Sioux Falls Children's Home
Referral and Admission Process

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

Initial Referral

_____ Contact Joan Sim to make a referral and ensure child is appropriate for CHS programs.
Joan Sim, SFCH, (605) 334-6004 or joan.sim@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.

- 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.
- 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.
- Schools, Bureau of Indian Affairs, Tribal Social Services, etc. sent the completed referral packet and supporting documentation directly to State Review Team facilitators.
- Parent referrals—please contact Megan Newling with the State Review Team:

Megan.Newling@state.sd.us
Phone: 605-773-3448
Fax:605-773-7183

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

Contact the child's school district.
For further assistance please contact Joan Sim with SFCH at (605) 334-6004 or email at joan.sim@chssd.org.

ADMISSIONS PACKET INSTRUCTIONS

Residential & Evaluation/Short-Term Care Program

A. Complete Packet and return

_____ Pre-Placement Information Form
_____ PRTF referral made (see included form) / 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

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#:_____

Address:_____
Street City SD Zip Code

Home Telephone Number:_____ Parent Work Phone #: _____

Name and relationship of person filling out form: _____

Worker: _____E-Mail Address: _____

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

Name of School: _____

Grade in School: _____ Special Class? _____No _____Yes

If Yes, what kind? _____

Insurance Information **(Please provide us with insurance cards)**

_____Medicaid: State: _____Medicaid # _____

Managed Care?_____ No _____Yes Primary Care Provider: _____

Phone # _____

_____Private Insurance or Other Insurance

Insurance Co:_____Employer:_____
Address:_____
Primary Insured:_____ Does insurance cover:_____
Date of Birth:_____ _____ Medical
Social Security #:_____ _____ Dental
Group #:_____ _____ Vision
Phone #:_____ _____ Prescriptions

TREATMENT HISTORY

Dates	Name of Person/Facility and Address	Location Town/State	Type of Placement

FAMILY HISTORY

List parents, brothers and sisters and others. (Specify whether full, half, step, adoptive or foster.)

NAME First Name Last Name	Sex	Age	Resident	
Father:				__ _full _____adoptive ___step _____foster
Mother:				___full _____adoptive ___step _____foster
Siblings:				___full _____adoptive ___step _____foster
				___full _____adoptive ___step _____foster
				___full _____adoptive ___step _____foster
				___full _____adoptive ___step _____foster
				___full _____adoptive ___step _____foster
				___full _____adoptive ___step _____foster

Who provided this information? Gathered from which documentation?

_____

Parental Marital History: ____married, ____single, ____widowed, ___divorce/separation? If so, how do you think the child was affected?

_____

With who has the child lived?

_____

_____

Current family composition and living arrangement for the child (include relatives and non-relatives who live in the home)

_____

_____

Describe the child's living conditions/home environment: (House, trailer, how many bedrooms, child's sleeping arrangement, farm or city, yard, etc.?

_____

_____

Parents' legal history:

_____

_____

Parental employment or income source(s):

_____

_____

Any history of chemical use or neglect/abuse by parents:

_____

_____

Any history of chemical use or neglect/abuse by other family members:

_____

_____

_____

Health or mental problems of parents:

_____

_____

_____

Health or mental problems of other family members:

_____

_____

_____

Current Family/Peer Relationships/Dynamics:

Describe the child's relationship with parents:

_____

_____

Describe the child's relationship with siblings:

_____

_____

Describe the child's relationships with peers:

_____

_____

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:

_____

_____

CHILD'S HEALTH AND DEVELOPMENTAL HISTORY

The child's biological mother's name _____

The child's biological father's name _____

The child's biological parents were **married/not married** when the child was born.

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

_____

Was there early childhood trauma which may have affected the child? Times when the child may have feared for his/her life or that of someone close to them?

_____

_____

_____

_____

_____

_____

_____

What kind of messages has the child received from people about the kind of child they are?

_____
_____
_____
_____
_____

Medical Information:

Clinic: _____

Address: _____

Phone #: _____

Doctor: _____

Was the mother ill during pregnancy? _____No _____Yes

If yes, describe the illness and any treatment, medication or special diet the mother received:

_____

Was alcohol, drugs or tobacco used during pregnancy? _____No _____Yes

Was your child born prematurely? _____ No _____Yes – number of weeks?_____

How long did labor last?_____ _____ Birth Weight_____
How was the child born? _____ Head first ____Feet first ____Breech (buttock's first)
_____Cesarean _____ Other _____Not known

Were there any difficulties or peculiarities in the child's appearance or behavior at birth or during Infancy? _____No _____ Yes . If yes, describe:

_____
_____

Was the infant given oxygen? ____ No _____ Yes – for how long?_____
Blood transfusions? ____ No _____ Yes
Placed in an incubator? _____No _____ Yes – for how long?_____ _____
Other medical treatment? _____No _____ Yes – describe_____

_____

At what age did your child first smile?_____ Walk alone?_____
Say his/her first word?_____ Speak in sentences?_____
At what age was bowel training complete?____ _____Urinary training?_____
Was there any difficulty in training? _____No _____Yes – Describe: _____

_____
_____

Any past or present problems in bowel or urinary control? _____No _____ Yes –
Describe: _____
_____

Has your child ever experienced a serious illness or injury? _____No _____ Yes –
Describe: _____

Has your child had any other hospitalizations? _____No _____Yes – Describe:_____
_____

Does your child have any physical disabilities? _____ No _____Yes – Describe:_____
_____

Has your child had:
Head injuries: _____ _No _____Yes – Describe:_____
Seizures: _____ No _____Yes – Describe:_____
Abnormal motor movements or twitches? _____ No _____Yes – Describe:_____
_____

