Place of Hope, Inc.
Application for Admission

COTTAGE FOR GIRLS

GENERAL INFORMATION

Child's Name:

Social Security Number:

Date of Birth: **Current Age:**

Place of Birth (city, state or city, country):

Sex: Select One **Race:** **Primary Language:**

Current Type of Placement: Select One

If other, please specify:

Name of Current Placement (if applicable):

Current Address:

Current Phone:

Medicaid Coverage: Select One **Medicaid Number:**

Other Insurance Information:

Reason for Removal from Biological Home:

Reason for Referral to POH:

When is Admission Needed?

Anticipated Length of Stay or Discharge Date:

Place of Hope Use Only:

Date of Admission: ______________________________ Client #:______________

GENERAL INFORMATION CONTINUED

DCM Placing Child:

District:
Location:

Cell Phone: Office Phone:
Email:
Fax:

DCM Supervisor:

District:
Location:

Cell Phone: Office Phone:
Email:
Fax:

Guardian Ad Litem:

Cell Phone: Office Phone:
Email:
Fax:

Attorney:

Cell Phone: Office Phone:
Email:
Fax:

Therapist:

Cell Phone: Office Phone:
Email:
Fax:

Targeted Case Manager:

Agency:
Cell Phone: Office Phone:
Email:
Fax:

CASE PLAN INFORMATION

Case Plan Goal:

☐ Reunification ☐ Long Term Foster Care/APPLA

☐ Adoption ☐ TPR

☐ Other:

Case Plan Goal Date:

Next Court Date:

Barriers to Permanency:

Permanency Plan Details & Target Dates:

FAMILY HISTORY

Biological Mother

Name:

Date of Birth: **SSN:**

Occupation: **Race:**

Address:

Best Contact Number:

Currently Married? ☐ Yes ☐ No

Primary Language:

Is child allowed contact with biological mother? ☐ Yes ☐ No

If yes, please attach court order and indicate levels of contact below:

Phone Contact: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Visitation: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Please indicate frequency & level:

Biological Father

Name:

Date of Birth: **SSN:**

Occupation: **Race:**

Address:

Best Contact Number:

Currently Married? ☐ Yes ☐ No

Primary Language:

Is child allowed contact with biological father? ☐ Yes ☐ No

If yes, please attach court order and indicate levels of contact below:

Phone Contact: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Visitation: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Please indicate frequency & level:

Siblings

Name: **Age:**

Phone Number:

Placement & Address:

Last contact with child:

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain:

Name: **Age:**

Phone Number:

Placement & Address:

Last contact with child:

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain:

Name: **Age:**

Phone Number:

Placement & Address:

Last contact with child:

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain:

Name: **Age:**

Phone Number:

Placement & Address:

Last contact with child:

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain:

Name: **Age:**

Phone Number:

Placement & Address:

Last contact with child:

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain:

PLACEMENT HISTORY

Date of Initial Removal from Home:

City of Initial Removal:

Number of Placements (including current placement):

Complete Placement History in Chronological Order:

Placement	Date Placed	Date Moved	Reason for Move

ACADEMIC HISTORY

Current School:

Current Grade Level:

School Phone:

School Contact Person:

Academic Status:

- ☐ Regular Education
- ☐ IEP
- ☐ 504 Plan
- ☐ Alternative Education
- ☐ SLD
- ☐ EBD
- ☐ Speech Language Services
- ☐ ESE
- ☐ ESOL
- ☐ Other:

Has the child ever been retained? ☐ Yes ☐ No

If yes, what age and grade?

Current GPA: **Date of Last Report Card:**

Full Scale IQ:

List Academic Services Identified:

List Academic Needs Identified:

Date of Last Educational Evaluation:

Test Battery Given:

Where are these records held?

