

**Department of Social Services
Child Protection Services**

**Department of Corrections
Group/Residential Referral Application**

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security Number: _____

Male: Female: Race: _____ Height: _____ Weight: _____

Medicaid Number: _____ CID Number: _____

Discharge Plan: _____ Permanent Plan: _____

Level of Service – Please check the level of service that is being sought for the youth.

Community Based Services	NON-PRTF SERVICES	PRTF SERVICES
<input type="checkbox"/> Out of School Time	<input type="checkbox"/> Short Term Assessment	<input type="checkbox"/> Residential Treatment
<input type="checkbox"/> Independent Living	<input type="checkbox"/> Professional Foster Care	<input type="checkbox"/> Intensive Residential Treatment
<input type="checkbox"/> Crisis Stabilization	<input type="checkbox"/> Therapeutic Emergency Foster Care	
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Group Care–Short Term (30 – 120 days)	
<input type="checkbox"/> Community Reintegration	<input type="checkbox"/> Group Care–Long Term (6 to 12 months)	

Has the Child been reviewed by the State Review Team (SRT)? Yes No

Date that placement is needed:

Tribal Information

Tribe: _____ Enrollment Number: _____

Family Services Specialist

Name: _____ Office: _____

Email Address: _____

Work phone Number: _____ Fax Number: _____

Cell Phone Number: _____

Supervisor: _____

Group/Residential Referral Application (Continued)

Juvenile Corrections Agent

Name: _____ Office: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Supervisor: _____

Emergency Numbers

Mother's Name: _____ Father's Name: _____

Telephone Number: _____ Telephone Number: _____

Person to Contact in case of Emergency: _____ Phone Number _____

Person or Relative child has been living with: _____

Siblings

Name	Age	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Group/Residential Referral Application (Continued)

Materials to be Included

- Removal/Commitment Order giving Custody to the State
- Latest Report to the Court
- Initial Family Assessment or Juvenile Offender Intake Summary
- Copy of the Social Security Card
- Copy of Birth Certificate
- Copy of Most Recent Psychiatric Evaluation
- Copy of Most Recent Psychological Evaluation
- Copy of Discharge Summaries From Prior Placements

School Record

- Current IEP Current Grade Level: _____ IQ Score (if available): _____
- Report Cards
- Other Services Provided
 - Speech
 - Language
 - Counseling by School
 - Behavior Issues

Medical Records

- EPSDT, Immunization Records, TB Test, Dental, Vision, Hearing

Dates Of Last:

TB Test:	_____	Dental Visit:	_____
Vision Test:	_____	Hearing Test:	_____
Physical Exam:	_____		

- List Allergies:**

- Current Medications:**

Group/Residential Referral Application (Continued)

Name & Phone Number of:

Child's Doctor: _____ Telephone: _____

Child's Dentist: _____ Telephone: _____

Placement History:

Name of Facility	Dates of Service	Completed Successfully	
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	To	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Abuse & Neglect History:

Drug / Alcohol History:

Child: _____

Parents: _____

Fetal Alcohol Spectrum Disorder Information: _____

Who Can Child Have Contact With:

Name	Relation to Student	Monitored	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Should the person above be invited to meetings related to the student?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Group/Residential Referral Application (Continued)

No Contact List

Name	Relation to Student	

Discipline used in last Placement: _____

What worked? _____

What did not work? _____

Last Monthly Reporting Form: _____

Behaviors

- | | | | | | |
|--------------|--|-------------------|--|------------------|--|
| Aggression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexual Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexual Behaviors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fire Starter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicidal Ideation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Self Harm | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Run Away | <input type="checkbox"/> Yes <input type="checkbox"/> No | Huffing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol Use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Car Theft | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Active | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If Sexual Behaviors category is marked "yes":

Was sexual offender treatment recommended, and if so has the child completed? Yes No

If yes, where was sexual offender treatment completed at?

Please list any other behaviors that the child may need services for:

Please describe or give examples of each item checked Yes or listed as other:

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Additional information that would be helpful to know to provide appropriate care for the child:

Reasons For Placement / Desired Treatment Outcome:

Discharge Plan. Please indicate in as much detail as possible what the discharge plan is for this student upon completion of this program:

Have Parents/Immediate family been notified of this possible placement? If No, please explain:

In order to maintain safety and security within the facility it may be necessary to utilize seclusion and/or restraint at times. The guidelines for the use of seclusion/restraint are enforced through licensing regulations.
Is the use of seclusion and restraint approved for this referral? Yes No

Name of Person Completing This Form

Date