Children's Home Society
Referral and Admission Process

To secure placement in a residential program, the following items need to be completed:

Initial Referral

_____ Contact Joan Sim or Sue Andrews to make a referral and ensure child is appropriate for CHS programs.
Joan Sim, SFCH, (605) 334-6004 or joan.sim@chssd.org
Sue Andrews, BHCH, (605) 343-5422 or sue.andrews@chssd.org

Residential Funding

(Department of Social Services, Department of Corrections, Tribal Social Services, School Districts, Bureau of Indian Affairs, Parents)

_____ Secure Medicaid funding for residential placement
Complete South Dakota PRTF Referral Form for psychiatric services for individuals under 21 years of age. Submit completed packet to State Review Team.

1. CPS social workers—send referral packets to Pierre; CPS state office in Pierre scans the record and sends it to State Review Team facilitators via a PDF file.
2. DOC Juvenile Correction Agents—submit referral packet to direct supervisor; supervisor sends referral packet to the Director of Classification; Sioux Falls state office scans the record and sends it to State Review Team facilitators via a PDF file.
3. Other referrals—parents, schools, Bureau of Indian Affairs, Tribal Social Services, etc. send the completed referral packet and supporting documentation directly to State Review Team facilitators at

   Dept. of Social Services
   Megan Newling /Auxiliary Placements
   700 Governors Dr.
   Pierre, SD 57501
   (605) 773-3448
   megan.newling@state.sd.us

The State Review Team will request documentation for review that may include the following child assessments and evaluations:

- Psychological evaluation
- Psychiatric evaluation
- Discharge summary and notes from psychiatric hospitalization
- Education records
- Counseling records and history
- Medical records
- Form 534/Child Profile (DSS referrals need to use this form for residential placements)

The State Review Team will review information and will approve or deny the referral. Approved referrals will be forwarded to the PRO-Team for final approval.

Educational Funding

_____ Secure educational funding
If the child is in the state's custody, contact Megan Newling at the Department of Education, (605) 773-3448, or megan.newling@state.sd.us
If the state does not have custody, contact the child's school district.
If the child is enrolled in a Bureau of Indian Affairs funded school in the Great Plains Region and on an IEP, contact your region's Educational Line Officer.
For further assistance please contact Joan Sim at SFCH, (605) 965-3117, joan.sim@chssd.org; or Sue Andrews at BHCH, (605) 343-5422, sue.andrews@chssd.org

ADMISSIONS PACKET INSTRUCTIONS

Residential & Evaluation/Short-Term Care Program

A. Complete Packet and return

_____ Pre-Placement Information Form
_____ PRTF referral made / Placement Agreement
_____ Tuition Agreement to be signed by School District designee

B. Include Copies of:

_____ Birth Certificate
_____ Social Security Card
_____ Immunization Records
_____ Title XIX Card
_____ Court Orders

C. Request Previous Records: (please sign as many releases as necessary)

_____ Records from Previous Placements
_____ Medical Records
_____ Psychological Evaluations
_____ Psychiatric Evaluations

D. Request School Cumulative File be released to CHS

_____ Release of Information signed with School District contact
_____ Current IEP, dated within the last year
_____ Multi-Disciplinary Evaluation Report (s) including Education Evaluation & Psychological Evaluation
_____ Related Services Evaluation Reports including Speech/Language, Occupational Therapy and Physical Therapy
_____ Attendance History, Report Cards, Progress Reports

PLEASE CONTACT THE ADMISSIONS COORDINATOR IF YOU HAVE ANY QUESTIONS
Joan Sim, Sioux Falls:(605) 965-3117 or Sue Andrew, Rapid City:(605) 343-5422

Today's Date: _____

CHILDREN'S HOME SOCIETY
PRE-PLACEMENT INFORMATION

Please fill in all items as completely as you can. Use extra pages, as necessary. If you do not have the information requested, please write "unknown". If an item does not apply to your child, write "not applicable". **If you have documentation on the subject already, please attach a copy rather than repeating the information on this form.**

Child's Name: _____

Date of Birth: _____ SS#:_____ Medicaid #:_____

Race: White Black American Indian Hispanic _____ Gender: Male Female

Name and relationship of person filling out form: _____

Name and relationship of person with custody of the child: _____

Parent 1: Biological Adoptive Foster parent (circle) Other relative _____

Name: _____

Address: _____

_____

Phone #: _____

Email: _____

Parent 2: Biological Adoptive Foster parent (circle) Other relative _____

Name: _____

Address: _____

_____

Phone #: _____

Email: _____

CPS Worker: _____ What office? (city): _____

E-Mail Address: _____ Phone #/ext.:_____

School child attends: _____

Grade in School: _____ Is child on an IEP? Yes No

If Yes, what kind of services? Physical Therapy Occupational Therapy Speech

Reason for Admission: _____

_____

_____

_____

_____

_____

_____

_____

CHILD'S HEALTH AND DEVELOPMENTAL HISTORY

Child Medical Information:

