Kansas Department for Aging and Disability Services

UNIVERSAL PACKET

SERVICE ENTRY AUTHORIZATIONS

Client Name ________________________ Client ID# ____________ DOB ____________

Initial when applicable	**Authorization**	**Explanation**
	Exceptions of Confidentiality	**By signing below and initialing, the client indicates his/her understanding that providers at this agency may communicate with supervisors or other staff within the Community Mental Health Center without a release of information to provide the client with quality services. In addition, information about the client can be shared if he/she threatens to harm self or someone else or as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.**
	Authorization to communicate with placement provider	**By signing below and initialing, the client indicates his/her understanding that staff from the Community Mental Health Center has consent to initiate communication for the purpose of coordinating and scheduling timely mental health services with the client's placement provider.**
	Authorization to assign payment and release information	**By signing below and initialing, the client consents to treatment and agrees to assign payment directly to the CMHC for the benefits otherwise payable to client but not to exceed the balance due to of the CMHC's regular charges for this period of service. A photocopy of this authorization shall be considered as effective and valid as the original. The client also authorizes the release of information that pertains to the client's condition and the services delivered (including any treatment for alcohol or drug abuse) as necessary in processing health insurance and/or Title XIX claims. This consent shall be valid for the period of time required to allow complete processing of the client's claims for reimbursement. The consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.**
	Sharing pharmacy and lab information	**If medications should be prescribed or laboratory tests required as part of my treatment, I hereby give consent to release my name to the pharmacy or indigent program so that I may obtain medications and to assist in filling and managing prescriptions for me. The client also gives consent to release information for the purpose of obtaining laboratory results that are needed as part of the client's treatment.**

TO BE COMPLETED AT FIRST FACE TO FACE MEETING WITH THERAPIST

	Disclosure of licensure information	**By signing below and initialing, the client indicates that the licensure of the provider has been disclosed to the client as follows _______. Individuals with these qualifications are not authorized to practice medicine or prescribe drugs. This agency does employ staff credentialed to prescribe medications and the client may request a referral for that service.**

Client Signature _____________________________________ Date ________________

Parent/Guardian Signature ____________________________ Date ________________

Legal Custodian Signature ____________________________ Date ________________

Consent for Mental Health Treatment
for Child/Youth in Foster Care or Juvenile Justice System

By signing below, you are authorizing the designated Community Mental Health Center (CMHC) to provide the minor child named below with mental health and/or substance abuse services, which may include individual counseling, group therapy, psychiatric evaluation, medication services (including prescribing medications), and/or other related services. These services will be provided by the CMHC in accordance with appropriate state and federal laws.

By signing below, you agree that you are the legal guardian of the child listed below and that you authorize the CMHC to provide mental health and/or substance abuse services. Those services may include individual counseling, group therapy, psychiatric evaluation, medication services, and/or other related services. These services will be provided in accordance with the appropriate state and federal laws. You understand that this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. By signing below, you are granting permission for your child to participate in activities/programs, including transportation to and from these activities. You understand that this may involve transportation to locations external to the agency, by staff, representatives and/or volunteers.

By signing below, you confirm that you have received a copy of your rights as a client and have received an explanation of these rights if you have requested one.

By signing below, you agree that you have been offered a copy of The Notice of Privacy Practices.

I, ____ (Print Name of Guardian or Legally Authorized Agency Representative) do hereby consent for ______________________________(Print Name of Child/Youth) to receive mental health services as listed above) at ______________________________ (Print Name of CMHC).

