|  |  |
| --- | --- |
| 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 | |

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| --- | --- | --- | --- | --- | --- |
| **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 |
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| **PLACEMENTS OR HOSPITALIZATIONS** | | | | | |
| Location | Date  Placed | Reason Placed | | Date  Discharged | Reason Discharged |
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| **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 |
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| List anticipated problems or roadblocks to the success of in-home services | | | | | |

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| **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 | | |

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| --- | --- | --- | --- |
| 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 |
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| Comments on school behavior, attitude, etc. | | | |
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| Educational / Vocational goals | | | |
| Interests / Hobbies | | | |
| List child’s special interests and/or hobbies | | | |

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

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

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| **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: | |

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| **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: | | | |

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| **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) | | |
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| 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) | | |
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| 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.

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| **SIGNATURES** |

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| Parent |  | Date |
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| Parent |  | Date |
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| 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) |