Primary Physician: _____

Clinic: _____

Address:(City/State) _____

Phone #: _____

Was alcohol, drugs or tobacco used during pregnancy? Yes No Explain _____

Was your child born prematurely? Yes No Explain _____

At what age was bowel training complete? _____

At what age was urinary training complete? _____

Was there any difficulty in training? Yes No Explain _____

Are there past or present problems in bowl or urinary control? Yes No Explain _____

Has your child experienced a serious illness or injury? Yes No Explain _____

Has your child had any hospitalizations? Yes No Explain _____

Does your child have any physical disabilities? Yes No Explain _____

Has your child had:

Head injuries? Yes No Explain _____

Seizures? Yes No Explain _____

Abnormal motor movements or twitches? Yes No Explain _____

Is your child currently taking any medication? Yes No

Name of ordering physician/clinic: _____

Date of last Exam? _____

Name of medication(s) / what is it prescribed for?

_____/_____

_____/_____

Has your child taken medication in the past? Yes No

Name of medication? / what was it prescribed for?

_____/_____

_____/_____

Is your child allergic to any medication? Yes No

What medication?_____

Type of reaction?_____

Is your child allergic to any food items? Yes No

What?_____

Type of reaction?_____

Is your child Lactose intolerant? Yes No Explain _____

_____

Has your child:

Lost more than 10 pounds in the past 6 months Yes No

Gained more than 10 pounds in the past 6 months Yes No

Does your child wear glasses? Yes No

Full time wear? _____

Date of last exam: _____

Ophthalmologist/Optometrist: _____

Address(City/State):_____

Has your child been to a dentist? Yes No

Received orthodontic care? Yes No

Date of last exam:_____

Dentist:_____

Address (City/State):_____

Self-Help Skills:

Make simple sandwich	Yes	No	
Use microwave oven	Yes	No	
Pour drinks	Yes	No	
Showering/bathing independently	Yes	No	
Wash hair independently	Yes	No	
Brush hair independently	Yes	No	
Brush teeth	Yes	No	
General cleanliness	Good	Average	Poor
Describe attitude toward personal cleanliness	_____		
Dress independently	Yes	No	
Tie shoes	Yes	No	
Attitude / concerns about the way they dress?	_____		
Chores child is responsible for.	_____		
	_____		
	_____		
	_____		

FAMILY

List biological parents, brothers and sisters and others in immediate family.

NAME First Name, Last Name	Sex	Age	Currently living in the home? y/n	Specify: Full, Half
Parent 1:				
Parent 2:				
Siblings:				

Parental Marital History: (circle) Married Single Widowed Divorce/Separation

Were parents married when child was born? Yes No

Has anyone in the child's biological family had problems such as:

Relationship to child:		Relationship to child:	
_____	alcoholism	_____	illegal behaviors
_____	anxiety	_____	learning difficulties
_____	attention difficulties	_____	obesity
_____	autism/Asperger's	_____	seizures
_____	depression	_____	short stature
_____	diabetes	_____	tics
_____	drug abuse	_____	thyroid problems

Please explain any interruptions in caregiving. Identify and explain times the child did not live with the primary caregiver (foster placements, relative placements, hospitalizations, other placements away from home)._____

_____

_____

Has the child experienced trauma? (Times when the child may have feared for his/her life or that of someone close to them.) _____

_____

_____

Has the child experienced physical abuse, sexual abuse, emotional abuse, or neglect? Yes No

Explain:_____

_____

_____

Has the child witnessed domestic violence? Yes No Explain: _____

_____

Has the child experienced factors which make them vulnerable to being taken advantage of? _____

_____

List child current family composition and living arrangement. (Include relatives and non-relatives living in the home.)

