

Children's Square USA
PMIC Application

Name:	DOB:	Gender:
Social Security #	Height:	Weight:
Is the child under a court order? <input type="checkbox"/> No <input type="checkbox"/> Yes, CINA <input type="checkbox"/> , Delinquent <input type="checkbox"/>		

	Primary Insurance name:	Secondary Insurance name:	Dental Insurance name:
Policy #			
Plan			
Coverage Types	Family: YES NO Dental: YES NO RX: YES NO EYE: YES NO	Family: YES NO Dental: YES NO RX: YES NO EYE: YES NO	
Policy Holder's Name			
Policy Holder's DOB & SS#			
Insurance through Employer?			
Employer Name	_____	_____	_____
Telephone	_____	_____	_____
Address	_____	_____	_____

(Please attach copies of both sides of all insurance & /or Medicaid cards)

If your child is Medicaid eligible, have you enrolled your child in the Pediatric Integrated Health Homes program?		
YES	NO	Had not heard of the program

	Mom:	Dad:
Address	_____ _____	_____ _____
Phone	H: () W: () C: ()	H: () W: () C: ()
Email		
County		

Guardian (if different from parents): _____

Address: _____

Phone: () _____

Email: _____

County: _____

Who is the child living with? _____

Where is the child expected to live after PMIC? _____

Siblings	Where Live	Ages

Who did you find out about PMIC from _____

Professional Contacts	DHS – JCO - CMHW	Guardian At Litem
Name		
Address	_____	_____
Phone	()	()

What was the final event that made you decide on PMIC Placement?

Describe on-going issues that helped make the decision for PMIC:

Self Harm/Suicidal ideation - attempts: _____

Physical Harm to others: _____

Aggression toward property: _____

Drug use (include nicotine and caffeine use): _____

Run behavior: _____

Delinquent Behavior: _____

Sexualized Behavior: _____

Current Services	Therapy	Medication Management	BHIS
Company			
Person			
Telephone			
FAX			
Dates			

Primary Care Physician: _____

Address: _____

Phone: () _____ Fax: () _____

Past Placements	Phone	Fax	Dates
Psychiatric Hospital:			
Partial/Day Treatment:			
PMIC/Group Care:			
Shelter:			
Detention:			

Diagnosis: _____

Current Medication: Drug Name	Dosage	Time Given

Past Medications: _____

Medical Issues: _____

SCHOOL INFORMATION

Home School: _____

Address: _____ Phone: _____

Grade: _____ Credits earned (if applicable) _____ of _____

Special Education Services

IEP _____ 504 Plan _____

Performance:

Behavior at school: _____

Mental illness or substance use/abuse by immediate or extended family members: _____

Strengths of the Student: _____

Support System for Student: _____

Goals or Outcomes for PMIC:

Student: _____

Family: _____

Family involvement:

When one member of a family comes to PMIC, the whole family shares concerns, worries, and the discomfort of the separation. Regularly scheduled family therapy sessions and visitation will be planned by you and your family's therapist. Family therapy will be scheduled weekly and you will set up visits with your child through your family therapist.

Will you be able to be involved in family therapy weekly at the Children's Square campus? _____

Do you have means of getting to your appointments at the Children's Square campus? _____

Will you be able to visit your child regularly on the Children's Square campus? _____

When your child has progressed in treatment, will you be able to have your child come home for visits? _____

In addition to family therapy, we also ask out parents/guardians to attend scheduled Medication Reviews, Quarterly Progress Reviews, school staffing, Family Day educational/support group, 2-day training regarding various diagnoses your child may have, parenting classes etc. Staffings are held during normal business hours to accommodate the psychiatrist schedules and any other professionals involved in your child's treatment.

Would you be able to attend regularly scheduled staffings? _____

Would you be able to attend informational trainings/parenting classes/support groups as recommended by your family therapist? _____

Please fill out marking the current severity of each behavior. Please remember the guide to the numbers.

1= does not do or has not been an issue. 2= mild or happens at times but is not a big issue
 3= moderate or frequent (several times per week). 4= severe or more days than not (or daily)

Behavior	1	2	3	4	Behavior	1	2	3	4
Unable to concentrate or focus					Destruction of property at home				
Restless/unable to sit still					Vandalism				
Too much energy					Physically fighting with others				
Forgetful					Verbally fighting with others				
Sleep disturbance (wake up early, can't fall asleep, hard to get up,)					Verbal abuse, profane language				
Change in appetite					Steals from family, school or community				
Change in weight (up or down)					Lying				
Sad or depressed					Does not follow house rules				
Crying spells					Cruelty to people				
Low energy					Fire setting				
Low motivation					Cruelty to animals				
Loss of interests					Bed-wetting				
Thoughts of suicide					Soiling problems				
Suicide attempts					Does not do school work				
Self harm					Tardiness				
Thoughts of hurting or killing others					Does not go to school				
Flashbacks					Peer issues at school				
Nightmares					Authority issues at school				
Panic attacks					Sexualized behavior				
Hyperventilates					Sexual problems				
Worried about weight or appearance					Runaway behavior				
Phobias					Feeling mind playing tricks				
Compulsions					Thinks people are spying on him/her				
Obsessions					Auditory hallucination				
Overly sensitive					Visual hallucination				
Shyness					Thinks different from others				
Anxious or nervous					Odd or bizarre beliefs				
Racing thoughts					Moods swings				
Social withdrawal					Anger				
Overly dependent					Extreme sibling rivalry				
					Binge/purge of food				
					Gambling				

