

**UNIVERSAL APPLICATION**

To be used for Placement Assistance, RBWO Program Designation, and Specialized Foster Care Waivers

<b>Date:</b>		<b>Application Type</b>	
<b>Referring County:</b>			
<b>Name of Referring Case Manager</b>			
<b>Email Address</b>			
<b>Office Number</b>		<b>Cell Number</b>	
<b>Please complete the information below – DO NOT SKIP</b>			
<b>Case Manager Name</b> <i>If different from referring</i>		<b>Email</b>	
		<b>Fax</b>	
<b>Office Number</b>		<b>Cell Number</b>	
<b>Address</b>		<b>City/Zip</b>	
		<b>County</b>	
<b>Supervisor Name</b>		<b>Email</b>	
<b>Office Number</b>		<b>Cell Number</b>	
<b>Legal Custodian</b>		<b>Commitment Date</b>	

**YOUTH IDENTIFYING INFORMATION**

*Complete ALL sections in their entirety with information known at the time of Referral/Applicaition*

<b>Youth's Name</b>		<b>Date of Birth</b> <i>MM/DD/YYYY</i>		<b>Age</b>	
<b>Gender</b>	Male	Female	<b>SSN</b>		
<b>Ethnicity:</b>			<b>Sexual Orientation</b>	Drop down	
<b>Religious Affiliation</b>			<b>Primary Language</b>		
<b>Permanency Goal</b>					
<b>Discuss Progress towards permanency goal below</b>					
<b>Is this a foster care reentry</b>	Yes	No	<b>Is this a failed adoption</b>	Yes	No
<b>Reason Youth Entered Foster Care</b>			<b>Reason Placement is needed</b>		
<b>Type of Placement Needed</b>					
<b>If child is to be placed in a foster home (DFCS or CPA) – indicate situations which are appropriate - Mark with "X"</b>					
	Cross-Cultural			With other children	
	Single Parent Family			With younger children	
	Two-parent Family			With older children	
	Single Gay/Lesbian Family			Must be only child	
	Same-Sex Couple			With pets	
<b>What does the youth believe their "ideal" foster family would look?</b>					
<b>As the referring case manager, how would you describe the "ideal" family for this youth?</b>					

WAIVER			
INITIAL	RENEWAL	DATE TO BE EFFECTIVE:	
Applying for:			
If SSI has been applied for please update Characteristics Section of Person Detail Page in SHINES.		Has the caregiver statement been obtained that describes the child's daily functioning, needs, and efforts required to care for the child	
Please select current program designation:		<b>Please Note:</b> If there is a current and/or expiring waiver please attach!	

TRAUMA HISTORY			
Trauma Type	Place an X	Most Recent Date of Occurrence (Month/Year)	Provide a brief summary of all trauma types selected
Neglect			
Emotional Abuse			
Physical Abuse / Domestic Violence			
Sexual Abuse (victim)			
Parental/Caregiver Mental Illness			
Caregiver Criminal Behavior / Incarceration			
Caregiver Drug Use / Abuse			
Adoption Disruption / Dissolution			
Child of Veteran			
Other			

BEHAVIORAL / MEDICAL INFORMATION	
<i>If records have been obtained please attach and submit with this request/application</i>	
<b>Psychological Evaluation</b>	
Date of Most Recent Evaluation: _____ Assessor: _____	
Axis I: _____ Axis II: _____	
Axis III: _____ Axis IV: _____	
Axis V: _____ GAF: _____	
Full Scale IQ: _____	
<b>Medical Information</b>	
Date of last physical exam: _____ Treating Physician: _____	
Address: _____ City: _____ Zip: _____	
List of all known medial conditions/health concerns: _____	
_____	
List all known allergies: _____	
_____	
<b>Dental Information</b>	
Date of last dental exam: _____ Treating Physician: _____	
Address: _____ City: _____ Zip: _____	
List any known dental issues: _____	
_____	

**Vision Exam**

Date of last vision exam: \_\_\_\_\_ Treating Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

List any known visual impairments: \_\_\_\_\_

\_\_\_\_\_

Does the youth wear glasses, contacts, or any other corrective lenses? \_\_\_\_\_

If yes, please indicate which type: \_\_\_\_\_

**CURRENT MEDICATION**

*List all medications the child is currently taking, including over the counter medications, vitamins, and supplements*

Name of Medication	Dosage/Frequency	Prescribing Physician	Reason Needed

**PLACEMENT / TREATMENT HISTORY**

*Print and attach youths Placement Log from Georgia SHINES for all placements since entry into care. Use the codes below to list each out-of-home placement for the past 2 years that are **NOT** currently in SHINES.*

Code	Placement Type	Code	Placement Type
01	Adoptive Home	15	Jail
02	Biological Home	16	Medical Hospital
03	County Detention	17	Medical Hospital/Inpatient
04	Drug/Alcohol Rehab Center	18	Residential Job Corps Center
05	Foster Care (Regular)	19	Residential Treatment Center
06	Foster Care (Specialized)	20	School Dormitory
07	Foster Care (Therapeutic Treatment)	21	Supervised Independent Living
08	Group Home	22	OCCP/OTP
09	Home of Family Friend	23	Youth Detention Center
10	Home of Relative	24	Crisis Stabilization Unit
11	Homeless	25	PRTF
12	Independent Living/Friend	26	Other _____
13	Independent Living/Self		
14	Intensive Treatment Unit		

Code	Placement Name	Beginning Date	Ending Date	Why Youth Left

EDUCATION INFORMATION			
Name of School/Education Program		Address	
Grade Level		Type of School	
Does the youth have an IEP		If yes, Date of last Update	
If youth is currently not enrolled please indicate reason why			

EMPLOYMENT HISTORY/ELIGIBILITY	
Is the youth employed	If not, are they eligible for employment
<p>If the youth has been employed, or is currently employed, please describe the type of jobs held and the dates of employment.</p> <p>If the youth is ineligible/unable to become employed please explain why.</p>	

SPECIAL NEEDS	
<i>Place an "X" by all that apply</i>	
<input type="checkbox"/> Learning disability	<input type="checkbox"/> Mild Intellectual Disability
<input type="checkbox"/> Moderate Intellectual Disability	<input type="checkbox"/> Severe Intellectual Disability
<input type="checkbox"/> Autism	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Visual Impairment / Blind	<input type="checkbox"/> Hearing Impairment/Deaf
<input type="checkbox"/> Speech-Language Impairment	<input type="checkbox"/> Orthopedic Impairment / Wheelchair Access
<input type="checkbox"/> Specialized Adaptive Devices	<input type="checkbox"/> Other Health Impairment _____
<input type="checkbox"/> Other Needs _____	<input type="checkbox"/> Unknown – youth has been in care less than 72 hours

SUPPORT SERVICES PROVIDED WITHIN THE LAST YEAR				
Agency Type	Place an "X" to select		Agency Name	Agency Address and/or County
	Current (w/in 3 months)	Historical (w/in 3-12 months)		
DJJ Probation				
Substance Abuse				
Private Mental Health				
Community Mental Health				
Day Treatment				
Wrap Services CBAY				
Wrap Services Non-Waiver				
Individual Therapy				
Family Therapy				
Community Support Individual				
Respite Services				
Behavior Aide				
Crisis Stabilization				

## SUPPORT SERVICES PROVIDED WITHIN THE LAST YEAR

Agency Type	Place an "X" to select		Agency Name	Agency Address and/or County
	Current (w/in 3 months)	Historical (w/in 3-12 months)		
Hospitalization				
Other: _____				

## BEHAVIOR HISTORY

General Behaviors	Place "X" to select	Date of Last Occurrence	Provide brief description for all behaviors selected:
Difficulty concentrating, restless, impulsive			
Underactive, lack energy.			
Act disobediently at home.			
Acts disobediently at school.			
Associates with children who get into trouble.			
Doesn't get along well with other children			
Is bullying or mean/gets into fights			
Lies and/or cheats.			
Feels no guilt after misbehaving			
Runs away			
Makes false allegations against adults/peers			
Has volatile temper tantrums			
Indiscriminately goes with or to unfamiliar adults			
Exhibits multiple fears, obsessions and worries			
Exhibits insatiable neediness (i.e. clinging behavior.)			
Appears cooperative and submissive but usually does not follow through on actions or requests.			
Child acts older than chronological age. Attempts to parent other children.			
Mood and Anxiety Behaviors	Place "X" to select	Date of Last Occurrence	Provide brief description for all behaviors selected:
Appears sad, unhappy			
Has trouble sleeping			
Stares blankly			
Expresses feeling worthless or inferior			
Withdraws, does not get involved with others			
Worries excessively, preoccupied with minor annoyances			
Complaint of psychosomatic ailments			
Sudden mood changes			
Has stopped speaking			
Elimination and Eating Disorders	Place "X" to select	Date of Last Occurrence	Provide brief description for all behaviors selected:
Wets self during the day			
Wets bed at night			
Has bowel movements other than in toilet			
Smears or plays with bowel movement or urine			
Compulsive Eating			
Anorexia-child refuses to maintain a minimally normal body weight			
Bulimia-child maintains normal body weight through bingeing and purging			
Overuse of diuretics and/or laxatives			
Detachment from Reality	Place "X" to select	Date of Last Occurrence	Provide brief description for all behaviors selected:

Hallucinations (Auditory, Visual, or Tactile)			
Disorganized or incoherent speech			
Experiences delusions			
<b>Sexually Active or Offending Behaviors</b>	<b>Place "X" to select</b>	<b>Date of Last Occurrence</b>	<i>Provide brief description for all behaviors selected:</i>
Sexually Promiscuous			
CSEC/Human Trafficking Victim			
Sexually provocative			
Exhibits self in public			
Sexually peeks at others			
Masturbates in public			
Sexual play with peers			
Other sexual problems			
Coerces other children into sexual acts			
Sexually molests other children			
Has exhibited sexual aggressiveness			
Has the youth faced Charges			
<b>Danger to Self / Danger to Others</b>	<b>Place "X" to Select</b>	<b>Date of last Occurrence</b>	<i>Provide brief description for all behaviors selected:</i>
Verbal or physical suicidal threats			
Suicidal gestures			
Talks about suicide			
Serious self-abusive behavior			
Places self in dangerous situations			
Exhibits life threatening aggression			
Physically aggressive behavior toward a child that results in/potentially causes injury			
Physically aggressive behavior toward an adult that results in/potentially causes injury			
Verbally threatens others			
Damages or destroys property			
Steals			
Vandalizes			
Is cruel to animals			
Carries Weapons			
Sets fires			
Ritualism			
Gang involvement			

<b>Please describe below all interventions that have been successful- <i>Required field, do not skip!</i></b>
<b>List at least three (3) strengths and/or special abilities/interests/extracurricular activities of the youth:</b>

## SUBSTANCE ABUSE AND DEPENDENCE

Complete this section for both historical and current episodes of abuse/dependence

Name of Substance Used	Method of Administration	Frequency of Use	Age at First Use	Last Time Used
How many substance abuse treatment episodes has the youth experienced?				

## VISITATION AND CONTACT

Name \_\_\_\_\_ Relationship to youth \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Are Contacts to be Supervised \_\_\_\_\_  
 Frequency of contact \_\_\_\_\_

Types of contacts allowed – *select all that apply:*

Telephone          Social Media          Face-to-Face          Overnight

Name \_\_\_\_\_ Relationship to youth \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Are Contacts to be Supervised \_\_\_\_\_  
 Frequency of contact \_\_\_\_\_

Types of contacts allowed – *select all that apply:*

Telephone          Social Media          Face-to-Face          Overnight

Are there any persons with whom contact is not allowed?		If yes, please enter their information below
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Name _____ Relationship to youth _____ Home Phone _____ Mobile Phone _____ Email Address _____	Name _____ Relationship to youth _____ Home Phone _____ Mobile Phone _____ Email Address _____
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Does the youth have siblings in Care		If yes, how many?
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If there are siblings, list their name and current placement	
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Can the siblings be placed together? <i>If no, explain below</i>		Can they share sleeping areas? <i>In no, explain below</i>	
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### ADDITIONAL DOCUMENTS

*Attach the following documents if available at the time of application/referral – place an "X" next to those attached*

	Psychological and/or Psychiatric Evaluation
	Trauma Assessment
	School transcripts and school withdrawal forms
	Copy of Birth Certificate
	Copy of Social Security Card
	Medical, dental, and vision records from most recent visits
	DJJ Probation Requirements
	Court Order
	Copy of Permanency Plan
	Copy of WTLP – <i>if applicable</i>
	Other pertinent information

### ADDITIONAL CONSIDERATIONS

#### ADOPTION STATUS

Is there an adoption, or signing of Form 150 anticipated with the current foster parent within the next 90 days?	
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#### CSEC

Has a referral been made to GA Cares to be assessed for CSEC?	
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To date, has the child been assessed by GA Cares?	
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If the child has been assessed by GA Cares, have they been confirmed a victim of CSEC?	
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If the child has not been assessed by GA Cares, what are the indicators for CSEC Involvement? <i>(please list below)</i>	
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Has a referral been made to one of the state approved Domestic Minor Sex Trafficking (DMST) safe homes for placement consideration?	
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This form can be signed electronically. Please click on the field above your designated signature line and follow the instructions to sign before submission.

DFCS Case Manager Signature

DFCS Supervisor Signature

RBWO Provider Signature