Common Application for Child Placement
Intermountain Family-Based Services

Date: ______________________

PART A

ATTACHMENT CHECKLIST

Child's Full name Referring Agency K# or JPO# ____________________________

____

LAST FIRST MIDDLE Social Security

____

Date of Birth Sex Race

____

Tribal Enrollment Number Tribal Affiliation

Name and Address of Agency Making referral: ______________________________

____

Name and Phone Number of Agency representative making the referral: ___________

____

Case Manager Name, Agency and phone if different

____

Document (original or copies) Attached Forthcoming Not Available Does not apply

1. Birth Verification

Birth Certificate				
Social Security				
Tribal Enrollment				

2. Legal Records

DFS and Probation Dispositional Orders				
Custody Orders				
Pre-Dispositional Orders				
Parental Agreement				

Document (original or copies)	Attached	Forthcoming	Not Available	Does not apply

3. Educational

Cumulative Record File				
Immunization Record				
CST				
IEP				
Court Orders/Informed Consents General Education				
Transcripts				
Immunizations				
Attendance				
Special Education				
ED Diagnosis				
Psychological				
CST				
IEP				

4. Physical Health/Disabilities

Physical Examination/ EPSDT/Well Child Physical				
Immunization Record (unless provided by school)				
Vision Records				
Dental Records				
Nutrition				
Prescribing MD with Phone Number and Current Medications				

5. Mental Health

Treatment History				
Psychological Reports				
Psychiatric Reports				
Certificate of Need				
UR Certification				
Sex Offender Evaluation				
Current Mental Status				
Current Diagnosis and Name and Phone of Therapist				

Document (original or copies)	Attached	Forthcoming	Not Available	Does not apply

6. Other

IV-E Eligibility				
Psycho/Social History				
Reports to the Court				
Discharge Summaries From Previous Tx				
SNAP Plan				
Medicaid Card				
Private Insurance Info.				
Release of Information other than Educational				

7. Additional Information:

____

____

____

____

____

____

____

____

____

PART B

COMMON APPLICATION FOR THERAPEUTIC FOSTER CARE

Identifying Information

Child's Full Name   Referring Agency K# or JPO# ______________________________

____
LAST   FIRST   MIDDLE

____
Height   Weight   Religious Preference

____
Eye Color   Hair Color   Identify Characteristics/scars

Child's current location or placement: ____

Agency and County of financial responsibility: __________________________________
____

I. Referring Information

1. Briefly describe your impressions of the child including present problems:
____
____
____

2. Briefly deescribe the child's strengths: ____________________________
____
____

3. What length of time do you anticipate will this child be receiving services on this level of care: ____
____
____

4. Discharge Plan ____
____

II. Custody Status

Who has custody of this child?

Mother ____ Y ____ N
Father ____ Y ____ N
Guardian ____ Y ____ N
DFS ____ Y ____ N If yes, is it Permanent____ Y___ N
Temporary ____Y ___ N

Have parental rights been terminated?

Mother ____ Y ____ N ____ Unknown
Father ____ Y ____ N ____ Unknown

Will family members participate in therapy? ____ Y ____ N

Can this child return Home? Permanently ____ Y ____ N
for visits only ____ Y ____ N
not at all ____ Y ____ N
Unknown ___________

Parent(s) Mother: ____
Name Phone #
Address: ____

Father: ____
Name Phone #
Address: ____

Step Parent(s): ______________________________________
Name Phone #
Address: ____

Step Parent(s): ______________________________________
Name Phone #
Address: ____

Guardian: ____
Name Phone #
Address: ____

Sibling(s) Name DOB Residence

____
____
____
____

Other Individuals significant to this child

Name Relationship Address Phone

____
____
____
____

III. Education
Highest grade completed: ________________________________
Currently Enrolled: ____________________________________
District of Residency: __________________________________
District of current enrollment: __________________________
Educational needs:
Regular classroom: ____________________________________
Full Special Education: ________________________________
Part Time Special Education: ____________________________
Day Treatment: ____
Other: ____

Does this child have a Surrogate? ____ Y ____ N
If yes, provide name, address and phone number: ____________________________
____

IV. Juvenile Justice History

Does this child have history of involvement with the juvenile justice system?
____ Y ____ N ____ Unknown

