



Methodist Children's Home
A Community of Hope and Healing

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) _____

Is there anyone the child is **NOT** permitted to have contact with? (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, UNCLE, 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 **using substances**? Yes No

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 **experiencing hallucinations/psychosis**? Yes No

Is there a risk or history of the child **acting out sexually**? Yes No

Is there a risk or history of the child **running away**? Yes No

Is there a risk or history of the child **starting fires**? Yes No

Is there a risk or history of the child **harming animals**? 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. 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".

Educational Information

Last School Attended: _____ Parish: _____ Grade: _____

School Address: _____ City: _____ State: _____ Zip: _____

Full Scale IQ score if available: _____ 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: _____ Follow-Up Date: _____

Specialist: _____ Phone: _____

Address: _____ Date Last Seen: _____ Follow-Up Date: _____

Dentist: _____ Phone: _____

Address: _____ Date Last Seen: _____ Follow-Up Date: _____

Eye Doctor: _____ Phone: _____

Address: _____ Date Last Seen: _____ Follow-Up Date: _____

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.*

Please provide accurate information about your **CHILD’S MEDICAL HISTORY or CURRENT MEDICAL CONDITIONS**
Check any item that applies. If yes, specify and explain.

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

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Bone/Muscle	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Ear Tubes
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Splenectomy	<input type="checkbox"/> Kidney Surgery	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> Other

If **NO** surgeries check box: None

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

Name of Facility	Admit Date	Discharge Date	Reason for Medical Hospitalization	Follow-up Date (If Needed)

Has the child had prior GeneSight testing? Yes No

If “YES” provide a copy of the results.

Female Children ONLY

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

Birth Control: Yes No

Type: Pill Depo Shot – date last given: _____ Implant – Date Placed: _____ By Whom: _____

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

<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> HPV/Genital Warts	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Hepatitis A, B, or C	<input type="checkbox"/> Herpes	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Trichomoniasis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> 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