Referral  Enrollment

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral** | | | |
| **Name (last, first):** | | | **DOB:** |
| **Gender**:  Female  Male  Cisgender  Gender Nonconforming  Nonbinary  Queer  Questioning  Transgender  Transgender Female  Transgender Male | | | |
| **Date of Referral**: | **Time of Referral**: | **Age of referred**: | |
| **Managing Office** - **Campus/Town/Building**: | | | |
| **Initial person handling referral (worker of record):** | | | |
| **Name of Referral Source Agency/ Org. :**  **Name of Contact at Referral Source**:       **Phone Number/Email:** | | | |
| [See HSA 1115 for list of programs and modifiers]  **Program(s) individual is being**  Referred to  Enrolled in **:**  **Modifier (if applicable):** | | | |

|  |  |  |
| --- | --- | --- |
| *Enrollment* | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Date of Enrollment:** | **Time of Enrollment:** | **Target Discharge Date:** | | | **Staff Responsible***(person making decision to admit)****:*** | | | **Service Facility:** *(Actual**Location [campus, building or foster home] where client will be enrolled or living)* | | **Unit:** *(if applicable)* | | | **Classroom #** *(if applicable):* | | **Primary Worker**: | | | **Primary Worker Role:** Primary Service Provider/ Clinician | | **Other Worker(s):** | | | **Other Worker(s) Roles:** | | **1.** | | | Teacher (if applicable) | | **2.** | | | Psychiatrist/ NP (if applicable) | | **3.** | | |  | | **4.** | | |  |   **Funder Information**   |  | | --- | | **Medicaid Number:**       **DSS Case #:** | | **Name of Funding County:**       *[For Customized: County, TFC, RFC, Residential (DSS Custody) programs only]* | | | |
|  | | |
| **Relationship of Referral Source:** *(Check one)*   |  |  |  | | --- | --- | --- | |  | | | | Developmental Group | Special Education | Health Care Provider | | External Medicaid Service Coordinator | Speech/Language Provider | MH Practitioner | | Judge | Teacher of Visually Impaired | Pre-adoptive Resource | | Nutritional Services | Attorney for the Child | Probation Officer | | Occupational Therapist | Child Care Provider | School Contact | | Other Provider | Community Advocate | Volunteer | | Physical Therapist | Dentist | Self or Parent Referred (FCSS/ERB, | | Social Worker | DHHS/DSS Worker | PAT, Family Advoc, Family Emp, Adoption, | | OCFS/DJJOY Worker | Youth Court | Kinship Care, FC:ST, FSS:Adult, Parent Ed) | | | |
| **Primary Reason for Referral (***choose one only):*   |  |  |  | | --- | --- | --- | | Adoption Information/Adoption Issues | Interpersonal Relationship Difficulties | | | CPS Issues | Juvenile/Adult Legal System | Self-abusive Behavior | | CSE Classification | Legal Services | Sexual Aggression/Perpetration | | Dangerous Behavior | Mental Health/Psychiatric Issues | Sexual Reactivity/Acting Out | | Developmental Delay | Parental Substance/Alcohol Use/Abuse | Social Support Issues | | Environment/Basic Needs Issues | Parenting Skills | Trauma Related Issues | | Family Issues/Crisis | Pregnancy/Teen Parent | Transition to Self-Sufficient Adulthood | | From Family Court: Reason Unknown | Pre-School Education (Needed) | Unmanageable Behavior | | Health/Medical Issues | Prog End Unable to Return Home | Child Care Issues | | Homeless/Risk of Homelessness/Transient | School Behavior/Learning Difficulties |  | |  |  |  |   **Living Situation the night before Enrollment** *(where did client spend the night before enrollment in program-check one)***:**   |  |  |  | | --- | --- | --- | | Adoptive Home  Parent/Guardian Home | Homeless/Transient  Inpatient General Hospital - Psych | OMH Community Residence  Other (Specify) | | Alcohol/Substance Treatment Ctr | Inpatient Hospital - Medical | Other Relative's Home (Non-parental Non-Guardian) | | DDSO Residence | Inpatient Private Psych Facility | Residential Placement- HFA | | DFY Community Group Home | Inpatient State Psychiatric Hospital | RTC –Non HFA | | Foster Home: DSS | Living on Own | RTF - Non HFA | | Foster Home: Non-DSS | Non-Secure Detention | Runaway Shelter | | Grandparent(s) Home | OCFS Facility or GH | Secure Detention/ Incarceration | | | |
