

Yahweh Center Children's Village
5000 Lamb's Path Way
Castle Hayne, NC 28429

PO Box 10399
Wilmington, NC 28404

(910) 675-3533 – telephone
(910) 675-9229- fax or
(910) 675-3405 – fax
www.yahwehcenter.org

Application for Service

Please attach the following documents with the submission of this application:

- **Most recent psychiatric evaluation**
- **Most recent psychological testing**
- **Medication history**

Case Manager's Name: _____ Phone: _____ Fax: _____
 Address: _____

 Email: _____

Legal Custodian: _____ Relationship: _____
 Address: _____
 Phone: _____ Fax: _____
 Email: _____

Other Contact Person(s): _____
 Telephone number(s): _____

Reason for referral: _____

FAMILY HISTORY

Biological Mother's Name: _____
 Date of Birth: _____ Race: _____
 Address: _____
 Telephone Number: _____
 Educational Level: _____ Criminal Record: _____
 Social Security Number: _____

Biological Father's Name: _____
 Date of Birth: _____ Race: _____
 Address: _____
 Telephone Number: _____
 Educational Level: _____ Criminal Record: _____
 Social Security Number: _____

Are Parents : Married Separated Divorced Never Married Deceased
 Have parental rights been terminated?: Yes No If so, when? : _____

Adoptive Mother's Name: _____
 Date of Birth: _____ Race: _____
 Address: _____
 Telephone Number: _____
 Educational Level: _____ Criminal Record: _____
 Social Security Number: _____

Adoptive Father's Name: _____
 Date of Birth: _____ Race: _____
 Address: _____
 Telephone Number: _____
 Educational Level: _____ Criminal Record: _____
 Social Security Number: _____

SIBLINGS

Name	DOB/Ages	Placement

Are there any special conditions/restrictions for family contact? _____

Family History: _____ Criminal Activity (specify): _____
 _____ Inappropriate Sexual Behavior _____ Child Abuse _____ Substance Abuse (specify): _____
 _____ Psychiatric Illness (specify): _____
 _____ Treatment Disruption _____ Suicide _____ Other: _____

Brief family history on education, behavior, development, adoption, psychological, legal, parent's psychiatric history, other: _____

CLIENT CLINICAL ISSUES

- | | | |
|---|---|--|
| <input type="checkbox"/> Abandonment Issues
<input type="checkbox"/> Alcohol/Drug Abuse
<input type="checkbox"/> Assaultive (Physical) *
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Property Destruction
<input type="checkbox"/> Homeless
<input type="checkbox"/> Lying
<input type="checkbox"/> Physical Impairment
<input type="checkbox"/> Perception of Reality
<input type="checkbox"/> Oppositional
<input type="checkbox"/> Socially Immature
<input type="checkbox"/> Behavior
<input type="checkbox"/> Suicidal *
<input type="checkbox"/> Truancy
<input type="checkbox"/> Victim of Sexual Abuse * | <input type="checkbox"/> Anxiety
<input type="checkbox"/> Antisocial Behavior
<input type="checkbox"/> Assaultive (Sexual) *
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Fire Setting
<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Low Self-Esteem
<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Phobic Behavior
<input type="checkbox"/> Self Injuring Behavior *
<input type="checkbox"/> Sexually Inappropriate *

<input type="checkbox"/> Cruelty to Animals *
<input type="checkbox"/> Victim of Neglect
<input type="checkbox"/> Victim of Emotional Abuse | <input type="checkbox"/> Arson
<input type="checkbox"/> Unruly/Unmanageable
<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Depression
<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Impulsive
<input type="checkbox"/> Loss/Grief Problems
<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Difficulty with Siblings
<input type="checkbox"/> Stealing

<input type="checkbox"/> Running Away
<input type="checkbox"/> Victim of Physical Abuse |
|---|---|--|

Please explain in detail any items marked above with an (*): _____

Safety Issues: _____

PLACEMENT HISTORY

Placement (begin with current)	Dates (from-to)	Reason for Discharge:

MEDICAL INFORMATION

Diagnosis (DSM)	Date	Source
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

IQ: _____ **Verbal** _____ **Performance** _____ **Full Scale**

Examiner: _____ **Date:** _____

LOE: _____ **GAF:** _____

<u>Medications</u>	<u>Dosage</u>	<u>Instructions</u>

Medical Conditions (past and present):

- | | | |
|---|---|---|
| <input type="checkbox"/> Lice | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> STD | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Ringworm | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> TB | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> Other: _____ |

Date of Last Physical Exam: _____ **Last Dental Exam:** _____ **Last Eye Exam:** _____

Allergies: _____

Dental Appliances: Yes: _____ No: _____ **Contacts:** Yes: _____ No: _____ **Glasses:** Yes: _____ No: _____

Special Dietary Needs?: _____

ACADEMIC INFORMATION

Is the child currently in school? _____ **Yes** _____ **No** **If yes, where?** _____

What grade is the child in? _____ **Is the applicant long term suspended?** _____ **Yes** _____ **No** _____ **in process**

Contact person at school for the records? _____

Phone Number: _____ **Fax Number:** _____ **E-mail:** _____

Is the child working on grade level? _____ **Yes** _____ **No** **Does the child have an IEP?** _____ **Yes** _____ **No**

Can the client return to public school at the end of the program? _____ **Yes** _____ **No**

Special Education Services Received: _____

Academic Strengths: _____

Academic Problems: _____

School Behavioral Issues: _____

Number of School Suspensions last year? _____

COURT HISTORY

Does client have a criminal record? ___ Yes ___ No

Offense

Conviction Dates and Disposition of case

Pending Charges: _____

Is client on probation? ___ Yes ___ No

Is placement Court Ordered? ___ Yes ___ No

TREATMENT GOALS

Client Goals: _____

Family Goals: _____

Agency Goals: _____

Educational Goals: _____

Other: _____

PLANNING

What is the discharge plan from the Yahweh Center Children's Village? _____

What is the permanent plan for this child? _____

Is there a current need to revise the permanent plan for this child? ___ If yes, please explain: _____

State the goals toward which the family and child are working to achieve the permanent plan? _____

PROFESSIONAL INVOLVEMENTS

Please list all mental health professionals (psychiatrists, psychologists, therapists, educational consultants, etc.) and treatment programs that have been involved with this child. (Use additional sheets as necessary)

1. Name: _____ Program Name: _____

Type of service: _____ Dates of Service: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

2. Name: _____ Program Name: _____

Type of service: _____ Dates of Service: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

3. Name: _____ Program Name: _____

Type of service: _____ Dates of Service: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

4. Name: _____ Program Name: _____

Type of service: _____ Dates of Service: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

In addition to this application, the following documents will be required at ADMISSION:

- 1. Copy of Service Plan from LME**
- 2. Copy of Service Orders**
- 3. Copy of Residential Authorization Form (RAF) – as applicable**
- 4. Copy of Social Security Card**
- 5. Copy of Medicaid Card**
- 6. Copy of Court Order giving legal custody to DSS if child is in DSS custody**
- 7. Copy of Physical Examination (must be dated no more than 30 days prior to admission)**
- 8. Copy of Birth Certificate**
- 9. Copy of School IEP**

SEND THIS COMPLETED APPLICATION TO:

**OLIVIA ADAIR, MSW, LCSW
YAHWEH CENTER CHILDREN'S VILLAGE
PO BOX 10399
WILMINGTON, NC 28404
PHONE (910) 675-3533
EMAIL: oadair@yahwehcenter.org**

YOU MAY ALSO FAX THE APPLICATION TO (910) 675-3405