



Application for Emergency/Pre-Placement Admission to CHRIS Kids

Please complete and fax, along with the following items, to:
 404.564.4719 ATTN: Intake Coordinator or email to
intake@chriskids.org

- Psychological evaluation, if available
- Social History, if available. If not, please complete Social History Form, Page 4 - 6 of this application)
- Current Diagnosis/Diagnostic Impressions

Name:		SS #:	Application Date:
Age:	DOB:		Sex:
Height:	Weight:		Ethnicity:
Insurance Information - Company Name:			
Group or ID #		Type of Coverage: (PPO, Medicaid, HMO)	
Expiration date:			
Reason for referral:			
Anticipated length of stay:			
Custodial Agency/Custodian:		County (if DJJ, include Region):	
Case Worker/Court Service Worker:		Title:	Agency:
Address:			
Phone#:	Cell #:	Additional means of communicating w/custodian required:	
		Fax:	
After Hours #:		Email:	
Supervisor's Name:		Phone:	
		Email :	

Principal Family Contact(s):		Relationship:	
Address:			
Phone: (home)		(work)	
Phone contact? Yes <input type="checkbox"/> No <input type="checkbox"/>	Who provides supervision?		
Face-to-face? Yes <input type="checkbox"/> No <input type="checkbox"/>	Overnight visits permitted? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Supervision Required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Can participate in program? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Add'l Family Contact(s):		Relationship:	
Address:			
Phone: (home)		(work)	
Phone contact? Yes <input type="checkbox"/> No <input type="checkbox"/>	Who provides supervision?		
Face-to-face? Yes <input type="checkbox"/> No <input type="checkbox"/>	Overnight visits permitted? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Supervision Required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Can participate in program? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Reason for Change of Placement:			
Placement Prior to Admission:			
Last school attended:		Grade:	
Special Ed? Yes <input type="checkbox"/> No <input type="checkbox"/>		Passing? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Legal Restrictions regarding family contact? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please describe:			
Are there pending or recent charges? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:			

PRESENTING AND HISTORICAL ISSUES (check any that apply)

History	Presenting		History	Presenting		History	Presenting	
		Alcohol/Drugs			Gang			Psych Hospitalization
		Animal Abuse			Juvenile Court			Runaway
		Cult			Medical/Illness			Self Mutilation
		Depression			Violence re peers			Sex Offense
		DFCS / DJJ			Weapons			Sexual Abuse
		Emotional Abuse			Medication			Sexual Acting Out
		Enuresis/Encopresis			Neglect			Suicidal/Homicidal
		Family D/A			Physical Abuse			Violence re authority
		Fire Setting			Psychosis			Other

Most recent high risk incident: _____

Positive behaviors the youth seeks to practice: (anger control, cessation from drug use)

List the projected primary goals of the service plan from referral source perspective:
1) _____
2) _____
3) _____

Medical Information regarding youth

<input type="checkbox"/> Allergies (list below)	<input type="checkbox"/> Deafness/Hearing disorder	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Nebulizer
<input type="checkbox"/> Anemia/blood disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> STD's
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Epipen	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Stomach/intestine problems
<input type="checkbox"/> Corrective lens(es)	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> + TB skin test

If any are checked above, please explain:

Has this youth ever had a communicable disease? Yes No If so, please explain: _____

Does the youth currently have a respiratory illness? Yes No If so, please explain: _____

Does this child have any unusual or special dietary/nutritional needs which would require other than a normal diet?
 Yes No If so, please explain: _____

Does this child have any problems in **physical functioning** which would interfere with living in a group care setting or normal participation in a peer group process?

Yes No If so, please explain: _____

Medications No Yes If 'Yes' please list:

Medication Name	Purpose	Amount On Hand	Refills?

Name: (please print) _____

Signature: _____ Date: _____



SOCIAL HISTORY

Please complete if a pre-prepared social history is not available.

Name:		Date:
Program:	Therapist:	
Source of information:		
Physical description:		
Presenting concerns:		
Previously addressed concerns:		
Presenting strengths:		
History of therapeutic interventions		
History of agency (DFCS/ DJJ) involvement:		
Medical History - General:		

Family History:

Placement History:

Educational History:

Substance Abuse History:

Suicidal/Homicidal/Self-Harm History:

Interpersonal Relationships:
Peers-

Authority-

Leisure Interests and Community Involvement:

Current Diagnosis:

Medications:

Current Needs/ Recommendations:

Discharge/ Permanency Plan:



This form **must** be completed by the current placement if the youth applying for services is stepping down from a higher level of care.

