CARE HORIZON

Care Horizon Inc. Child Application
To be completed by PARENT/GUARDIAN

Child's Name:_____ Social Security Number:_____
First Middle Initial Last

Address:_____ County:_____
Street City State Zip Code

Phone Number:_____ May we leave a message from our office: YES NO

Email address:_____ May we contact you via email? YES NO

Child's Birth date:_____Age:_____ Gender: ____Male ____Female Race:_____

Is child of Hispanic origin: ____YES ____NO If yes, detail:_____ Mother's Maiden Name:_____

Method of Communication: _____Verbal/Spoken ____Written _____Use Pictures ____Assistive Technology ____TTY

Primary Language: ____English ____Spanish ____American sign language Other:_____

Is your child an American Citizen _____YES _____NO If other, please detail_____

Who does child primarily live with? ____Both Mother and Father ___Mom ___Dad ___Other:_____

Who referred you for services_____ Reason for referral: _____

Does your child have health insurance: YES NO If yes, provider name:_____

Does your household receive (check all that apply): ____Medicaid ____Medicare ____VA Benefits ____Link Card ____WIC ____SSDI
____SSI ____TANF ____Energy Assistance ____Subsidized Housing ____Unemployment ____None

Resources: Is your child involved with any other agency? ___YES ___NO If yes, please detail:_____

Parent/ Guardian _____ _____ _____
Name Relationship Phone

_____ _____ ____ _____
Street Address City State Zip Code

Parent/ Guardian _____ _____ _____
Name Relationship Phone

_____ _____ ____ _____
Street Address City State Zip Code

Does your child have any special needs: ____YES ____NO If yes, detail:_____

Does y our child have any urgent or critical medical conditions? _____YES ____NO
If yes, please detail_____

Who lives in the household with the child? Check all that apply

___Parent(s)/Guardian(s) of child ___Siblings ___Grandparents of child ___Other relative(s) ___Non-relative(s) ___Parent's significant other

Presenting Concern:
What do you feel is the main concern for your child?

How has the problem caused problems in your life and the child's life within the past year?

Did your child just start having this problem: ____YES ____NO
If no, for how long has he/she had problems:_____
Does his/her problems interfere with his/her daily functioning: ____YES ____NO

Has your child:

Ever had thoughts of hurting himself/herself? ____YES ____NO
Ever made a suicide attempt? ____YES ____NO If yes, when:_____
Been hospitalized for suicide thoughts/attempts? ____YES ____NO If yes, when:_____
Had thoughts of hurting someone else? ___YES ___NO

Is your child currently:

Having thoughts of hurting himself/herself? ____YES ____NO
Having thoughts of hurting someone else? ____YES ____NO
Do you feel your child is in danger NOW? ____YES ____NO If yes, please explain:_____
Is your child involved with a gang? ____YES ____NO
Is your child involved in an elder abuse situation? ____YES ____NO
Are you, or your child, in any other dangerous situation? ____YES ____NO If yes, please explain:_____
Do you have enough food to eat? ____YES ____NO
Do you believe you need medication? ____YES ____NO
Additional thoughts or comments:_____

Needs/Preferences:

What are your preferences for treatment based on the services we have available (check all that apply):
____Counseling ____Community support ____Crisis assistance ____Case management ____Family therapy/counseling
____Medication monitoring ____Psychiatric ____Group counseling ____Other: _____

What do you hope your child will gain from the services he/she receives? What is your desired outcome?:

Care Horizon Inc. encourages the participation of family or persons in your child's support system during every phase of treatment. Do you wish to have anyone present during your assessment? ___YES ___NO
If yes, who:_____

As the parent/guardian of the above named child, I am requesting services for my child and give consent for treatment. I agree to participate in the intake, assessment and treatment planning process.

_____ _____
Signature Date

Please complete the attached medication form detailing your child's medications

FOR CARE HORIZON STAFF USE ONLY:
APPLICATION REVIEWED BY:

_____