List any school problems (e.g. truancy, excessive absences, suspensions, fighting, refusal, grades, etc.):

List any bus problems or behaviors:

List any extracurricular activities:

MEDICAL HISTORY
BIRTH TO PRESENT

- ☐ Birth Defects — If so, explain:
- ☐ Asthma — If so, list date of Onset and Current Treatment to Date:
- ☐ Anemia — If so, list date of Onset and Current Treatment to Date:
- ☐ Blood Disorder — Name of Blood Disorder (or Disease) :
- ☐ Cancer — If so, list date of Onset and Current Treatment to Date:
- ☐ Diabetes — If so, list date of Onset and Current Treatment to Date:
  - ☐ Type 1 ☐ TYPE 2
- ☐ Epilepsy — If so, list date of Onset and Current Treatment to Date:
- ☐ HIV/AIDS — If so, list date of Onset and Current Treatment to Date:
- ☐ Kidney Disease — If so, list date of Onset and Current Treatment to Date:
- ☐ Heart Disease — If so, list date of Onset and Current Treatment to Date:
- ☐ Hemophilia — If so, list date of Onset and Current Treatment to Date:
- ☐ Liver Disease — If so, list date of Onset and Current Treatment to Date:
- ☐ Pneumonia — If so, list date of Onset and Current Treatment to Date:
- ☐ Seizure — If so, list date of Onset and Current Treatment to Date:
- ☐ Sexually Transmitted Disease
  - If so, list date of Onset, duration, & course of treatment:
- ☐ Skin Disorder — Name of Skin Disorder (or Disease) :
- ☐ Sleep Disturbance — If so, list date of Onset and Current Treatment to Date:
- ☐ Diptheria — If so, list date of Onset and Current Treatment to Date:
- ☐ Measles — If so, list date of Onset and Current Treatment to Date:
- ☐ Mumps — If so, list date of Onset and Current Treatment to Date:
- ☐ Rheumatic Fever — If so, list date of Onset and Current Treatment to Date:
- ☐ Scarlet Fever — If so, list date of Onset and Current Treatment to Date:

☐ Small Pox If so, list date of Onset and Current Treatment to Date:

☐ Tuberculosis If so, list date of Onset and Current Treatment to Date:

☐ Typhoid If so, list date of Onset and Current Treatment to Date:

☐ Whooping Cough If so, list date of Onset and Current Treatment to Date:

Has the child ever experienced the following:

☐ Night Terrors List behaviors associated with this problem:

☐ Sleep Walking List behaviors associated with this problem:

☐ Night Sweats List behaviors associated with this problem:

☐ Fear of the Dark List behaviors associated with this problem:

☐ Encapresis List behaviors associated with this problem:

☐ Insomnia List behaviors associated with this problem:

☐ Fear of Bedtime List behaviors associated with this problem:

☐ Difficulty Walking List behaviors associated with this problem:

☐ Enuresis List behaviors associated with this problem:

☐ Coma

☐ Spinal Injury

☐ Back pain/injury (muscular)

☐ Head trauma or injury

Please explain injury in detail:

☐ Broken bones

☐ Please explain injury in detail:

☐ Bowel trouble (impaction, obstruction, loose)

☐ Kidney trouble

☐ Urinary tract infection

List frequency and cause:

Has the child experienced the following?

- ☐ Conjunctivitis
- ☐ Nail fungus
- ☐ Foot fungus
- ☐ Warts
- ☐ Frequent bloody nose
- ☐ Cuts or sores that won't heal
- ☐ Bleeding tendencies
- ☐ Frequent thirst
- ☐ Fainting
- ☐ Periods of Unconsciousness
- ☐ Frequent colds/flu
- ☐ Sinusitis
- ☐ Ear, nose, throat trouble
- ☐ Running ears
- ☐ Clogged ears
- ☐ Difficulty hearing
- ☐ Hearing loss
- ☐ Vision loss
- ☐ Eye trouble
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ Shortness of breath
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Jaundice
- ☐ Stomach trouble
- ☐ Ulcers
- ☐ Tumor
- ☐ Appendicitis
- ☐ Hernia
- ☐ Swollen/painful joints

Does the child have allergies to the following?

☐ Food (dairy, sugars, peanuts, etc.)

