



Dear Applicant,

We are glad that you have chosen CHRIS Kids TransitionZ Program. Our mission is to help young adults learn skills associated with a successful transition into adulthood and to provide supportive and affordable housing. Some of our services include assistance with: completing and obtaining a high school diploma or GED; enrolling in and completing post-secondary education; interviewing and resume writing skills; asset attainment and money management and daily living skills to include, but is not limited to utilizing community resources, food preparation and transportation.

To enroll in the program the young adult must be:

1. Between the ages of 17-24;
Exception: If applicant is under age of 18, a legal guardian is required to sign a lease.
2. Willing to complete a mental health assessment;
3. Willing to submit to a criminal background check;
4. Employed and working at the minimum, 30 hours per week; or
5. In an educational program and working a minimum of 20 hours per week; and
6. Willing to participate in services.

Young adults enrolled in our program receive support from TransitionZ program staff to ensure that they reach their future goals. Each young adult will be provided individualized attention by their assigned TransitionZ Case Manager who will ensure that a plan is developed to ensure successful completion of the Individualized Service Plan. All young adults are further supported by Resident Advisors, who conduct daily living skills and ensure the safety of all residents enrolled in the TransitionZ Program.

You should expect from us a mutual relationship of collaboration, accountability, and transparency to ensure that the young adult's needs are met and that all opportunities for independence are explored. We look forward to your participation in the service planning process and an ongoing dialogue to discuss the young adult's strengths and needs. Your commitment to ensuring that the young adult obtains the necessary skills that exhibit independence is critical to their success in the program.

After you review the information and complete the application and attached documents, please fax to 404-564-0082 or email to raeleen.trujillo@chriskids.org to begin the application process. If you have any questions, concerns, or information you would like to share, please feel free to reach me by e-mail at raeleen.trujillo@chriskids.org or by phone at 404-564-3450. Thank you in advance for your partnership with CHRIS Kids and the TransitionZ program.

Raeleen Trujillo
TransitionZ Intake Coordinator

Shemeka Frazier-Sorrells
TransitionZ Program Director



CHRIS KIDS

Application for Admission for CHRIS Kids TransitionZ

Type of Application: _____ DFCS/DJJ _____ Homeless Voucher

Full Name (include middle initial):		Application Date:	
Medicaid #		SS #:	
DOB:		Age:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:			
Phone Number:		Email Address:	
City:	County:	State:	Zip Code:
Payor/Funding: (Select all that apply)			
<input type="checkbox"/> Self-Pay <input type="checkbox"/> State Contracted Svcs. <input type="checkbox"/> SSI <input type="checkbox"/> DJJ <input type="checkbox"/> DFCS			
Leasing Information:			
Have you ever been evicted from an apartment or home? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Name of Property _____ Date Evicted: _____		Household Income per year: <input type="checkbox"/> 0-\$9,999 <input type="checkbox"/> \$10,000 – \$19,999 <input type="checkbox"/> \$20,000 - 29,000 <input type="checkbox"/> over \$30,000	
		Do you have a checking or savings account? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the current balance: _____ (checking) _____ (savings)	
Are there any other persons who will occupy the apartment? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete below:			
Name	Gender (M/F)	Date of Birth	Relationship to Applicant
Insurance Provider			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other (please explain): <input type="checkbox"/> Self-Pay			
Insurance Provider: _____ Group or ID # _____ Expiration date: _____		Type of Coverage:	

Ethnicity: American Indian White/Caucasian
 Hispanic Asian
 Black/African American Multi-racial
 Other single race:

Religion: Protestant/Catholic Christian
 Muslim Other:

English Proficiency: Proficient Limited-Spanish Primary Language Limited-Primary Language Other

Referral Source: (Check all that apply.)
 Self DFCS MAAC Other
 Family State Hospital Juvenile Justice - Region:
Special Population (Check all that apply.)
 Vision impairment HIV + Pregnant Hearing impairment None

Psychological Assessment Information: Date of Assessment: _____
Full Scale IQ: _____ Name of Assessment: _____
Achievement Scores: Math: _____ Reading: _____

DSM Multi-Axial Assessment					
Axis I Primary	Axis I Secondary	Axis II Primary	Axis II Secondary	Axis III Primary	Axis III Secondary

Service History within past 18 months
Number of Inpatient Hospitalizations:
Number of Crisis placements:
Number of ER/Crisis Team Involvements:

Allegations
Has there been any allegations against staff? No Yes
if yes: Pending substantiated unsubstantiated

Medications No Yes If 'Yes' please list.

Medications (List primary psychiatric first.)

