New Way of Southwest Louisiana, LLC

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PRTF APPLICATION AND ADMISSION ASSESSMENT FORM

YOUTH INFORMATION

Child's Full Legal Name: _____ DOB: _____ Age _____

Referring Party: _____ Phone #: _____

DCFS / Hospital / Parent or Guardian / Other Name: _____

Email: _____Work #: _____ Fax #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Child's SSN: _____JETS/TIPS # _____ Is child emancipated, married or had a child? ☐Yes ☐ No

Bayou Health Plan: ☐Aetna ☐ Healthy Blue ☐AmeriHealth ☐ LA Healthcare Connections ☐United Health Care

Medicaid # _____ BHP Member #: _____

Other Insurance? _____

Allergies: _____

Gender: ☐Male ☐Female Height: _____ Weight: _____ Ethnicity/Race: _____ Eye Color: _____

Hair Color: _____ Sexual Orientation (optional): _____ Religion: _____

Social Class (optional): _____

Child's Living Arrangement: ☐Parents ☐Group Home ☐Foster Home ☐Detention ☐Other: _____

Child's Living Arrangement Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Need for assistive technology when receiving services? ☐Yes ☐ No Primary Language: _____

Need for an interpreter or other assistance for cultural barriers? ☐Yes ☐ No

Name the Adult(s) that has Custody of the Child (please provide custody order if necessary):

Father: _____ Rights? Yes / No Home# _____ Cell# _____ SSN: _____

Mother: _____ Rights? Yes / No Home# _____ Cell# _____ SSN: _____

Other 1: _____ Rights? Yes / No Home# _____ Cell# _____ SSN: _____

Other 2: _____ Rights? Yes / No Home# _____ Cell# _____ SSN: _____

Is child a previous resident of New Way PRTF? ☐Yes ☐ No If "Yes" what dates: _____

CURRENT BEHAVIORS

Why is admission into a PRTF required at this time? _____

_____

RISK ASSESSMENT

Is there risk or history of the child **attempting suicide**? ☐Yes ☐No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there risk or history of the child **harming self/others**? ☐Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there risk or history of the child **harming animals**? ☐Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there a risk or history of the child starting **fires**? ☐Yes ☐No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there risk or history of the child **acting out sexually** with others? ☐Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there a history of the child **being sexually abused**? ☐Yes ☐No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Is there risk or history of the child **running away**? ☐Yes ☐No. If "yes", explain with behaviors, dates of evets, etc.:

_____

_____

Are there other **needs or behaviors** that put this child at special risk? ☐Yes ☐ No. If "yes", explain with behaviors, Dates of events, etc.: _____

_____

SUBSTANCE USE

Does this child have a history of drinking, smoking, over the counter drugs are illegal substance use? ☐ Yes ☐ No. If "yes", describe in detail (what substance, frequency of use, amount, duration, last use, urinary drug screen results):

_____

_____

COORDINATED SYSTEM OF CARE INVOLVEMENT

Has the child or family received case management or support services from CSOC, WAA, FSO, CFT, Magellan?

A Wrap Around Agency? ☐Yes ☐No If, "yes", which WAA? _____

If, "yes", the WAA worker's name: _____

A Family Support Organization? ☐Yes ☐No If, "yes" which FSO? _____

If, "yes", the FSO worker's name: _____

A Magellan RCM Case Manager? ☐Yes ☐No If, "yes", name of Case Manager: _____

A Child and Family Team? ☐Yes ☐No If, "yes", name of CFT participants: _____

_____

_____

TARGETED TREATMENT GOALS

What are the goals for treatment which cannot be met in a less intensive level of care? _____

_____

_____

_____

_____

PREVIOUS TREATMENT

Has child received treatment from an Outpatient Therapist? ☐Yes ☐No

Name/Credentials: _____ Phone: _____

Start Date: _____ Last Appt: _____ Freq: Weekly Bi-Monthly Monthly Mode: Indiv Family Group

Provide History of Child's Previous Hospitalizations and Out-of-Home Placements:

Name and Type of Facility	Admit Date	Discharge Date	Reason for Placement

Current Psychiatric Diagnosis: _____

Date of Diagnosis: _____ Assessment Completed by: _____

Primary Care Physician: _____ Phone: _____

Previous Psychiatric Diagnosis: _____

Date of Diagnosis: _____ Assessment Completed by: _____

FAMILY INFORMATION

CURRENT FEMALE CARETAKER (MOTHER, FOSTER MOTHER, STEPMOTHER, AUNT, GRANDMOTHER, ADOPTIVE MONTHER, ETC.) (circle one)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Years of School Completed: _____ Employer: _____ Job: _____

