Attachment D:

CHILDREN'S SERVICES REFERRAL APPLICATION
(formally known as Universal Application Form)

Date of Referral: _______________ Date Placement or Service Needed: _________________

Reason for Referral/Statement of Need (Explain client's problems and needs, and include an estimate of the severity of the client situation. Attach additional page as necessary):

Requested Service or Placement:

CLIENT INFORMATION

Client Name: ______________________________ AKA/Nickname: _____________________

SSN (last four digits): xx-_______ Medicaid Number: ____________________ Age: _______

Birthdate: ____________________ Gender: ______ Height: _______ Weight: _____

County of Legal Residence/Custody: ______________ US Citizen? ___ Legal Immigrant? ___

Current Placement/Location: ___________________________________ LOC: ____________

PARENT/GUARDIAN/RESPONSIBLE PARTY

Name: ______________________________________ Relationship to Client: _______________

Address: ____

Telephone: ____________ Fax: _________________ E-mail: _______________________

REFERRING PARTY

Agency & Office: ___________________________ Caseworker: ________________________

Telephone: ______________ Fax: _______________ E-mail: ___________________________

Address: ____

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Client Name: ______________________________

Other Involved Agencies: ____

CLIENT STRENGTHS

Strengths: (Check all that apply)

☐ Strong Family Support ☐ Other Personal Support ☐ On Grade-Level
☐ Appropriate Reading Level ☐ Average/Above IQ ☐ Good Verbal Skills
☐ Resiliency/Coping Skills ☐ Good Socialization Skills ☐ Good Personal Hygiene
☐ Interests_______________ ☐ Interests_______________ ☐ Other _______________
☐ Religious Affiliation/Preference ____

CLIENT PROBLEMS (Check all that apply, **indicating whether a problem is Current (C), within the last three months, or in the Past** (**P**), and the **frequency or severity rating (SR)** of the issue – **1 = Not too frequent or serious; 2 = moderately frequent or serious; 3 = very frequent and/or severe**. You must describe or explain all items checked, in the space below the chart.):

C	P		SR	C	P		SR
☐	☐	Abandonment/Attachment Issues		☐	☐	Aggressive (Physical)	
☐	☐	Aggressive (Verbally)		☐	☐	Alcohol/Drug Use	
☐	☐	Anxiety		☐	☐	Arson/Fire Setting	
☐	☐	Attention Seeking		☐	☐	Chaotic Home Situation	
☐	☐	Delusional		☐	☐	Destroys Property	
☐	☐	Mild Depression/Sadness		☐	☐	Moderate/Severe Depression	
☐	☐	Difficulty with Authority		☐	☐	Developmentally Delayed	
☐	☐	Encopresis		☐	☐	Fire Setting	
☐	☐	Eating Disorder		☐	☐	Hyperactive	
☐	☐	Lies/Not Truthful		☐	☐	Loss/Grief Difficulties	
☐	☐	Low Self-Esteem		☐	☐	Oppositional/Defiant	
☐	☐	Phobic Reactions/Behavior		☐	☐	Physical/Medical Conditions (specify)	
☐	☐	Poor Personal Hygiene		☐	☐	Problems with Walking	
☐	☐	Poor Social Skills		☐	☐	Problems at School	
☐	☐	Self-Destructive Behavior		☐	☐	Sexually Inappropriate	
☐	☐	Sibling Related Difficulty		☐	☐	Suicidal Gestures/Attempts	
☐	☐	Steals		☐	☐	Truancy	
☐	☐	Needs Protection from Others		☐	☐	Unruly/Ungovernable	
☐	☐	Aggressive (Sexual)		☐	☐	Poor Coping Skills	
☐	☐	Antisocial/Criminal Behavior		☐	☐	Poor Reality Orientation	
☐	☐	Autism/Autism Spectrum		☐	☐	Running Away	
☐	☐	Cruelty to Animals		☐	☐	Sexually Provocative	
☐	☐	Expelled/Not in School		☐	☐	Adjudicated/Convicted Sexual Offender	
☐	☐	Manic/Mood Swings		☐	☐	Suicidal Ideation	
☐	☐	Enuresis/Bedwetting		☐	☐	Trust Issues	
☐	☐	Functionally Illiterate		☐	☐	Victim of Neglect	
☐	☐	Impulsive		☐	☐	Victim of Physical Abuse/Violence	
☐	☐	Manipulative		☐	☐	Victim of Sexual Abuse	
☐	☐	Parental Neglect Issues		☐	☐	Victim of Emotional Abuse	
☐	☐	Language Limitations		☐	☐	Wheelchair/Adaptive Devices	
☐	☐	Gang Involvement		☐	☐	Other (specify	
☐	☐			☐	☐		

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Client Name:
____

Explanation (attach additional pages as necessary):

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Client Name_____________________________

PLACEMENT HISTORY

Number of Previous Placements: Please list all placements **in past 3 years**, including periods of incarceration and psychiatric hospitalizations. Attach additional or separate page(s) if desired.

Placement (include type or LOC)	Dates (From/To)		Reason for Discharge

1.2 MEDICAL INFORMATION

CURRENT DIAGNOSES – ICD-9 or DSM IV-TR (list past diagnoses if relevant):

Axis	**Diagnosis**	**Date Given**	**Source**

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MEDICATIONS (List all **current** medications, dosages, and instructions. Attach additional page if needed):

Medication Name	Dosage	Instructions

Client's Primary Physician: Phone:

Date of Last: Physical Exam: Dental Exam: Eye Exam:

Allergies

Special Dietary Needs:

List any current or prior medical conditions, physical disabilities, adaptive devices, or specialty medical care that a Provider needs to accommodate.

SCHOOL INFORMATION

Official Home School District (where parent/guardian/custodial agency resides):

Is the client currently attending any school? ☐ **Yes** ☐ **No** **If NO**, why not: ______________________________

Is the client currently functioning on grade level? ☐ **Yes** ☐ **No** Comments: __________________________

List last five schools attended, beginning with the current/most recent school:

1.1.1 SCHOOL ATTENDED	**DATES**		**GRADE**	**COMPLETED?**

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Has client ever been classified Special Education? ☐ **UNKNOWN** ☐**NO** ☐**YES**

IF YES, primary classification: ________________________ Secondary Classification: ___________________________

Does client have a current IEP?	☐ No	☐Yes	IF YES, date:
Does client have a section 504 Accommodation Plan?	☐ No	☐Yes	IF YES, date:
Is client currently under recommendation for expulsion?	☐ No	☐Yes	IF YES, Explain below:

Explain any school-related problems or conditions needing to be accommodated:

Attach any additional information or documentation necessary to make an informed placement decision (including CALOCUS/CASII or CBCL when appropriate).