INNERCEPT, LLC
PROGRAM APPLICATION

When completing this application, please attach additional sheets if the space provided is not adequate fo your responses. Please indicate when more than one person provides responses. If you have any questions when filling this out, contact our office for clarification. **This information must be accurate as this application is also used for screening potential Innercept residents.**

Today's Date:	Child's Legal Name: (First, Middle, Last)		Gender	Past Legal Name(s):	Nickname:
Birthdate:	Age	Race/Ethnicity (optional):	Social Security Number:		
Address:			City/State:		Zip:
Home Phone:		Birthplace: (City & State)	Religious Preference (optional):		
Adopted? Y/ N	If yes, age of adoption:		Citizenship:		
Eye/Hair Color:		Height:	Weight:		
Identifying Marks:					
Last Grade Completed:					

Has the applicant ever received specialized education services? ☐ Yes ☐ No
If yes, is an IEP or 504 Plan currently in place? ☐ Yes ☐ No
If so, please forward copies of this information with this application.

Who is raising the child?

(1) _____ _____ _____ _____
Name DOB Occupation Relationship to Student

(2) _____ _____ _____ _____
Name DOB Occupation Relationship to Student

Who has legal custody? **Please provide a copy of documentation if appropriate.**	Who referred you to our program? Phone # of referral source?

What caused you to seek evaluation/treatment at this time?

How long has your child been dealing with these issues?

Has anything happened recently to worsen your child's difficulties?

PARENT / GUARDIAN INFORMATION	
Mother's full legal name: (first, middle, last)	
Maiden Name:	
Custody Status:	Marital Status:
If divorced, please attach copy of custody paperwork.	
Social Security Number:	Address same as above: ☐ Yes ☐ No
If your address is not the same as the student, please continue below:	
Work Phone: Fax: Cell:	
Email Address:	
Business Address:	

Father's full legal name: (first, middle, last)	
Custody Status:	Marital Status:
If divorced, please attach copy of custody paperwork.	
Social Security Number:	Address same as above: ☐ Yes ☐ No
If your address is not the same as the resident, please continue below:	
Work Phone: Fax: Cell:	
Email Address:	
Business Address:	

Please list all siblings, ages and addresses if different from applicants.

Name	DOB	Address	Same

Attach additional pages if necessary.

Other Guardian's full legal name: (first, middle, last)		Social Security Number:	
Custody Status:		Marital Status:	
If divorced, please attach copy of custody paperwork.			
Address same as above: ☐ Yes ☐ N	Religious Pref:(optional)		
If your address is not the same as the student, please continue below:			
Address:		City/ State:	Zip:
Work Phone: ( )	Fax: ( )	Cell: ( )	
Any other contact phone:			
Business Address:		City/ State:	Zip:

Please attach additional sheet for step-parents or other persons holding guardianship for this applicant. In the event of the death of a biological or adopted parent, note below:

_____

_____

ADDITIONAL CONTACT INFORMATION, in case of emergency:			
Name of Contact: (first, middle, last)		Relationship:	
Address:	City/ State:		Zip:
Work Phone: ( )	Fax: ( )	Cell: ( )	
Any other contact phone:			
Business Address:		City/ State:	Zip:

Is there another person or entity besides parent/guardian providing financial sponsorship for this applicant? ☐ Yes ☐ No If so, who?

If yes, please indicate the following:

Name of Contact: (first, middle, last)		Relationship:	
Address:	City/ State:		Zip:
Work Phone: ( )	Fax: ( )	Cell: ( )	
Any other contact phone:			
Business Address:		City/ State:	Zip:

OUT OF HOME PLACEMENT(S)		**N/A**
Name and Location:		
Contact name:		Phone:
Dates of placement:	From:	To:
Reason for placement and transfer:		

_____

_____

_____

_____

_____

Name and Location:		
Contact name:		Phone:
Dates of placement:	From:	To:
Reason for placement and transfer:		

Name and Location:		
Contact name:		Phone:
Dates of placement:	From:	To:
Reason for placement and transfer:		

PREVIOUS TREATMENT PROVIDERS (therapists, psychiatrists, medical providers, etc.)		
Name and Location:		
Contact name:		Phone:
Dates of treatment:	From:	To:
Reason for treatment and benefits seen:		

Name and Location:		
Contact name:		Phone:
Dates of treatment:	From:	To:
Reason for treatment and benefits seen:		

Name and Location:		
Contact name:		Phone:
Dates of treatment:	From:	To:
Reason for treatment and benefits seen:		

ACADEMIC HISTORY	
Last school attended:	City/ State:
Grade level at time of application:	Est. GPA:
Contact name:	Phone:
Dates of Attendance:	
Reason for removal:	

Other schools attended:	City/ State:
Dates of Attendance:	
Reason for removal:	

Other schools attended:	City/ State:
Dates of Attendance:	
Reason for removal: _____ _____	

Brief summary of the events leading up to seeking this placement:
Is there a time line provided?: ☐ Yes ☐ No

_____
_____
_____
_____

What are your goals for this placement?

