PRTF APPLICATION AND ADMISSION ASSESSMENT FORM

Admissions: Phone: 318-255-5020 Fax: 318-734-9060 Email: admissions@LMCH.org

YOUTH INFORMATION

Child's Full Legal Name: _____ Date of Birth: _____

Child's SSN: _____ JETS # (if OJJ custody) or TIPS # (if DCFS custody): _____

Healthy Louisiana Plan: ☐ Aetna Betterhealth ☐ AmeriHealth Caritas ☐ Louisiana Healthcare Connections
☐ United Health Care ☐ Humana Healthy Horizons ☐ Healthy Blue

Medicaid #: _____ *Healthy Louisiana* Plan Member #: _____

Any other Insurance available? _____ Is the child emancipated, married, or has a child? ☐ Yes ☐ No

Allergies: _____

Sex: ☐Male ☐Female Height: _____ Weight: _____Ethnicity/Race: _____ Eye Color: _____ Hair Color: _____

Child's Current Placement: ☐ Parents ☐ Group Home ☐ Foster Home ☐ Detention ☐ Other: _____

Child's Current Placement Address: _____

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

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

Referring Agency (Hospital, Insurance, DCFS, OJJ, LDH, etc): _____ Phone #: _____

Contact Name: _____ Email: _____

Name the Adult(s) who have Custody of the Child *(please provide custody order if necessary)*:

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

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

Other: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

DCFS/OJJ: _____ How long has the child been in custody? _____

Have Parental Rights been Terminated for Biological Parents: ☐ Yes ☐ No (explain) _____

With whom is the child ***NOT*** permitted to have contact? (Legal documentation is required, ie. Court Order)

_____

CURRENT FEMALE CARETAKER – <u>PLEASE CIRCLE ONE</u>: MOTHER, AUNT, GRANDMOTHER, ADOPTIVE MOTHER, OTHER

Full Name: _____ DOB: _____ Occupation: _____

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

Cell Phone: _____ Alternate Phone: _____ Email: _____

CURRENT MALE CARETAKER – <u>PLEASE CIRCLE ONE</u>: FATHER, UNCLE, GRANDFATHER, ADOPTIVE FATHER, OTHER

Full Name: _____ DOB: _____ Occupation: _____

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

Cell Phone: _____ Alternate Phone: _____ Email: _____

Siblings' Names	Sex	Age or DOB	Lives with

CURRENT BEHAVIORS

Why is admission into a Psychiatric Residential Treatment Program required at this time? _____

RISK ASSESSMENT

Is there a risk or history of the child **attempting suicide**? ☐ Yes ☐ No
Is there a risk or history of the child **harming self/others**? ☐ Yes ☐ No
Is there a risk or history of the child **harming animals**? ☐ Yes ☐ No
Is there a risk or history of the child **starting fires**? ☐ Yes ☐ No
Is there a risk or history of the child **acting out sexually** with others? ☐ Yes ☐ No
Is there a risk or history of the child **running away**? ☐ Yes ☐ No
Is there a risk or history of the child **using substances**? ☐ Yes ☐ No
Do other **needs**, **legal charges**, **activities**, or **behaviors** put this child at special risk? ☐ Yes ☐ No

Explain any items marked Yes above with behaviors, dates of events, etc. (if substance use, specify type, frequency, amount, duration, last use, and drug screen results): _____

History of HEALTHY LOUISIANA Medicaid Funded Care

Has the child or family received services from a **Coordinated System of Care Agency (CSOC)**? ☐ Yes ☐ No
Has the child or family received services from a **Wrap Around Agency (WAA)**? ☐ Yes ☐ No
Has the child or family received services from a **Family Support Organization (FSO)**? ☐ Yes ☐ No
Has the child or family received services from a **Managed Care Organization case manager**? ☐ Yes ☐ No
Has the child or family received services from a **Child and Family Team**? ☐ Yes ☐ No

If "yes" to any above, name the organization and persons with whom you spoke: _____

Has the child previously been a Methodist Children's Home resident? ☐ Yes ☐ No

If Yes, when and where? _____

TARGETED TREATMENT GOALS

What are the goals for treatment that a less intensive level of care cannot meet? _____

_____

_____

PREVIOUS TREATMENT

Has the 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 a History of the Child's Most Recent Psychiatric Hospitalizations and Out-of-Home Placements:

PLEASE HAVE DOCUMENTS AVAILABLE FROM PSYCHIATRIC HOSPITALS: **Number of Psychiatric Hospitalizations**: _____

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

HISTORY OF ABUSE, NEGLECT AND CRIME VICTIMIZATION

Does the child have a history of **physical abuse**? ☐ Yes ☐ No
Does the child have a history of **sexual abuse**? ☐ Yes ☐ No
Does the child have a history of **mental/emotional abuse**? ☐ Yes ☐ No
Does the child have a history of **neglect**? ☐ Yes ☐ No
Does the child have a history of **exposure to domestic violence**? ☐ Yes ☐ No
Does the child have a history of **exposure to pornography**? ☐ Yes ☐ No
Does the child have a history of **exposure to adult sexual behavior**? ☐ Yes ☐ No
Does the child have a history of **sexually maladaptive behaviors**? ☐ Yes ☐ No
Does the child have a history of being a **victim of a crime**? ☐ Yes ☐ No
Does the child have a history of **other psychological trauma**? ☐ Yes ☐ No

Please describe the **child's** history regarding any of the above questions marked Yes.