Name of Child/Youth: ____ Date of Birth: _________/___/_____
Child/Youth's Social Security Number: _________________________
Name of Parent/Relative, Guardian or Foster Parent in whose home this child/youth will be residing:

____

Phone Number for Parent/Relative, Guardian or Foster Parent: ______________________________

Street Address where child/youth will be residing while in treatment: __________________________

City, State, Zip code: ____

Name of Guardian and/or Legally Authorized Agency Representative responsible for child/youth:

____

Phone Number for Guardian and/or Legally Authorized Agency Representative Office Number______________

Cell Phone Number: __________________________ Agency Name: _________________________

Signature of Guardian or Legally Authorized Agency Representative: ___________________________

Date: _________________________

Signature of Witness: _______________________________________ Date: __________________

Signature of Child/Youth: ____________________________________ Date: __________________

(Age 13 or older for Mental Health Treatment and 14 or older for Substance Abuse Treatment)

PLACEMENT PROVIDER

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: ____________________________________ Date of Birth: ____/____/____ Age: ______________
Social Security Number: ___________________________ Medicaid ID: ________________ MCO: _____________________
Or Third Party Insurance: _____________________________________

I _____________________________________, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: ____ Telephone Number: ______________________________
Address of Office: _______________________________________ Fax Number: ____________________________________
City, State, Zip: ____ Email Address: __________________________________

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: ____Provider Name of Applicable: _____________________
Address: ____ City, State, Zip: ___________________________________
Telephone Number: __________________ Fax Number: ____________________ Email Address: _________________________

	Entry/ Admission Report		Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Case Consultations		Other
	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)__________________

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: ________________________

NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: ____ Date: ______________________________
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: ____________________________________ Date: ______________________________

Printed Name of Person Authorized to Sign: ____

Relationship to Child/Youth: _______________________________
Address and Phone Number: ____

C. Signature of Witness: ____ Date: ______________________________

* NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment Information, and HIV/AIDS (or other communicable disease) Information.

PRIMARY HEALTH PROVIDER

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: ______________________________________ Date of Birth: ____/____/____ Age: ______________
Social Security Number: _____________________________ Medicaid ID: _________________ MCO: _____________________
Or Third Party Insurance: ___________________________________

I _______________________________________, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: ____ Telephone Number: ______________________________
Address of Office: ____ Fax Number: ____________________________________
City, State, Zip: ____ Email Address: _________________________________

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: ____Provider Name of Applicable: ________________________
Address: ____ City, State, Zip: _______________________________
Telephone Number: ___________________ Fax Number: _____________________ Email Address: _________________________

	Entry/ Admission Report		Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Case Consultations		Other
	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)__________________

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _________________________

NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: ____ Date: ______________________________
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____________________________________ Date: ______________________________

Printed Name of Person Authorized to Sign: ____

Relationship to Child/Youth: _______________________________
Address and Phone Number: ____

C. Signature of Witness: ____ Date: ______________________________

* NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment Information, and HIV/AIDS (or other communicable disease) Information.

SCHOOL

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: _____________________________________ Date of Birth: ____/____/____ Age: ______________
Social Security Number: _____________________________ Medicaid ID: _________________ MCO: _____________________
Or Third Party Insurance: _____________________________________

I _______________________________________, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: ____ Telephone Number: ______________________________
Address of Office: ____ Fax Number: ____________________________________
City, State, Zip: ____ Email Address: __________________________________

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: ____Provider Name of Applicable: ________________________
Address: ____ City, State, Zip: ___________________________________
Telephone Number: ___________________ Fax Number: _____________________ Email Address: _________________________

	Entry/ Admission Report		Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Case Consultations		Other
	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)__________________

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _________________________
NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: ____ Date: ______________________________
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____________________________________ Date: ______________________________

Printed Name of Person Authorized to Sign: ____

Relationship to Child/Youth: _______________________________
Address and Phone Number: ____

C. Signature of Witness: ____ Date: ______________________________

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FOSTER CARE CONTRACTOR

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's First Name: ____________________________________ Date of Birth: ____/____/____ Age: ______________
Social Security Number: ______________________________ Medicaid ID: _________________ MCO: _____________________
Or Third Party Insurance: _____________________________________

I ____, hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: ____ Telephone Number: ______________________________
Address of Office: ____ Fax Number: ____________________________________
City, State, Zip: ____ Email Address: _________________________________

☐ To Disclose to AND/OR ☐ To Obtain From

Name of Agency: ____Provider Name of Applicable: ________________________
Address: ____ City, State, Zip: ____________________________________
Telephone Number: ___________________ Fax Number: _____________________ Email Address: _________________________

