



brooklawn
child & family services

APPLICATION FOR SERVICES

Person Completing this Application: _____ Relationship to Child: _____

If child is currently in a psychiatric hospital please complete the application & attach the following assessments: Psychiatric, Psychosocial & Psychological

Child's Name: _____ Date of Birth: _____ Age: _____
 Height: _____ Weight: _____ Race: _____ Hair Color: _____
 Color of Eyes: _____ Other ID Marks: _____
 Social Security Number: _____

Child's Current Placement and City: _____
 Custodial Parent's Name: _____ Telephone #: _____
 Custodial Parent's Address: _____

Street City State Zip
 Medical Assistance Card # _____ Passport # _____

Private Insurance Name & Number: _____

Physician Name: _____ Address: _____ Phone # _____

Dentist: _____ Address: _____ Phone # _____

Does child have IMPACT Plus services? Yes _____ No _____

If yes, name of Service Coordinator: _____

SIGNIFICANT PERSONS

Mother: _____ Date of Birth: _____

Type of Parent: Birth _____ Adoptive _____ Step _____ Currently Involved With Child: Yes _____ No _____

Address: _____
 Street City State Zip

Telephone #: Home: () Work: () Pager: _____

Father: _____ Date of Birth: _____

Type of Parent: Birth _____ Adoptive _____ Step _____ Currently Involved With Child: Yes _____ No _____

Address: _____
 Street City State Zip

Telephone #: Home: () Work: () Pager: _____

1. PRESENTING PROBLEMS: Briefly describe the child's current behavior problems:

2. SPECIAL NEEDS, PROBLEMS AND BEHAVIORS:

Any history of being a danger to others?
Yes _____ No _____

Number of runaways from home: _____

Number of runaways from placements: _____

Any history of setting fires?
Yes _____ No _____

Any history of suicidal ideation, gestures and/or attempts? If yes, please describe? _____

3. CURRENT LEGAL HISTORY: Yes ___ No ___ If yes, please list current legal charges: _____

4. PLACEMENT HISTORY: Has the child ever been placed in a treatment facility and/or psychiatric hospital? Yes _____ No _____ If yes, how many and list placement names and dates: _____

5. SEXUAL PROBLEMS: Yes _____ No _____ If yes, please describe behaviors: _____

6. SUBSTANCE USE HISTORY: Does the child have a history of substance use? Yes _____ No _____ If yes, list substances used and frequency: _____

Has the child previously received Chemical Dependency Treatment? If yes, please list facilities and dates: _____

7. HISTORY OF ABUSE/NEGLECT OF REFERRED CHILD:

Has the child been abused? Yes _____ No _____ Suspected _____

Physical: Yes ___ No ___ Suspected _____

Sexual: Yes ___ No ___ Suspected _____

Emotional: Yes ___ No ___ Suspected _____

Neglect: Yes ___ No ___ Suspected _____

Abandonment: Yes _____ No _____

8. FAMILY/PARENT INVOLVEMENT:

Parent or Guardian closely connected with the child:
Mother ___ Father ___ Other _____

Parental Rights Terminated? Yes _____ No _____

Will family/guardian participate or cooperate in treatment? Yes _____ No _____

May child have contact with family? Yes ___ No ___
Specify: _____

Please list names & approximate ages of siblings as well as significant others living in the child's home.