| **Client Address Type:** *(Check one)*  Referral  Updated address for Enrollment   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Alcohol/Substance Treatment Center | Inpatient Hospital - Medical | Other Relative's Home (Non-parental Non-Guardian) |  |  |  | | DDSO Residence | Inpatient Private Psychiatric Facility | Parent/Guardian Home: Adoptive |  |  |  | | DFY Community Group Home | Inpatient State Psychiatric Hospital | Parent/Guardian Home: Biological |  |  |  | | Foster Home: DSS | Living on Own | RTC |  |  |  | | Foster Home: Non-DSS | Non-Secure Detention | RTF |  |  |  | | Grandparent(s) Home | OCFS Facility or GH | Runaway Shelter |  |  |  | | Homeless/Transient | OMH Community Residence | Secure Detention/ Incarceration |  |  |  | | Inpatient General Hospital - Psych | Other (Specify) |  |  |  |  | | | |
| **Client Address:**  Same as Referral  Updated for Enrollment  Zip Code       Street Address:  School District:      Client Phone #: | | County: |
| **DEMOGRAPHICS**  Referral  Enrollment | |  |
| **Ethnicity & Ethnicity Detail:** *[Script: “In order to develop a plan that best meets your needs, utilizing your strengths, and builds and links you to community supports, I’d like to ask you about your cultural identity.”*  **Non-Hispanic/ Non- Latino** | **Hispanic/ Latino**   |  |  | | --- | --- | | Cuban  Puerto Rican | Other Origin  Unknown | | Mexican/Mexican-American/Chicano | |  |  | | |
| **Race & Race Detail:**   |  |  |  | | --- | --- | --- | | **American Indian or Alaska Native** | **Asian/ Pacific Islander** | **Black/African American** | | **White** | **Other:** | **Unknown** | | **Multi-Racial** *(select all that apply)*  American Indian or Alaska Native  Asian/ Pacific Islander  Black/African American  White  Other  Unknown   |  |  | | --- | --- | | **Primary Language Spoken:** | **Secondary Language Spoken:** | | **Current Grade Level**  **Name of School Contact & ph. #:** | | | **(For Health Home Referrals Only) Type of Health Home program** *(check one)*  **Health Home: Behavioral Health** **Health Home: Children** **Health Home: Chronic Adult**  **Health Home: Developmentally Disabled** **Health Home : Long Term Care** | |   **Social Security # of client at enrollment** *(for clients in Care Day, Foster Care, Day Tx programs only):* | | | |  | | | | **Child Client Personal Income Amount & Source**  **Source:***Check primary source**[Script: “In order to develop a plan that best meets your needs, including your financial needs, I’d like to ask you about your source(s) of income and the amount.”*   |  |  |  | | --- | --- | --- | | Aid for Dependent Children | None | Supplemental Security Income | | Alimony | Other | TANF | | Child Support | Retirement Pension | Unemployment Compensation | | Disability Insurance/Worker's Compensation | Savings or Investments | Unknown | | Family or Relative | Social Security Disability Insurance (SSDI) | VA | | General Relief/Welfare | Social Security Retirement | Wages/Salary Income | | | | | | |

**Insurance Information:**

For Residential/Foster Care**-** {Payer= Non-Billable: Information Only}  *BIN # = Bank Identification No. (6 digit); PCN # = Processor Control No.(varying # of digits)* ***(SCAN ENLARGED copy of the front & back of ALL insurance cards to Sheila Miller-Serafin )***

