DCF – 787 (12/2017)

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| General Information (USE THE **TAB BUTTON** TO MOVE TO THE NEXT TEXT BOX) | |
| Area Office/Referrer: | Date Completed: |
| AO DMHAS Liaison: | Phone #: |

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| DCF Contact Information | |
| SW: | #: |
| SWS: | #: |
| PS: | #: |

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| Client Information (**FN**= first name of the client/**LN** = last name of the client) | | | | | | | |
| **FN**: | | **LN**: | | DOB: | Age: | | Gender: |
| Case ID: | Person ID: | | Ethnicity: | | | Language:  -Enter Primary- | |

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| Social Security Information | | |
| SSN: | Receiving SSI: | SSI Application completed: |

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| Commitment/Guardian Information | | | |
| Legal Status: | | | |
| Legal Guardian Name: | | Phone #: | |
| Address: | | | |
| City: | State: | | Zip: |

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| Placement Information | | | |
| Current Placement (include foster parent name): | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Current Placement: | Comment: | | |
| If not at home are there plans for reunification? | | | |

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| Educational Information (\*Note: The Exit Criterion is found on the youth’s IEP) | | | | | | | | |
| Current Grade: | Nexus: | | | | | | Special Ed.: | |
| Exit Criterion\*: | | | | | Graduation Date (m/yyyy): | | | |
| Most current IEP Date: | | | Post High School Planning: | | | | | |
| IQ Scores: VIQ:    PIQ:     FSIQ: | | | | Test: | | | | Date tested: |
| IQ Scores: VCI:     PRI:     WMI:     PSI:     FSIQ:     IQ is Valid: | | | | | | | | |
| DMR Potential: | | Applied to DMR: | | | | Appealed (if denied): | | |

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| Acquired/ Traumatic Brain Injury Potentiality (ABI/TBI)  Please note for youth with ABI/TBI issues, you must include medical records to support the condition: |
| Has the youth had a head or brain injury? |

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| Legal Information | | | |
| Legal Issues: | | Citizenship Status? | |
| On Parole:  End Date: | On Probation: End Date: | | Megan’s Law: |
| Worker:       #: | | | |
| Supervisor:       #: | | | |
| Comments or Conditions of Probation/Parole (limited to 150 characters):  N/A | | | |

## Current Diagnoses

Note: Diagnoses *must* be within the past year. Please include documentation to support the diagnoses listed below, or the packet will be returned.

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| Diagnosed by: | Date: |

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| **MH Diagnoses** (One diagnosis per textbox): | | |
| 1) | 2) | 3) |
| 4) | 5) | 6) |
| 7) | 8) | 9) |

*Medications: check if client is refusing to take medication(s):*

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| --- | --- |
| Prescribed by: | Date: |

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| Medication(s) (One medication per textbox): | |
| 1) | 2) |
| 3) | 4) |
| 5) | 6) |
| 7) | 8) |

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| Medical Issues (up to 150 characters): |
| N/A |

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| Additional Notes (up to 350 characters): |
| N/A |