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CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS  
(Please describe the behaviors within the last 30-45 days)

<table>
<thead>
<tr>
<th>☐ Abandonment Issues</th>
<th>☐ Anxiety</th>
<th>☐ Arson</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alcohol/Drug Abuse</td>
<td>☐ Antisocial Behavior</td>
<td>☐ Stool/Feces smearing</td>
</tr>
<tr>
<td>☐ Assaultive (Physical)</td>
<td>☐ Assaultive (Sexual)</td>
<td>☐ Assaultive (Verbal)</td>
</tr>
<tr>
<td>☐ Bedwetting</td>
<td>☐ Eating Disorder</td>
<td>☐ Depression</td>
</tr>
<tr>
<td>☐ Property Destroying</td>
<td>☐ Fire Setter</td>
<td>☐ Developmental Disability</td>
</tr>
<tr>
<td>☐ Homeless</td>
<td>☐ Hyperactive</td>
<td>☐ Impulsive</td>
</tr>
<tr>
<td>☐ Intellectual Disability</td>
<td>☐ Low Self-Esteem</td>
<td>☐ Lying</td>
</tr>
<tr>
<td>☐ Loss/Grief Difficulties</td>
<td>☐ Physical Impairment</td>
<td>☐ Parent Neglect Issues</td>
</tr>
<tr>
<td>☐ Perception of Reality</td>
<td>☐ Phobic Behavior</td>
<td>☐ Physical Disability</td>
</tr>
<tr>
<td>☐ Self-Destructive Behavior</td>
<td>☐ Sibling Related Difficulty</td>
<td>☐ Oppositional</td>
</tr>
<tr>
<td>☐ Social Immaturity</td>
<td>☐ Sexually Inappropriate Behavior</td>
<td>☐ Stealing</td>
</tr>
<tr>
<td>☐ Suicidal</td>
<td>☐ Running Away</td>
<td>☐ Truancy</td>
</tr>
<tr>
<td>☐ Unruly/Ungovernable</td>
<td>☐ Cruelty to Animals</td>
<td>☐ Hygiene/Cleanliness Issues</td>
</tr>
</tbody>
</table>
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Member Name: ______________________________
ID#: _______________________________________

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<table>
<thead>
<tr>
<th>Address:</th>
<th>Telephone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity:</td>
<td>Education Level:</td>
</tr>
<tr>
<td>Criminal Record:</td>
<td>☐Yes ☐No ☐Unknown</td>
</tr>
</tbody>
</table>

Father’s Name:
Address:
Telephone Number:
Ethnicity:
Education Level:
Criminal Record: | ☐Yes ☐No ☐Unknown |

How many siblings does Member have?

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are siblings in out of home placements? | ☐Yes ☐No ☐Unknown |

If yes, please indicate where: ☐DSS Foster Care ☐Relatives ☐Incarcerated ☐Group Home ☐Other:

FAMILY DYNAMICS / FAMILY SOCIAL HISTORY:

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

☐Criminal Activity
☐Child Abuse

☐Inappropriate Sexual Behavior
☐Treatment Disruption

☐Psychiatric Illness
☐Substance Abuse

☐Suicide
☐Other

AUTHORIZED CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Types of Contact With Member (supervised, letter, etc.)</th>
<th>Date of Release of Information</th>
</tr>
</thead>
</table>

|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |
|                          |              |         |                  |                                                   |                                |

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Are there any special conditions/restrictions for visits home?
Any "no contact" orders?

