www.intermountainresidential.org
Jill Richards, BA, Admissions
Direct: 406-457-4778 or jillr@intermountain.org
Fax: 406-442-7949 (Attn: Jill Richards)

RESIDENTIAL APPLICATION

***Child's Full name*:** **Date:_____**

_____
Last *First* *Middle* *Social Security #*

_____
Date of Birth *Sex* *Race*

_____
Height *Weight* *Religious Preference*

_____
Eye Color *Hair Color* *Identifying Characteristics/scars*

_____
Tribal Affiliation *Tribal Enrollment Number*

Referral Source:

_____
Name

_____
Address

_____

_____
Phone

Child's current location or placement:

_____
Name *Contact Person*

_____
Address

_____

_____
Phone

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Referring Information

1. Briefly describe your child's presenting problems:

2. Briefly describe the child's relevant family/social history:

3. Briefly describe the child's strengths:

4. a. Parent(s) goal(s) in treatment:

   b. Child's goal(s) in treatment:

5. Diagnosis:

   Who made the above diagnosis and when was it established:

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6. Discharge Plan:

_____
_____
_____
_____
_____

<u>Custody Status</u>:

Who has custody of this child?

____ Y	____ N	Mother
____ Y	____ N	Father
____ Y	____ N	Guardian
____ Y	____ N	Adoptive Mother
____ Y	____ N	Adoptive Father
____ Y	____ N	DPHHS or other social service agency
		____*Y* ____ *N* *If yes, is it Permanent*
		____*Y* ____ *N* *Temporary*

Name of agency:_____

Have birth parental rights been terminated?

Mother	____ Y	____ N	____ Unknown
Father	____ Y	____ N	____ Unknown

Will family members participate in therapy? ____ Y ____ N

Can this child return Home? *Permanently*: ____ Y ____ N
For visits only: ____ Y ____ N
Not at all: ____ Y ____ N
Unknown: ____

Does the child have a Guardian ad Litem or CASA advocate? ____ Y ____ N

If yes, provide contact information:

_____
Name

_____
Address

_____
Phone

Parent(s):

Birth Mother: _____
Name *Phone #*
Address: _____

Birth Father: _____
Name *Phone #*
Address: _____

Step Parent(s): _____
Name *Phone #*
Address: _____

Step Parent(s): _____
Name *Phone #*
Address: _____

Adoptive Parent(s): _____
Name *Phone #*
Address: _____

Adoptive Parent(s): _____
Name *Phone #*
Address: _____

Legal Guardian: _____
Name *Phone #*
Address: _____

Sibling(s):

Name:	*DOB:*	*Residence:*

Other Individuals significant to this child:

Name:	*Relationship:*	*Address:*	*Phone:*

Education

Current grade: _____
Current School: _____
Resident School District: _____
District of current enrollment (if different): _____
Is this child a Special Ed student? _____
If yes, Label? _____
Does this child have a Surrogate Parent? ____ Y ____ N
If yes, provide name, address and phone number: _____
_____

Juvenile Justice History

Does this child have history of involvement with the juvenile justice system?
____ Y ____ N ____ Unknown
If yes, please describe:_____
_____
_____

Abuse/Neglect History:

Does child have a history with Child Protective Services or Social Services? ____ Y _____ N
If yes, how long? _____
Does this child have a history of abuse/neglect? ____ Y ____ N ____ Unknown
If yes, to either or both questions, describe: _____
_____
_____
_____
_____
_____
_____
_____

Placement History

Has the child been placed away from home before? ____ Y ____ N

This section is designed to reflect disruptions or changes in the child's living situation. Include all agency out of home placements, independent placements, adoptive placements and breakdowns. If the information is available in the social history, make that notation. You do not have to complete this section if the information is available on another document. Make the notation that the document is attached. End with most current:

Name of Provider/Relative/Other	***Dates*** *From:*	*To:*	*Reason for Termination:*

Health and Medications:

What are the child's current medications?

Medication:	*Dosage:*	*Start date:*	*Symptoms treated with this med:*

Name of prescribing physician(s):	*Phone numbers:*

Financial Information

Person, Agency, County or Insurance company of financial responsibility (please list all that apply):

_____

_____

_____

_____

Does child receive SSI? ____ Y ____ N ____ Unknown

If yes, amount _____

Payee _____
Name

_____
Address

Additional Information

Please provide any other additional information you feel is pertinent.

