Department of Social Services
Child Protection Services

Group Care Application

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

Date of Birth: _____

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

Medicaid Number: _____ CID Number: _____

Discharge Plan: _____ Permanent Plan: _____

Date of Referral for CANS Assessment (required): _____

Date Placed in QRTP (Group Care): _____ If not in QRTP, Date that Placement is Needed _____

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

Community Based Services	QRTP (Group Care) Services
☐ Out of School Time	☐ Short Term Assessment
☐ Independent Living	☐ Group Care–Short Term (30 – 120 days)
☐ Crisis Stabilization	☐ Group Care–Long Term (6 to 12 months)
☐ Respite Care	
☐ Community Reintegration	

Tribal Information

Tribe: _____ Enrollment Number: _____

Family Services Specialist

Name: _____ Office: _____

Email Address: _____

Work phone Number: _____ Fax Number: _____

Cell Phone Number: _____

Supervisor: _____

Group Care 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 Care Application (Continued)

Materials to be Included

- ☐ Removal/Commitment Order giving Custody to the State
- ☐ Latest Report to the Court
- ☐ Child Case Plan
- ☐ 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 Care Application (Continued)

☐ **Name & Phone Number of:**

Child's Doctor: ______________________ Telephone: ______________

Child's Dentist: ______________________ Telephone: ______________

Placement History:

☐ **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 ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	
		Yes ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	
		Yes ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	
		Yes ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	
		Yes ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	
		Yes ☐ No ☐
Should the person above be invited to meetings related to the student?	Yes ☐ No ☐	

Group Care 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	☐ Yes ☐ No	Sexual Abuse	☐ Yes ☐ No	Sexual Behaviors	☐ Yes ☐ No
Fire Starter	☐ Yes ☐ No	Suicidal Ideation	☐ Yes ☐ No	Self Harm	☐ Yes ☐ No
Run Away	☐ Yes ☐ No	Huffing	☐ Yes ☐ No	Drug Use	☐ Yes ☐ No
Alcohol Use	☐ Yes ☐ No	Car Theft	☐ Yes ☐ No	Sexually Active	☐ Yes ☐ 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:**

_____

_____

_____

_____

_____

_____

_____

Group Care Application (Continued)

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**