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: ________________ Age: ___________

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

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

Medicaid #: ________________________ *MCO Member ID* #: ____________________________________

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 GUARDIAN

***PLEASE CIRCLE ONE*: MOTHER, AUNT, GRANDMOTHER, ADOPTIVE MOTHER, DCFS CASE WORKER, OJJ PROBATION OFFICER, OTHER**

Full Name: ______________________________ DOB: ______________ Occupation: ______________________________

Street: ______________________________ City: ______________________ State: ________ Zip: ____________

Cell Phone: ______________________ Alternate Phone: ____________________ Email: ______________________________

CURRENT MALE GUARDIAN

***PLEASE CIRCLE ONE*: FATHER, AUNT, GRANDFATHER, ADOPTIVE FATHER, DCFS CASE WORKER, OJJ PROBATION OFFICER, 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 (If marked "Yes" explain below)

Is there a risk or history of the child **attempting suicide**? ☐ Yes ☐ No
Is there a risk or history of the child **harming self**? ☐ Yes ☐ No
Is there a risk or history of the child **harming 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 **running away**? ☐ Yes ☐ No
Is there a risk or history of the child **using substances**? ☐ Yes ☐ No
Is there a risk or history of the child **acting out sexually**? ☐ 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 perpetrating against others**? ☐ 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"**.

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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 "If **Yes**, please **Circle** which plan."

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 *You **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.

Condition	Yes	No		Condition	Yes	No
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: ____

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____

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