



Dear Caseworker,

We are glad that you have chosen the CHRIS Kids Independent Living Program for the young adult in your care. Our mission is to help our residents learn the basic skills required for a successful transition to independence. Specifically, we assist them with time management, budgeting and money management, job readiness, interviewing and resume-writing, completing high school or the GED, enrolling in college, applying for financial aid, community living, food preparation, and daily hygiene.

Our program staff, including the Resident Advisors, the Case Manager, the Operations Manager, and the Program Director each has a role in facilitating a successful transition to independence. As the guardian of the resident, you have a role as well. We not only *welcome* your participation in the service planning process but *expect* that you will collaborate with us on an ongoing basis as well as on a monthly basis by participating in monthly service planning meetings with our team. If you are unable to participate in person, we would like for you to participate by phone. Then, we will send you the updated service plan for your signature. Your commitment to this evaluation process is critical in order to ensure that the young adult is identifying and progressing toward appropriate goals that will lead to a smooth transition to independence. We value and need your experience, your information, and your commitment in this process.

We recommend that you make contact with your resident on a weekly basis. We can facilitate a phone call to make sure this occurs. We would also like for you to give us permission to approve passes for your resident when appropriate. We encourage the residents to develop relationships in the community. Of course, you will need to let us know if there are recommendations regarding these contacts and passes.

We would like to develop and maintain a healthy, open collaboration with you throughout the youth's stay with us. In that endeavor, we welcome your input, feedback, and questions regarding our program. Please feel free to reach us by phone or by e-mail if you have concerns, questions, or information you would like to share. You can reach our Case Manager, James Kizer, at 404-717-6813 or at james.kizer@chriskids.org. You can reach me at 404-564-3409 or at greg.sterchi@chriskids.org. We conduct our monthly service plan meetings the last week of every month. Mr. Kizer will contact you with the specific date and time of the meeting.

You will receive some information that will help you learn about our program and your part in creating success for our residents. If you have any questions or need more information, please don't hesitate to contact us. Thank you in advance for your partnership with the CHRIS Kids Independent Living Program.

Sincerely,

Greg Sterchi, LPC
Program Director



Application for Admission for CHRIS Kids Transitional Living Services (Pre-Placement Referral Form)

Please note, our application has changed to meet the needs of Medicaid and state funding sources. Please complete the application as thoroughly as possible.

***These Items are required.**

Please complete and fax, along with the following items, to: 404.564.4719

- Current Psychological/ Psychosexual evaluation (*Testing scores no greater than 2 years old*)
- Social History or FPBP Assessment
- Incident reports, police and/or court reports for last 90 days, if applicable

*Full Name (include middle initial):		Application Date:	
Medicaid #		*SS #:	
DOB:		Age:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address Line 1			
Address Line 2			
*City	*County	*State	*Zip Code
*Payor/Funding (select all that apply)			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Peachcare <input type="checkbox"/> Champus <input type="checkbox"/> DJJ <input type="checkbox"/> DJJ/DFCS			
<input type="checkbox"/> DFCS <input type="checkbox"/> State Contracted Svcs. <input type="checkbox"/> Medicaid Waiver <input type="checkbox"/> Self Pay (parents) <input type="checkbox"/> Private Insurance			
<input type="checkbox"/> DBHDD <input type="checkbox"/> MAAC <input type="checkbox"/> Other (please explain):			
Group or ID # _____		Type of Coverage:	
Expiration date:			
*Ethnicity <input type="checkbox"/> American Indian <input type="checkbox"/> White/Caucasian : <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Other single race:			
Religion: <input type="checkbox"/> Protestant/Catholic <input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Other			
*Number of Individuals in Household (if in parental/family custody):			
*English Proficiency: <input type="checkbox"/> Proficient <input type="checkbox"/> Limited-Spanish Primary Language <input type="checkbox"/> Limited-Primary Language Other			
*Referral Source (Check all that apply.)			
<input type="checkbox"/> Self <input type="checkbox"/> DFCS <input type="checkbox"/> MAAC <input type="checkbox"/> Other <input type="checkbox"/> Family <input type="checkbox"/> State Hospital <input type="checkbox"/> Juvenile Justice - Region:			
*Special Population (Check all that apply.)			
<input type="checkbox"/> Vision impairment <input type="checkbox"/> HIV + <input type="checkbox"/> Pregnant <input type="checkbox"/> Hearing impairment <input type="checkbox"/> None			
Psychological Assessment Information: Date of Assessment: _____			
Full Scale IQ: _____		Name of Assessment: _____	
Achievement Scores: Math: _____		Reading: _____	