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan/Contract:** | Medicaid  Medicaid Managed Care Medicaid HMO Dental Vision Pharmacy  Medical | | |
| **Client’s Medical Insurance Carrier:** | |  | |
| **Client’s Policy Number:** | |  | |
| **Name of Policy Holder:** | |  | **DOB:** |
| **Relationship to Insured person:** | |  | |
| **BIN # & PCN # (if applicable):** | | **BIN#:** | **PCN #:** |
| **Plan/Contract:** | Medicaid  Medicaid Managed Care Medicaid HMO Dental Vision Pharmacy  Medical | | |
| **Client’s Medical Insurance Carrier:** | |  | |
| **Client’s Policy Number:** | |  | |
| **Name of Policy Holder:** | |  |  |
| **Relationship to Insured person:** | |  | |
| **BIN # & PCN # (if applicable):** | | **BIN#:** | **PCN #:** |

**Legal Guardianship and Custody**   Referral  Enrollment

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client is freed (***enter County information below) (refer to your DIS for guidance if needed)*  **Termination Of Parental Rights:** *(Complete if applicable)*  *N/A*  Termination of Parental Rights: Father: Finalize Date:        Termination of Parental Rights: Father: Pending  Termination of Parental Rights: Mother: Finalize Date:        Termination of Parental Rights: Mother: Pending  **Designation of Parental Authority:**  *N/A*(*Complete if parent/guardian has designated someone else to act in parental authority AND has not gone through the legal system. (Requires form HSA #133))*  **Type** *(relationship to Client):* Non-Related Caregiver Other Non-Parent Relative  **Name:**  **Effective Date of designation**:       **End Date of designation:**       *NYS requires re-authorization every 6 months.*  **Type of Legal Guardianship:** *(is usually parents)*   |  |  |  |  | | --- | --- | --- | --- | | County Commissioner (see below) | Non-Related Caregiver | Destitute | Parent (refer to Family Information section) | | Temporary/ Emergency | Other Non-Parent Relative | Self |  |   **(For County Guardianship) Name of County :**       **Address :**  **Effective Date of Guardianship (default to referral date if unknown):**  **Type of Legal Custody:**   |  |  |  |  | | --- | --- | --- | --- | | County Commissioner (see below) | Non-Related Caregiver | Destitute | Parent (refer to Family Information section) | | Temporary/ Emergency | Other Non-Parent Relative | Self |  |   **(For County Custody) Name of County :**       **Address :**  **Effective Date of Custody (default to referral date if unknown):** |
| |  |  | | --- | --- | | **Enrollment** | | | **Family Structure:**  Other: Non-Relative  Other: Relative  Parent(s) | | | **Name:**       Guardian Custodian  Male  Female **DOB:       (required)**  **Relationship to Client:**   |  |  |  | | --- | --- | --- | | Parent | Aunt/Uncle | Other Related Adult | | Self | Other Related Caregiver | Other Non-Related Adult | | Grandparent | Other Non-related Caregiver |  | | *If guardian/custodian is not related, complete all information here; or enter information in Family Information / Primary Adult section below.*  **Address:**  **Phone**: H:       C:  **Ethnicity :**    **Race:** | | **Name:**       Guardian Custodian  Male  Female **DOB:       (required)**  **Relationship to Client:**   |  |  |  | | --- | --- | --- | | Parent | Aunt/Uncle | Other Related Adult | | Self | Other Related Caregiver | Other Non-Related Adult | | Grandparent | Other Non-related Caregiver |  | | *If guardian/custodian is not related, complete all information here; or enter information in Family Information / Primary Adult section below.*  **Address:**  **Phone**: H:       C:  **Ethnicity :**    **Race:** | | **Name:**       Guardian Custodian  Male  Female **DOB:** (required)  **Relationship to Client:**   |  |  |  | | --- | --- | --- | | Parent | Aunt/Uncle | Other Related Adult | | Self | Other Related Caregiver | Other Non-Related Adult | | Grandparent | Other Non-related Caregiver |  | | **Address:**  **Phone**: H:       C:  **Ethnicity :**  **Race:** |   ***Please inform the caller to bring all Court Orders, and Guardianship/Custody documentation to the initial meeting. If the caller is unsure of what to bring, or they have questions related to the legal documentation, please ask them to call the staff person coordinating the referral.*** |