_____
_____
_____
_____

MENTAL HEALTH / BEHAVIOR HISTORY

Does your childs's history (past or present) include the following? Please explain.	
Yes / No	Suicidality
Yes / No	Past Suicide Attempts
Yes / No	Running Away
Yes / No	Substance Use / Abuse
Yes / No	Fire setting in inappropriate locations or situations / Destruction of one's own or other's property
Yes / No	Urinates or has bowel movements in inappropriate places
Yes / No	Attention/ Concentration/ Memory problems/ Forgetfulness

Yes / No	Regularly lies or steals from others
Yes / No	Regularly refuses to follow directions or comply with rules
Yes / No	Excessive physical complaints (headache, stomachache, etc.)
Yes / No	Very argumentative, negative, irritable
Yes / No	Repetitive thoughts or behaviors that interfere with daily life (e.g., excessive counting, checking behaviors, hand washing).
Yes / No	Difficulty separating from parent/caregiver
Yes / No	Perfectionism
Yes / No	Nervousness/ worries too much
Yes / No	Depression/ hopelessness
Yes / No	Anxiety
Yes / No	Mood Swings
Yes / No	Mania
Yes / No	Too much energy/ seems driven by a motor or fidgets constantly / can't stay seated
Yes / No	Speaks or acts without stopping to think of possible consequences
Yes / No	Appetite problems (e.g., eats too much, won't eat at all, eating disorder)
Yes / No	Sleep problems (e.g., sleeps too much, can't sleep but is tired, doesn't seem to need sleep)
Yes / No	Hearing or seeing things/ people that others cannot
Yes / No	Disorganized speech/ behavior/ odd beliefs

LEARNING DISABILITIES:

Yes / No	Repeating or skipping a grade
Yes / No	Educational evaluation/ testing (e.g., learning problems or lack of academic progress)
Yes / No	IEP/ Special Education/ Resource Room
Yes / No	Suspensions/ expulsions
Yes / No	Dysgraphia
Yes / No	Comprehension
Yes / No	Processing
Yes / No	Written Language
How does your child get along with teachers and other school staff?	
How is your child's current academic progress? Is this different from earlier progress?	

*Attach additional sheets if necessary

PSYCHIATRIC HISTORY

Has your child/young adult had previous testing?

Psychiatric Evaluation: ☐ Yes ☐ No
Where_____ When_____

Psychological Testing: ☐ Yes ☐ No
Where_____ When_____

Neurological Evaluation: ☐ Yes ☐ No
Where_____ When_____

If yes, please forward copies of report(s) to our office.

Past and Current Psychiatric Medications:				
Dates	Names of Medication	Dosage	Results/Side Effects	Name of M.D
Does your child have any Medication allergies? If so, please name and describe reaction.				

Does your child have a history of any of the following?	
Yes / No	Therapy or Counseling (Outpatient):
Yes / No	Psychiatric Hospitalization
Yes / No	Day School in psychiatric/ hospital setting
Yes / No	Residential Treatment (lived at facility):

MEDICAL HISTORY:

Who is your child's primary care physician:
Name:_____ Phone number:_____
City/ State:_____

When was your child's last physical examination: _____

Were there any concerns or recommendations: _____

Does your child have a history of any of the following? If yes, please explain.	
Yes / No	Hearing/ vision problems
Yes / No	Head Injury/ loss of consciousness/ concussion
Yes / No	Seizures

Yes / No	Tics (sudden muscle twitches or vocal expressions such as grunts that child seems unable to control)
Yes / No	Chronic ear infections
Yes / No	Chronic medical issues such as: Diabetes, thyroid problems, asthma, allergies, arthritis, heart, blood pressure, etc.

DEVELOPMENTAL HISTORY:

Was your child: Premature ☐ Yes ☐ No Overdue ☐ Yes ☐ No If so, how many weeks_____ Birth weight_____ What was the birth mother's age at time of child's birth:

DURING PREGNANCY/ DELIVERY, did any of these happen? If yes, please explain.