	Entry/ Admission Report		Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Case Consultations		Other
	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here:

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify)__________________

I understand I may revoke this authorization verbally or in writing at any time except for any Information that has already been sent Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year: _________________________

NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law. I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient: ____ Date: ______________________________
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian: _____________________________________ Date: ______________________________

Printed Name of Person Authorized to Sign: ____

Relationship to Child/Youth: _______________________________
Address and Phone Number: ____

C. Signature of Witness: ____ Date: _______________________________

* NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment Information, and HIV/AIDS (or other communicable disease) Information.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's Full Name: ______________________ **Date of Birth:** ____/ ____/ ____ Age: ________

Social Security Number: ____________ **Medicaid ID:** ____________ **MCO:** ____________

ThirdParty Ins: ____________

I ______________________ hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency: ______________________ Telephone Number: ____________

Address of Office: ______________________ Fax Number: ____________

City, State, Zip: ______________________ E-mail Address: ____________

________ **To Disclose To AND/OR** ________ **To Obtain From**

Name of Agency: ______________________ Provider Name If Applicable: ____________

Address: ______________________ City, State, Zip: ____________

Telephone Number: ____________ Fax Number: ____________ E-mail Address: ____________

	Entry/ Admission Report		Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Case Consultations		Other
	Progress Notes/Log Notes/Reports		

All of the records authorized above may be released unless actual dates of treatment are specified here: ____________

___ **A. It is understood that this information will be used for the purpose of:**

____ Evaluation ____ Treatment ____ Follow-Up Care ____ Other (specify) ____________

*I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization expires: (check one)

Specific date or event as indicated; not to exceed one year. ____________

NOTE: If no expiration date is specified, this authorization automatically expires one year from date of signature.

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B. Signature of either party is acceptable:

Signature of Patient ______________________ Date ____________

(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian ______________________ Date ____________

Printed Name of Person Authorized to Sign ______________________

Relationship to Child/Youth ______________________

Address and Phone # ______________________

C. Signature of Witness ______________________ Date ____________

*** NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment information, and HIV/AIDS (or other communicable disease) information.**

Foster Care or Juvenile Justice Mental Health Referral

Original: □ Yes □ No Date: __________

Update: □ Yes □ No Date: __________

Child/Youth Name: _________________________________Date of Birth: _____/_____/_________

Alias Name (Birth Name if Adopted): ____

Placement Provider Name: _____________________________________Phone:_________________________

Address (where residing): ______________________________________Phone: ________________________

City, State, Zip: ____Social Security #: ________________

County of Court Jurisdiction: ____________________________________

Name of Child Welfare or KDOC-JS Management Provider Designee legally authorized to consent for treatment:
____

Role: ____

Address, City and State: ____

Work Phone: _________________________________ Cell Phone: ____________________________

Sex	**Race**	**Ethnicity**	**Eligibility for SSI or SSDI**
☐Male	☐American Indian or Alaska Native	☐Hispanic or Latino	☐Not applicable
☐Female	☐Asian	☐Not Hispanic or Latino	☐Eligible and Receiving Payment
	☐Black or African American		☐Eligible but not Receiving Payment
	☐Native Hawaiian or other Pacific Islander		☐Potentially Eligible
	☐White		☐Determined to be Ineligible by Review & Decision
	☐Other		☐Determination Decision on Appeal

Education

Name of School:____ **Present Grade:**____________________________

Special Education Services: □ Yes □ No

Most grades are currently: □ A □ B □ C □ D □ F

INSURANCE INFORMATION

Primary Insurance Company Name: ________________________________(Includes Medicaid/Medicare)

ID#: ___________________________Subscriber: ___________________________DOB:_______________

Subscriber SSN: ___________________________ Subscriber Employer:_____________________________

Secondary Insurance Company Name: ______________________________(Includes Medicaid/Medicare)

ID#: ___________________________Subscriber: ___________________________DOB:_______________