**Order of Protection:** Is there a Court Order of Protection involving this client? N Y

If yes, who is the client not allowed to have contact with       ? (Attempt to obtain a copy of the Court Order)

What is the timeframe of the Order of Protection? Start Date:       Stop Date:

**Court Order needed for Placement/ Enrollment -** *N/A*

|  |  |
| --- | --- |
| Date Court Order Received: | Date Court Order Requested: |

**Legal Status:** *(current legal status – if applicable, check as many as apply)* *N/A*

|  |  |  |
| --- | --- | --- |
| Legal/Court: Arrest/Incarceration | Legal/Court: Missed Court Date | Legal/Court: Court Ordered (Re-) Placement Risk |
| Legal/Court: Family Court | Legal/Court: PINS | Legal/Court: Legal Involvement |
| Legal/Court: Juvenile Delinquent | Legal/Court: PINS Diversion | Legal/Court: Adjournment in Contemplation of Dismissal (ACD) |
| Legal/Court: JD Diversion | Legal/Court: Violation of Cond Release | Legal/Court: Violation of Probation/Parole |
| Legal/Court: Juvenile Offender | Legal/Court: Violation of Court Condition | Trauma: Physical/Emotional Abuse /**Neglect**/Assault *(if client has been neglected)* |
| If any of the above are checked, note the legal charges against the client- if applicable: | | |

**Disabilities:** (*OMH programs - check one only, and OPWDD Eligibility)*

|  |  |  |
| --- | --- | --- |
| Development: Mental Retardation/ Developmental Disability | Health/ Medical: Visual Impairment | Behavior: Alcohol/ Substance Use or Abuse |
| Health/ Medical: Deaf/ Hearing Impaired | Psychiatric/ Mental Health: Disability | Health/Medical: Physically Disabled |
| Health/ Medical: Ambulation Impairment | Social: Homebound | Education: Disability |
| Eligible for OPWDD Services |  |  |

**Serious Persistent Mental Illness/ Serious Emotional Disturbance: (***OMH programs only- check one only if known)*

|  |  |
| --- | --- |
| Psychiatric / Mental Health: SED | Psychiatric/ Mental Health: SPMI |

**Residential (OCFS) Diagnostic Package Only:** Funder Evaluation Package Option

|  |  |  |
| --- | --- | --- |
| Resid. Treatment HTP: 45 day Diagnostic Eval | Resid. Treatment HTP:60 day Diag. Eval | Resid. Treatment HTP: 90 day Diag. Eval |

**Referring Diagnosis –** *(required for all OMH & HCBS programs. Other programs-if known. Mark which dx is priority 1)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ICD-10 code** | **Description** | **Primary** | **Secondary** | **Tertiary** | **Other** | **Unknown** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
| **Diagnosed by**: | | | | **Date Diagnosed:** | | |

**CSE Classification:** *(for youth/child programs only: complete if client has been classified as a student with a Special Educ. Disability)*  *N/A*

|  |  |  |
| --- | --- | --- |
| School: CSE 504 Plan | School: CSE Blind/ Visually Impaired | School: CSE Intellectual Disability |
| School: CSE Autism | School: CSE Deaf | School: CSE Multiple Disability |
| School: CSE Emotional Disturbance | School: CSE Deaf and Blindness | School: CSE Orthopedic Impaired |
| School: CSE Other health impaired | School: CSE Hearing Impaired | School: CSE Preschool Student with Disability |
| School: CSE Traumatic Brain Injury | School: CSE Learning Disabled | School: CSE Speech/Language Impaired |