CLIENT'S MEDICAL HISTORY

Child's Name _____ Date of Birth _____

Legal Custodian/Parent(s) _____

Information Provided by _____ Relationship _____

Address: _____ Phone: _____

Immediate Family History: Any health problems in the child's parents or siblings which are concern in tracking this child's health?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia/blood disease | <input type="checkbox"/> Deafness | <input type="checkbox"/> Heart Attack under 60 | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Death at young age | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach/intestine problems |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> + TB skin test |
| <input type="checkbox"/> Substance Abuse (name of substance(s): _____) | | | |
| <input type="checkbox"/> Other _____ | | | |

Child's History:

Epilepsy? _____ If yes, Rx treatment: _____

Type and description of seizures: _____

Allergies/adverse reactions to medication, food, etc.: _____

Asthma? _____ Current problems? Yes No Describe: _____

Diabetes? _____ If yes, current treatment? _____

Sickle Cell Anemia? _____

Past hospitalizations? (medical or psychiatric): _____

Surgery: _____

History of communicable diseases (including STDs): _____

History of chronic health problems: _____

History of birth control medication? Yes No Don't know If yes, type: _____

Currently on birth control medication? Yes No

Mental disorder or emotional illness: _____

Does this child have any history of mental illness **which is life threatening, indicates severe personality disorganization or deterioration, or may affect the treatment process in a residential treatment environment?**

Yes No If Yes, please explain: _____

Active TB in the past? Yes No IF yes, is treatment completed? Yes No Comments: _____

Has child had TB infection without active disease in the past? Yes No Comments: _____

If Yes, is treatment completed? Yes No Comments: _____

If No, and child is considered at risk, **date of most recent PPD:** _____ **Results:** _____

Does this child have any unusual or special dietary/nutritional needs which would require other than a normal diet?

Yes No If so, please explain: _____

Does this child have any problems in **physical functioning** which would interfere with living in a group care setting or normal participation in a peer group process?

Yes No If so, please explain: _____

Please indicate any problems in the following areas:

Motor Development and functioning: _____

Sensorimotor Functioning: _____

Speech, hearing or language functioning: _____

Visual Functioning: _____

Does child wear glasses or contacts: Yes No

Oral Health/Hygiene: _____

Date of most recent dental appointment: _____

Is child currently receiving Orthodontic care? Yes No

If yes, name and address of Orthodontist: _____

All Current Medications (both prescription and non-prescription): _____

If the child has been consistently followed by a particular physician and/or dentist in the recent past, please list these individuals below:

Physician: _____ Phone number: _____

Address: _____

Dentist: _____ Phone Number: _____

Address: _____

Signature of Person Completing form: _____ Date: _____

Please print name signed: _____ Relationship to child: _____

Phone number: _____

Information verified by: _____ Date: _____

Please fax this document to the Intake Team at 404.564.4719 as it is completed.



DOCUMENTS AND FORMS

Documents Required for Emergency or Pre-Placement – no exceptions

1. Completed Application
2. Social History (if not available, use page 4-6 of application)
3. Medicaid Card or temporary authorization
4. Custody Order
5. Signed Placement Agreement (CHRIS Kids Form)
6. Signed Authorization for Release of Information (CHRIS Kids Form)
7. Signed Permission for Medical Care (CHRIS Kids Form)
8. 1 month prescription of all medications (Physician may call into our pharmacy – PeachCare at xxxxx or to any of the following 24 hr pharmacies: CVS, Walgreens or Eckerds)
9. Clothing for at least 5 days

Documents Required at Placement or within 3 Business Days of Emergency or Pre-Placement

1. Certified Birth Certificate
2. Certified Social Security Card
3. Current Psychological Assessment (within 2 years) or scheduled appointment for Psychological Assessment
4. Documentation of physical within past 12 months – should include:
 - RPR
 - Urinalysis
 - CBC blood work
 - Vision exam
 - Hearing exam
 - PPD - TB test results
5. Immunization records
6. Pregnancy test (females only)
7. Documentation of dental exam and treatment if recommended within past 6 months
8. Education information to include transcripts and withdrawal from previous school
9. IEP (if appropriate)
10. Information regarding any funds left in youth's DFCS clothing budget
11. DFCS case plan

CHRIS Kids forms that must be completed at placement or within 3 business days of placement

1. Intake Assessments
2. Caseworker Agreement
3. Activities Consent
4. Behavior Management System Agreement
5. Clothing and Extra Belongings List
6. Consent for Release of Information in Treatment
7. Need to Know Form
8. Notice of CHRIS Kids Privacy Practices
9. Photograph and Transport Consents
10. Drug Screening Acknowledgement
11. Need to Know Form
12. Placement Contract – Youth
13. Resident Goal Agreement
14. Therapeutic Holding Acknowledgement
15. CHRIS Kids Rights acknowledgement

Possible Caseworker Activities after Emergency Placement

Face-to-face intake interview with multifunctional team
Physical and Dental Appointment
Appointment for Psychological