

Contact:		Date Received:	
Agency:			
Phone:		Fax:	
Child Information			
Last:		First:	
Middle:			
Date of Birth		Sex	Race
		Social Security No.	Medicaid No.
Currently residing with:			
Biological Parent(s)	Relative	Foster Family	Other Specify:
Legal Guardian:			
<input type="checkbox"/> DSS: _____ <input type="checkbox"/> Biological Parent(s): <input type="checkbox"/> Other (Please specify):			
Current Treatment :			
<input type="checkbox"/> Outpatient Services <input type="checkbox"/> Psychiatric <input type="checkbox"/> Other (Please specify):			
Diagnosis/Problem			
Diagnosis:			
History/Current Presenting Problems (please check all that apply)	<input type="checkbox"/> Sexual Offending Behavior <input type="checkbox"/> Physical Aggression Toward Other <input type="checkbox"/> Physical Aggression Toward Property <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Stealing <input type="checkbox"/> Fire Setting <input type="checkbox"/> Runaway within past two months <input type="checkbox"/> Non-compliance with rules <input type="checkbox"/> Multiple School Suspension <input type="checkbox"/> Current Drug Use <input type="checkbox"/> Gang Involvement <input type="checkbox"/> Hx of Sexual Abuse (victim) <input type="checkbox"/> Hx of Physical Abuse (victim) <input type="checkbox"/> Other: _____ _____ _____		

Behavioral/ Crisis Plan or does child require restrictive interventions?					
Medications:					
Service(s) Required					
Individual	Family	Collateral	Group	Psych iatric	Other
Residential Placement (Past 6 Months)					
This includes any hospitalizations, detention, or other out of home placement.					
Facility:		Type of Placement	L O S		
Facility:		Type of Placement	L O S		
Facility		Type of Placement	L O S		
Facility		Type of Placement	L O S		
Questionnaire					
Will racial /cultural preference affect placement?					
Will religious preference affect placement?					
Will location affect placement?					
Is there a history of drug or alcohol abuse?					
Current drug treatment?					
Educational History?			<input type="checkbox"/> Long-term suspensions/expulsion <input type="checkbox"/> BED		

	<input type="checkbox"/> Special Education <input type="checkbox"/> Current IEP <input type="checkbox"/> Current Alternative School Placement <input type="checkbox"/> Regular Classes
Level of family involvement?	
Current medical problems?	
Date of last physical?	
Is there a history of violence or criminal activity? If yes, please provide explanation.	<input type="checkbox"/> Felonies <input type="checkbox"/> Probation
<u>Comments (Include placement deadline)</u>	

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:

Therapeutic Homes

Fayetteville Office	Southern Pines Office
Cheryl Morgan	Barbara Rich
Program Manager	Program Manager
(910) 867-8889, x247	(910) 692-9915, x103