**Supportive Case Management** Program Only:  SPOA Involvement: Wyoming County

**Permanency Plan Goal** *-*  *N/A*

|  |  |  |
| --- | --- | --- |
| Discharge to adoption | Discharge to guardianship | Placement with a fit and willing relative |
| Discharge to Adult Residential Care | Discharge to another planned permanent living arrangement | Return to parents (Reunification) |

**Family Information:** Referral  Enrollment

*Family’s definition of who they consider to be a part of their family – the person does not need to live with them. Do Not include foster home information.*

*When selecting ethnicity and race for family members below, please select from the following choices:*

*[Script: “In order to develop a plan that best meets your needs, utilizing your strengths, and builds and links you to community supports, I’d like to ask you about your family’s cultural identity.”*

|  |
| --- |
| **Ethnicity & Ethnicity Detail:**  **Hispanic/Latino Non-Hispanic/ Non- Latino** |
| **Race & Race Detail:**  **American Indian or Alaska Native**  **Asian/ Pacific Islander**  **Black/ African American**  **White Other Unknown**  **Multi-racial (**select all that apply) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Primary Adult**  **in Home:** | **Home Phone:**       **Cell Phone:**  **FECT Preferred Contact Method (Residential & Day Tx only):**  **Cell Phone**  **Day Phone** **Email**  **Text Cell**  **Evening Phone** | | |
| **DOB:**       **F**  **M** | | | **Ethnicity/ Detail** *choose from above* **:** |
| **Address:** | | | **Race/Detail:** *choose from above* **:** |
| **Email Address:** (will be used to send customer satisfaction survey to- if email is to be used as a regular form of communication b/w this person and the clinical team then a separate authorization needs to be obtained):        no email / does not want to use email | | | |
| **Relationship to Client:**   |  |  | | --- | --- | | Parent | Aunt/Uncle | | Self | Other Related Caregiver | | Grandparent | Other Non-related Caregiver | | | **Employer:**      [Employment History tab]  **Status:**   |  |  |  | | --- | --- | --- | | Disabled | Inmate of Institution | Retired | | Full Time:35 Hour or more per week | Part Time:Less than 35 Hours per week | Sheltered Employment/ Workshop,etc. | | Homemaker | Other | Unemployed | | |
| **Income Source:***Check primary source*[Employment History tab]  *[Script: “In order to develop a plan that bests meet your needs, including your financial needs, I’d like to ask you about your source(s) of income.”*   |  |  |  | | --- | --- | --- | | Aid for Dependent Children | None | Supplemental Security Income (SSI) | | Alimony | Other | TANF | | Child Support | Retirement Pension | Unemployment Compensation | | Disability Insurance/Worker's Compensation | Savings or Investments | Unknown | | Family or Relative | Social Security Disability Insurance (SSDI) | VA | | General Relief/Welfare | Social Security Retirement | Wages/Salary Income | | | | |
| **Highest Educ. Degree completed**  [Degrees Tab] **:**   |  |  |  | | --- | --- | --- | | High School Diploma: IEP | Further Specialized Studies | Less Than Grade 12 | | High School Diploma: Local | Graduate Courses | Post-Graduate Studies | | 2 Years College/Associate Degree | Graduate Degree | Some College | | 4 Year College/Undergraduate Degree | High School Diploma: Regents | Trade or Technical School | | | | |
| **Personal Collateral:***(can this person have contact with the client ? )*  Y  N  **Do they want to receive Mailings from Hillside?  Y N Are they an emergency contact ?  Y N**   |  | | --- | | **For Residential/Foster Care and Day TX Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Primary Adult**  **in Home:** | **Home Phone:**       **Cell Phone:**  **FECT Preferred Contact Method (Residential & Day Tx only):  Cell Phone**  **Day Phone Email  Text Cell  Evening Phone** | | |
| **DOB:**       **F  M** | | | **Ethnicity/Detail:** *choose from above***:** |
| **Address:** | | | **Race/Detail:** *choose from above***:** |
| **Email Address:** (will be used to send customer satisfaction survey to- if email is to be used as a regular form of communication b/w this person and the clinical team then a separate authorization needs to be obtained):        no email / does not want to use email | | | |
| **Relationship to Client:**   |  |  | | --- | --- | | Parent | Aunt/Uncle | | Self | Other Related Caregiver | | Grandparent | Other Non-related Caregiver | | | **Employer:**      [Employment History tab]  **Status:**   |  |  |  | | --- | --- | --- | | Disabled | Inmate of Institution | Retired | | Full Time:35 Hour or more per week | Part Time:Less than 35 Hours per week | Sheltered Employment/ Workshop,etc. | | Homemaker | Other | Unemployed | | |
| **Income Source:***Check primary source*[Employment History tab] *[See above script]*   |  |  |  | | --- | --- | --- | | Aid for Dependent Children | None | Supplemental Security Income | | Alimony | Other | TANF | | Child Support | Retirement Pension | Unemployment Compensation | | Disability Insurance/Worker's Compensation | Savings or Investments | Unknown | | Family or Relative | Social Security Disability Insurance (SSDI) | VA | | General Relief/Welfare | Social Security Retirement | Wages/Salary Income | | | | |
| **Highest Educ. Degree completed**  [Degrees Tab] **:**   |  |  |  | | --- | --- | --- | | High School Diploma: IEP | Further Specialized Studies | Less Than Grade 12 | | High School Diploma: Local | Graduate Courses | Post-Graduate Studies | | 2 Years College/Associate Degree | Graduate Degree | Some College | | 4 Year College/Undergraduate Degree | High School Diploma: Regents | Trade or Technical School | | | | |
| **Personal Collateral:***(can this person have contact with the client ? )*  Y  N  **Are they an Emergency Contact:  Y N Do they want to receive Mailings from Hillside?  Y N**   |  | | --- | | **For Care Day (Bed Based) and Attendance (Day TX) Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | |

**Other Family members:** *(not foster home members)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | | **Gender:** **M**  **F** |
| **Lives with Family:  Y**  **N If no, list address:**  **Relationship in Family:** *(what is this person’s relation to the family as a whole [ not the client]?)*   |  |  |  | | --- | --- | --- | | Adopted Son/Daughter | Other Related Caregiver | Other: Related Child | | Aunt/Uncle | Other Related Family Member (Non Caregiver) | Parent | | Foster Child | Other: Non-Related Adult | Professional/Foster Parent | | Grandchild | Other: Non-Related Caregiver | Self | | Grandparent | Other: Non-Related Child | Sibling\*\* | | Niece/Nephew | Other: Related Adult | Son/Daughter | | | | |
| **Ethnicity/Detail :**  *[See script above and choose from options above]* | | **Race/Detail:** *choose from above***:** | |
| |  |  |  | | --- | --- | --- | | **Do they want to receive Mailings from Hillside?  Y N**   |  | | --- | | **For Care Day (Bed Based) and Attendance (Day TX) Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | | |
| **Is Emergency Contact:  Y N Phone #:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | | **Gender: M  F** |
| **Lives with Family:  Y  N If no, list address:**  **Relationship in Family:** *(what is this person’s relation to the family as a whole [ not the client]?)*   |  |  |  | | --- | --- | --- | | Adopted Son/Daughter | Other Related Caregiver | Other: Related Child | | Aunt/Uncle | Other Related Family Member (Non Caregiver) | Parent | | Foster Child | Other: Non-Related Adult | Professional/Foster Parent | | Grandchild | Other: Non-Related Caregiver | Self | | Grandparent | Other: Non-Related Child | Sibling\*\* | | Niece/Nephew | Other: Related Adult | Son/Daughter | | | | |
| **Ethnicity** *See script above and choose from options above***:** | | **Race:** *choose from above***:** | |
| |  |  |  | | --- | --- | --- | | **Do they want to receive Mailings from Hillside?  Y N**   |  | | --- | | **For Care Day (Bed Based) and Attendance (Day TX) Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | | |
| **Is Emergency Contact:  Y N Phone #:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | | **Gender: M  F** |
| **Lives with Family:  Y  N If no, list address:**  **Relationship in Family:** *(what is this person’s relation to the family as a whole [ not the client]?)*   |  |  |  | | --- | --- | --- | | Adopted Son/Daughter | Other Related Caregiver | Other: Related Child | | Aunt/Uncle | Other Related Family Member (Non Caregiver) | Parent | | Foster Child | Other: Non-Related Adult | Professional/Foster Parent | | Grandchild | Other: Non-Related Caregiver | Self | | Grandparent | Other: Non-Related Child | Sibling\*\* | | Niece/Nephew | Other: Related Adult | Son/Daughter | | | | |
| **Ethnicity/Detail** *See script above and choose from options above***:** | | **Race/Detail:** *choose from above***:** | |
| |  |  |  | | --- | --- | --- | | **Do they want to receive Mailings from Hillside?  Y N**   |  | | --- | | **For Care Day (Bed Based) and Attendance (Day TX) Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | | |
| **Is Emergency Contact:  Y N Phone #:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | | **Gender: M  F** |
| **Lives with Family:  Y  N If no, list address:**  **Relationship in Family:** *(what is this person’s relation to the family as a whole [ not the client]?)*   |  |  |  | | --- | --- | --- | | Adopted Son/Daughter | Other Related Caregiver | Other: Related Child | | Aunt/Uncle | Other Related Family Member (Non Caregiver) | Parent | | Foster Child | Other: Non-Related Adult | Professional/Foster Parent | | Grandchild | Other: Non-Related Caregiver | Self | | Grandparent | Other: Non-Related Child | Sibling\*\* | | Niece/Nephew | Other: Related Adult | Son/Daughter | | | | |
| **Ethnicity/Detail** *See script above and choose from options above***:** | | **Race/Detail:** *choose from above***:** | |
| |  |  |  | | --- | --- | --- | | **Do they want to receive Mailings from Hillside?  Y N**   |  | | --- | | **For Care Day (Bed Based) and Attendance (Day TX) Programs:** | | Can visit Client:  Y N Can pick up client:  Y N Can call into or receive calls from client:  Y N | | | | | |
| **Is Emergency Contact:  Y N Phone #:** | | | |

