

**THERAPEUTIC FOSTER HOME
GROUP HOME, INSTITUTION, OR RESIDENTIAL TREATMENT
APPLICATION FOR ADMISSION**

PERSON MAKING REFERRAL _____ CONTACT TELEPHONE # _____

ADDRESS _____

CHILD _____ DOB _____ AGE _____ SEX _____ RACE _____
 First Middle Last

REASON FOR REFERRAL: _____

HEIGHT _____ WEIGHT _____ EYE COLOR _____ HAIR COLOR _____ SOC. SEC. # _____

LEGAL STATUS: DEPENDENT _____ CHINS _____ DELINQUENT _____ OTHER _____

LEGAL CUSTODIAN: _____

ADDRESS: _____

MEDICAL HISTORY:

CHECK IF CHILD HAS HAD:

_____ MEASLES _____ MUMPS _____ CHICKEN POX _____ SCARLET FEVER _____ WHOOPING COUGH

_____ TB SKIN TEST DATE _____ WHERE _____ RESULTS _____

_____ SICKLE CELL ANEMIA TEST DATE _____ WHERE _____ RESULTS _____

PRESCRIBED MEDICATIONS CHILD CURRENTLY TAKES _____

HOSPITALIZATIONS:

NAME OF HOSPITAL	DATE ADMITTED	DOCTOR	REASON FOR ADMISSION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DESCRIBE ANY PHYSICAL, MEDICAL, DEVELOPMENTAL OR PSYCHOLOGICAL PROBLEMS THAT WILL REQUIRE SPECIAL ATTENTION IN CARING FOR THIS CHILD:

CHECK IF CHILD HAS EVER HAD A PROBLEM WITH:

_____ HEAD _____ HEARING _____ VISION _____ MOUTH _____ LEARNING _____ SWALLOWING

_____ NECK _____ HEART _____ LUNGS _____ URINARY _____ TALKING _____ BREATHING

_____ FEET _____ BACK _____ SKIN _____ RECTUM _____ WALKING _____ CHEWING

_____ HANDS _____ ABDOMEN _____ NOSE _____ GENITALIA _____ CRAWLING _____ OTHER

_____ ARMS _____ LEGS _____ THROAT _____ ALLERGIES _____ SITTING

IF CHECKED, PLEASE EXPLAIN:

EDUCATION:

CURRENT/LAST ATTENDED SCHOOL _____ GRADE _____

ADDRESS _____ PHONE _____

IF SPECIAL EDUCATION, CHECK AS APPROPRIATE: _____ LD _____ EF _____ EMR

HAS CHILD BEEN TESTED: _____ DATE _____ WHERE _____

CHECK APPLICABLE SCHOOL PROBLEMS:

_____ PEER PROBLEMS _____ AGGRESSION TOWARD PERSONS _____ AGGRESSION TOWARD PROPERTY

_____ TRUANT/SCHOOL AVOIDANT _____ PROBLEMS WITH TEACHERS _____ UNDERACHIEVER

_____ UNDERSOCIALIZED _____ THEFT _____ OTHER (SPECIFY) _____

PARENTAL/FAMILY INFORMATION:

PARENTS' MARITAL STATUS: _____ MAR _____ SEP _____ DIV _____ WID _____ NEVER MARRIED

FATHER: DOB _____ SOC. SEC. # _____ LIVING _____ DECEASED _____

IF DECEASED, DATE AND CAUSE OF DEATH: _____

NAME _____

ADDRESS _____ PHONE _____

PLACE OF EMPLOYMENT _____

PRESENT SPOUSE (COHABITING?) _____

GENERAL HEALTH _____ DATE OF LAST CONTACT WITH AGENCY _____

MOTHER: DOB _____ SOC. SEC. # _____ LIVING _____ DECEASED _____

IF DECEASED, DATE AND CAUSE OF DEATH: _____

NAME _____

ADDRESS _____ PHONE _____

PLACE OF EMPLOYMENT _____

PRESENT SPOUSE (COHABITING?) _____

GENERAL HEALTH _____ DATE OF LAST CONTACT WITH AGENCY _____

SIBLINGS:

NAME	SEX	AGE	ADDRESS & PHONE

Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-13.

Recipient Name Recipient Medicaid Number

Date of Birth Race Sex County of Residence

Facility Name and Address Planned Admission Date

PHYSICIAN CERTIFICATION:

1. I am not employed or reimbursed by the facility.
2. I have competence in diagnosis and treatment of mental illness.
3. I have knowledge of the patient's situation.
4. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
5. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
6. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Printed Name of Physician Physician Signature Phone Number Date

Physician Address License Number

Printed Name of Other Team Member Signature Phone Number Date

Printed Name of Other Team Member Signature Phone Number Date