Revised 7/2012

Residential Services
Admission Application

Admission Staff:	Date of Placement:	Date of Referral:

Child's Information

Last Name	First Name	Middle Name	Date of Birth	Race

Age:	Gender:	Height:	Weight:	Eye Color:	Hair Color:

Soc. Sec. #:	Birth Place: *(County/State)*	Medicaid Number:

Current Address:

City:	County:	State:	Zip:

Religious Preference:	Any identifying marks/characteristics?

Any Cultural affiliations relevant to placement:

Who has custody of child?	What type?

Sexual Orientation: ☐Heterosexual ☐Lesbian ☐Gay ☐Bisexual ☐Transgender ☐Questioning ☐Unknown

Presenting Circumstance

Placing Agency

Custodial Agency:	Case Worker/P.O.:	Region:

Address:

City:	County:	State:	Zip:

Phone #:	Fax #:	Cell #
Emergency #:	Email :	After hour #:
Supervisor's Name:	Phone:	Email:

On Call Placing Case Worker:	Office Phone #:

Cell/Alternate #	Email:	Fax:

Where is child coming from? (i.e., home, detention, hospital, group home, etc.):

Why is placement desired?

Is this a 72 hr. (Respite) placement? ***Date of Pick-up?*** ***Print Name:***
Signature:

Has parental rights been terminated? If yes, When/Who:

To Be Completed By DJJ Case Worker/Representative

Program Manager Name:

Office #:	Cell #:

Residential Placement Specialist:

Office #:	Cell #:

Child's Placement History *(list present placement first)*

Date	Placed with	Relationship	Length of Placement	Reason for Discharge

Education History

Current School:	Phone #	☐ GED or ☐ Graduate

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Address:	**City:**	**State:**	**Zip:**

Education Classification: ☐ Regular ☐ IEP ☐ Self Contained ☐ Psycho Education ☐ Partial Spec Ed

School Status: ☐ Attending ☐ Suspended ☐ Expelled ☐ Alternative ☐ On-site ☐ Other:

Describe attendance: ☐ less than 3 days last month ☐ 3 or more days last month ☐ All days were unexcused

Highest grade completed: ☐ On grade level ☐ Behind grade level ☐ Repeating grade

Medical

List Current Medication taking: ***(You will need a 30 day supply at admissions)*** ☐ **No Medication**

1.	**3.**
2.	**4.**

Date of Last Physical Exam:	**Date of Last Dental Exam:**	**Date of Last Ear/Eye:**

List Allergies ***(include food/medication):***

Other health problems, physical limitations or special needs:

DSM Multi –Axial Assessment

Axis I Primary	Axis I Secondary	Axis II Primary	Axis II Secondary	Axis III Primary	Axis III Secondary

Substance Abuse

Type of Substance(s): ☐ None ☐ Alcohol ☐ Drugs ☐ Both **Age at first use:**

☐ No current drug use ☐ Marijuana/hashish ☐ Cocaine (crack/rock) ☐ Cocaine (coke) ☐ Nicotine (cigarettes)
☐ Amphetamines (Meth/uppers/speed/ecstacy ☐ Barbiturates (Tuinal/Seconal/downers) ☐ prescription
☐ Phencyclidine (PCP/angel dust) ☐ Opiate Narcotics(Heroin) ☐ Other:

Frequency use of: ☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month

Route of Administration: ☐ Oral ☐ Smoking ☐ inhalation ☐ Injection ☐ Unknown ☐ Other:

Tobacco use: ☐ Yes ☐ No, If yes, how long have you been a smoker? **How many cigarettes per day?**

Behavior characteristics of the Child:

Please rate the client's greatest behavioral dysfunction over the past 12 months using the code below. (Place an X in the box)