List:

☐ Medication (antibiotics, asprin, codeine, anesthesia, etc.)

List:

☐ Other (pollens, wool, chemicals, etc.)

List:

Has the child ever had a reaction to any medication?

If yes, list medication and resolution for reaction:

Please list and special diets or dietary restrictions (e.g. reduced calories, diabetic, etc.):

Has the female used a contraceptive? ☐ Yes ☐ No ☐ Unknown

If yes, specify type:

Does the female applicant have a pregnancy history? ☐ Yes ☐ No ☐ Unknown

If yes, please answer the following:

Currently Pregnant: ☐ Yes ☐ No ☐ Unknown
Number of children born alive*:
Number of children stillborn:
Number of miscarriages:
Number of pregnancy terminations:

*Please provide the following information for children born: child's name, guardian name, address, and phone number.

Please list any complications with any pregnancy:

Please list result from complications:

Hospitalizations and Surgery History

Hospitalizations requiring surgery:

Date: Age at time:
Type of Surgery: Reason for surgery:

Date: Age at time:
Type of Surgery: Reason for surgery:

Date: Age at time:
Type of Surgery: Reason for surgery:

Date: Age at time:
Type of Surgery: Reason for surgery:

Hospitalizations not requiring surgery:

Date: Age at time:
Reason for hospitalization:

Date: Age at time:
Reason for hospitalization:

Date: Age at time:
Reason for hospitalization:

Date: Age at time:
Reason for hospitalization:

Dentist & Pediatrician Information

Dentist Name:
Dentist Phone:
Date of last dental exam:
List any dental concerns or needs:

Pediatrician Name:
Pediatrician Phone:
Date of last physical:
List any medical concerns or needs:

MENTAL HEALTH

Does the child have a CBHA? ☐ Yes ☐ No

If yes, please provide a copy with this application.

Has the child ever had a DSM IV Diagnosis? ☐ Yes ☐ No

If yes, please provide the following:

	Diagnosis	**Justification**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V/CGAS		

Current Medication:

Name of Medication:
Dosage:
Purpose:

Name of Medication:
Dosage:
Purpose:

Name of Medication:
Dosage:
Purpose:

Name of Medication:
Dosage:
Purpose:

Psychologist/Psychiatrist Name:

Agency:
Phone Number:

*Please include all psychological/psychiatric assessments.

Applicant has experienced/demonstrated the following:
check all that apply

- ☐ abandonment
- ☐ physical abuse
- ☐ sexual abuse
- ☐ lying
- ☐ alcohol use
- ☐ negative attitude
- ☐ tobacco use
- ☐ no remorse for actions
- ☐ argumentative
- ☐ history of running away
- ☐ clothes wetting
- ☐ sexually inappropriate behavior
- ☐ curfew problems
- ☐ stealing
- ☐ destructive
- ☐ suicidal ideations
- ☐ easily agitated
- ☐ homicidal ideations
- ☐ gang related behavior
- ☐ other:

- ☐ hyperactive
- ☐ hypo active
- ☐ lacks respect for others
- ☐ verbally aggressive
- ☐ mood swings
- ☐ inhalant use
- ☐ no motivation
- ☐ anger management
- ☐ poor self image
- ☐ bed soiling
- ☐ sexually active
- ☐ cruelty to animals
- ☐ socially isolated
- ☐ delinquency
- ☐ violent behavior
- ☐ extreme sibling rivalry
- ☐ suicide attempts
- ☐ fire setting
- ☐ homicidal attempts

- ☐ neglect
- ☐ lacks responsibility
- ☐ physically aggressive
- ☐ manipulative behavior
- ☐ drug use
- ☐ inappropriate peer relationships
- ☐ excessive attention seeking
- ☐ poor hygiene
- ☐ bed wetting
- ☐ self injury/mutilation
- ☐ clothes soiling
- ☐ sexual perpetrator
- ☐ defiant
- ☐ truancy
- ☐ disrespectful to authority
- ☐ suicidal gestures
- ☐ fighting
- ☐ homicidal gestures