



**Arkansas Department of Human Services  
 Division of Children and Family Services  
 Specialized Placement  
 Admission Form/Referral Application**

Due to the sensitive nature of the information displayed below, this document is **confidential**.

The following information will help providers in determining the best plan for the child you are referring. It is essential that it be completed before admission can be considered.

**CHILD'S NAME** \_\_\_\_\_ Date of Referral: \_\_\_\_\_

- Services Requested:
- Comprehensive Residential Treatment
  - Residential Treatment
  - Therapeutic Foster Care
  - DDS Specialized Care
  - Other

Services Requested by the date of: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Religion: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Application made for SSI: Yes  No  Date made: \_\_\_\_\_ Social Security? Yes  No  Date Made: \_\_\_\_\_

Is child's Medicaid active? Yes  No  If no, state reason: \_\_\_\_\_

Is child on Medicaid Spindown? Yes  No  If yes, give amounts and other date relevant: \_\_\_\_\_

Child referred by: \_\_\_\_\_ County: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Child DCFS Caseworker: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Alternative Contact: \_\_\_\_\_

Child presently resides with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**In Case of Emergency Notify:** Name: \_\_\_\_\_ On-Call/Beeper: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## PLACEMENT DATA

- A. State the reason for referral, why this is in the best interest of the child and family, proposed benefits to the child by receipt of services selected on page 1 (i.e. CRT, Residential Treatment, Therapeutic Foster Care, DDS Specialized Home), and how you feel the program will help:

- B. If originating county is more than one hour travel from requested placement describe efforts made to find placement in your region. Distance child will be from biological family:

What barriers will this present to family?

How will these barriers be overcome?

- C. This child's current goal is: Reunification  Adoption  Independence  Other

List barriers preventing this child from reaching this goal (include both child and family problems):

- D. What are goals, objectives, and proposed time frames regarding the specific plan for treatment for the child and/or family? Include tentative plans for the child and family after requested services are terminated:

- E. If the child's goal is independence, has the child taken the Independent Living Skills Assessment? Yes  No   
If yes, include the resulting report. If no, why not and when will they take the Assessment?

- F. Describe the current status of any reunification efforts, particularly the level of parental commitment to this process:

- G. Describe the efforts to serve the child at home; detailing treatment attempted and reasons why no longer feasible, treatment needed and reasons why not feasible in current situation if placement is requested:

- H. Describe visitation plans if the child is to be placed. List any restrictions or special instructions.

- I. Has the family been made aware of this referral? Yes  No

- J. Describe the parents' feelings about placement:

- K. Describe the child's perception of placement:

- L. Child's next staffing is scheduled for: \_\_\_\_\_

- M. Child's next administrative review is planned for: \_\_\_\_\_

- N. Child's next court review is scheduled for: \_\_\_\_\_

Child's Attorney Ad Litem (AAL): \_\_\_\_\_

AAL Phone Number: \_\_\_\_\_

Child's CASA volunteer (if applicable): \_\_\_\_\_

CASA Phone Number: \_\_\_\_\_

Child's Transitional Services Coordinator (if applicable): \_\_\_\_\_

Coordinator's Phone Number: \_\_\_\_\_

## RELEVANT HISTORY OF CHILD

A. Describe the child:

B. Date child entered into DCFS care? \_\_\_\_\_ Explain circumstances surrounding child entering care:

C. List in chronological order all placements (including foster parents) the child has had including date placed, date removed, reasons for placement and removal: **Attach Placement History sheet from CHRIS.**

Name/Type Of Placement	Date Placed	Reasons For Placement	Date Removed	Reason For Removal

D. Has the child been abused (sexually, physically, emotionally, or neglected)? Yes  No  If there has been more than one occurrence of abuse or neglect, please provide dates and describe individual occurrences:

E. Does child have any history of self harm/mutilating behavior? Yes  No  Explain:

F. Describe any history of aggressive behavior towards children, adults, animals (explain and be specific):

G. Has the child set fires? Yes  No  Explain:

H. Describe any history of alcohol, tobacco, or illegal drug use by the child:

I. Do you believe this child to be sexually active? Yes  No  Explain:

J. Has a true determination of sexual abuse been founded on this child? Yes  No  If yes, explain:

K. Describe all other significant behavior problems of the child:

L. Describe significant events in the child's life (honors, arrests, death of friends or relatives):

M. Identify the child's strengths and weaknesses:

N. Describe skills, achievements, and interests:

What does the child like to do?

O. Explain the daily schedule the child is used to (highlight any problems with routines such as bed time, waking up, waiting, leaving for school, household chores, etc.):

P. Religion/Denomination: \_\_\_\_\_ Level of Interest: \_\_\_\_\_

## FAMILY HISTORY

### A. Biological Mother

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Race: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Type of Work: \_\_\_\_\_ Salary: \_\_\_\_\_

If deceased, give date of death: \_\_\_\_\_ Cause: \_\_\_\_\_

If remarried, name of stepfather: \_\_\_\_\_

If parents are divorced, give date: \_\_\_\_\_ Place: \_\_\_\_\_

No. of pregnancies: \_\_\_\_\_ No. of living children: \_\_\_\_\_

### B. Biological Father

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Race: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Type of Work: \_\_\_\_\_ Salary: \_\_\_\_\_