Age _____ Religious Affiliation: _____

CURRENT MALE CARETAKER (FATHER, FOSTER FATHER, STEPFATHER, UNCLE, GRANFATHER, ADOPTIVE FATHER, ETC.) (circle one)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Years of School Completed: _____ Employer: _____ Job: _____

Age _____ Religious Affiliation: _____

SIBLINGS

Sibling's Name	Sex	Age or DOB	Lives with

Have Parental Rights been Terminated for Biological Parents: ☐Yes ☐No

Anyone the child is *NOT* permitted to have contact? (legal documentation is required, i.e. Court Order)

_____

_____

EDUCATIONAL INFORMATION

Last School Attended: _____ Grade: _____

School Phone #: _____ School Contact Person: _____

School Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

List school behavior strengths: _____

_____

List school behavior weaknesses: _____

_____

Is the child currently in school? ☐ Yes ☐ No

Is the child currently suspended? ☐ Yes ☐ No

Does the child have an IEP? ☐ Yes ☐ No

MEDICAL INFORMATION

Child's Primary Care Physician: _____ Phone: _____

Street: _____ City: _____ State: _____ Fax: _____

Date of last visit with PCP: _____

Please describe child's current medical problems: _____

_____

_____

Please List ALL Current Medications:

Name of Medication	Dosage	Route	Frequency	Prescribed by:	Prescribed as Treatment for:

Is child compliant with current prescribed medications? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No If "yes", describe _____

Are child's Immunizations Current? ☐ Yes ☐ NO *You MUST provide a COPY OF CHILD'S IMMUNIZATION RECORD.*

Dentist _____ Date of last visit _____

Dental problems _____

Psychiatrist _____ Date of last visit: _____

Previous outpatient counselors: _____

Current outpatient counselor: _____ Date of last visit: _____

Special plans for treatment at time of Discharge: _____

_____

HISTORY OF ABUSE, NEGLECT AND CRIME VICTIMIZATION

Please describe the child's history of abuse, neglect and crime victimization:

Physical Abuse: _____

_____

_____

Sexual Abuse: _____

_____

_____

Mental/Emotional Abuse: _____

_____

_____

Neglect: _____

_____

_____

Exposure to Domestic Violence: _____

_____

_____

Exposure to Pornography: _____

_____

_____

Exposure to Adult Sexual Behavior: _____

_____

_____

Sexual Maladaptive Behaviors: _____

_____

_____

Victim of a Crime: _____

_____

Witness of other Trauma: _____

_____

Legal Problems _____

_____

FUNCTIONAL STRENGHTS

For each area of life below, please indicate the child's strengths.

Social: _____

_____

Family: _____

_____

School: _____

_____

Religious: _____

_____

ADLS: _____

_____

Other life areas: _____

_____

SUPPORT SYSTEMS

In each area below, list the individuals who are actively supportive of the child and/or family.

Family: _____

_____

Social: _____

_____

School: _____

_____

Religious: _____

_____

Treatment/Therapeutic: _____

_____

Please describe the child's religious preference: _____

STATEMENT OF APPLICATION FOR ADMISSION

Name of Person Completing this Application: _____

Relationship to Child: _____ Date: _____

I, the undersigned Parent or Legal Guardian, apply to New Way of Southwest Louisiana PRTF for Psychiatric Residential Treatment Facility (PRTF) services for the child named above whom I hold legal custody or placement authority. I certify the information provided in this application is true. I agree to provide changes in information related to this application and any requested information asked by New Way of Southwest Louisiana PRTF. I also agree to fully cooperate with New Way of Southwest Louisiana PRTF as an active participant in the planning and treatment of the child.

Does any other adult have legal rights to this child? ☐ Yes ☐ No

If, "Yes", please provide name and explain: _____

_____

Signature of Parent(s), Legal Guardian(s), DCFS, or other Requesting Child's Admission

_____	_____
Parent/DCFS Signature	Date
_____	_____
Printed Name	Relationship to Child
_____	_____
Parent/DCFS Signature	Date
_____	_____
Printed Name	Relationship to Child
_____	_____
Legal Guardian Signature	Date
_____	_____
Printed Name	Relationship to Child