***DSM Multi-Axial Assessment**

Axis I Primary | Axis I Secondary | Axis II Primary | Axis II Secondary | Axis III Primary | Axis III Secondary

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***Service History** within past 18 months

Number of Inpatient Hospitalizations:

Number of Crisis placements:

Number of ER/Crisis Team Involvements:

***Medications** No Yes If 'Yes' please list.

***Medications** (List primary psychiatric first.)

Name	Purpose

Active medical diagnosis? No Yes If 'yes', please describe:

***ALLERGIES:**

***Living Situation**

- At home with family
- Supported Living
- Psychiatric Hospital (PRTF)
- Jail/Correctional Facility
- Foster Home
- Group Home
- Residential Program

***Employment Status**

A. Employment

Not Employed Date Employed: _____ Hrs worked during a typical week: _____
Hourly or monthly wage: Hourly Wage _____ Monthly Wage _____

B Volunteer Time during a typical week spent doing volunteer work in a community setting: _____ hours

***School**

- Regular school programming
- Enrolled in an alternative school (IEP)
- Pursuing GED
- No longer in school

Number of days absent from school in past month if enrolled: _____

Years of Education: What is the highest level of education that the youth has completed? _____

Legal Status

- a. Date youth entered Care: _____ N/A
County Case Plan Expiration Date: _____ N/A
Custody Order Expiration Date: _____ N/A
- b. Legal Custody (Check any that apply) Parental custody DFCS Custody
 Other Court-Appointed Guardian
- c. Legal Involvement (Check any that apply.)
 DFCS Juvenile Justice Probation Jail/Law Enforcement
- d. Juvenile Justice System Involvement:
Has client been involved with juvenile justice system in the past year? Yes No
(Includes arrests, probation, commitments, adjudications, diversions, or awaiting sentencing)
- e. Arrests: Number of arrests, regardless of nature of offense or outcome, in the past 30 days: _____

Addiction and Substance Abuse

Has this youth ever used/abused substances? Yes No

Type of Substance(s) Used:

- | | | | |
|--|------------------|--|------------------|
| <input type="checkbox"/> Marijuana | Frequency: _____ | <input type="checkbox"/> None | |
| <input type="checkbox"/> Alcohol | Frequency: _____ | <input type="checkbox"/> Tobacco | Frequency: _____ |
| <input type="checkbox"/> Amphetamines | Frequency: _____ | <input type="checkbox"/> Huffing | Frequency: _____ |
| <input type="checkbox"/> Crack/cocaine | Frequency: _____ | <input type="checkbox"/> prescription drug abuse | Frequency: _____ |
| <input type="checkbox"/> other (please describe) _____ | | | |

Age at First Use: _____

Is there a history of family drug/alcohol abuse? Yes No If yes, please describe: _____

Has youth ever received in-patient treatment for substance use? Yes No

If so, when and where? _____

Placement Prior to Admission:

Reason for Change of Placement:

Total Number of
Prior Placements:

Last School Attended:

Are there pending or recent charges? Yes No If yes, please describe:

***Custodial Agency/Custodian:**

County: (if DJJ, include Region)

Case Worker/Court Service Worker:

Title:

Agency:

Address:

***Phone #:**

Cell #:

***Additional means of communicating w/custodian required:**
Fax:

After Hours #:

Email:

***Supervisor's Name** (required):

Phone:

Email :

Principal Family Contact(s):

Name:

Relationship:

Address: _____
 Street _____

 City, state, zip _____

Phone contact? Yes No Who provides supervision? _____
 Face-to-face? Yes No Overnight visits permitted? Yes No
 Supervision Required? Yes No Can participate in program? Yes No