Person filling out form: _____ Date: _____

Name:
CSUSA #: Title 19:

DOB:
Legal Status:

AGE:

Gender:

Social History

Medical issues (past and current): _____

Surgeries (what and when): _____

Drug/Food/Other Allergies (please list reaction): _____

Last physical exam (month/year): _____ By Whom: _____

Last Dental exam (month/year): _____ By Whom: _____

Braces and or retainer? _____

Last Eye exam (month/year): _____ By Whom: _____

Glasses or contacts? _____

Student's relationship with family members: _____

Contact with extended family:

Maternal: _____

Paternal: _____

Religious Practices:

Preference: _____

Attendance: _____

Activities or programs: _____

Childhood History:

Complications during Pregnancy: _____

Complications at birth: _____

Developmental Milestones met average times? _____ If no, which ones were delayed? _____

Name:

DOB:

AGE:

Gender:

CSUSA #:

Title 19:

Legal Status:

Events of early childhood: (Since birth has the child experienced any of the following):

Parents got married/separated/divorced/dated/remarried (who and when): _____

Witnessed domestic Violence (by who and when): _____

Losses/deaths: _____

Traumas: _____

Injuries: _____

Parent(s) extended medical issues/hospitalizations etc.: _____

Parent(s) legal issues to include jail/prison time: _____

Moves during life (from where to where and when): _____

Financial Status:

Student's work history: _____

Adoption Subsidy (how much?) _____ SSDI (how much?) _____

Child Support (how much?) _____ Other financial support _____

Where Mom and/or Stepmother works and when: _____

Where Dad and/or Stepfather works and when: _____

Friendships:

Can the student make and maintain friendships? _____

Name:

DOB:

AGE:

Gender:

CSUSA #:

Title 19:

Legal Status:

What is the student able to do with his/her friends? _____

Are student's friends positive or negative influence? _____

How? _____

Sexualized Behavior:

Has student displayed sexualized behavior? _____

If yes, describe what they are: _____

Family History:

Issues pertaining to Mom:

Medical issues: _____

Legal issues: _____

Issues of Maternal side of family:

Medical issues: _____

Legal issues: _____

Issues pertaining to father:

Medical issues: _____

Legal issues: _____

Issues for paternal side of family:

Medical issues: _____

Legal issues: _____

Student substance use/abuse/dependence: (describe usage and age started)

Alcohol: _____

Marijuana/street drugs: _____

Prescription drug abuse: _____

Over the counter medications: _____

Caffeine: _____

Energy drinks: _____

Nicotine: _____

Strengths of family: _____

Name:

DOB:

AGE:

Gender:

CSUSA #:

Title 19:

Legal Status:

Community resources used by family:

Sports:

Boy/Girl Scouts, 4-H etc:

YMCA/Boys-Girls club etc:

Groups or activities Participated In:

History of Abuse: by who and when

Emotional:

Physical:

Sexual:

IQ Testing? Yes _____ No _____

When, where, results?

Name: _____ DOB: _____ AGE: _____ Gender: _____
CSUSA #: _____ Title 19: _____ Legal Status: _____

CHILDREN'S SQUARE U.S.A.

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

INDEPENDENT TEAM ASSESSMENT

YES NO

- X _____ 1. Available community resources for ambulatory care do not meet the treatment needs of this child.
- X _____ 2. Proper treatment of this child's psychiatric condition requires service on a residential inpatient basis under the direction of a physician.
- X _____ 3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

Physician's Signature (M.D. or D.O.)

Date

Printed Name & Credentials

Professional's Signature

Date

Printed Name & Credentials

Professional's Signature

Date

Printed Name & Credentials

Name: _____
CSUSA #: _____ Title 19: _____

DOB: _____
Legal Status: _____

AGE: _____



Authorization to Release Professional Information

Please complete this form in its entirety. Items or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. A copy of this signed form will be provided to the undersigned. This authorization may be revoked

I hereby authorize _____
(name/agency and address)

to release to **Children's Square USA, PO Box 8-C, Council Bluffs 51502 fax: 712-325-8200**
(name/agency and address)

the records of: Name: _____
Last First MI Previous Name

Covering the periods of healthcare (Date(s) of service):