_____

_____

_____

Educational Information

Last School Attended: _____ Parish: _____ Grade: _____

School Address: _____ City: _____ State: _____

Zip: _____ Full Scale IQ score if available: _____ List school behavior Strengths/weaknesses: _____

_____ Does the child have a 504 or IEP plan? ☐ Yes ☐ No

Provide reason for 504 or IEP plan if applicable: _____

Names of the Child's Doctors

Primary Care Physician: _____ Phone: _____

Address: _____ Date Last Seen: _____

Specialist: _____ Phone: _____

Address: _____ Date Last Seen: _____

Dentist: _____ Phone: _____

Address: _____ Date Last Seen: _____

Eye Doctor: _____ Phone: _____

Address: _____ Date Last Seen: _____

Current Psychiatric Diagnosis: _____

Date of Diagnosis: _____ **Assessment Performed by:** DOCTOR'S NAME: _____

DSM diagnosis: _____

_____

MEDICAL INFORMATION: **Please List ALL Current Medications:**

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

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

Are the child's Immunizations Current? (Check one): ☐ Yes ☐ No Y*ou **MUST** provide a copy of the IMMUNIZATION RECORD.*

Has the child EVER HAD or currently HAS any of the following? Check each item. If yes, specify and explain.

Please provide accurate information about your child's MEDICAL HISTORY.

Anaphylaxis	▫ Yes	▫ No		Hearing Impairment	▫ Yes	▫ No
Anemia	▫ Yes	▫ No		Heart Murmur	▫ Yes	▫ No
Aneurysm	▫ Yes	▫ No		High Cholesterol	▫ Yes	▫ No
Arrhythmia (heart)	▫ Yes	▫ No		Hypertension (High Blood Pressure)	▫ Yes	▫ No
Arthritis	▫ Yes	▫ No		Kidney Stones	▫ Yes	▫ No
Asthma	▫ Yes	▫ No		Lupus	▫ Yes	▫ No
Back Pain/Injury	▫ Yes	▫ No		Multiple Sclerosis	▫ Yes	▫ No
Bleeding Disorder	▫ Yes	▫ No		Ovarian Cysts	▫ Yes	▫ No
Broken Bones	▫ Yes	▫ No		Pancreatitis	▫ Yes	▫ No
Cancer	▫ Yes	▫ No		Pneumonia	▫ Yes	▫ No
Chronic Pain	▫ Yes	▫ No		Psoriasis	▫ Yes	▫ No
Concussions	▫ Yes	▫ No		Reflux/Esophagitis	▫ Yes	▫ No
Crohn's Disease	▫ Yes	▫ No		Renal Failure	▫ Yes	▫ No
Cystic Fibrosis	▫ Yes	▫ No		Seizures/Convulsions	▫ Yes	▫ No
Diabetes	▫ Yes	▫ No		Shunts of any kind	▫ Yes	▫ No
Eating Disorder	▫ Yes	▫ No		Sickle Cell Anemia/ Sickle Cell Trait	▫ Yes	▫ No
Endometriosis	▫ Yes	▫ No		Skin Problems/Chronic Rash/ Eczema	▫ Yes	▫ No
Epilepsy	▫ Yes	▫ No		Sleep Apnea	▫ Yes	▫ No
Eye Problems	▫ Yes	▫ No		Spina Bifida	▫ Yes	▫ No
Fainting	▫ Yes	▫ No		Tumors	▫ Yes	▫ No
Gallstones	▫ Yes	▫ No		Ulcers	▫ Yes	▫ No
Headaches	▫ Yes	▫ No		Other	▫ Yes	▫ No

Explain all "Yes" answers: _____

_____

_____

Surgery: (If the child has ever had surgery for these conditions, check the box and write the date beside it.)

○ Appendectomy	○ Bone/Muscle	○ Heart Surgery	○ Ear Tubes
○ Adenoidectomy	○ Splenectomy	○ Kidney Surgery	○ Tonsillectomy
○ Eye Surgery	○ Gallbladder	○ Brain Surgery	○ Other

Medical Hospitalizations (*NON-PSYCHIATRIC*): Number of Previous Hospitalizations: _____

Name of Facility	Admit Date	Discharge Date	Reason for Medical Hospitalization

Female Children ONLY

Onset of menses: _____ Difficult/Painful Periods ☐ Yes ☐ No # of Pregnancies: _____

Birth Control: ☐ Pill ☐ Depo Shot – date last given _____ ☐ Implant – Placed on: _____

Sexually Transmitted Diseases (Males AND Females): Check the box and write the treatment date in the box if applicable.

▫ HIV/Aids	▫ HPV/Genital Warts	▫ Chlamydia
▫ Hepatitis A, B, or C	▫ Herpes	▫ Syphilis
▫ Trichomoniasis	▫ Gonorrhea	▫ Other

STATEMENT OF APPLICATION FOR ADMISSION

Name of Person Completing this Application: _____

Relationship to Child: _____ Date: _____

I (we), the undersigned Parent(s) or Legal Guardian(s), do hereby apply to Louisiana United Methodist Children and Family Services, Inc. for Psychiatric Residential Treatment Facility (PRTF) services for the child named above for whom I (we) hold legal custody and/or placement authority. I(we) certify the information provided in this PRTF Application and Admission Assessment Form and the attached documents is true and accurate to the best of my (our) knowledge. I(we) agree to share additional information related to this application as it becomes available and/or is requested by Louisiana United Methodist Children and Family Services. I (we) also agree to cooperate with LUMCFS to fully and actively support the child's plan of care, to which we mutually agree.

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

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

Signatures of Parent(s) or Legal Guardians(s) Requesting Child's Admission

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Child

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Child

www.LUMCFS.org/admissions