HILLSIDE

...a continuum of care for children, adolescents and their families.

HILLSIDE THERAPEUTIC FOSTER CARE

Application for Admission

Please type or print clearly. APPLICANT refers to the name of the individual being considered for admission. It is the policy of Hillside to admit and treat all applicants without regard to race, creed, color, or national origin.

Biographical Information

Applicant's Name: ______________________________

Current Placement Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

County: ______________________ Phone: (_____) ______________

Sex: ______________ Race: ______________ Date of Birth: ______ / ______ / ______

Place of Birth: ______________________ Social Security #: ________ - ______ - __________

Height: ______________ Weight: ______________ lbs.

Applicant's Present Residence: (check one)

☐ Home ☐ Group Home ☐ Foster Home ☐ Hospital ☐ Residential Treatment Center

☐ Other (please specify): ______________________________

Placement History

PLACEMENT	DATES PLACED

Family Information

Father's Name: ______________________________ DOB: ______ / ______ / ______

Relationship to Applicant: (check one) ☐ Birth Parent ☐ Step-father ☐ Adoptive Father

Home Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

Home Phone: (_____) ______________ Employer: ______________________

Mother's Name: ______________________________ DOB: ______ / ______ / ______

Relationship to Applicant: (check one) ☐ Birth Parent ☐ Step-mother ☐ Adoptive Mother

Home Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

Home Phone: (_____) ______________ Employer: ______________________

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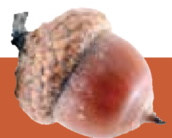

Over 120 Years Caring for Children and Families

Family Information (Continued)

Birth Parents' Names:

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____________________

Deceased? ☐ Mother ☐ Father ☐ Both

Family Involvement: (type, frequency) ____________________

____

____

Legal Guardian's Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Relationship to Applicant: ____________________ Work Phone: (_____) ____________________

Who has custody of Applicant? ☐ Mother ☐ Father ☐ Other: ____________________

What is the Permanency Plan for the applicant as of the last court review? ____________________

____

Siblings Names:

NAME	DOB	SEX	CURRENT PLACEMENT

Does child have contact with siblings? List frequency and supervision: ____________________

____

Referral Information

Referral Source Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Phone #: (_____) ____________________

Reason for Referral: ____________________

____

____

____

____

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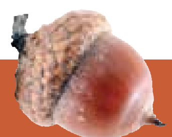

Funding Source: ☐ DFCS ☐ DJJ ☐ MHDDAD ☐ Other: ______________________

What is the category of funding for the youth at this time? (Please check one.)

☐ Traditional ☐ Base WO ☐ Max WO ☐ SBWO ☐ SMWO ☐ Other: ______________

What is the agency amount approved by DFCS? ______________________

What is the foster parent amount approved by DFCS? ______________________

Financial Information

Current Medical Insurance Company: ______________________

Policy #: ______________________

Policy Holder's Name: ______________________

Who will be responsible for paying for incidentals for child? ______________________

____

What other fees/costs will your agency pay for regarding the applicant? ______________________

____

Educational Information

Current Grade: __________ Last School Attended: ______________________

Educational Services Child Receives: ______________________

School Address: ______________________

City: ______________________ State: __________ Zip Code: ______________

Name of School Board: ______________________

____

Educational/Vocational Goals: ______________________

____

Behavioral/Emotional Information

Please List Presenting Problem(s):

____

____

____

____

____

Please list all previous core, MRO, mental health agencies or therapists associated with the applicant:

AGENCY OR PROFESSIONAL	PHONE	DATE(S) SEEN

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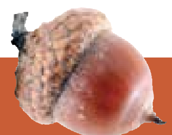

Behavioral/Emotional Information (Continued)

Would you like the youth to continue with the same provider, if possible? ☐ Yes ☐ No

Has Psychological Testing been completed within the last 2 years? Date: ______ / ______ / ______

Most Recent DSM IV Diagnosis:

Axis I: ____

____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Medical Information

Does the applicant now have or has he/she ever had any of the following?

Physical Limitations? ☐ Yes ☐ No

Please Specify: ____

A need to wear glasses or contact lenses? ☐ Yes ☐ No

A hearing impairment? ☐ Yes ☐ No

Please Specify: ____

A speech impairment? ☐ Yes ☐ No

Any experience with seizures? ☐ Yes ☐ No

Please list the date of applicant's last dental exam: ______ / ______ / ______

Please specify any allergies: ____

____

Please list any dietary restrictions: ____

____

Please list the date and results of the last physical exam: (child must have an exam within three months of entering the program/ if emergency safety interventions are going to be used a doctor must specify that it is safe to use these.)

Date: ______ / ______ / ______ Results: ____

____

____

Is applicant currently on medication? ☐ Yes (please list) ☐ No

MEDICATION	DOSAGE	REASON FOR MEDICATION	PERSON PRESCRIBING

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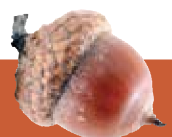

Medical Information (Continued)

Was the applicant on medication in the past? ☐ Yes (please list) ☐ No

MEDICATION	DOSAGE	REASON FOR MEDICATION	PERSON PRESCRIBING

Placement Recommendations

Please specify a one or two parent home, any location preferences, restrictions regarding other children in home, race concerns, religious requirements, and any other placement recommendations: ____

____

____

____

____

____

____

____ ______________________

Signature of Parent/Referring Worker Date

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