DBH
Division of Behavioral Health

YOUTH COMMUNITY PLACEMENT APPLICATION FORM

REFERRAL AGENCY		DATE
REFERRAL WORKER	PHONE	E-MAIL

1. CLIENT DATA

NAME	DOB	GENDER	DMH ID#	SS#

ADDRESS	CITY	STATE	ZIP	COUNTY

INSURANCE	POLICY NUMBER
INSURANCE	POLICY NUMBER

CURRENT SCHOOL	PHONE	GRADE	IQ

IEP
Yes ☐ No ☐ If yes, reason

2. PARENT/GUARDIAN

PARENT/GUARDIAN NAME		RELATIONSHIP	
ADDRESS		CITY	STATE / ZIP
COUNTY	HOME PHONE	CELL PHONE	WORK PHONE

3. HOUSEHOLD MEMBERS

NAME	RELATIONSHIP TO YOUTH

4. PHYSICAL HEALTH

CURRENT PHYSICIAN	PHONE	DATE OF LAST VISIT

IMMUNIZATIONS CURRENT	DATE OF LAST EYE EXAM	DATE OF LAST DENTAL EXAM
Yes ☐ No ☐		

MEDICAL DIAGNOSIS

ALLERGIES	IF YES, LIST ALLERGIES	EPI PEN REQUIRED
Yes ☐ No ☐		Yes ☐ No ☐

5. MENTAL HEALTH

CURRENT PSYCHIATRIST	PHONE	DATE OF LAST VISIT
CURRENT THERAPIST(S)	PHONE	DATE OF LAST VISIT

6. DSM-5 DIAGNOSIS

ICD-10-CM	DISORDER	SEVERITY

7. MEDICATIONS

MEDICATION NAME	DOSAGE	PRESCRIBER

8. BEHAVIORS *(Please identify all behaviors)*

Mild	Moderate	Severe	Behavior
☐	☐	☐	Breaks rules or get in trouble
☐	☐	☐	Impulsive or hyperactive
☐	☐	☐	Youth does things that are risky or dangerous
☐	☐	☐	Has unrealistic thoughts, fears, or worries
☐	☐	☐	Has sleeping problems
☐	☐	☐	Has social problems
☐	☐	☐	Development is delayed
☐	☐	☐	Has eating or body image problems
☐	☐	☐	Has repetitive, rigid, or strange behaviors
☐	☐	☐	Is moody or sad
☐	☐	☐	May be abusing tobacco, alcohol or drugs
☐	☐	☐	Has suicidal thoughts/behaviors or tries to hurt him/herself
☐	☐	☐	Picks fights, bullies, hurts or threatens others
☐	☐	☐	Destroys property
☐	☐	☐	Runs away
☐	☐	☐	Problem sexual behaviors

Please explain any behaviors marked moderate or severe.
Please explain trauma history of youth, as applicable.
Family plan for involvement with youth while out of home.
Reason for out-of-home referral (previous interventions, resources utilized/in place, placement goals).
Discharge/placement goals.