_____

_____

_____

_____

_____

_____ _____
Signature of Parent/Guardian Completing the Form *Date*

ALL INFORMATION IS CONFIDENTIAL

SIGNIFICANT EMOTIONAL/BEHAVIORAL INDICATORS

Child's Name: _____ Date of Birth: _____

____ Holdings:

____ Behaviors endangering/injuring self:

____ Behaviors endangering/injuring others:

____ Suicidal ideation/intent/attempt:

____ Homicidal ideation/intent/attempt:

____ Sexually inappropriate behaviors (e.g., exposing self, public masturbation, sexual touching):

____ Running away:

____ Fire setting/preoccupation with fire:

____ Cruelty to animals:

____ Destructive to property:

____ Stealing:

____ Lying:

____ Bladder/bowel difficulties:

____ Self-loathing, self-dislike:

____ Poor social skills, poor ability to understand social or nonverbal cues:

____ Difficulty with ADL's (hygiene, dressing, etc.):

____ Poor peer relationships (e.g., controlling, bullying, avoidance):

____ Indiscriminately affectionate or resistant to nurture:

____ Overdependence on adults (e.g., clinging, shadowing, and helplessness):

____ Withdrawn/detached/isolated:

____ Hyper vigilant:

____ Lack of anger control (e.g., tantrums, profanity, yelling):

Child's Name:_____

____ Noncompliance/Oppositionality/Manipulative:

____ Low frustration tolerance or difficulty with transitions:

____ Poor impulse control:

____ Poor attention span/lack of concentration:

____ Extreme activity level, fidgetiness, restlessness:

____ Lethargic, underactive, slow moving:

____ Eating disturbance (e.g., under eats, over eats, hoards food):

____ Sleep disturbance (e.g., nightmares, insomnia, sleep walking):

____ Somatic complaints/accident prone:

____ Self-stimulating/self-soothing behaviors (e.g., thumb sucking, rocking, touching genitals):

____ Impaired cause and effect thinking/lack of regard for consequence:

____ Lack of regard or empathy for others:

____ Anxious behaviors (picking at self, biting nails, etc.):

____ Hypersensitivity to stimulus (e.g., sound, touch, visual):

____ Obsessive/compulsive thoughts and behaviors:

____ Dissociative episodes:

____ Disturbed thinking (e.g., tangential, flight of ideas, loose associations, poor reality testing):

____ Paranoid/delusional thinking:

____ Auditory or visual hallucinations/illusions:

____ Mood disturbance (e.g., depressed, anxious, manic):

____ Affect disturbance (e.g., inappropriate, labile, flat, brittle):

____ Other/comments:

GROWTH AND DEVELOPMENT ASSESSMENT

Name of Child: _____ Date _____

Name of Person Completing Form _____

Pregnancy and Development

Mother's health condition during pregnancy: _____

Birth weight: _____ APGAR_____

Breast-fed? ___ Yes ___ No Steady weight gain? ___ Yes ___ No Failure to Thrive ___ Yes ___ No

Any evidence of colic? _____ Yes _____ No Contented baby? _____ Yes _____ No

Age sat unsupported: _____ Crawled: _____ Stood: _____ Walked: _____

Age Talked: _____ Age Toilet trained: _____

Nutritional Assessment

Does your child have any known food allergies? _____

Is your child now on or previously been on special diet? If so, prescribed by whom and for what purpose?

_____

What is your child's usual appetite? _____

What is your child's weight history? Has he or she experienced any recent weight changes? _____

_____

Does your child have any problems with chewing or swallowing? _____

Height of biological parents (if known)? _____

Pain Screen

Pain perception is an individual response that can be affected by many factors including a history of abuse and neglect. Please help us assess your child's response to pain by answering the following questions:

What is the child's usual response to pain? _____

Any unusual perceptions noted? _____

What is your child's CURRENT level of pain with 1 being no pain and 10 being intense, unbearable pain? What is the location and source of that pain? _____

_____

Are there any other factors that we should know when assessing your child's pain level? _____

_____

SEXUAL ASSESSMENT
(if applicable)

Name of Child: _____ Date _____

Name of Person Completing Form _____

1. What type of sexual behaviors has child engaged in?

_____

_____

_____

_____

2. How often? History - when began, etc.

_____

_____

_____

3. Age of person the child engages in sexual activities with? Same age peer, adult, younger/older child.

_____

_____

4. Relationship to child - friend (close/casual), sibling, relative, stranger.

_____

_____

5. Was any trickery, bribery, emotional or physical force used?

_____

_____

6. Motivation for child's sexual behavior? Precipitating factors?

_____

_____

7. Affect when confronted?

_____

_____

8. Response when confronted?

_____

_____

PLAY AND DAILY ACTIVITIES ASSESSMENT

Name of Child: _____ Date _____

Name of Person Completing Form _____

1. Sports (interests, participation, skills):

_____

_____

2. Special Interests/Talents:

_____

_____

3. Please list daily activities engaged in by the child:

_____

_____

4. Please list the child's favorite activities:

_____

_____

Can he/she:

_____ catch a ball?
_____ swim?
_____ ride a bicycle?
_____ throw a ball?
_____ ice/roller skate?
_____ play card or board games

5. Is/Does the child:

YES NO

___ ___ As physically active as they could be.
___ ___ Feel awkward or uncoordinated in physical activities.
___ ___ Feel they have to win when they play games
___ ___ Enjoy those activities that they do well.
___ ___ Often bored in their free time.
___ ___ Like to learn new recreational activities.