Add'l Family Contact(s): Relationship: _____
 Name: _____

Address: _____
 Street _____

 City, state, zip _____

Phone: (home) _____ (work) _____

Legal Restrictions regarding family contact? Yes No
 If yes, please describe: _____

Are other family members available to participate in the program? Yes No

If so, Name: _____ Relationship: _____
 please list: _____
 Name: _____ Relationship: _____

Are there family members or other individuals not currently involved who are potential resources for this youth? Yes No If so, please list: _____

Family of Origin Income: 0-\$9,999 \$10,000 – \$19,999 \$20,000 - 29,000 over \$30,000
 unknown

PRESENTING AND HISTORICAL ISSUES

History	Presenting		History	Presenting		History	Presenting	
		Alcohol			Fire Setting			Psych Hospitalization
		Animal Abuse			Gang/Cult			Runaway
		Enuresis/ Encopresis			Juvenile Court			Self Mutilation
		Depression			Medical/Illness			Sex Offense
		DFCS			Violence re peers			Sexual Abuse
		DJJ			Weapons			Sexual Acting Out
		Drugs			Medication			Suicidal
		Emotional Abuse			Neglect			Violence re: authority
		Family D/A			Physical Abuse			Other (explain below)

Most recent high risk incident: _____

If incident reports regarding high risk behaviors (as requested on the first page) are not available, please describe any incident involving the following behaviors within the last 90 days – physical aggression, AWOL, substance/alcohol use, school suspension or expulsion, sexual acting out, self-harm or police involvement: _____

Strengths and Skills: _____

Positive behaviors the applicant seeks to practice: (examples: emotional regulation, independence/life skills)

Please document any need for special consideration of sexual, cultural, religious, national, racial or ethnic identity issues: _____

Will it be possible for this child to have a pre-placement visit? Yes No

Name: (please print) _____

Signature: _____ Date: _____

Please fax this document to the Intake Team at 404.564.4719 when completed.



CLIENT'S MEDICAL HISTORY

This form **must** be completed by the *current* placement if the youth applying for services is stepping down from a higher level of care.

Child's Name _____ Date of Birth _____

Legal Custodian/Parent(s) _____

Information Provided by _____ Relationship _____

Address: _____ Phone: _____

Immediate Family History: Any health problems in the child's parents or siblings which are concern in tracking this child's health?

- Anemia/blood disease Deafness Heart Attack under 60 Sickle Cell Anemia
- Asthma Death at young age Heart Murmur Stomach/intestine problems
- Birth Defects Diabetes HIV Stroke
- Blood pressure Epilepsy/seizures Kidney problems + TB skin test
- Substance Abuse (name of substance(s): _____)
- Other _____

Child's History:

Epilepsy? _____ If yes, Rx treatment: _____

Type and description of seizures: _____

Allergies/adverse reactions to medication, food, etc.: _____

Asthma? _____ Current problems? Yes No Describe: _____

Diabetes? _____ If yes, current treatment? _____

Sickle Cell Anemia? _____

Past hospitalizations? (medical or psychiatric): _____

Surgery: _____

History of communicable diseases (including STDs): _____

History of chronic health problems: _____

History of birth control medication? Yes No Don't know If yes, type: _____

Currently on birth control medication? Yes No

Mental disorder or emotional illness: _____

Does this child have any history of mental illness **which is life threatening, indicates severe personality disorganization or deterioration, or may affect care in a residential environment?**

Yes No If Yes, please explain: _____

Active TB in the past? Yes No IF yes, is treatment completed? Yes No Comments: _____

Has child had TB infection without active disease in the past? Yes No Comments: _____

If Yes, is treatment completed? Yes No Comments: _____

If No, and child is considered at risk, **date of most recent PPD:** _____ **Results:** _____

Does this child have any unusual or special dietary/nutritional needs which would require other than a normal diet?

Yes No If so, please explain: _____

Does this child have any problems in **physical functioning** which would interfere with living in a group care setting or normal participation in a peer group process?

