
| Address:       |
| City:       | State:    | Zip:       |

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| Placement Information |
| Current Placement (include foster parent name):       |
| Address:        |
| City:  | State:     | Zip:       |
| Current Placement:  | Comment:       |
| If not at home are there plans for reunification?  |

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| Educational Information (\*Note: The Exit Criterion is found on the youth’s IEP) |
| Current Grade:     | Nexus:        | Special Ed.: |
| Exit Criterion\*:   | Graduation Date (m/yyyy):      |
| Most current IEP Date:        | Post High School Planning:  |
| IQ Scores: VIQ:    PIQ:     FSIQ:     | Test:  | Date tested:     |
| IQ Scores: VCI:     PRI:     WMI:     PSI:     FSIQ:     IQ is Valid:  |
| DMR Potential:  | Applied to DMR:  | Appealed (if denied):  |

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| Acquired/ Traumatic Brain Injury Potentiality (ABI/TBI)Please note for youth with ABI/TBI issues, you must include medical records to support the condition: |
| Has the youth had a head or brain injury?   |

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| Legal Information |
| Legal Issues:  | Citizenship Status?  |
| On Parole:  End Date:        | On Probation: End Date:        | Megan’s Law:  |
| Worker:       #:        |
| Supervisor:       #:        |
| Comments or Conditions of Probation/Parole (limited to 150 characters): N/A |

## Current Diagnoses

Note: Diagnoses *must* be within the past year. Please include documentation to support the diagnoses listed below, or the packet will be returned.

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| Diagnosed by:       | Date:       |

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| **MH Diagnoses** (One diagnosis per textbox):  |
| 1)        | 2)       | 3)       |
| 4)       | 5)       | 6)       |
| 7)       | 8)       | 9)       |

*Medications: check if client is refusing to take medication(s):* *[ ]*

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| Prescribed by:        | Date:       |

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| Medication(s) (One medication per textbox):  |
| 1)        | 2)       |
| 3)        | 4)       |
| 5)       | 6)       |
| 7)        | 8)       |

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| Medical Issues (up to 150 characters):  |
| N/A |

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| Additional Notes (up to 350 characters):  |
| N/A |