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

Residential Application

Date Submitted:
Submitted By:

Client Information

Name:
Gender:
Date of Birth:
Age:
SSN:
Address:
City/State/Zip:
Country:
Phone:

Ethnicity:
Height:
Weight:
School Grade:
Religious Pref:
Identifying Characteristics/Scars:
Tribal Affiliation:
Tribal Enrollment Number:
Eye Color/Hair Color:

Parent/Guardian Information

Parent/Guardian:
Relationship:
Name:
Address:
Home Phone:
Mobile Phone:
Email:

Preferred Contact Method:
DOB:
SSN:
Job Title:
Employer:
Work Phone:
Work Email:

Parent/Guardian:
Relationship:
Name:
Address:
Home Phone:
Mobile Phone:
Email:

Preferred Contact Method:
DOB:
SSN:
Job Title:
Employer:
Work Phone:
Work Email:

Referral Source Information:

How did you first hear about Intermountain?

Name(s) of the referral source

Phone:

Address:

City/State/Zip:

Email:

Current Location or Placement of Child:

Name:

Contact Person:

Address:

Phone:

Duration at current placement:

May we contact? Yes No

Referral Information:

Describe in detail the child's presenting problems:

Thoroughly describe the child's relevant family/social history:

Describe the child's strengths:

Parents(') goal(s) in treatment:

Child's goal(s) in treatment:

Diagnosis: (Include current and previous)

Who made the above diagnosis and when was it established?

Discharge Plan:

Custody Status

Who has custody of this child?

If DPHHS or other social service agency, is it permanent or temporary?

Name of agency:

Have parental rights been terminated? (if yes, include when)
Mother
Father
Will family members participate in therapy?

Can this child return home?

Does this child have a Guardian ad Litem and/or CASA advocate? If yes, provide contact information (Name, address, Phone Number)

Family/Contacts Section

Parents:

Name:	Relationship:	Address:	Phone:

Siblings:

Name:	Relationship:	Residence:	DOB/Age:

Other Significant Individuals:

Name:	Relationship:	Address:	Phone:

Education

Current Grade:
Current School:
District of current enrollment (if different):

Is this child a Special Ed student?   If yes, please explain:

Is this child on an IEP?   If yes, Label:

If on an IEP, what is the date of the IEP?

Describe educational history:

Describe behaviors in school:

Does this child receive Occupational therapy? If yes, through IEP or private?

Does this child receive Speech and Language therapy? If yes, through IEP or private?

Juvenile Justice History

Does this child have history of involvement with the juvenile justice system? If yes, please describe:

Abuse/Neglect History

Does this child have a history with Child Protective Services or Social Services? If yes, how long?

Does this child have a history of abuse/neglect? If yes, please explain:

Placement History

Has the child been placed away from home before?
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 placement/provider /relative/other	Dates From/To	Reason for Termination

Health and Medications

Allergies: (Please include allergies to food, medications, other)

Reaction:

Current Medications: (include dose, frequency, start date, etc)

Contact information for prescribing physician:

Name:

Address:

City/State/Zip:

Phone:

Primary Physician or MT Passport Provider:

Address:

Phone Number:

Last Medical Exam & MD:

Dentist:

Address:

Phone Number:

Last Dental Exam:

Health Information

Please check if any of the following and explain below:

- 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:

Financial Information

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

Does child receive SSI? If yes, amount:

Payee Name:
Payee Address:

Additional Information

Please provide any other additional information you feel is pertinent:

Significant Emotional/Behavioral Indicators

Please select any significant emotional/behavioral indicators and **describe**:

Holdings:
____B

Behaviors endangering/injuring self:
____

Behaviors endangering/injuring others:
____

Suicidal ideation/intent/attempt:

Homicidal ideation/intent/attempt:

Sexually inappropriate behaviors (eg., 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 ADLs (hygiene, dressing, etc.):

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

Indiscriminately affectionate or resistant in nature:

Over-dependence on adults (e.g., clinging, shadowing, and helplessness):

Withdrawn/detached/isolated:

Hyper vigilant:

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

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, sleepwalking):

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, please explain:

Sexual Assessment (If Applicable)

What type of sexual behaviors has your child engaged in?

How often? History (where began, etc.):

Age of person the child engages in sexual activities with:

Relationship to child:

Was any trickery, bribery, emotional or physical force used? If yes, please explain:

Motivation for child's sexual behavior (list any precipitating factors):

Affect when confronted:

Response when confronted:

In addition to the completed application, please include documentation in the following areas in order to be considered for acceptance.

- Medical - include Immunization Records, last well child exam, and any significant medical history
- Educational - include IEP/504 plan, any educational records, behavior documentation, testing, etc
- Clinical - include clinical assessments, neuropsychological/psychological testing, treatment plans, discharge reports, etc

_________________________________ Legal Guardian/Parent Signature

__________________ Date

3240 Dredge Dr.
Helena, MT 59602
406.442.7920
Fax 406.442.7949
www.intermountain.org

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Caring Solutions ■ Strong Families ■ Healthy Communities

Authorization for Release, Disclosure and Exchange of Health Information

I, ______________________________, hereby authorize the disclosure of information from my health record.
(Name of Patient)

My date of birth is: __________________

☐ I authorize Intermountain to obtain information **FROM** the following Agency or individual.
☐ I authorize Intermountain to send information **TO** the following Agency or individual.

Name of Person/Organization/Facility:				
Address:			Email Address:	
City:	State:	Zip Code:	Phone:	Fax:

The purpose or need for this disclosure is:

☐ At the request of the authorized individual or entity.
Other: ____
(PLEASE SPECIFY)

The information to be disclosed from my health record:

☐ All Records ☐ Discharge Summaries ☐ Education Records
☐ Progress Notes ☐ Drug/Alcohol Treatment Records ☐ Immunization Records
☐ Clinical Assessments ☐ Treatment Plans ☐ Psychological Evaluation
☐ Medication Records ☐ Insurance, Billing, and Claims Records ☐ Psychiatric Records
☐ Psychotherapy Notes ONLY (may not be combined with any other authorization or release)

- OR -

Other: ____
(PLEASE SPECIFY)

By signing this Authorization, I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at Intermountain.
- The recipient of this information could re-disclose the information, except for alcohol and drug abuse information defined by 42 CFR Part 2, to others without my knowledge or authorization, in which event the privacy law may no longer protect my information.
- I have the right to revoke this authorization at any time in writing, except to the extent that Intermountain has already provided the information.
- Records disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), genetic information, and treatment for alcohol and drug abuse.
- This authorization will expire 12 months from the date below unless I revoke it in writing prior to that time.

Print Full Name Clients 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*

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: I hereby revoke this authorization to release information I provided to Intermountain that allowed Intermountain to use and disclose my Protected Health Information as I outlined on the release of information. I understand that this revocation does not apply to any action Intermountain has taken in reliance on the authorization I signed. This revocation does not revoke any and all previous authorizations to release information that I have provided to Intermountain.

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November 2018

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