Subscriber SSN: ___________________________ Subscriber Employer:_____________________________

Tertiary Insurance Company Name: ________________________________(Includes Medicaid/Medicare)

ID#: ___________________________Subscriber: ___________________________DOB:_______________

Subscriber SSN: ___________________________ Subscriber Employer:____________________________

CUSTODY STATUS

(Please select the current residential setting by placing an "X" before the selection)

☐	**1**	Child in KDOC-JS custody and lives at home	☐	**5**	Child is under DCF supervision, but not in their custody
☐	**2**	Child in KDOC-JS custody and out of home placement	☐	**6**	Child is under supervision of KDOC-JS, but not in their custody
☐	**3**	Child is in DCF custody and lives at home	☐	**7**	No KDOC-JS or DCF involvement
☐	**4**	Child is in DCF custody and out of home placement			

EDUCATIONAL PLACEMENT

(Please select the current educational placement by placing an "X" before the selection)

☐	**1**	Not applicable (not listed below)	☐	**13**	Not in school (GED)
☐	**2**	Institutional instruction: e.g. psych. Hospital, detention	☐	**14**	Not in school (expelled)
☐	**3**	Residential School	☐	**15**	Not in school (drop-out)
☐	**4**	Home-based instruction from school district	☐	**16**	Preschool
☐	**6**	Special Ed Classroom	☐	**17**	Other
☐	**7**	Regular classroom with Special Ed. Services or Consultation	☐	**18**	Alternative Education placement with Intensive Psychosocial
☐	**9**	Regular classroom (100% of the day, no Special Ed.)	☐	**19**	Not in school-Summer Break
☐	**10**	Home Schooling not provided by the school district	☐	**20**	Therapeutic Services in Preschool Children
☐	**11**	Not in school (suspended)	☐	**21**	Enrolled in Post Secondary Education (Technical School, College, Professional Development such as Cosmetology)
☐	**12**	Not in school (graduated)			

Are there currently any particular educational concerns? ____

____

____

RESIDENTIAL SETTING

(Please select the current educational placement by placing an "X" before the selection)

☐	**1**	Jail/Detention	☐	**8**	Emergency Shelter
☐	**2**	State Hospital	☐	**9**	Therapeutic Foster Care
☐	**3**	Inpatient Psychiatric Unit	☐	**10**	Foster Home
☐	**4**	Crisis Resolution/Stabilization Unit	☐	**11**	Temporarily living with a relative or family friend
☐	**5**	Drug/Alcohol Treatment Center	☐	**12**	Home of parent(s); Biological, Adoptive, or Legal
☐	**6**	Residential Treatment (PRTF)	☐	**13**	Independent Living
☐	**7**	Group Home (YRC)	☐	**14**	Homeless

JUVENILE JUSTICE & LAW ENFORCEMENT

(Please report the number of each category based on the previous 30 days)

	Total number of arrests		# of adjudicated misdemeanors
	# of adjudicated felonies for property crimes		# of law enforcement contacts (face-to-face contact not resulting in arrest)
	# of adjudicated felonies for crimes against persons		# of adjudicated felonies not property or persons
		☐	Not applicable

Does the child/youth have any pending or current charges? If yes, explain: ___________________________________

____

____

Does the child/youth have a No Run Order? □ Yes □ No □ Unknown

<u>Recent History of Present Situation</u>

Please describe the problems you are concerned about regarding this child/youth:

____

____

____

What mental health symptoms or behaviors is the child/youth currently demonstrating?

