LifeCare Coalition Outreach-Foster Family Agency

Facility # 507206867

121 East Orangeburg Avenue
(Suite 14), Modesto, Ca, 95350, USA
209-408-8048
209-336-6409 (EFax)

CHILD/YOUTH INTAKE FORM

Date:					
-		**Phone#:**		**Fax#:**	
SW Name:		**Phone#:**		**Fax#:**	
County:		**Email:**			
Child's Name:		**DOB:**		**Age:**	
Languages Spoken:		**Ethnicity:**			
Biogender:	-	**Sexualized Behavior**	-	**Sexual Orientation**	-
Gender Identity	-	**Gender Expression**	-	**AWOL RISK**	-
# of AWOL in the Last 6 months		**Pregnant**	☐ YES	☐ NO	
Type of Placement:	☐ **Reunification** ☐ **Short-Term** ☐ **Long-Term** ☐ **Receiving Home** ☐ **Mother & Non-Ward Child** ☐ **Child with Special Needs**_____				
Anticipated Length of Placement:					
Sibling Group Placement: ☐Yes ☐No (If Yes Siblings Names)					
Placement History (dates):	**Current Placement:**	☐ FFA (length of stay): _____ ☐ STRP/GH (length of stay): _____ ☐ FIRST TIME IN FOSTER CARE			
Reason for Move/Change:					
Reason for Dependency:	☐ **General Neglect** ☐ **Drug Abuse** ☐ **Physical Abuse** ☐ **Homelessness** ☐ **Other:** _____				

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Reason for Dependency Note:	

FAMILY:

Mother:		**Visitation:**	_	**Supervised:**	_	**How Often:**	
Father:		**Visitation:**	_	**Supervised:**	_	**How Often:**	
Other Significant Adults/Children:				**Visitation:**		_	
Visitation Location:							
People Not Authorized to See Child:							
Current/Anticipated Appointments:	_	**Type of Appointment**					

COURT **MEDICATION**

Next Court Date:		**Court Order:**	☐ **YES** ☐ **JV 223 APPROVED ON: _____** ☐ **NO**
Medication Name:			
Medical Concerns/Diagnosis:		**Allergies:**	_

THERAPY

Mental Health Services:	☐ **Yes** ☐ **No** ☐ **Needs to be Arranged**	**Wrap:**	☐ **Yes** ☐ **No** ☐ **Needs to be assessed**
Therapist Name:		**Phone #:**	
Address:			
Schedule/Frequency:			
Mental Health Notes:			

EDUCATION

Current School		**Grade Level:**	_
Address:		**I.E.P.:**	_
Special School Needs:			

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Please Place a check in the first column for the Client Place an M to indicate biological mother and or an F to indicate biological father in the second column.

IDENTIFYING PROBLEMS	**C**	**M/F**	**BEHAVIORAL ISSUES**	**C**	**M/F**	**LEGAL ISSUES**	C	M/F
Substance Abuse		-	Oppositional		-	Theft		-
Sexual Abuse		-	Lack of Impulse Control		-	Assault		-
Suicidal Ideation		-	Attitude Problems		-	Trespass		-
Suicidal Gestures		-	Assaultive		-	Molest		-
Self-Injurious Behavior		-	Verbally Abusive		-	Burglary		-
Physically Abusive		-	School Problems		-	Weapons		-
Physically Abused		-	Smoking		-	Vandalism		-
Gang Affiliations		-	Sexual Acting Out		-	Battery		-
Mental Health Diagnosis		-	Peer Difficulties		-	Arson		-
Hospitalization		-	Isolative		-	other		-
Health Problems		-	Tantrums		-			-
Physical Limitations		-	Other		-			-
Enuresis		-			-			-
Encopresis		-			-			-
CSEC		-			-			-
Other: _____		-			-			-

Please Explain All Checked Boxes Above:

Special Needs:

Special Transportation Needs:

Dangerous Propensities: ☐ **Yes** ☐ **No (describe)**

Cannot be placed with:

☐ Younger Children ☐ Older Children ☐ Siblings ☐ Specific gender: ☐ Male ☐ Female

☐ Single Parent home ☐ Dual parent home ☐ No Pets ☐ Pets

☐ Other: _____

Additional Notes:

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WOD or Intake Worker:		**Date:**	
Signature:		**Date:**	

FOSTER FAMILIES CONTACTED:	**COMMENTS:**

-	**HOME:**		**HOME #:**		**CHILD#:**		
AGENCY SOCIAL WORKER CONTACTED			**DATE:**				