If deceased, give date of death: \_\_\_\_\_ Cause: \_\_\_\_\_

If remarried, name of stepmother: \_\_\_\_\_

If parents are divorced, give date: \_\_\_\_\_ Place: \_\_\_\_\_

No. of children fathered: \_\_\_\_\_ No. of living children: \_\_\_\_\_

C. List biological family members:

Name	Relationship	Marital Status	DOB	Current Grade	Employment/School Name, Address, Phone

D. Are other children in family placed outside of biological home? Yes  No  Who and where placed?

E. Name other family members or people residing in biological home:

F. Describe the current family situation:

G. Describe the current relationships the child has with family members including history of visits, current visitation plan, and plan for continuing visitation:

H. Describe family's contacts with social service agencies and/or counselors, etc.:

I. Describe any family history of medical problems: Use the following abbreviations: (C) Child, (M) Biological Mother, (F) Biological Father, (S) Sibling, (O) Other

- |                    |                         |                                       |
|--------------------|-------------------------|---------------------------------------|
| _____ Tuberculosis | _____ Heart Disease     | _____ Congenital Crippling Conditions |
| _____ Cancer       | _____ Hypertension      | _____ Anemia                          |
| _____ Syphilis     | _____ Epilepsy          | _____ Rheumatic Fever                 |
| _____ Allergies    | _____ Mental Illness    | _____ Other Diseases: _____           |
| _____ Diabetes     | _____ Bleeding Diseases | _____                                 |

Give dates of problems and family relationship:

J. Describe any family history of psychiatric problems, including substance abuse/dependence.

K. Significant Others (Include Foster Family Members)

Name	Relationship	Marital Status	Date of Birth	Current Grade	Employment/School Name, Address, Phone

L. Describe significant other persons (relatives, friends, foster parents) in the child's life.

# Medical History of Child

## A. Medical History of Child

Last physical exam by Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Last dental exam by Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Last vision exam by Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Last hearing screening by Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of PACE Evaluation (please attach if evaluation has been completed): \_\_\_\_\_

Is the child awaiting the results of an STD or drug screen? Yes  No

## B. Allergies

Does the child have any allergies to medication? Yes  No  If yes, list

To Food? Yes  No  If yes, list

Any other allergies? Yes  No  If yes, list:

C. Does the child have any physical disabilities? Yes  No  If yes, describe:

D. Has the child had any medical hospitalizations? Yes  No  If yes, explain:

E. Has child had any surgeries? Yes  No  If yes, explain:

F. Does child have any significant medical problems? Yes  No  If yes, explain:

**G. Medical and Dental History (Give Approximate Dates)**

Measles (Rubeola)		Whooping Cough		Hearing Difficulty	
Measles (Rubella)		Mumps		Vision Difficulty	
Chicken Pox		Ear Infection		Rheumatic Fever	
Kidney Disease		Convulsions		Meningitis	
Encephalitis		Tuberculosis		Diabetes	
Allergy (Type)		Congenital Defects (Types)		Operations	
Burns/Accidents		Deformities Of Teeth Or Mouth		Other (Specify)	

**H. List all current medications the child is taking and for what reason:**

**I. Does child have history of high temperatures? Yes  No  Convulsions? Yes  No   
Bedwetting? Yes  No  Day/night soiling? Yes  No  If yes, explain/describe:**

**J. Describe developmental history including ages, crawling, walking, talking, toilet training:**

**K. Describe biological mother's pregnancy and delivery of child (term, complications, etc.):**

**1. Was child exposed to drugs/alcohol during mother's pregnancy? Yes  No  If yes, explain:**

**2. What was child's birth weight? \_\_\_\_\_**

3. Did the child have jaundice, breathing difficulties, seizures? Yes  No  If yes, explain:

4. Did child cry excessively? Yes  No  If yes, describe:

5. Did child like to be held and cuddled as an infant? Yes  No  Describe:

**L. Psychiatric History**

1. Describe all prior psychiatric treatment efforts (service provider, corresponding dates):

2. Child's last psychological evaluation was completed on: \_\_\_\_\_ by: \_\_\_\_\_

Report the child's most recent DSM diagnosis given by a mental health professional. Include date given and name of professional.

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V \_\_\_\_\_

3. Has this child been referred for TFC by a mental health professional? Yes  No  If yes, who, when, and why?

# SCHOOL HISTORY

## A. Educational Status

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Tests, Evaluations? Yes  No  Dates: \_\_\_\_\_

## B. Educational History

List all schools the child has attended:

School	Address	Dates/Grades Attended

C. Has this child ever received Special Education Services? Yes  No  (If the child has an IEP or 504 plan, please attach.) If yes, describe classification and services provided:

D. Has this child repeated any grades? Yes  No  If yes, which ones and why?

E. Describe attendance record:

F. Describe special class or tutoring:

G. Describe level of academic achievement:

H. Describe classroom behavior:

I. Describe favorite courses:

J. Has the child ever been suspended or expelled? Yes  No  Describe:

K. Other information:

### Legal History

A. **Legal status of child** (attach copy of Court Order):

Legal guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Court of Jurisdiction: \_\_\_\_\_ Date of Decree: \_\_\_\_\_

Type of Custody:  Permanent  Temporary Date of Next Hearing: \_\_\_\_\_

B. Describe the child's history of juvenile delinquency or other illegal behavior. If the child has been on probation, list county, offenses and probation period:

### Other Significant Data

**If you are unable to place the child at this time, please shred this document.**