Admission Application

Kids in Focus___ Girls in Focus ___ Little Kids in Focus ___ Little Kids in Focus II ___ Kids in Focus II ___

Instructions: When completing the application please do not leave blanks. If the requested information is unavailable or unknown please indicate so on the application by writing "unknown" or "N/A". It is essential that information provided on the application is accurate and current.

Child's Full Name:	**Referral Date:**	**Child's Social Security Number:**
Address:	**Date of Birth:** **Age:**	**Place of Birth:**

Referring Agency: **Contact Name:**			**Supervisor Name:**	**Legal Guardian:** **Emergency Contact:**
Address: (Include Physical & Mailing)		**Telephone:** **Fax:** **Email:**	**Telephone:** **Email:**	**Telephone:**

REASON FOR ADMISSION / CURRENT PRESENTING CONCERNS (within the last week)	
Summarize the child's current behaviors (within the past week). **Examples:** - Physical/ verbal aggression. - Truancy - Sexual activity - Fire setting - Peer/ family conflict - Drug use - Depression - Self harm (cutting, suicide attempt etc.)	

PRESENTING CONCERNS (by history)	
Summarize the child's behaviors by history **Examples:** - Physical/ verbal aggression. - Truancy - Sexual activity - Fire setting - Peer/ family conflict - Drug use - Depression - Self harm (cutting, suicide attempt etc.)	

Describe the Behavior Support Needs of the Child: *Please specify each problematic behavior of the child and provide information as indicated to assist him/her in self-managing*
Identify positive behavior(s):
Identify problem behavior(s):
Identify triggers for problematic behavior(s):
Identify successful intervention strategies for problem behaviors:
What techniques has the child used to self-manage anger and anxiety:

Describe the protection needs of the child: *Include any protective or restraining orders, prohibited contacts, etc.*

ADDITIONAL REVELANT DETAILS: BEHAVIOR HISTORY SCREENING			
Yes	No	BEHAVIOR	IF YES, DESCRIBE BELOW
		Substance Abuse?	
		Runaway History?	
		Physical Aggression?	
		Fire Setting?	
		Self Harm?	
		Sexually Active?	
		Sexual Offenses Against Others?	
		Legal History/ Charges?	Probation officer: Tel:

		Eating Problems/ Disorder?	
		Bedwetting?	
		Property Destruction?	
		Other	

Client strengths and interests:	

MENTAL HEALTH HISTORY			
List the previous services that have been used. Include timeframes & name of agency or placement. Indicate whether intervention was effective or not.	Placement/ Service	Date	Successful Y/N
Additional Information:			

Current DSM IV Diagnosis	**Axis I:**		**Test Date:**	
	Axis II:		**Evaluator:**	
	Axis III:		**Verbal I.Q:**	
	Axis IV:		**Performance I.Q:**	
	Axis V:		**Full Scale I.Q:**	

Developmental History: Describe child as an infant & toddler. Note any delays in reaching developmental milestones. Were there any complications at birth?	

FAMILY INFORMATION	
Parents Names and Addresses	**Mother:** ______ **Address:** ______ **Email Address:** ______ **Telephone Number (Home)** ______ **(Work)** ______ **(Cell)** ______ **(Pager)** ______ **Father:** ______ **Address:** ______ **Email Address:** ______ **Telephone Number (Home)** ______ **(Work)** ______ **(Cell)** ______ **(Pager)** ______
Parental Involvement: *Who is involved? Describe the parent's level of involvement with the child.*	
Relevant Family History:	
Who lives in the home?	

EDUCATIONAL INFORMATION

EDUCATION:

Current/Most Recent School Placement: ______ **County:** ______

Telephone Number ______ **Grade:** ______

School Address : ______

______

Special Education Needs: LD/ED/Other ______

Communication Problems: ______

IEP Eligible: Yes __________ No ______________

Last Date of IEP: ___________________ **Responsible County for IEP:** ____________________________

History of Truancy: Yes ________ No ____________

MEDICAL HISTORY

Date of Last Physical Exam: __________ **Name of Physician:** _________ **Phone.**________

Date of Last Dental Exam: ___________ **Name of Dentist:** ___________ **Phone.**________

TB Test Current: Yes ____ No ____ Unknown: ____

Immunizations Current: Yes ____ No ____

Currently Pregnant: Yes ____ No ____ **If Yes, Expected Due Date:** __________________

Current Medications			
Medication Name	**Start Date**	**Dosage & Frequency**	**Targeted Symptoms**

Previous Medications			
Medication Name	**Stop Date**	**Dosage & Frequency**	**Targeted Symptoms**

Medication Allergies: Yes____ No___ **If Yes, Describe:** _____________________________________

Food/Environmental Allergies: Yes____ No___ **If Yes, Describe:** ______________________________

Corrective Lenses: Yes _____ No ________ **Last Date of Eye Exam:** ____________________

Significant Medical Conditions	**Yes**		**No**		If Yes, Provide detail below and explain any treatment needs:

INSURANCE INFORMATION:

Please provide a copy of the front and back of the youth's insurance card(s)

I. Youth's Primary Medical Insurance: _________________ Policy Number: ________________________

Subscriber's Name: __________________ DOB: __________ Social Security No. ____________________

II. Youth's Secondary Medical Insurance: ________________ Policy Number: ______________________

Subscriber's Name: __________________ DOB: __________ Social Security No. ____________________

If youth has Medicaid, it is an HMO, FAMIS, VA Premier, Optima or Straight? _____________________

Kids in Focus will not be responsible for payment of medication costs and any medical appointments or procedures (initial physical and dental appointments do not apply)

Party Responsible for Co-Pays and unpaid bills? ____

CPS Reports: **List any CPS reports that have been made involving the child. Include date of report, nature of allegation and outcome.** (Attach paper if needed)
What are your expectations and goals for the child's placement at Kids in Focus?

By signing below you verify that the information on this application is accurate.

Completed by: ___________________________ Date: ____________
Signature of referring worker