Has your child had:
Chicken Pox _____ No _____Yes
Ear infections _____No _____Yes
Skin problems _____ No _____Yes Explain:_____

Is your child currently taking any medication? _____No _____ Yes
What medication?_____
_____
Why is it prescribed?_____

Has your child taken medication in the past? _____No _____Yes
What medication?_____

Is your child allergic to any medication? _____ No _____Yes
What medication?_____

Type of reaction?_____

Is your child allergic to anything else? _____No _____Yes
What?_____

Type of reaction?_____

Does your child wear glasses? _____No _____Yes
Full time wear _____
Date of last exam_____
Opthalmologist/Optometrist_____
Address_____Phone_____

Has your child been to a dentist? _____No _____ Yes
Received orthodontic care? _____No _____Yes
Date of last exam:_____
Dentist:_____
Address: _____ Phone_____

Has you child had difficulties sleeping? _____No _____ Yes
Describe: _____
_____

Is your child:

Underweight	_____No	_____Yes
Overweight	_____No	_____Yes
On a special diet	_____No	_____Yes
Allergic to any food	_____No	_____Yes
Lactose intolerant	_____No	_____Yes
Having difficulty eating because of tooth or mouth problems or braces	_____No	_____Yes

If yes, explain
_____
_____

Has your child:

Lost more then 10 pounds in the past 6 months	_____No	_____Yes
Gained more than 10 pounds in the past 6 months	_____No	_____Yes

Has anyone in your biological family had problems such as:

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

Please describe:_____
_____
Have they ever received treatment for any of these conditions? _____No _____Yes

Are they currently being treated? _____No _____Yes

Please explain type of treatment and give names of any medications:
_____
_____
_____

Is the child's mother HIV positive? _____No _____Yes _____Unknown

Does the child have any history of IV drug use? _____No _____Yes _____Unknown

Has the child had sexual intercourse? _____No _____Yes _____Unknown

Child's Self-Help Skills:
What can the child do for him/her self?
_____
_____
_____

Hygiene skills? Showering/bathing, hair care, brushing teeth, general cleanliness and attitude towards cleanliness. _____
_____

Dressing – can she/he dress them self or concerns about the way they dress? Toileting issues?
_____
_____

Religion/Cultural involvement/Spiritual influences/Linguistics:

What is the child's denominational preference – what religion or church does the child attend?
_____
_____

To what extent has the child been involved in religious activities?
_____
_____

What is child's cultural heritage and how has it impacted the child's life?_____
_____
_____

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

Legal Status:

_____ _____

How does custody affect the child and treatment?

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

Community Resources Utilized: (TANF, YMCA, Boys and Girls Club, Mentors, Church, etc.)

PLANNING INFORMATION

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?

_____

*(For Child) – when you're mad, sad or afraid, how can staff help you feel better?

_____

What are the Child's and Family's Expectations and Preferences for Treatment?

_____.

_____

_____

Recommendations: (Parent/Referents' input. Recommendations are determined from the findings in this report by the treatment team and family/referent. What needs to be addressed with the child/family?)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Move to Immediate Instructions on MTP

SCREENING TOOL

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

_____	Generally worried or nervous.	_____	Any sexual touching of self.
_____	Fearful of school.	_____	Any sexual touching of others.
_____	Fearful of the dark.	_____	Nightmares.
_____	Fearful of strangers.	_____	Difficulty in playing with others.
_____	Fearful of animals.	_____	Hearing voices (auditory hallucinations).
_____	Fearful of public speaking.	_____	Seeing objects/person others do not see (visual hallucinations).
_____	Fearful of leaving home.	_____	Fails to pay attention to details.
_____	Worry about something happening to him/her.	_____	Has difficulty maintaining Attention.
_____	Afraid of being apart from you.	_____	Does not listen when spoken to directly.
_____	Other fears_____	_____	Does not follow through on instructions and fails to finish tasks.
_____	Extremely shy.	_____	Has difficulty organizing tasks and activities.
_____	Worry about things before they happen.	_____	Avoids, dislikes or is reluctant to do tasks that require sustained mental effort. (such as schoolwork or homework).
_____	Perfectionist.	_____	Loses things necessary for tasks or activities.
_____	Reoccurring thoughts or images.	_____	Easily distracted.
_____	Hoarding items.	_____	Forgetful in daily activities.

_____ Checking or doing the same thing over and over.

_____ Frequently washes hands.

_____ Excessive fear or germs.

_____ Alcohol or drug abuse.

_____ Any past physical or sexual abuse

_____ Any sexual play or talk.

_____ Is often “on the go” or often acts as if “driven by motor”.

_____ Loses temper.

_____ Argues with adults.

_____ Actively defies or refuses to comply with adults’ requests or rules

_____ Gets into fights.

_____ Problems with authority figures.

_____ Lies frequently.

_____ Runs away.

_____ Truant from school.

_____ Takes things that don’t belong to him/her.

_____ Plays with matches/sets fires.

_____ Cruelty to others.

_____ Decreased energy.

_____ Cannot be cheered up.

_____ Fidgets or squirms in seat.

_____ Leaves seat frequently.

_____ Runs or climbs excessively.

_____ Has difficulty playing.

_____ Down on self/worthless/guilty

_____ Unable to have fun.

_____ Withdrawal from parents.

_____ Change in school performance

_____ Sensitive to rejection.

_____ Complains about stomach aches/headaches

_____ Wishes he/she was not here

_____ ”I wish I was dead.” “You/d be better off without me, if I was gone

_____ Any self-destructive acts such as cutting of wrists.

_____ Overdose.

_____ Physically aggressive.

_____Destructive to property or objects.

_____ Cruelty to animals.

_____ Loss of interest in activities

_____ Significant weight loss/gain

_____ Sleeping too little/too much

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_____