First Name, Last Name	Sex	Age	Currently living in the home? y/n	Specify: Full, Adoptive, Step, Foster

Current Family/Peer Relationships/Dynamics:

Describe the child's relationship with parents: poor fair neutral good excellent

Describe the child's relationship with siblings: poor fair neutral good excellent

Describe the child's relationships with peers: poor fair neutral good excellent

What does the family do for leisure time and fun? _____

_____

What discipline is used? Describe how each parent disciplines. _____

_____

How is affection shown? Describe how each parent shows affection. _____

_____

	Biological Parents	Current Care Provider
Legal History		
Employment or income source		
Substance Use		
Substance abuse/addiction		
Physical health/mental health problems?		

Religion/Cultural involvement/Spiritual influences/Linguistics:

Denominational preference: Catholic Lutheran Christian Other _____

Has the child been involved in religious activities? Yes No
If yes describe: _____

What is child's cultural heritage and to what extent has the child been involved in cultural activities?

_____

What gender specific needs does the child have?_____

_____

Any issues that may be triggered by male or female staff? _____

_____

What languages has the child been exposed to? What languages does the child speak? Primary language used by the child? Family? _____

_____

Grief Issues:

Any significant deaths? (people/pets) Yes No Who? _____

_____

_____

What losses has the child experienced – due to separation? Absences? Moves? _____

_____

_____

Describe the child's understanding of death, afterlife, or fascination with death. _____

_____

_____

Legal Status:

How does custody affect the child and treatment? _____

_____

Has the child had any legal difficulties? If yes, please explain. _____

_____

What is the relationship between the presenting conditions and legal involvement of the child or parent? (Is the placement voluntary or ordered?) _____

_____

How will the child's legal status affect treatment?

_____

_____

TREATMENT HISTORY			
Dates	**Name of Person/Facility and Address**	**Location Town/State**	**Type of Placement** **Inpatient / outpatient/ homebased**

Community Resources Utilized: (circle all that apply)

TANF YMCA Boys and Girls Club Mentors Church Daycare Other _____

TREATMENT PLANNING INFORMATION

PARENT:

*What is the most significant behavior that is preventing the child from being able to be successful at home/school? _____

_____

*What can staff do to help your child control his/her behavior before he/she hurts self or others? _____

_____

_____

*List reasons (if any) why your child should not be physically managed or secluded from other children.

_____

_____

*What can staff do to help calm your child before he/she becomes verbally or physically aggressive? _____

_____

_____

*What are the parent's/person referring's expectations for treatment? _____

_____

_____

CHILD:

When you are mad, sad, or afraid, how can staff help you feel better? _____

_____

_____

What are the child's expectations for treatment? _____

_____

SCREENING TOOL

Check if the following current problems are greater when comparing to children of the same age and sex.

____ Anxious, worried, or nervous

____ Fearful of school

____ Fearful of the dark

____ Fearful of strangers

____ Fearful of animals

____ Fearful of leaving parents

____ Fearful about something happening to self

____ Other fears _____

____ Extremely shy

____ Perfectionist

____ Replays traumatic events

____ Hoarding items

____ Sexual touching of self

____ Sexual touching of others

____ Past physical or sexual abuse

____ Sexual play or talk

____ Nightmares

____ Difficulty playing with others

____ Auditory hallucinations

____ Visual hallucinations

____ Attention difficulties

____ Trouble listening

____ Difficulty finishing tasks

____ Difficulty organizing tasks and activities

____ Avoids tasks that require sustained mental effort (schoolwork, homework)

____ Loses things

____ Easily distracted

____ Acts as if "driven by a motor

____ Fidgets or squirms in seat

____ Forgetful

____Compulsive behavior

AUTHORIZATION CONTACT WITH CHILD FORM

Please complete so that CHS staff know who is authorized or unauthorized to have visits/phone calls with the child. This list can be updated/changed at anytime by contacting the child's therapist.

Please circle below for each item per person(s) wishing to have contact with the child.

YES = Authorization is allowed
NO = Authorization is NOT allowed
• = Visit/Call MUST be supervised by CHS staff

Child_____ Parent/Guardian_____

Phone Number_____

Person/Relationship Phone #	On-Campus Visits	Off-Campus Visits	In-coming Calls	Out-going Calls
	YES NO •	YES NO •	YES NO •	YES NO •
	YES NO •	YES NO •	YES NO •	YES NO •
	YES NO •	YES NO •	YES NO •	YES NO •
	YES NO •	YES NO •	YES NO •	YES NO •
	YES NO •	YES NO •	YES NO •	YES NO •
	YES NO •	YES NO •	YES NO •	YES NO •

PERSONS **NOT** AUTHORIZED TO HAVE CONTACT WITH THE CHILD:

_____

_____

_____

_____

Person(s) completing this form:

_____ _____

Date_____