____

____

____

____

____

How long have you been concerned about this child/youth? ____

Family history of mental illness? □ Yes □ No □ Unknown (e.g. depression, schizophrenia, etc)

If yes, explain: ____

Family history of substance abuse? □ Yes □ No □ Unknown

If yes, explain: ____

History of family suicidal, homicidal, or self-injurious behavior? □ Yes □ No □ Unknown

If yes, explain: ____

History of child/youth suicidal, homicidal, or self-injurious behaviors? □ Yes □ No □ Unknown

If yes, explain: ____

Has this child/youth ever been sexually abused? □ Yes □ No □ Unknown

If yes, by whom? What is the relationship to the perpetrator? _____________________________________

____

____

Has this child/youth ever been physically abused? □ Yes □ No □ Unknown

If yes, by whom? What is the relationship to the perpetrator? _____________________________________

____

____

Has this child/youth ever been neglected? □ Yes □ No □ Unknown

If yes, explain: ____

Is there a history of child/youth trauma? □ Yes □ No □ Unknown

If yes, explain: ____

____

____

Please list all members of the family-of-origin and give related information

Name	Relationship to Child/Youth	Legal Guardian	Age	Residence
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		
	□ Father □ Step-Father □ Mother □ Step-Mother □ Sibling	□ Yes □ No		

Who is child/youth closest to in his/her family? ____

What do you consider to be this child/youth's strengths? _____________________________________

Please describe mother's health during pregnancy with this child/youth:__________________________

Any pregnancy problems? □ Yes □ No □ Unknown

If yes, explain: ____

Were there any health problems during infancy or early childhood? □ Yes □ No □ Unknown

If yes, explain: ____

Are there any developmental issues? (walking, talking, potty training, etc.) □ Yes □ No □ Unknown

If yes, explain: ____

Does the child/youth have any I/DD issues? □ Yes □ No □ Unknown

If yes:

Is the child on the I/DD Wait list? □ Yes □ No □ Unknown
If so, what CDDO are they connected to? ____
Is the child on the I/DD Waiver? □ Yes □ No □ Unknown
If so, Please sign a ROI for the I/DD case manager
Is the child on the Autism Waiver? □ Yes □ No □ Unknown
If so, Please sign a ROI for that Autism provider

Medical Information

Is this child/youth currently experiencing any illness or physical complaints? □ Yes □ No □ Unknown
If yes, explain: ____
Please list all prescription medications this child/youth is **currently** taking and dosage:
____
____
Name of Physician who prescribed these: ____
Please list all prescription medications this child/youth has taken in the **past six months:**
____
____
Please list all current over-the-counter medications or herbal preparations this child/youth is taking (kind and quantity): ____
____
What medications has this child/youth **previously** taken for psychiatric conditions?
____

Please list all drug allergies and adverse reactions this child/youth has had to medications:

Name of Drug:	Type of Adverse Reactions:
__________________	____
__________________	____
__________________	____
__________________	____

Please list all other non-medication allergies: ____
____

Please list all PREVIOUS mental health and/or substance use disorder treatment this child/youth has received:

Facility	**Location**	**Type of Care** (Inpatient, Outpatient, Substance Use)	**Month and Year**
			From ______ to ______
			From ______ to ______
			From ______ to ______

Please list prior and present mental health diagnoses: ____
____

Is the child/youth on the SED Waiver? If so, through which Community Mental Health Center? ________________
____

Recommendations based on the initial assessment will be made by the QMHP. Services necessary to meet the needs of the client may include:

- Case Management
- Home Based Family Therapy
- Psychosocial Group
- Attendant Care
- Individual Therapy
- Psychiatric-Medication Services
- Parent Support
- SED Waiver-Parent Support
- Family Therapy

Have you or others ever been concerned about this child/youth's drinking or drug use? □ Yes □ No
If yes, explain: ____
____

Why is this child/youth in custody? ____

Number of Foster Care placements since the child/youth entered DCF custody:____________________

How long in the current placement? ____

In an emergency, who can we notify? Name: ______________________ Relationship: _____________

Street Address: ____ Home Phone: ____________

City: _____________________State: ____________Zip:________ Business Phone: ______________

Form Completed by: ____ Date: ______________

Consent to Photograph

I am the Legal Guardian / Custodial parent of (please print) _________________________________.
I hereby give my permission for him / her to be photographed solely for identification purposes.

____ ______________________
Legally Authorized Agency Representative Signature **Date**

For Office Use Only:
Reviewed By: _________________________ Initials for Additions: ________ Date: ______________