Yes No If so, please explain: _____

Please indicate any problems in the following areas:

Motor Development and functioning: _____

Sensorimotor Functioning: _____

Speech, hearing or language functioning: _____

Visual Functioning: _____

Does child wear glasses or contacts: Yes No

Oral Health/Hygiene: _____

Date of most recent dental appointment: _____

Is child currently receiving Orthodontic care? Yes No

If yes, name and address of Orthodontist: _____

All Current Medications (both prescription and non-prescription): _____

If the child has been consistently followed by a particular physician and/or dentist in the recent past, please list these individuals below:

Physician: _____ Phone number: _____

Address: _____

Dentist: _____ Phone Number: _____

Address: _____

Signature of Person Completing form: _____ Date: _____

Please print name signed: _____ Relationship to child: _____

Phone number: _____

Information verified by: _____ Date: _____

Please fax this document to the Intake Team at 404.564.4719 as it is completed.



Consent for Release of Information

Person's Full Name

Date of Birth

Social Security Number

The following agencies, organizations and stakeholders have my permission to exchange/give/receive/ share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating and/or providing services for the above named person. Please identify by checkmark all that apply.

- Adults serving in Foster Care or other caretaking roles
- Department of Family and Children/Youth Services
- Department of Juvenile Justice
- Juvenile Courts
- Fulton Family Resource
- MAAC
- Mental Health (Public/Private)
- Public/Private Hospitals
- CHRIS Counseling Center**
- Relatives of the Youth (please specify)

_____ _____

**Please select if you wish your child to receive clinical services through CHRIS Counseling Center.

I authorize exchanging/giving/receiving/sharing/re-disclosing of the following information if needed by the receiving organization to secure, coordinate or provide services to the individual. *Check yes or no and initial.*

Check one Initial
 Yes No _____
 Yes No _____
 Yes No _____

- Identifying information: name, birth date, sex, ethnicity, address, and telephone #.
 Social Security Number
 Case Information:
- The above identifying information
 - Treatment/service history
 - Individualized Education Plans (IEPs)
 - Individualized Service Plans (ISPs)
 - Medical (except for HIV, AIDS, and drug and alcohol treatment records)
 - Other personal information regarding the individual named above
 - Social history
 - Psychological evaluations
 - Transition plans
 - Grades

Information regarding the following shall *not* be released unless initialed below:

Check one Initial
 Yes No _____ HIV and AIDS related diagnoses
 Yes No _____ Substance abuse diagnosis and treatment
 Yes No _____ Other, specify: _____

I understand that the Consent for Release of Information expires one year from the date below unless otherwise indicated herein by the client or his/her representative. I also understand that I may cancel my Consent for Release of Information at any time by stating so in writing with the date and my signature, and delivering it to CHRIS Kids. The revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was revoked.

I understand that this authorization will remain in effect for:

- Ninety (90) days unless I specify an earlier expiration date here: _
- One (1) year
- The period necessary to complete all transactions on accounts related to services provided to/for me

_____/_____/_____
Guardian or Custodial Parent Date

_____/_____/_____
Witness/Agency Representative Date

Please fax this document to the Intake Team at 404.564.4719 as it is completed.



CLINICAL SERVICES OPTIONS FORM

Your youth, _____, has been referred for placement at the CHRIS Kids Transitional Living Program. Please let us know if your youth will need clinical services while in placement and if so, what specific services by selecting from the list below:

- | | |
|---|--|
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Psychological assessment |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Nursing/Nutrition Assessment |
| <input type="checkbox"/> Group Training | <input type="checkbox"/> Medication administration (injection medication administration) |
| <input type="checkbox"/> Family Training | <input type="checkbox"/> Community Support Individual |
| <input type="checkbox"/> Behavior Aide Services | <input type="checkbox"/> Specialized service: |
| <input type="checkbox"/> Psychiatric Assessment | |
-

CHRIS Kids can offer all of these services within our therapeutic milieu and/or clinic. However, you have the choice of electing to have these services provided by another vendor. If your youth is accepted to our group home, we can provide you with a list of service providers in the area if you have not already identified one, or you can view a list of service providers at www.mygcal.com.