|  |
| --- |
| **\*\* Sibling in Program:** Please ask parent/guardian ifany of the above named siblings are currently receiving services from Hillside?  N  Y If Yes, which one(s) **DIS**: send email to Marjorie Montag |

**Additional information for the Family Household**

|  |  |
| --- | --- |
| **Family Household Size(How many live in the household):** | **Total Income:**       *[Script: “In order to develop a plan that bests meet your needs, including your financial needs, I’d like to ask you about your income.”* |

**Outside Organization Collaterals:** *(individuals who have a professional relationship with the client such as DSS Workers, Probation Officers, Attorney for Child {Law Guardian}, Pastor, School District contact)*

|  |  |
| --- | --- |
| **1.Organization Name**: | Relationship to Client: |
| Address: | |
| (Local) Worker Name: | (Local) Worker Phone:       Is Emergency Contact:  Y N  **IF DSS- Afterhours No.:** |
| Eligible Visitor:  Y  N | Can pick up client:  Y  N |
| **2.Organization Name**: | Relationship to Client: |
| Address: | |
| (Local) Worker Name: | (Local) Worker Phone:       Is Emergency Contact:  Y N  **IF DSS- Afterhours No.:** |
| Eligible Visitor:  Y  N | Can pick up client:  Y  N |
| **3.Organization Name**: | Relationship to Client: |
| Address: | |
| (Local) Worker Name: | (Local) Worker Phone:       Is Emergency Contact:  Y N  **IF DSS- Afterhours No.:** |
| Eligible Visitor:  Y  N | Can pick up client:  Y  N |

