CARE AFFILIATES
BEHAVIORAL HEALTH SERVICES

Resident Placement Form

Personal Information

Full Name: _____
Date of Birth: _____
Gender: _____
Height: _____
Weight: _____
Eye Color: _____
Hair Color: _____
Race: _____
Address: _____
Phone Number: _____
Email Address: _____
Emergency Contact: _____
(Name and Phone Number of Emergency Contact)

Background Information

Referring Agency/Individual: _____
Reason for Referral: _____
Previous Placements (if any): _____

Siblings: _____

Family: _____

Current Needs and Preferences

- **Type of Facility Preferred:***(e.g., Group Home, Assisted Living Facility, Residential Treatment Center)*

  _____
- **Location Preferences:** _____

- **Special Requirements:***(Any specific needs or accommodations required, such as medical or behavioral support)*

  _____

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Living Arrangements

- **Describe past five years' living situations:**
  - **Placement:** _____
  - **Duration:** _____
  - **Reason for Leaving:** _____

_____

_____

Medical Information

- **Primary Care Physician:** _____
  (Name and Contact Information of Primary Care Physician)
- **Medical Conditions:** _____

- **Medications:** _____
  _____
  _____
  (List any current medications and dosage)

Behavioral Health Information

- **Diagnoses:** _____

- **Therapy/Counseling History:***(Brief summary of previous therapy or counseling experiences)* _____

- **Current Treatment Needs:**
  _____
  _____
  _____

Legal History

- Has the client been involved in the legal system? _____
- ( ) Yes ( ) No
- If yes, explain: _____
- **Legal Status:** _____
- **Funding Source:** _____
  (e.g., Medicaid, Private Pay)
- **Other Relevant Information:** _____

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Medical Information

- **History of Suicide Attempts/Ideations:**
  - ( ) Yes ( ) No
  - If yes, explain: _____
- **History of Violent Behavior:**
  - ( ) Yes ( ) No
  - If yes, explain: _____

Community Contacts

Name: _____
Relationship: _____
Phone Number: (_____) _____
Address: _____
City: _____
State: _____
Zip Code: _____

Name: _____
Relationship: _____
Phone Number: (_____) _____
Address: _____
City: _____
State: _____
Zip Code: _____

Emergency Contact:

Name: _____
Phone: _____

Substance Use History

- **Does the client have a history of substance use?**

- ( ) Yes ( ) No
- Substances Used: _____
- Date of First Use: _____
- Frequency of Use: _____
- Date of Last Use: _____
- Longest Period of Abstinence: _____
- Previous Treatment History:
  - ( ) Yes ( ) No
  - **Type of Treatment:** _____
  - **Facility Name:** _____
  - **Dates:** _____

Education

Can the client read? ( ) Yes ( ) No
Can the client write? ( ) Yes ( ) No
Can the client do simple math? ( ) Yes ( ) No
Highest Grade Completed: _____
Current School: _____

Discharge Planning

Discharge planning begins at admission and focuses on long-term stability and successful transition.

To support this process, please provide the following:

1. **What is the expected discharge living arrangement?**
   ☐ Return to family home
   ☐ Independent living
   ☐ Foster/kinship placement
   ☐ Supportive housing
   ☐ Other: _____
2. **What skills or progress areas should the resident achieve prior to discharge?**
   _____
   _____
3. **Discharge Goal Statement** *(required)*
   Please describe the primary goal for the resident for discharge in one or two sentences:

Goal for discharge:

4. **Target outcomes discharge:** *(check all that apply)*
   - ☐ Maintain safety with no self-harm incidents
   - ☐ Consistent engagement in mental health treatment
   - ☐ Stable school or employment participation
   - ☐ Improved emotional regulation and coping skills
   - ☐ Medication adherence
   - ☐ Positive community and peer engagement
   - ☐ Other: _____

Attachments Required

1. Social Security Card
2. Birth Certificate
3. Recent Health Screening
4. Psychosocial Assessment
5. Physical Examination within the last 12 months
6. Discharge Summaries
7. Substance Abuse Assessment
8. Treatment Notes
9. Previous Plan of Care