1 = not applicable 2 = currently 3 = history

Behavior	1	2	3	Behavior	1	2	3	Behavior	1	2	3
curses at others				shows no remorse				sexual acting out			
challenges authority				doesn't show empathy				lies			
does not accept criticism				doesn't handle being told no by adults				teases other children			
steals				inserts objects into rectum				run away			
school issues				sexually aggressive				damages property			
sad or unhappy				fire setting				poor hygiene			
abusive to animals				perpetrator				stubborn			
explosive / yells				strikes adults				abuse issues			
self mutilates				noncompliant				manipulative			
strikes peers				impulsive				exposes self to other			
swallows nonfood items or overdoses				substance use / abuse				seeks out negative peers			
quick temper or temper tantrums				secretive				suicide threats			
argues				overreacts				bangs own head			
gang				anger issues				criminal activity			

Child's SNAP *(Skills, Needs, Abilities and Preference)*

Strengths (assets, resources):

Needs (liabilities, weaknesses):

Abilities (skills, talents, competencies)

Preferences (those things the client thinks, feel will enhance his/her treatment experience):

Family Background Information

Parent/Guardian Name(s)	Home	Work	Cell

Current Address:	**City:**	**State:**	**Zip:**

Religious Preference:	**Education Level:**	**Occupation:**

Supervised visits permitted? ☐ Yes ☐ No **Phone contact permitted?** ☐ Yes ☐ No
Overnight visits permitted? ☐ Yes ☐ No **Off Campus visits permitted** ☐ Yes ☐ No

Parent/Guardian Name(s)	Home	Work	Cell
Current Address:	**City:**	**State:**	**Zip:**

Religious Preference:	**Education Level:**	**Occupation:**

Supervised visits permitted? ☐ Yes ☐ No **Phone contact permitted?** ☐ Yes ☐ No
Overnight visits permitted? ☐ Yes ☐ No **Off Campus visits permitted** ☐ Yes ☐ No

Are parents married: ☐ Yes ☐ No **Do parents live together:** ☐ Yes ☐ No **Date of Divorce:**

Legal Guardian: **Legal Custody:** **Physical Custody:**

Family income: ☐ 0 - $9,999 ☐ $10,000 - $19,000 ☐ $20,000 - $29,000 – over $30,000

List brothers, sisters (including half or step) grandparents, near relatives or adult friends:

Name	Race	Sex	Birth Date	Relationship	Address/Phone

Any legal restrictions on either parent involvement? ☐ Yes ☐ No **If yes, what?**

Can parent/guardian participate in program? ☐ Yes ☐ No **If yes, who?**

Name/Relationship:

Name/Relationship:

Permanency Plan

- ☐ **Return permanent custody to:**
- ☐ **Permanent placement with a relative through adoption**
- ☐ **Permanent placement with a relative through legal guardianship or permanent custody**
- ☐ **Permanent custody terminated with:**
- ☐ **Adoption (non-relative)**
- ☐ **Legal guardianship/permanent custody (non relative)**
- ☐ **Other planned living arrangement through emancipation or independent living program**
- ☐ **Other planned permanent living arrangement through relative long-term care**
- ☐ **Other planned permanent living arrangement through non-relative long term care**

List permanent connections and relationships to this child:

1.

2.

Trauma / Family History

Type of Trauma (if applicable)	Description
Neglect	
Emotional Abuse	
Physical Abuse / Domestic Violence	
Sexual Abuse (victim)	

Parental/Caregiver Mental Illness	
Caregiver Criminal Behavior / Incarceration	
Caregiver Drug Use / Abuse	
Adoption Disruption / Dissolution	
Child of Veteran	

Required Case Plan Contact (Including Sibling Visits)

Name:	**Relationship:**
Address:	
Phone Number 1:	**Phone Number 2:**
Name:	**Relationship:**
Address:	
Phone Number 1:	**Phone Number 2:**

Is agency required to support visitation with parent or guardian? Yes☐ No☐ If yes How?

Is agency required to assist in sibling visits? Yes☐ No☐ If yes how?

Agency comments:

Medication

Name of Medication	**Dosage and Frequency**	**Reason**

Substance Abuse/ Dependence/ Use?

