

Contact:		Date Received:	
Agency:		File No.	
Phone:		Fax:	

RESIDENTIAL PLACEMENT REQUESTED: Group Home () Therapeutic Home ()

This application provides the information necessary to decide whether to admit the child. If admitted, the documents relating specifically to admission will be required.

Child Information

Last:		First:		Middle:	
Date of Birth	Grade Level	Sex	Race	Social Security No.	Medicaid No.

Currently residing with:

Biological Parent(s)	Relative	Foster Family	Other Specify:

Legal Custodian:

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Diagnosis/Problem

Diagnosis:	
Presenting Problem:	
Behavioral/ Crisis Plan or does child require restrictive interventions?	
Medications:	

Service(s) Required

Individual	Family	Collateral	Group	Psychiatric	Other

Residential Placement (Past 6 Months)

Facility:		Type of Placement	LOS
Facility:		Type of Placement	LOS
Facility		Type of Placement	LOS
Facility		Type of Placement	LOS

Questionnaire

Will racial preference affect placement?	
Will religious preference affect placement?	
Will location affect placement?	
Is there a history of drug or alcohol abuse?	
Special education history?	<input type="checkbox"/> Long-term suspensions/expulsion <input type="checkbox"/> BED
Level of family involvement?	
Current medical problems?	
Date of last physical?	
Is there a history of violence or criminal activity?	<input type="checkbox"/> Felonies <input type="checkbox"/> Probation

Comments (Include placement deadline)

Funding source if known (check all that apply): Area Program/Medicaid DSS Private Insurance
Other

CTSP/TARGET POPULATION approved. Effective Date _____

Please return this Application for Services Form to:

Cardinal Clinic, LLC
Attn.: Treatment Foster Care
1540 Purdue Drive, Suite 200
Fayetteville, NC 28303
(910)401-1024 FAX

or telephone your request to:
Carol Doyle
(910)864-0187, ext. 246