Current Competencies: (yes or no)

_____ clean room
_____ shower
_____ brush teeth
_____ chores
_____ walk to school
_____ ride bus
_____ dress self
_____ toileting
_____ wash hands

Child's Health Record

Child's Name:_____ **Sex:____ Birthdate**:_____ **SS#**:_____
Last First Middle

Child's Address: _____

Emergency Contact and Phone No.: _____

Father's Name:_____ **Phone No**. _____
Last First Middle

Mother's Name:_____ **Phone No**. _____
Last First Middle

Guardian's Name:_____ **Phone No**. _____
Last First Middle

Primary Physician or MT Passport Provider: Address: Phone Number: Last Medical Exam & MD: _____ **Dentist:** Address: Phone Number: Last Dental Exam:	**ALLERGY (specify)**: ☐ Heart Condition: ☐ Congenital Defects (i.e. cleft palate, etc.): ☐ Epilepsy (date of onset): ☐ Diabetes: ☐ Surgery: ☐ Ear Infections (ear tubes and date inserted): ☐ Asthma: ☐ Chicken Pox: ☐ Injuries: ☐ Other:
Significant family health history - diabetes, TB, mental illness:	
Physical restrictions or health problems that may require special seating, bathroom privileges, etc.:	
Special diet or food restrictions:	
Current medications- Name and Dosage(s): Prescribing MD:	
Reason for medication:	

Name of person completing health form: _____ Date: _____
Referral – ChildHlthRec 5/02

SPEECH/LANGUAGE and OCCUPATIONAL THERAPY ASSESSMENT

Name of Child: _____ Date _____

Name of Person Completing Form _____

Has your child received previous Occupational Therapy or Speech Language Therapy interventions, either through an Individual Education Plan or privately?

Speech and Language
___Yes ___ No If Yes, check one or both ___IEP ___Private

Occupational Therapy
___Yes ___ No If Yes, check one or both ___IEP ___Private

Does your child exhibit any of the following speech or language delays? (check all boxes that apply)

Yes	No	
___	___	Reading comprehension or writing below an age appropriate level.
___	___	Difficulty understanding one-step or multi-step instructions, either verbally or written.
___	___	Difficulty expressing themselves, leaves out essential information, uses vague information or jumps around when telling about an experience.
___	___	Stuttering or articulation difficulty.
___	___	Struggles socially to understand and responding to other's non-verbal cues.

Does your child have any of the following motor or sensory symptoms? (check all boxes that apply)

Yes	No	
___	___	Awkward/clumsy
___	___	Poor balance
___	___	Physical activities are challenging
___	___	Difficulty using scissors
___	___	Undefined hand dominance
___	___	Poor writing legibility
___	___	Easily overstimulated by noise or tactile sensitivities
___	___	Other

At Intermountain, we must be able to meet the needs of your child's health as well as emotional needs on our campus. As a result, immunization and well child information must be provided to Intermountain as part of the admission process.

Please complete the Authorization form on the following page with the information for the provider who will provide immunization records and documentation of most recent well-child or physical exam to Intermountain. If information needs to be requested from multiple providers, please complete multiple Authorization forms.

500 S. Lamborn
Helena, MT 59602
406.442.7920
Fax 406.442.7949
www.intermountain.org

intermountain Residential
Hope + Healing for Children + Families

Authorization for Release, Disclosure and Exchange of Health Information

Name of Client: _____ **Birth date:** _____

Effective Date:_____

Date, event, or condition upon which this consent expires, not to exceed one year from when the release takes effect:_____
_____
_____

Person(s) or Entity (s) to whom information may be released, exchanged or disclosed:

Name/Agency: _____
Mailing address: _____
City/State/Zip: _____
Phone Number: _____ Fax Number: _____

Information to Release/Disclose/Exchange: (Check all that apply)

☐ Medical	☐ Education Records	☐ Therapy Notes
☐ Progress Notes	☐ Drug/Alcohol	☐ Treatment Plans
☐ Clinical Assessments	☐ Discharge Summaries	☐ Immunization Record
☐ Medication Records	☐ Insurance, Billing, Claims Information	☐ Psychological Evaluation

☐ Other (please specify) _____

I understand this authorization is not valid without the required signature. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment with Intermountain. However, there may be consequences with the intended recipient of this information. I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization, in which event the privacy law may no longer protect my information. I understand I have the right to revoke this authorization at any time in writing, except to the extent that Intermountain has already provided the information. I understand this authorization will expire at the date, event or condition listed above and no later than 12 months from the effective date unless I revoke it in writing prior to that time. To the extent that I am authorizing the disclosure of information above that specifically relates to alcohol or drug abuse, the Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by my written authorization or otherwise permitted by 42 C.F. R Part 2 of HIPAA. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose.

_____

Print Full Name Signature Date

_____

Print Full Name Signature Date

AUTHORITY TO SIGN ON BEHALF OF PATIENT:
Please check applicable box if signing on behalf of patient and provide a copy of authorizing document for items marked below with an asterisk (*).

□Parent of Minor Child □Legal Guardian* □Power of Attorney* □Other Personal Representative Designation*

An administrative fee of $15.00 for the searching and handling of recorded health care information +.25¢ per page may be charged if so applicable under the law.

REVOCATION SECTION
I hereby REVOKE the foregoing Authorization and Consent to Disclosure and Exchange of Information in its entirety.

Signature_____ Date_____

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