Yes / No	Birth mother took street drugs or used alcohol regularly
Yes / No	Birth mother became ill, took prescription medication, or was injured
Yes / No	Delivery was induced or baby delivered through cesarean section
Yes / No	Baby had trouble breathing/ turned blue/ needed oxygen or became ill or received medication
Yes / No	Baby was injured or was born with a birth defect or became ill or received medication

<u>Was your child</u> either early or late for any major developmental milestones? (sitting up, crawling, standing, walking, language, toilet training). If yes, please explain.
Did your child have any problems with sleeping or eating as an infant?

SOCIAL HISTORY:

Does child have regular contact with biologic parents? Please explain
What is the primary type of discipline in your home?
Describe your child's current relationships with family members:
Please describe your child's current social behavior with peers: With adults (including figures of authority):
Is your child able to make and keep friends over time?
How many friends does she/ he have? Any "best friends"?
Does your child have any history of physical neglect, physical or sexual abuse, or abandonment? Please elaborate.
Has your child ever experienced a life-threatening trauma other than abuse? (e.g., witnesses domestic violence, was in an automobile accident, experienced a natural disaster?) If yes, please explain.

If child has experienced past trauma does he/ she continue to have trauma-related nightmares, intrusive thoughts, "flashbacks", or other significant symptoms?	
Has your child experienced significant loss (e.g., death of or separation from family, friend, pet).	
Has your child ever engaged in inappropriate sexual behavior? If so, please explain.	
Is your child sexually active?	
On Birth Control?	
Pregnancy/Paternity?	
STD's?	
Yes / No	Is your child using alcohol or street drugs (which drugs, how much, for how long)
Yes / No	Has your child received chemical dependency treatment?
Yes / No	Does your child have a legal history? Please elaborate:

STRENGTHS AND ABILITIES

What are your child's strengths or talents?

MISCELLANEOUS

Are there any other areas of concern that were not covered by this form?

PSYCHIATRIC AND MEDICAL HISTORY OF CHILD'S BIOLOGIC FATHER:

Does child's Biologic Father have any history of the following? If yes, Please explain.	
Yes / No	Psychiatric illness (e.g., depression, anxiety, bipolar disorder, attention - deficit disorder, Tourette's, Schizophrenia, etc.)
Yes / No	Learning disabilities
Yes / No	Substance abuse
Yes / No	Legal problems
Yes / No	Medical problems (e.g., diabetes, asthma, heart problems, cancer, etc.)
Does the immediate or extended family of child's biologic father have any history of the items described above? Please explain, including the relationship of family member to child.	

PSYCHIATRIC AND MEDICAL HISTORY OF CHILD'S BIOLOGIC MOTHER:

Does child's Biologic Mother have any history of the following? If yes, Please explain.	
Yes / No	Psychiatric illness (e.g., depression, anxiety, bipolar disorder, attention - deficit disorder, Tourette's, Schizophrenia, etc.)
Yes / No	Learning disabilities
Yes / No	Substance abuse
Yes / No	Legal problems
Yes / No	Medical problems (e.g., diabetes, asthma, heart problems, cancer, etc.)
Does the immediate or extended family of child's biologic mother have any history of the items described above? Please explain, including the relationship of family member to child.	

Goals:

Please attach a copy of insurances

PRIMARY MEDICAL COVERAGE	
Company Name:	Company Address:
Subscriber Name:	Subscriber Address:
Social Security Number:	Group Number:
Phone Number(s):	Phone Number(s)):

Copy of Card Attached? ☐ Yes ☐ No

SECONDARY MEDICAL COVERAGE	
Company Name:	Company Address:
Subscriber Name:	Subscriber Address:
Social Security Number:	Group Number:
Phone Number(s):	Phone Number(s)):

Copy of Card Attached? ☐ Yes ☐ No

DENTAL COVERAGE (IF THERE IS COVERAGE)	
Company Name:	Company Address:
Subscriber Name:	Subscriber Address:
Social Security Number:	Group Number:
Phone Number(s):	Phone Number(s)):

Copy of Card Attached? ☐ Yes ☐ No

VISION COVERAGE (IF THERE IS COVERAGE)	
Company Name:	Company Address:
Subscriber Name:	Subscriber Address:
Social Security Number:	Group Number:

Phone Number(s):	Phone Number(s)):

Application Completed by:

_____ _____

Name Date

_____ _____

Name Date