



Application for Emergency/Pre-Placement

Please complete and fax, along with the following items, to:  
(678) 947-6106 Attn: Intake or e-mail to  
[jh\\_casemanager@comcast.net](mailto:jh_casemanager@comcast.net)

\_\_\_\_ Psychological evaluation, if available  
\_\_\_\_ Social History, if available If not, please complete  
Social History Form Page 5-6 of this application

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity \_\_\_\_\_

Insurance Information – Company Name: \_\_\_\_\_

Group or ID #: \_\_\_\_\_ Type of Coverage: (PPO, Medicaid, HMO) \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Anticipated length of stay: \_\_\_\_\_

Custodial Agency/Custodian: \_\_\_\_\_ County: \_\_\_\_\_

Case Worker/Court Service Worker: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

After hours # \_\_\_\_\_ Fax # \_\_\_\_\_

E-mail address: \_\_\_\_\_

Supervisors Name: \_\_\_\_\_ Phone # \_\_\_\_\_

\*\*All children, meeting RBWO requirements of Jesse's House, are designated emergency placements upon acceptance. Acceptance in to long-term placement will be determined by Jesse's House staff no later than 60 days after intake and communicated to the Placing Agency.

Principal Family Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work) \_\_\_\_\_

Phone contact \_\_\_\_\_ yes \_\_\_\_\_ no

Face-to-face \_\_\_\_\_ yes \_\_\_\_\_ no

Supervision required? \_\_\_\_\_ yes \_\_\_\_\_ no

Who provides supervision?

Overnight visits? \_\_\_\_\_ yes \_\_\_\_\_ no

Additional Family Contact(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work) \_\_\_\_\_

Phone contact \_\_\_\_\_ yes \_\_\_\_\_ no

Face-to-face \_\_\_\_\_ yes \_\_\_\_\_ no

Supervision required? \_\_\_\_\_ yes \_\_\_\_\_ no

Who provides supervision?

Overnight visits? \_\_\_\_\_ yes \_\_\_\_\_ no

Reason for Change of Placement: \_\_\_\_\_

Placement prior to admission: \_\_\_\_\_

Last School attended: \_\_\_\_\_ Grade: \_\_\_\_\_

Special Education? \_\_\_\_\_ yes \_\_\_\_\_ no

Passing? \_\_\_\_\_ yes \_\_\_\_\_ no

Legal restrictions regarding family contact? \_\_\_\_\_

Are there pending or recent charges? If yes, please explain \_\_\_\_\_

**Behavioral and Psychological Development and History (check any that apply)**

History	Present		History	Present	
		Alcohol/Drugs			Runaway (number of times)
		Animal Abuse			Self Mutilation
		Depression			Sex Offense
		Enuresis/Encopresis			Sexual Acting Out
		Family Drug and Alcohol			Suicidal/Homicidal
		Fire Setting			Violence with authority
		Violence with peers			Simple battery charges
		Weapons			Assault charges
		Psych Hospitalization			Other _____

Most recent high risk incident: \_\_\_\_\_  
\_\_\_\_\_

Positive behaviors the youth seeks to practice: (anger control, stress management...)  
\_\_\_\_\_  
\_\_\_\_\_

List the projected primary goals of the service plan:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**Medical Information (check all that apply)**

<input type="checkbox"/> allergies	<input type="checkbox"/> deafness/hearing	<input type="checkbox"/> heart murmur	<input type="checkbox"/> Nebulizer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> STD's
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Epipen	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Corrective lens	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> + TB skin test

If any of the above are checked, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has this youth every had a communicable disease? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, explain \_\_\_\_\_

Does this youth have any unusual or special dietary needs which would require other than a normal diet? \_\_\_\_\_ yes \_\_\_\_\_ no If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Does this child have any problems in physical functioning which would interfere with living in a group care setting or normal participation in a peer group process?  
\_\_\_\_\_ yes \_\_\_\_\_ no If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Medications \_\_\_\_\_ yes \_\_\_\_\_ no If yes, please list

Medication Name                      Purpose                      Amount on hand                      Refills?

- 1)
- 2)
- 3)

Prior to the admission, I (the custodian) have been informed of the services, environment, age ranges and behavioral characteristics of the other children in this placement. I have determined that the placement environment is appropriate and does not represent an undue risk to the health and safety of the child or children being placed.

Name: (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### Social History

Completion required if a prepared social history is not available

Name	Date
Source of Information	
Physical description:	
Presenting Concerns:	
Previously addressed concerns:	
Presenting strengths:	
Placement History:	
Medical History – general:	
Family History:	

Educational History (include history of school behavior):
Substance Abuse History:
Suicidal/Homicidal/Self-Harm History:
Interpersonal Relationships: Peers –  Authority –
Leisure Interests/Hobbies:
Current needs/recommendations:
Discharge/Permanency Plan: