South Carolina Department of Social Services

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral: ____________________ Date Placement or Service Needed: ____________________

Reason for Referral/Statement of Need (Explain client's problems and needs, and include an estimate of the severity of the client situation. Attach additional page as necessary):

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Requested Service or Placement: ____

CLIENT INFORMATION

Client Name: ______________________ AKA/Nickname: ______________________ SSN: ______________

Medicaid Health Plan: ______________________ Medicaid No.: ______________________

Private Insurance Plan: ______________________ Policy No.: ______________________

Age: ________ Birthdate: ______________ Gender: ______________ Height: __________ Weight: __________

County of Legal Residence/Custody: ______________________ US Citizen? ______ Undocumented Immigrant? ______

Current Placement/Location: ______________________________ LOC: ______________________

PARENT/GUARDIAN/RESPONSIBLE PARTY

Name: ______________________________ Relationship to Client: ______________________

Address: ____

REFERRING PARTY

Agency and Office: ______________________________ Caseworker: ______________________

Telephone: ______________________ Fax: ______________________ E-mail: ______________________

Address: ____

Supervisor's Name: ____

Telephone: ______________________ Fax: ______________________ E-mail: ______________________

Emergency contact number for afterhours/weekends/holidays: ______________________________

Other Involved Agencies: ____

CLIENT STRENGTHS (Check all that apply)

❑ Strong Family Support
❑ Other Personal Support
❑ On Grade-Level
❑ Appropriate Reading Level
❑ Average/Above IQ
❑ Good Verbal Skills
❑ Resiliency/Coping Skills
❑ Good Socialization Skills
❑ Good Personal Hygiene
❑ Religious Pref: ______________
❑ Interests: ______________
❑ Other: ______________

Client Name: ____________________________________

CLIENT PROBLEMS (Check all that apply, **indicating whether a problem is Current (C) or in the Past (P).**

C	P		C	P	
❑	❑	Abandonment/Attachment Issues	❑	❑	Aggressive (Physical)
❑	❑	Aggressive (Verbally)	❑	❑	Alcohol/Drug Use
❑	❑	Anxiety	❑	❑	Arson/Fire Setting
❑	❑	Attention Seeking	❑	❑	Chaotic Home Situation
❑	❑	Delusional*	❑	❑	Destroys Property
❑	❑	Mild Depression/Sadness	❑	❑	Moderate/Severe Depression
❑	❑	Difficulty with Authority	❑	❑	Developmentally Delayed
❑	❑	Encopresis	❑	❑	Fire Setting*
❑	❑	Eating Disorder	❑	❑	Hyperactive
❑	❑	Lies/Not Truthful	❑	❑	Loss/Grief Difficulties
❑	❑	Low Self-Esteem	❑	❑	Oppositional/Defiant
❑	❑	Phobic Reactions/Behavior	❑	❑	Physical/Medical Conditions
❑	❑	Poor Personal Hygiene	❑	❑	Problems with Walking
❑	❑	Poor Social Skills	❑	❑	Problems at School
❑	❑	Self-Destructive Behavior*	❑	❑	Sexually Inappropriate*
❑	❑	Sibling Related Difficulty	❑	❑	Suicidal Gestures/Attempts*
❑	❑	Steals	❑	❑	Truancy
❑	❑	Needs Protection from Others	❑	❑	Unruly/Ungovernable
❑	❑	Aggressive (Sexual)	❑	❑	Poor Coping Skills
❑	❑	Antisocial/Criminal Behavior	❑	❑	Poor Reality Orientation
❑	❑	Autism/Autism Spectrum	❑	❑	Running Away
❑	❑	Cruelty to Animals	❑	❑	Sexually Provocative*
❑	❑	Expelled/Not in School	❑	❑	Adjudicated/Convicted Sexual Offender*
❑	❑	Manic/Mood Swings	❑	❑	Suicidal Ideation
❑	❑	Enuresis/Bedwetting	❑	❑	Trust Issues
❑	❑	Functionally Illiterate	❑	❑	Victim of Neglect
❑	❑	Impulsive	❑	❑	Victim of Physical Abuse/Violence
❑	❑	Manipulative	❑	❑	Victim of Sexual Abuse
❑	❑	Parental Neglect Issues	❑	❑	Victim of Emotional Abuse
❑	❑	Language Limitations	❑	❑	Wheelchair/Adaptive Devices
❑	❑	Gang Involvement	❑	❑	Other

On the following page please describe or explain all items checked above. For those checked items, provide further details on those with an asterisk.

Client Name: ______________________________

Explanation: (Attach additional pages as necessary)

Client Name: ______________________________

PLACEMENT HISTORY

Number of Previous Placements: ________ Please list all placements **in past 3 years,** including periods of incarceration and psychiatric hospitalizations. Attach additional or separate page(s) if desired.

Placement (include type or LOC)	Dates (From/To)		Reason for Discharge

1.2 MEDICAL INFORMATION

CURRENT DIAGNOSES – ICD-10 or DSM V: (List past diagnoses as well as current ones)

Axis	Diagnosis	Date Given	Source

Client Name: ____________________

MEDICATIONS: (List all **current** medications, dosages, and instructions. Attach additional page if needed.)

Medication Name	Dosage	Instructions

Client's Primary Physician: ____________________ Phone: ____________

Date of Last: Physical Exam: ____________ Dental Exam: ____________ Eye Exam: ____________

Allergies: ____________________

Special Dietary Needs: ____________________

List any current or prior medical conditions, physical disabilities, adaptive devices, or specialty medical care that a Provider needs to accommodate:

____

SCHOOL INFORMATION

Official Home School District: (Where parent/guardian/custodial agency resides)

Is the client currently attending any school? ❑ Yes ❑ No **If NO,** why not? ____________________

____

Is the client currently functioning on grade level? ❑ Yes ❑ No Comments: ____________________

____

List last five schools attended, beginning with the current/most recent school:

School Attended	Dates (From/To)		Grade	Completed?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Client Name: ______________________________

Has client ever been classified Special Education? ❑ UNKNOWN ❑ No ❑ Yes

IF YES, primary classification: ____________________ Secondary Classification: ____________________

Does client have a current IEP? ❑ Yes ❑ No **IF YES,** date: ____________________

Does client have a section 504 Accommodation Plan? ❑ Yes ❑ No **IF YES,** date: ____________________

Is client currently under recommendation for expulsion? ❑ Yes ❑ No **IF YES,** explain below:

Explain any school-related problems or conditions needing to be accommodated: ____________________

Client Goals: Please list the client's plan and treatment goals to achieve permanency.

______________________________ ____________________

Signature and Title of Person Referring Date