If yes: Number of referrals to Juvenile Probation ____________________________

Number and types of Adjudications ________________________________
____
____

Offenses ____
____

Present Status ____

V. Special Needs

Is child danger to self? ____ Y ____ N ____ Unknown

Has this youth had a. Suicidal gesture ____ Y ____ N ____ Unknown
b. Suicidal attempts ____ Y ____ N ____ Unknown

Suicide Risk Assessment: _____ High _____ Moderate _____ Low

Other: Explain ____
____

Is child danger to others? ____ Y ____ N ____ Unknown

If yes, explain ____
____

Number of runaways from home: _______________
from placements: _______________

History of fire setting ____ Y ____ N ____ Unknown

History of cruelty to animals ____ Y ____ N ____ Unknown

History of Explosive Behaviors ____ Y ____ N ____ Unknown

Has this child been sexually abused ____ Y ____ N ____ Unknown

If yes, briefly explain ____
____
____

Is this child a sex offender ____ Y ____ N

If yes, what is the risk to re-offend _____ High _____ Moderate _____ Low

Explain sexual offense history ____
____
____
____
____

Special Needs program

Maternity ____ Y ____ N If yes, due date ________

Independent Living ____ Y ____ N

Other ____ Y ____ N
If other explain ____
____

VI. Placement History

Has the child been placed away from home before? ____ Y ____ N

If yes, how many? ____

Placement History: End with most current:

This section is designed to reflect disruptions or changes in the child's living situation. Include all agency out of home placements, independent placements, adoptive placements and breakdowns. If the information is available in the social history, make that notation. You do not have to complete this section if the information is available on another document. Make the notation that the document is attached.

Name of Provider/Relative/Other From To Reason for Termination
____
____
____
____
____
____
____

VII. Substance Abuse

Does Child have substance abuse history? ____ Y ____ N ____ Unknown
If yes, indicate type and degree: ____
____
____

Has child received chemical dependency treatment? ___ Y ___ N ___ Unknown
If yes, what kind? Inpatient ___ Y ___ N ___ Unknown
OutPatient/ Community Based___ Y ___ N ___ Unknown
Current status: ____
____
____

VIII. Abuse/Neglect History

Does child have a history with DFS? ____________ If yes, how long __________
Does this child have a history of abuse/neglect? ____ Y ____ N ____ Unknown

If yes, to either or both questions, describe: ______________________________
____
____

Does the child have a Guardian ad Litum? ____ Y ____ N
If yes, name, address and phone number _________________________________
____

IX. Physical Health/Disabilities

Does this child have a diagnosed or suspected health condition or disability?
____ Y ____ N ____ Unknown

Describe the condition/disability and treatment required if any: _______________
____
____

Does the disability fit the definition of Developmental disabilities as defined by MCA? ____ Y ____ N ____ Unknown ____ N/A

Is the child currently receiving DD Services? ____ Y ____ N
If yes, describe the service and provide the name and address of the provider: ___
____
____

Does the child receive any medications for this condition/disability?
____ Y ____ N ____ Unknown

If yes, specify drug, dosage, length of time on this medication: ______________
____

Name, address and phone number of prescribing physician: _________________
____

Does child/youth receive SSI? ____ Y ____ N ____ Unknown
Is yes, amount ____________
Payee ____
Name Address

Does the child require physical therapy for this disability/condition?
____ Y ____ N ____ Unknown

If yes, specify type, frequency, and provider's name and address: _______________
____
____
____

Specify any additional information which is pertinent to the physical condition/disability of this child: ____
____
____

X. Mental Health/Disabilities

Does this child have mental health needs which require assessment?
____ Y ____ N ____ Unknown

Name, address and phone number of current therapist:________________________
____
____

If yes, date of most recent psychological/psychiatric evaluation:
DMS II-R diagnosis:

Axis I ____
Axis II ____
Axis III ____
Axis IV ____
Axis V ____

Have medications been prescribed? ____ Y ____N ____ Unknown
If yes, specify Drug, Dosage, length of time on these medications:

____
____
____
____
____

Name of prescribing physician(s) and phone numbers: _______________________
____
____
____
____

XI. Other

Please provide any additional information you feel is pertinent.

____
____
____
____
____
____
____

_________________________________   _________________________________
Signature of Agency Representative Completing the Form   Date

<u>Please Submit Application to:</u>

Family-Based Services – Intermountain
3240 Dredge Drive
Helena, Montana 59601
(406) 457-4842
Fax: 406-442-7949