If you wish CHRIS Kids to provide clinical services to your youth, please indicate by selecting and signing below. **Additionally, choose "CHRIS Counseling Center" on the Release of Information that follows so we can share our referral information with the Diagnostic Assessment clinicians at the Center, and we can also schedule an intake appointment for clinical services immediately after your intake appointment for Group Home services.**

Thank You.

- I would like CHRIS Kids to provide all of the clinical service(s) listed above
- My preferences about what services will be provided by which vendors are listed below, along with transportation information.
- I do not wish CHRIS Kids to provide clinical services but have not selected an alternate service provider.

Service	Name of Provider	Transportation Arrangements
Individual Counseling		
Group Counseling		
Family Counseling		
Group Training		
Family Training		
Behavior Aide Services		
Psychiatric Assessment		
Medication Management		
Psychological assessment		
Nursing/Nutrition Assessment		
Medication administration		
Community Support Individual		
Specialized service:		

Name: _____ Title _____

Signature _____ Date _____

Please fax this document to the Intake Team at 404.564.4719 as it is completed.



PLACEMENT REQUIREMENTS CHECKLIST

Physical Exam Due: _____

Dental Exam Due: _____

Psychological Exam Due: _____

These documents are required before placement. If your youth is not accepted, these documents will be shredded.	Included	Reviewed	Pending (Date)
<i>Educational Documentation Requirements - Registering youth in public school is more complicated than ever due to new requirements and restrictions resulting from No Child Left Behind legislation. In order to make the already difficult transition into public school as seamless as possible, we ask that special attention be paid to forwarding the education documents listed below as soon as possible so our workers can begin the process of enrolling your child in school.</i>			
Current Individual Educational Plan /IEP, if applicable			
Behavior tracking form			
Original Transcript from last public school attended			
Withdrawal form from last school attended			
School records			
Medical History Documents Required			
Vision, Hearing and Dental (Form 3300)			
Current Medicaid card (copy of front & back), Insurance Info			
30-day RX of all meds; CHRIS Kids will fill upon admission.			
If transferring from RYDC/YDC: Clinic should transfer 30-day supply of meds to CHRIS Kids.			
Youth's Medical history – form provided			
Physical exam (within 12 months and to include) <ul style="list-style-type: none"> <input type="checkbox"/> RPR (required for dual-diagnosis residents) <input type="checkbox"/> Urinalysis <input type="checkbox"/> CBC blood work <input type="checkbox"/> PPD-TB test 			
Immunization Records (Must be up to date; showing vaccines and dates given, on an Immunization Form 3231)			
Dental Exam and treatment (within past 6 months)			
Pregnancy test (females only)			
Legal/State Document and Information Requirements			
Copy of birth certificate			
Valid Georgia I.D. (applies to youth 14 and older)			
Copy of signed Current Case plan with Permanency Plan			
Copy of Signed Written Transitional Living Plan			
Institutional Placement Agreement Form			
ILP Program Referral /Update Form (DFCS only)			
If DFCS Funded- ILP Waiver Letter (for ILP referrals)			
Copy of social security card			
Commitment papers and legal history			
Memo Authorization for MWO (DFCS only)			
Plan of Care Approval (DJJ only)			
List of any previous placements			
Court order AND DFCS Panel Review			

Amount of youth's annual clothing allowance left this fiscal year: \$ _____

Directions to the CHRIS Kids Office

3109 Clairmont Road, Suite B
Atlanta, GA 30329
404-486-9034 phone
404-486-9053 fax

From the south:

Take I-85 north to Clairmont Road.

On the exit ramp, get in the left lane (do not get in the far left lane which puts you on an access road).

Turn left onto Clairmont and follow for approximately half a mile.

Turn right into Century Center North (just before Extended Stay America).

We are in the next to the last building on the left.

From the north:

Take I-85 south to Clairmont Road.

Turn right onto Clairmont Road.

Follow Clairmont for approximately half a mile.

Turn right into Century Center North (just before Extended Stay America).

We are in the next to the last building on the left.