STRATEGIC BEHAVIORAL CENTER
ADMISSION APPLICATION

PERSON/AGENCY MAKING APPLICATION: **CASE#:**_____

AGENCY NAMEREFERRAL;_____

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE:_____

FAX:_____

POTENTIAL CLIENT:

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE:_____

COUNTY:_____ LME/MCO CONTACT PERSON:_____

LME/MCO:_____ LME/MCO #:_____

DOB:_____ AGE:_____ GENDER:_____ RACE:_____

HEIGHT :_____ WEIGHT:_____ SS#:_____

FINANCIAL INFORMATION: (ATTACH COPY OF INSURANCE CARD)

MEDICAID #:_____ HEALTH CHOICE#:_____

OTHER INSURANCE COMPANY NAME:_____

INSURANCE CO. ADDRESS:_____

INSURED (MEMBER) NAME:_____ SS#:_____

GROUP#: _____ PLAN#:_____

SUBSCRIBER#:_____ INSURANCE CO. PHONE#:_____

STRATEGIC BEHAVIORAL CENTER

CURRENT PLACEMENT:

☐ HOME ☐ LEVEL 3 ☐ LEVEL 4 ☐ DETENTION ☐ ACUTE ☐ TFC ☐ OTHER

AGENCY NAME: _____

POINT OF CONTACT: _____ EMAIL: _____

PHONE: _____ FAX: _____

LENGTH OF STAY: _____ DISCHARGE DATE: _____

REASON FOR NEED FOR NEW PLACEMENT: _____

_____

NUMBER AND TYPES OF RESTRICTIVE INTERVENTIONS IN THE LAST 30 DAYS: _____

_____

CUSTODY: ☐ PARENTS ☐ DSS ☐ OTHER: _____

MOTHER'S NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL ADDRESS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

FATHER'S NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL ADDRESS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

IF PARENTS ARE DIVORCED/UNMARRIED, WHAT IS CUSTODY ARRANGEMENT? _____

_____ (Provide documentation)

LEGAL CUSTODIAN/GUARDIAN: (PROVIDE DOCUMENTATION)

RELATIONSHIP: _____ EMAIL: _____

ADDRESS: _____

PHONE: _____ HAVE PARENTAL RIGHTS BEEN TERMINATED? _____ IF YES,

☐ MOTHER ☐ FATHER DATE OF TERMINATION: _____

HAS CLIENT BEEN ADOPTED? _____ DATE OF ADOPTION: _____

STRATEGIC BEHAVIORAL CENTER

CLIENT'S SIBLINGS:

NAME	AGE	RELATIONSHIP	SIBLING LIVES WITH WHOM?
_			

MEDICAL:

CURRENT MEDICAL ISSUES:

_____

PAST MEDICAL ISSUES/SURGERIES:

_____

ALLERGIES/ADVERSE MEDICATION REACTIONS:

_____

PRIMARY CARE PHYSICIAN:

NAME:_____

ADDRESS:_____

PHONE:_____

DATE OF LAST PHYSICAL EXAM:_____

DENTIST:

NAME:_____

ADDRESS:_____

PHONE:_____

DATE OF LAST DENTAL EXAM:_____

DOES CLIENT NEED/WEAR GLASSES: ☐ NO ☐ YES

DATE OF LAST EYE EXAM:_____

STRATEGIC BEHAVIORAL CENTER

MENTAL HEALTH INFORMATION (PROVIDE DATES AND SPECIFIC DETAILS)

CURRENT DIAGNOSES:

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

SUICIDAL/HOMICIDAL IDEATION/GESTURE/ATTEMPTS:

_____

_____

HISTORY OF PSYCHOSIS:

_____

_____

HISTORY OF PHYSICAL/EMOTIONAL/SEXUAL ABUSE; NEGLECT:

_____

_____

HISTORY OF RUNAWAYS:

_____

_____

DOES THE CLIENT REQUIRE A SEXUALLY REACTIVE PROGRAM ☐YES☐NO

HISTORY OF SEXUALIZED BEHAVIORS:

_____

_____

FAMILY HISTORY OF MENTAL ILLNESS / SUBSTANCE ABUSE: ☐ NO ☐ YES,

IF YES DESCRIBE: _____

_____

STRATEGIC BEHAVIORAL CENTER

SIGNIFICANT DEVELOPMENTAL HISTORY: ☐ NONE KNOWN ☐ YES, EXPLAIN:

_____

_____

_____

HISTORY OF CHEMICAL DEPENDENCY:

TYPE	AMOUNT	FREQUENCY	AGE AT FIRST USE	LAST USE

CURRENT MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	COMPLIANT
			YES NO
			YES NO
			YES NO
			YES NO

PRESCRIBING PHYSICIAN NAME AND PHONE NUMBER:_____

_____

TREATMENT HISTORY (OUTPATIENT, INPATIENT, RESIDENTIAL, HOSPITALIZATIONS)

AGENCY/ FACILITY	DATES

STRATEGIC BEHAVIORAL CENTER

CURRENT SYMPTOMS AND FUNCTIONING REQUIRING TREATMENT IN PRTF:

_____

_____

_____

LEGAL ISSUES:

CURRENT CHARGES:_____

PENDING COURT DATES/CHARGES:_____

_____

PROBATION OFFICER:_____

ADDRESS:_____

PHONE:_____ FAX:_____

COUNTY OF PROBATION:_____

IS CLIENT COURT ORDERED FOR TREATMENT: ☐ YES ☐ NO (PROVIDE COURT PAPERS)

ACADEMICS:

ASSIGNED GRADE LEVEL:_____ RETAINED IN WHAT GRADE?_____

IQ:_____ LAST SCHOOL ATTENDED:_____

DOES CLIENT HAVE A CURRENT IEP? ☐ YES ☐ NO (ATTACH COPY OF IEP)

EDUCATIONAL SETTING: REGULAR CLASS ☐ SPECIAL EDUCATION ☐ HOME BOUND ☐

GED PROGRAM ☐ OTHER ☐ EXPLAIN:_____

HAS CLIENT BEEN CLASSIFIED AS SPECIAL NEEDS UNDER PL 105-17? ☐ YES ☐ NO

IF SO, WHAT SPECIAL NEED(S)?_____

HAS CLIENT BEEN SUSPENDED/EXPELLED IN LAST SCHOOL YEAR? ☐ YES ☐ NO

IF YES WHY:_____