**Additional Personal Collaterals** *(individuals who do not have a professional relationship with the client)*

|  |  |
| --- | --- |
| **1. Name**:        M  F | Relationship to Client: |
| **DOB:**  **Address:**  Day Phone:  Evening Phone:  Cell Phone:       Email: | Is Emergency Contact:  Y N  Eligible Visitor:  Y  N  Can pick up client:  Y  N  Phone Contact with Client:  Y  N  Contact via Mail with Client:  Y  N |
| **2. Name**:        M  F | Relationship to Client: |
| **DOB:**  **Address:**  Day Phone:  Evening Phone:  Cell Phone:       Email: | Is Emergency Contact:  Y N  Eligible Visitor:  Y  N  Can pick up client:  Y  N  Phone Contact with Client:  Y  N  Contact via Mail with Client:  Y  N |
| **3. Name**:        M  F | Relationship to Client: |
| **DOB:**  **Address:**  Day Phone:  Evening Phone:  Cell Phone:       Email: | Is Emergency Contact:  Y N  Eligible Visitor:  Y  N  Can pick up client:  Y  N  Phone Contact with Client:  Y  N  Contact via Mail with Client:  Y  N |

**Health Practitioners for Client:**

|  |  |
| --- | --- |
| **Type**:  Dentist  Medical Provider  Mental Health Provider | **Phone #:** |
| **Organization Name**: | **Name of person:** |
| **Address:** | |
| **Type**:  Dentist  Medical Provider  Mental Health Provider | **Phone #:** |
| **Organization Name**: | **Name of person:** |
| **Address:** | |
| **Type**:  Dentist  Medical Provider  Mental Health Provider | **Phone #:** |
| **Organization Name**: | **Name of person:** |
| **Address:** | |

**Independent Living Skills:** Foster Care (Therapeutic) & Residential youth only:

|  |
| --- |
| Is child/youth eligible for Life Skills (ILS) training – (must first confirm w/ DSS worker that DSS is not planning to provide ILS themselves )  NO  YES (See below)  **DIS**- If yes is checked, send an email to Linda Flanagan with name of youth, DOB, client #. |

**Family Crisis Support Services/ ERB & ERB: Aftercare Only**:

|  |
| --- |
| CGAS Assessment Score:       Date of Assessment: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Status:**  Pending Denied/Rejected  Withdrawn  **Status Reason:**   |  |  |  |  | | --- | --- | --- | --- | | Accepted: Admission Scheduled | Denied: Needed Service not Offered | Pending: On Proposal (IRA only) | Withdrawn: Referred: Served by Different HFA Program | | Accepted: Waiting Funder and Family Approval | Denied: No foster home match | Pending: Waiting for Additional Information | Withdrawn: Relocation | | Accepted: On Wait List | Denied: No Funding available for Client | Pending: Waiting for Funder Approval | Withdrawn: Served by other agency | | Denied: Dangerous Behavior/ Safety Issues | Denied: No Service Provider Available | Withdrawn: Information Only | Withdrawn: Service not available in desired location | | Denied: Does not meet UM Criteria | Denied: Not in Geographic Service Area | Withdrawn: No Parent Interest | Withdrawn: Unable to contact | | Denied: Incompatible Milieu Composition | Denied: Program at Capacity | Withdrawn: No Show | Withdrawn: Wait list too long at this time | | Denied: Other Reason | Pending: Awaiting Program Decision | Withdrawn: No youth/child interest | Withdrawn: Withdrawn by funder | | Denied: Health Issues | Pending: Family Action Needed | Withdrawn: Plan not supported by court |  | | Pending: In Process | Pending: Program Admission Currently On Hold |  |  | |

**Additional Information:**

|  |
| --- |
|  |

HFA Staff person completing form:      Date:

**List additional family member information here:**