AGENCY INVOLVEMENT

☐ DSS County:
☐ DJJ County:
☐ Advocacy Agency:
☐ Mental Health Provider:
☐ MCO:

SCHOOL INFORMATION

Last School Enrolled:
District:
Last Grade Enrolled: ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Current IEP? ☐ Yes ☐ No Date:
Current 504 plan? ☐ Yes ☐ No Date:

IEP Classification: ☐ Unknown
☐ Autism ☐ Emotional Disturbance ☐ Hearing Impairment ☐ Blindness
☐ Deafness ☐ Orthopedic Impairment ☐ Specific Learning Disability ☐ Multiple Disabilities
☐ Visual Impairment ☐ Speech/Language Impairment ☐ Traumatic Brain Injury ☐ Developmental Delay
☐ Other Health Impairment (Specify): ________________________________

Any history of truancy? ☐ Yes ☐ No ☐ Unknown

Grades Repeated:
Suspending/Expulsions: ☐ Yes ☐ No Please describe reasons for suspensions & provide dates of most current:

COURT HISTORY

Does Member have a criminal record? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Offenses</th>
<th>Conviction Dates</th>
<th>Juvenile or Adult?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pending Charges? ☐ Yes ☐ No If yes, please list:
On probation? ☐ Yes ☐ No
• Probation Officer/ Court Counselor Name:

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Member Name: ______________________________
ID#: ______________________________

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- Contact Number:
- Probation Restrictions:

Is placement court ordered? ☐ Yes ☐ No (If “Yes, attach court order)

HISTORY OF SELF-INJURY AND RISK BEHAVIORS

Self-Injury:
- ☐ Does not apply
- ☐ cuts on body ☐ conceals cutting ☐ other:
- Has self-injury ever required medical attention? Please explain:

Suicidal Characteristics:
- ☐ Does not apply
- ☐ Suicidal thoughts ☐ Past Suicide Attempts ☐ Suicidal Plans
- Describe:
- Any method used in attempt? Please list:
- Were attempts planned: ☐ yes ☐ no ☐ sometimes ☐ don’t know

Homicidal Characteristics:
- ☐ Does not apply
- ☐ homicidal thoughts ☐ Past Attempts to harm others ☐ Homicidal Plans
- Describe:
- Any method used in attempt? Please list:
- Were attempts planned: ☐ yes ☐ no ☐ sometimes ☐ don’t know
- Does Member have access to weapons? Please explain

History of AWOL:
- ☐ Does not apply
- ☐ Runs away from home ☐ Has run from previous placements
- In the past year how many times has Member run?
- Where does he/she go?
- How long is he/she typically AWOL?

Substance Abuse History:
- ☐ Does not apply
- See below:

<table>
<thead>
<tr>
<th>Type of Substance</th>
<th>Frequency</th>
<th>Last Use</th>
<th>Type of Substance</th>
<th>Frequency</th>
<th>Last Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Marijuana</td>
<td></td>
<td></td>
<td>☐ Amphetamines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Cocaine</td>
<td></td>
<td></td>
<td>☐ Hallucinogens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Heroin/Opiates</td>
<td></td>
<td></td>
<td>☐ Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Inhalants</td>
<td></td>
<td></td>
<td>☐ Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sexualized Behaviors:
Member Name: ______________________________
ID#: _______________________________________

心理学行为:
- ☐ 不适用
- 请描述成员的任何性化行为（例如：暴露、性行为、性虐待行为、卖淫）

精神病学行为:
- ☐ 不适用
- 请描述以往/当前的精神病史:

ADDITIONAL COMMENTS
请使用此空间添加任何可能支持此申请的额外评论。

SUPPORTING REFERRAL DOCUMENTS
以下是可能需要作为此包或放置支持的项目。请准备好在需要时提交这些项目或在提供者的要求下提交。

- Universal Application
- Person Centered Plan/Sign Page
- Discharge Summaries from Hospitalizations/ Previous Treatment
- Consent to exchange information
- School Records/ IEP
- DSS records (if applicable)
- DJJ records (if applicable)
- Psychological Testing
- Sexual Harm Youth Evaluation
- Psychological Testing
- Immunization Records
- Birth Certificate
- Copy of Medicaid/ Insurance Cards
- Psychiatric evaluations
- Diagnostic Assessment ( or any other assessment completed)
- Treatment Authorization Request
- Court/Custody Orders

SIGNATURES

__________________________________________  __________________________
Member Signature                                      Date
(Please note if this application includes information about substance use, the member's signature must be obtained)

__________________________________________  __________________________
Legal Guardian Signature                             Date

__________________________________________  __________________________
Provider/Clinician/Care Coordinator Signature        Date

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