From (date) _____ To (date) _____

For the purpose of: PMIC placement evaluation

Please check one: () On-going information request valid for one year (x) one time information request valid for 90 days

Specific Authorization for Release of Information protected by State or Federal Law

I understand that the information to be released may include information in the following categories Client must (Initial) appropriate categories:

Mental Health _____

Substance Abuse _____ (alcohol/drug abuse-client must check & sign regardless of age) _____

Client Signature, age 12 & older (only when releasing info)

Check all that apply:

- | | | |
|------------------------------|----------------------------------|--------------------------------------|
| (X) Psychiatric Evaluation | (X) Psychiatric Notes | (X) Grade Reports |
| (X) Therapy Intake | (X) Therapy Progress Notes | (X) Individualized Education Program |
| (X) Laboratory Results | (X) Immunizations | (X) Other School Information |
| (X) Psychological Evaluation | (X) Social History | (X) Treatment Plan |
| (X) Discharge summary | () Other (please specify) _____ | |

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Name:
CSUSA #:

Title 19:

DOB:
Legal Status:

AGE:

Gender:

CHILDREN'S SQUARE USA
CHEMICAL ABUSE/DEPENDENCY ASSESSMENT

Chemical Abuse/Dependency History

Drug Type	Frequency of use (daily, several times a week, once a week, several times per month, tried, does not use)
Alcohol	
Marijuana	
Street drugs	
Prescription drug abuse	
Over the counter medications	
Caffeine	
Energy drinks	
Nicotine	
Other	

Past Chemical Abuse/Dependency Treatment

Assessments/evaluations:

SASSI (where and when):

Evaluations (where and when):

Inpatient Treatment:

Hospital:

Treatment Facility:

Out Patient Treatment:

Day Treatment:

Group Therapy:

Individual Therapy:

Family Therapy:

AA/NA :

How has drug/chemical use affected your child or family?

Name: _____ DOB: _____ AGE: _____ Gender: _____
 CSUSA #: _____ Title 19: _____ Legal Status: _____

Trauma/Loss Exposure Form

Child's Name: _____ Age: ____ # of Months in Current Placement: ____
 Form Completed by (Name/Title): _____ Date: _____

Reason for Current Evaluation (check all that apply):

Baseline Assessment: New Client: _____

Change in Placement (Specify): _____

New Trauma Reported : _____ Problematic Reactions/Behavior: _____

Other (Specify): _____

Trauma/Loss Exposure History:

Trauma Type	Yes/Suspected No/Unknown	Age(s) Experienced (be specific)
Sexual Abuse or Assault/Rape		
Physical Abuse or Assault		
Emotional Abuse/Psychological Maltreatment		
Neglect		
Serious Accident or Illness/Medical Procedure		
Witness to Domestic Violence		
Victim/Witness to Community Violence		
Victim/Witness to School Violence		
Natural or Manmade Disasters		
Forced displacement		
War/terrorism/Political Violence		
Victim/Witness to Extreme Personal/Interpersonal Violence		
Traumatic Grief/Separation (does not include placement in foster care)		
Systems Induced Trauma		

Name:

DOB:

AGE:

Gender:

CSUSA #: Title 19:

Legal Status:

B. Current Traumatic Stress Reactions

Reaction	Yes/No/Unknown	Definition
Re-experiencing		<i>These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.</i>
Avoidance		<i>These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.</i>
Numbing		<i>These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.</i>
Arousal		<i>These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.</i>

C. Attachment

Attachment Issues	Yes/No/Unknown	Definition
		<i>This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/interactions).</i>

D. Behaviors Requiring Immediate Stabilization

Behavior	Yes	No	Unknown
Suicidal Intent	Yes	No	Unknown
Active Substance Abuse	Yes	No	Unknown
Eating Disorder	Yes	No	Unknown
Serious Sleep Disturbance	Yes	No	Unknown

Name:

DOB:

AGE:

Gender:

CSUSA #: Title 19:

Legal Status:

E. Current Reactions/Behavior/Functioning

Regulation of Emotion	Yes/No/Unknown Does this interfere with child's daily functioning at home, in school or in the community	How to recognize Problem Behaviors (check Yes if child presents with any of the descriptors listed below)
Anxiety		<i>Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.</i>
Depression		<i>Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability. They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, grouchiness, hopelessness, or negativity. They may have frequent complaints of physical problems.</i>
Affect Dysregulation		<i>Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/wake cycle.</i>
Dissociation		<i>Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality often associated with traumatic experiences.</i>
Somatization		<i>Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.</i>
Attention Concentration		<i>Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.</i>
Regulation of Behavior	Yes/No/Unknown	Includes risky behaviors.
Suicidal Behavior		<i>Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.</i>
Self-Harm		<i>When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.</i>
Regression		<i>Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.</i>
Impulsivity		<i>Acting or speaking without first thinking of the consequences.</i>
Oppositional Behaviors		<i>Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.</i>
Conduct Problems		<i>Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.</i>