Connecticut Department of Children and Families
APPLICATION FOR RE-ENTRY TO ADOLESCENT SERVICES PROGRAM
DCF-2095
12/19 (Rev.)

Please fill out form completely and return to:

Social Worker Name:	DCF Office Select DCF Office

DEMOGRAPHIC INFORMATION

Youth LAST Name	Youth FIRST Name	Phone #:	E-mail:

Address (No. and Street)	Apt. #:	City:	State:	Zip:

DOB:	Age:	Gender: Please Select	Race: Please Select One	SS #:

	Name	Phone #:
Medical Provider		
Dental Provider		
Youth's Attorney		

DCF INVOLVEMENT

Most Recent DCF Worker's Name:	Phone #: (If available)::

Most Recent DCF Office:
Select DCF Office

Reason for Re-Entry Request: Please explain why you are requesting to re-enter DCF services and why you should be considered for re-entry

EDUCATION

School:	School Type: ☐ College ☐ Vocational ☐ High School	Grade:

Other (Please explain):

Education plans after completing high school:

Have You Completed a Life Skills Program? ☐ Yes ☐ No If yes, which program?

In the past 12 months have you: *(Please check all that apply):*

☐ Attended school regularly ☐ Received passing grades ☐ Been truant from school ☐ Been suspended from school

☐ Performed to your potential ☐ Received poor grades ☐ Been disruptive in school ☐ Been expelled from school

FAMILY / FRIENDS

What family, friends or other adult supports do you have in place?

	NAME:	Phone Number:
Parent/Guardian:		
Parent/Guardian:		
Spouse:		
Sibling:		
Sibling:		
Sibling:		
Sibling:		
Adult Support:		
Other:		
Other:		

COMMUNITY INVOLVEMENT

☐ Clubs/Organizations ☐ Volunteer ☐ Mentoring ☐ Paid Employment ☐ Participates in Religious Activities

☐ Other *(please specify)*:

MEDICAL AND MENTAL HEALTH

Do you have any unmet medical or dental needs? ☐ Yes ☐ No If Yes, please explain:

I agree to a substance use/abuse evaluation: ☐ Yes ☐ No	Youth Signature:	Date:
I agree to a mental health evaluation. ☐ Yes ☐ No	Youth Signature:	Date:
I agree to a physical health evaluation. ☐ Yes ☐ No	Youth Signature:	Date:

Are you currently in therapy? ☐ Yes ☐ No If no, have you ever been in therapy?: ☐ Yes ☐ No

If yes, please detail when, where, and the reason/purpose for therapy.

Name of Therapist:	Phone:

Are you currently on prescription medication? ☐ Yes ☐ No If yes, please complete the following.

Name of MEDICATION	PURPOSE for Medication

Are you pregnant? ☐ Yes ☐ No If yes, please specify expected delivery date.

If pregnant, where have you been receiving pre-natal care?:

Are you a parent? ☐ Yes ☐ No If yes, please complete the following:

Child's Name:	Child's Age	Child Lives with Me
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

LEGAL COURT INVOLVEMENT

Court History: ☐ Not Applicable ☐ Currently on Probation ☐ Probation Completed

Probation Officer:	Phone:
Attorney:	Phone:

Reason for Court Involvement:

Criminal Charges, if any:

Do you have any pending criminal charges? ☐ Yes ☐ No If yes, please explain:

WORK EXPERIENCE

Currently Employed? ☐ Yes ☐ No If yes, please complete the following:

Name of Employer:	Hours Worked Weekly:

Previous Employment History? ☐ Yes ☐ No If yes, list employer(s) and dates

EMPLOYER	Dates Employed FROM:	TO:

RESIDENCE HISTORY

Please list the last five places you have lived, beginning with the most current residence.

Name and Type of Residence (Family, Friend, DCF Placement, etc.)	Dates of Placement FROM:	TO:

I understand that DCF will review this application within the next 30 days to assess whether or not I will be able to re-enter the DCF Adolescent Services Program. I understand that failure to answer these questions truthfully may result in delay, further review or denial of the application.

Youth Signature:	Date: