GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES

UNIVERSAL APPLICATION

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

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

YOUTH IDENTIFYING INFORMATION

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

Youth's Name		**Date of Birth** *MM/DD/YYYY*		**Age**	
Gender	◉ Male ○ Female	**SSN**			
Ethnicity:	Select One	**Sexual Orientation**	Select One		
Religious Affiliation	Select One	**Primary Language**			
Permanency Goal					
Discuss Progress towards permanency goal below					
Is this a foster care reentry	☐ Yes ☐ No	**Is this a failed adoption**	☐ Yes ☐ No		
Reason Youth Entered Foster Care		**Reason Placement is needed**			
Type of Placement Needed	Select One				

If child is to be placed in a foster home (DFCS or CPA) – indicate situations which are appropriate - Mark with "X"

	Cross-Cultural		With other children
	Single Parent Family		With younger children
	Two-parent Family		With older children
	Singe Gay/Lesbian Family		Must be only child
	Same-Sex Couple		With pets

What does the youth believe their "ideal" foster family would look?	
As the referring case manager, how would you describe the "ideal" family for this youth?	

WAIVER	INITIAL ☐	RENEWAL ☐	DATE TO BE EFFECTIVE:
Applying for:	Select One		
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**	Select One
Please select current program designation:	Select One	***Please Note:*** 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

If records have been obtained please attach and submit with this request/application

Psychological Evaluation

Date of Most Recent Evaluation:_____ **Assessor:**_____

Axis I:_____ **Axis II:**_____

Axis III:_____ **Axis IV:**_____

Axis V:_____ **GAF:** _____

Full Scale IQ:_____

Medical Information

Date of last physical exam:_____ **Treating Physician:**_____

Address:_____ **City:**_____ **Zip:**_____

List of all known medial conditions/health concerns: _____

_____

List all known allergies:_____

Dental Information

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? Select One

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**	Select One
Does the youth have an IEP	Select One	**If yes, Date of last Update**	
If youth is currently not enrolled please indicate reason why			

EMPLOYMENT HISTORY/ELIGIBILITY

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

SPECIAL NEEDS

Place an "X" by all that apply

☐	Learning disability	☐	Mild Intellectual Disability
☐	Moderate Intellectual Disability	☐	Severe Intellectual Disability
☐	Autism	☐	Traumatic Brain Injury
☐	Visual Impairment / Blind	☐	Hearing Impairment/Deaf
☐	Speech-Language Impairment	☐	Orthopedic Impairment / Wheelchair Access
☐	Specialized Adaptive Devices	☐	Other Health Impairment _____
☐	Other Needs_____	☐	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 binging 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			

Sexually Active or Offending Behaviors	**Place "X" to select**	**Date of Last Occurrence**	*Provide brief description for all behaviors selected:*
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			
Danger to Self / Danger to Others	**Place "X" to Select**	**Date of last Occurrence**	*Provide brief description for all behaviors selected:*
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			

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

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 may 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** Select One
Frequency of contact Select One

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** Select One
Frequency of contact Select One

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?	Select One	If yes, please enter their information below

Name_____
Relationship to youth_____
Home Phone_____
Mobile Phone_____
Email Address_____

Name_____
Relationship to youth_____
Home Phone_____
Mobile Phone_____
Email Address_____

Does the youth have siblings in Care	Select One	If yes, how many?	

If there are siblings, list their name and current placement			
Can the siblings be placed together? *If no, explain below*	Select One	**Can they share sleeping areas?** *In no, explain below*	Select One

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 – *if applicable*
	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?	Select One
CSEC	
Has a referral been made to GA Cares to be assessed for CSEC?	Select One
To date, has the child been assessed by GA Cares?	Select One
If the child has been assessed by GA Cares, have they been confirmed a victim of CSEC?	Select One
If the child has not been assessed by GA Cares, what are the indicators for CSEC Involvement? *(please list below)*	
Has a referral been made to one of the state approved Domestic Minor Sex Trafficking (DMST) safe homes for placement consideration?	Select One

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