HOMESPACE CORPORATION INTAKE APPLICATION

REFERRAL INFORMATION

Date of Referral: ____________________

Program Referred To (circle 1): SILP Next Step Second Chance

Referring Agency: ____

Contact Person: ____________________________ Telephone #: _______________________

Please state the current reason for referral including anticipated date of transition into the program:

____

____

____

Was the youth homeless at the time of intake? Yes No

If not homeless, was there a risk of homelessness if not accepted to the program? Yes No

YOUTH'S DEMOGRAPHIC INFO

Youth's Name: ______________________________________ DOB/Age : _______________

Ethnicity: ____

Is the youth affiliated with a nationally recognized tribe? Yes No

If yes, Tribe name: ____________________________________

Current Address: ____

County of Origin : ___________________ County Worker: ___________________________________

If applicable:

Child’s Name: ____ Date of Birth: _____________

Child’s Name: ____ Date of Birth: _____________

Expected date of delivery: ______________________________

FAMILY INFO

Parent/Guardian Name: ____

Address: ____ Phone #: ______________________

Any visitation requirements (parent, siblings, etc.): Yes No If yes, explain: _____________________

____

Adult Resource (if applicable): ____

Address: ____ Phone #: ______________________

If applicable, name of your child(ren)’s father: ____

Does your child visit with his/her father? Yes No

If yes, what is the arrangement? ____

Additional Family Supports For Your Child (grandparents, godparents, aunts/uncles, etc):

____

____

PLACEMENT INFO

Reason for Placement: Abuse/Neglect PINS JD Voluntary

Permanency Plan Goal (PPG): Return to Parent APPLA Adoption

Case Initiation Date (CID): ______________

EDUCATION

Are you currently enrolled in school or an educational program (this includes a GED program): Yes No

If yes, Name and Address of School: ____

Current Grade Level: __________________ Anticipated Date of Graduation: ______________________

Do you have an IEP: Yes No Date of last evaluation: ______________________________

If not currently enrolled in a school or educational program:

Highest Grade Completed: 7 8 9 10 11 12 Some College Some Vocational

Name & Address of last school attended: ____

____

Do you have a desire to continue your education? Yes No

If yes, what program would you be interested in: ____

EMPLOYMENT

Employed? Yes ____ No ____

If yes: Part Time Full Time How many hours? ______ Length of employment: __________________

Employer's Name: ____

DAYCARE (if applicable):

Is your child in formal daycare: Yes No

If yes, Name of Provider: ____

Address: ____ Phone #: ____________________

Hours of Daycare: ____________________________ Transportation Provided: Yes No

Is this daycare paid by ECDSS? Yes No

If your child is not in daycare, are you interested in registering your child for daycare? Yes No

Who watches your child when you are working/going to schoo?: ____

In the event of an emergency do you have someone to watch your child? Yes No

If yes, name of person/people you can rely on: ____

MEDICAL HISTORY

Medicaid Number: ____

Youth's Physician: ____

Address: ____Telephone #: ____________________________

Child¢s Pediatrician: ____

Address: ____Telephone #: ______________________

Do you or your child(ren) have any medical conditions or illness? Yes No If yes, explain:

____
____
____

Do you or your child(ren) have any physical disabilities or impairments? Yes No If yes, explain:

____
____
____

Do you or your child(ren) take any prescribed medication? Yes No If yes, explain:

____
____

MEDICAL HISTORY CONTINUED:

Do you or your child(ren) have any allergies? Yes No If yes, explain:

____
____
____

Do you or your child(ren) have any unmet healthcare needs? Yes No If yes, explain:

____
____

Do you smoke cigarettes? Yes No

Do you use drugs and/or alcohol? Yes No ** If yes please explain further in the next section.*

MENTAL HEALTH/COUNSELING SERVICES

Are you currently enrolled in counseling? Yes No

If yes, Name and Address of Counselor: ____

How often do you attend counseling? ____

How do you currently get to counseling? ____

If you are not currently enrolled in counseling, have you ever been in counseling? Yes No

If yes, where did you attend? __________________ When did you stop treatment? ___________

Why did you stop treatment? ____

Are you interested in going back to counseling? Yes No

Do you currently have a mental health diagnosis? Yes No

If yes, what is your diagnosis? ______________________________

If no, have you ever had a diagnosis? ______________________________

Are you currently on medication for mental health needs(i.e. depression, anxiety, ADHD)? Yes No

If yes, what medication are you prescribed (name and dose)? ______________________________

____

Who prescribes your medication (name of physician or clinic)? ______________________________

Are you independent in taking your medication? ______________________________

If you are not currently on medication, have you ever been on medication for mental health needs? Yes No

If yes, what medication(s) were you on? ______________________________

When did you stop taking your medication? ______________________________

Why did you stop taking your medication? ______________________________

Are you interested in getting back on your medication? Yes No

Are you currently or have you ever been in drug and/or alcohol treatment? Yes No

If yes, what treatment program did you attend? ______________________________

What did you receive treatment for? ______________________________

If you have been discharged from treatment was it successfully? Yes No

If not currently in treatment, do you feel that you need treatment? Yes No

Are you linked with any Health Home or in-home services? Yes No

If yes, what agency are you linked with (name and contact info)

____

SOCIAL HISTORY

Have you ever been involved with Child Protective Services for your own child? Yes No
If yes, explain: ______________________________
____

Have you ever been involved with criminal court? Yes No If yes, explain (include any conditions, ACD, probation, etc.)______________________________

____

Have you ever been convicted of a crime? Yes No If yes, what offense: ______________________
Provide details: ____
____

Have you ever been in juvenile detention/non-secure detention? Yes No
If yes, provide details: ____
____
____

Are you currently or have you ever been placed on PINS? Yes No If yes, explain: ___________________
____
____

Are there any orders of protection to be aware of? Yes No If yes, please provide details

____

Have you ever been suspended from school and/or discharged from a program for fighting? Yes No
If yes, explain: ____
____

CURRENT STATUS

Individual and/or Family Strengths:
____
____
____

Interests and Activities:
____
____
____

Goals:
____
____
____

Reason you are interested in Homespace/Second Chance:
____
____
____

If you are applying for the Supervised Independent Living Program, please continue to page 7 to complete the Independent Living Skills Assessment

If you are applying for Second Chance Home or Next Step, you have completed the application – thank you!

INDEPENDENT LIVING SKILLS (*SILP APPLICANTS ONLY*)

Please rate yourself on the following IL skills:

- I prepare my own meals (circle the statement that best describes yourself)

  Always Sometimes Never

- I prepare and keep a monthly budget

  Always Sometimes Never

- I get myself to and from appointments on my own

  Always Sometimes Never

- I am comfortable making appointments for myself

  Always Sometimes Never

- I can resolve conflict with little help from adults

  Always Sometimes Never

- I keep my living space neat and clean

  Always Sometimes Never

- I am able to remember important appointments for myself and/or my child

  Always Sometimes Never

Please list items you already own and/or plan to purchase before moving into your apartment? ____________
____
____
____

Please list any IL goals you have for yourself over the next 12-months: ______________________________
____
____

HOMESPACE STAFF ONLY

Date of Youth Interview: ____________________

Program Accepted To (circle 1): SILP Next Step Second Chance

If accepted:

Anticipated Date of Transition: ___________________ Actual Date of Transition: ____________________

If denied, reason for Denial: ____

Follow-Up Needed/Referrals Made:
____
____
____
____