Name	Purpose

Active medical diagnosis? No Yes If 'yes', please describe:

ALLERGIES:

Living Situation:

- Parent/relative/friend Jail/Correctional Facility Group Home Supported Living
 Foster Home Residential Program Non Housing (such as car, park, sidewalk, street) Emergency Shelter
 Psychiatric Hospital (PRTF) Other: (please explain)

Reason for Homelessness (if homeless):**Last Permanent Address (if homeless; zip code, nearest major crossword, or city):****Employment Status:**A. Employment: Employed Yes No

If yes: Name of Employer: _____

Date Employed: _____ Hrs worked during a typical week: _____

Hourly or monthly wage: Hourly Wage _____ Monthly Wage _____

B. Volunteer: Volunteer Yes No

If yes: Location or Volunteer Organization _____

Average volunteer hours: _____

School:

- Regular school programming Enrolled in an alternative school (IEP) Pursuing GED
 No longer in school

Number of days absent from school in past month if enrolled: _____

Years of Education: What is the highest level of education that the applicant has completed? _____

Name of Last or Current School

Attended _____

Legal Status (current or past):a. Date youth entered Care: _____ N/ACounty Case Plan Expiration Date: _____ N/ACustody Order Expiration Date: _____ N/Ab. Legal Custody (*Check any that apply*) Parental custody DFCS Custody Other Court-Appointed Guardianc. Legal Involvement (*Check any that apply.*) DFCS Juvenile Justice Probation Jail/Law Enforcement

d. Juvenile Justice System Involvement:

Has client been involved with juvenile justice system in the past year? Yes No*(Includes arrests, probation, commitments, adjudications, diversions, or awaiting sentencing)*

e. Arrests: Number of arrests, regardless of nature of offense or outcome, in the past 30 days: _____

Addiction and Substance AbuseHas this youth ever used/abused substances? Yes NoType of Substance(s) Used: None Marijuana Frequency: _____ Tobacco Frequency: _____ Alcohol Frequency: _____ Huffing Frequency: _____ Amphetamines Frequency: _____ prescription drug abuse Frequency: _____ Crack/cocaine Frequency: _____ other (please describe) _____

Age at First Use: _____

Is there a history of family drug/alcohol abuse? Yes No If yes, please describe: _____Has applicant ever received in-patient treatment for substance use? Yes No

If so, when and where? _____

Are there pending or recent charges? Yes No If yes, please describe: _____**Custodial Agency/Custodian (present or past):**

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: (required):		Phone: _____
		Email : _____

Family Contact(s):
Name: _____ Relationship: _____

Address: _____
Street _____
City, state, zip _____

Phone Number: _____ Email Address: _____

Phone contact? Yes No Who provides supervision? _____
 Face-to-face? Yes No
 Supervision Required? Yes No

Add'l Family Contact(s): Relationship: _____
Name: _____

Address: _____
Street _____
City, state, zip _____

Phone: (home) _____ (work) _____

Legal Restrictions regarding family contact? Yes No
 If yes, please describe: _____

Are there family members or other individuals not currently involved who are potential resources for this youth? Yes No If so, please list: _____

PRESENTING AND HISTORICAL ISSUES

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

Most recent high risk incident: _____

If incident reports regarding high risk behaviors (as requested on the first page) are not available, please describe any incident involving the following behaviors within the last 90 days – physical aggression, AWOL, substance/alcohol use, school suspension or expulsion, sexual acting out, self-harm or police involvement: _____

Strengths and Skills: _____

Positive behaviors the applicant seeks to practice: (examples: emotional regulation, independence/life skills)

Please document any need for special consideration of sexual, cultural, religious, national, racial or ethnic identity issues: _____

Will it be possible for the applicant to have a pre-placement visit? Yes No

References:

Please list three personal and/or professional references that CHRIS Kids may contact on the applicant's behalf.

Name	Contact Number or Email	Relationship

Name: (please print) _____

Signature: _____ Date: _____

Please email this document to raeleen.trujillo@chriskids.org or fax to 404-564-0082 when completed.



CHRIS KIDS

TransitionZ Consent for Release of Information

Consumer's Full Name

Date of Birth

Social Security Number

Identification #

The following agencies, organizations and stakeholders have my permission to exchange/give/receive/ share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating and/or providing services for the above named person. Please identify by checkmark all that apply.