Name of Substance	**Method of Administration**	**Frequency of Use**	**Age at First Use**	**Last Used**

Legal

Past legal involvement with criminal or juvenile justice system within the last 12 months: ☐ Yes ☐ No If, yes explain:

Currently on Probation: ☐ Yes ☐ No If, yes Name of Probation Officer:

Number of arrest within last 30 days: ☐ No arrest ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Court Appointment / Family Team Meetings

Type:	**Date:**	**Time:**
Type:	**Date:**	**Time:**

NOTE* ALL AREAS OF FORMS SHOULD BE COMPLETED. PLEASE INSERT N/A WHERE APPLICABLE.

Positive Growth Inc.

Revised 7/2012

Approved Visitor and Communication Form

Resident Name	Advisor	☐ Probation Officer	☐ Caseworker	Phone #

List information on Parents, Guardians, Extended Family Members, and Adult Siblings for phone contact.

List others whom may have phone contact or visitation and indicate if the individual is approved to visit (V), or have telephone contact (P) by placing an (X) mark in the spaces provided.

APPROVED

V	P	Name	Relationship	Phone #	Address

***List any Court ordered restrictions on communication and visitation with Parents, Guardians, Adult Extended Family Members, and Adult Siblings. (Attach copy of order)**
***List others whom may not have phone contact or visitation and indicate the individual is not approved to visit (V), or have telephone contact (P) by placing an (X) in the space provided.**

RESTRICTED

V	P	Name	Relationship	Phone #	Address

The following persons may transport child:

1.	3.
2.	4.

______________________________ Probation Officer /Caseworker Signature

______________________________ Date

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Authorization for Clinical Treatment & Services

Positive Growth's Counseling Center provides high quality comprehensive mental health and outpatient substance abuse treatment and education services as part of our Community Based Core Services Program; provided in partnership with the Department of Human Resource, through its Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD). While your child resides at one of Positive Growth's residential group homes, please let us know what clinical services your child will need while in placement with us.

A Physician, Registered Nurse Practitioner or Physician Assistant, Licensed Clinician(s), Certified Substance Abuse Counselor(s) Pharmacist and Paraprofessional(s) are available to provide both mental health / addiction treatment services and support services.

Please indicate what clinical services your child will need by selecting from the list below:

- ☐ Behavioral Health Assessment
- ☐ Physical/Health Assessments and Care
- ☐ Nursing Assessment and Care
- ☐ Individual Counseling
- ☐ Group Counseling/Training
- ☐ Psychological Assessment
- ☐ Crisis Intervention
- ☐ Medication Management
- ☐ Community Support Individual
- ☐ Family Counseling/Training
- ☐ Anger Management
- ☐ Behavioral Aid Services
- ☐ Outpatient Substance Abuse Treatment and Education Program
- ☐ Other Service(s) needed:____

PARENTAL/GUARDIAN CONSENT

Last Name	First Name	Middle Name	Date of Birth	Race

The aforementioned child has my consent to receive services offered at Positive Growth Counseling Center located in Clarkston, Georgia. I have been informed of and understand the scope of services which may be provided. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing Positive Growth Counseling Center to provide services to the child in his best interest.

I consent to the release of relevant health information and medical records in connection with treatments to Positive Growth Counseling Center and its collaborating partners to facilitate the child's health needs. I further authorize Positive Growth Counseling Center to release information regarding the child's treatment to third party payors or others for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

I hereby authorize payment to Positive Growth Counseling Center and its contracted staff for Agency's usual and customary cost of treatment otherwise payable to me, but not to exceed the Agency's regular charges. I understand that I am financially responsible to Positive Growth Counseling Center and it contracted providers for the charges not covered by Medicaid and/or Insurance Plan.

I, (Consumer) ________________________________ understand that I have a choice concerning my treatment options. If your child is accepted into our residential program and wishes to use a provider other that Positive Growth Counseling Center, he will be provided with a list of providers in the area if you have not already selected a provider. If you have selected a provider other than Positive Growth Counseling Center, please provide us with the name of the provider and transportation information.

Name of Provider:			**Contact #:**
Address:	**City:**	**State:**	**Zip:**
Transportation Information:			
Authorizing Services: Signature – Parent/Guardian			**Date:**
Declining Services: Signature – Parent/Guardian			**Date:**
If a caseworker, Name of Agency/County**:**			**Date:**