- | | |
|----------------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Adults serving in Foster Care or other caretaking roles | <input type="checkbox"/> MAAC |
| <input type="checkbox"/> Department of Family and Children/Youth Services | <input type="checkbox"/> Mental Health (Public/Private) |
| <input type="checkbox"/> Department of Juvenile Justice/Probation | <input type="checkbox"/> Public/Private Hospitals |
| <input type="checkbox"/> Juvenile Courts | <input type="checkbox"/> CHRIS Counseling Center** |
| <input type="checkbox"/> Other | <input type="checkbox"/> Relatives of the Youth (please specify) |
| <input type="checkbox"/> _____ | |

**Please select if you wish your child to receive clinical services through CHRIS Counseling Center.

I authorize exchanging/giving/receiving/sharing/re-disclosing of the following information if needed by the receiving organization to secure, coordinate or provide services to the individual. *Check yes or no and initial.*

- | | | |
|----------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Check one | Initial | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | Identifying information: name, birth date, sex, ethnicity, address, and telephone #. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | Social Security Number |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | Case Information: |
| | | <ul style="list-style-type: none"> • The above identifying information • Treatment/service history • Individualized Education Plans (IEPs) • Individualized Service Plans (ISPs) • Medical (except for HIV, AIDS, and drug and alcohol treatment records) • Other personal information regarding the individual named above. • Social history • Psychological evaluations • Transition plans • Grades/Work schedule |

Information regarding the following shall **not** be released unless initialed below:

- | | | |
|----------------------------------------------------------|---------|-----------------------------------------|
| Check one | Initial | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | HIV and AIDS related diagnoses |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | Substance abuse diagnosis and treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | Other, specify: _____ |

I understand that the Consent for Release of Information expires one year from the date below unless otherwise indicated herein by the consumer or his/her representative. I also understand that I may cancel my Consent for Release of Information at any time by stating so in writing with the date and my signature, and delivering it to CHRIS Kids. The revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was revoked.

I understand that this authorization will remain in effect for:

- Ninety (90) days unless I specify an earlier expiration date here:** _____
- One (1) year from signed date**

Young Adult, Guardian, Custodial Parent

_____/_____/_____
Date

Witness/Agency Representative

_____/_____/_____
Date

APPLICATION CHECKLIST

The following information should be included in your application and emailed to raeleen.trujillo@chriskids.org or faxed to 404-564-0082 when completed

Name: _____ Date: _____

These documents are required to be considered for an interview:	Included	Reviewed	Pending (Date)
CHRIS Kids TransitionZ Application			
TransitionZ Consent for Release of Information			
Mental Health Evaluation or Psychological (as recent as 2 yrs).			
Current Social Assessment (DFCS/DJJ)			
Current Placement monthly notes and summaries (DFCS/DJJ)			

SERVICE TEAM INFORMATION & APARTMENT DIRECTIONS

Service Team Members

Staff	Name	Phone	Email Address
Program Director	Shemeka Frazier	404-486-9034, Ext. 1316	shemeka.frazier@chriskids.org
Operations Manager	David Cameese	678-665-2695 cell	david.cameese@chriskids.org
TransitionZ Intake Coordinator	Raeleen Trujillo	404-564-3450 office	raeleen.trujillo@chriskids.org
Nurse Educator	Wendy Segal	404-564-3417 office	wendy.segal@chriskids.org
Consumer Advocate	Hope Norris	404-564-3423 office	hope.norris@chriskids.org
Case Manager	Vincent Moore	404-717-6803 cell	vincent.moore@chriskids.org
Case Manager	Shelia Torbert	404-723-4259 cell	shelia.torbert@chriskids.org
Case Manager	Nelscine Ellis	404-200-7568 cell	nelscine.ellis@chriskids.org
Case Manager	Keith Banks	404-717-5017 cell	keith.banks@chriskids.org

Directions:

Summit Trail Apartments

Staff office - Building E 404-244-4618
 2045 Graham Circle SE, Atlanta, Georgia 30316-2933
 From I-20
 Take exit 62 for Flat Shoals Rd.
 Turn left at Flat Shoals Rd SE.
 Take the 1st left onto Fayetteville Rd SE.
 Take the 1st left on Graham Cir SE. Summit Trail
 apartments are on the left.

CHRIS Kids Office

1017 Fayetteville Road
 Atlanta, GA 30316
 phone 404-486-9034
 fax 404-486-9053

From I-75/85, take I-20 East, about 5 miles
 Exit at Flat Shoals Road (Exit 6)
 Turn LEFT on Flat Shoals Road
 Turn LEFT onto Fayetteville Road
 Turn LEFT onto Graham Circle.
 (All turns are less than 1/10th of a mile)

CHRIS Kids Administration and Counseling Center
 Building is first on the left.
 Come into First Floor Lobby.

Please note: Visitors must come to the staff office at TransitionZ in Building E, to present identification and sign in and out.