MBCH Children and Family Ministries

APPLICATION FOR PRIVATE PLACEMENT

(Confidential)

Please check campus and services being requested:

❍ Lowe-Frillman Campus	❍ Byrne Campus	❍ Hutchens Campus
11300 St. Charles Rock Road	P. O. Box 447	P. O. Box 568
Bridgeton, MO 63044	Peculiar, MO 64078	Mt. Vernon, MO 65712
314-739-6811	816-779-5173	417-466-7844
Pregnancy Services	*Therapeutic Group Home*	*Therapeutic Group Home*

APPLICANT

Person Completing Application: ____________________

Relationship: ____________________ Date: ____________

Referral Source: ____________________

GENERAL INFORMATION

Please provide the following information for the child in need of placement

Full Name: ____________________

Birth Place: ____________________

Date of Birth: ____________ Age: ________ Race: ____________

Please provide the following information for the person with whom the child is currently living:

Full Name: ____________________

Street Address: ____________________

City: ____________ State: ________ Zip: ____________

E-Mail Address: ____________________

Telephone: ____________________

Please provide the following information for the child's legal guardian:

Full Name: ____________________

Street Address: ____________________

City: ____________ State: ________ Zip: ____________

E-Mail Address: ____________________

Telephone: ____________________

INFORMATION ABOUT THE FAMILY

A. ❍ Biological ❍ Adoptive Father's Full Name: ____________________

Street Address: ____________________

City: ____________ State: ________ Zip: ____________

Telephone (Home): ____________________

B. ❍ Biological ❍ Adoptive Mother's Full Name: ____________________

Maiden Name: ____________________

Street Address: ____________________

City: ____________ State: ________ Zip: ____________

Telephone (Home): ____________________

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INFORMATION ABOUT THE FAMILY (CONT.)

C. Biological Parents:

			If Yes, What Date?
Ever Married?	❍ Yes	❍ No	________
Divorced?	❍ Yes	❍ No	________
Separated?	❍ Yes	❍ No	________
Father Deceased?	❍ Yes	❍ No	
Cause of Death	________		
Mother Deceased?	❍ Yes	❍ No	
Cause of Death:	________		

Adoptive Parents:

			If Yes, What Date?
Ever Married?	❍ Yes	❍ No	________
Divorced?	❍ Yes	❍ No	________
Separated?	❍ Yes	❍ No	________
Father Deceased?	❍ Yes	❍ No	
Cause of Death:	________		
Mother Deceased?	❍ Yes	❍ No	
Cause of Death:	________		

D. If parents have divorced and remarried, list current spouses:

Step-Father's Full Name: ________

Street Address: ________

City: ________ State: ________ Zip: ________

Step-Mother's Full Name: ________

Street Address: ________

City: ________ State: ________ Zip: ________

E. Siblings not seeking placement: (*Attach another page if necessary*)

	Full Name	Address	Date of Birth
1.			
2.			
3.			
4.			

F. Names and addresses of grandparents:

	Full Name	Address
1.		
2.		

G. Parent's health history:

Natural Parents: ________

Adoptive Parents: ________

RELIGIOUS INFORMATION:

Child's current church: ________

Street Address: ________

City: ________ State: ________ Zip: ________

Telephone: ________ Pastor: ________

Do you attend church regularly? ❍ Yes ❍ No

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SCHOOL HISTORY:

Child's Current School: ______________________ GED? ❍ Yes ❍ No

Street Address: ______________________

City: ____________ State: ____________ Zip: ____________

Grade Level: ________ Has Child Failed a Grade? ❍ Yes ❍ No If Yes, Which Ones? ____________

Is Child in Special Education? ❍ Yes ❍ No Self-Contained? ❍ Yes ❍ No

Generally, what kind of grades does child make? ❍ A, ❍ B, ❍ C, ❍ D, ❍ F

Does child have an active Individualized Education Plan (IEP)? ❍ Yes ❍ No IQ (If Known): ____________

Chronologically list schools attended. Check those in which there were problems. Explain in Social History.

1. ______________________ ☐ Had Problems
2. ______________________ ☐ Had Problems
3. ______________________ ☐ Had Problems
4. ______________________ ☐ Had Problems

MEDICAL/HEALTH INFORMATION:

List any health problems, handicaps, or allergies, accidents, or complications with previous surgeries or procedures:

Do you have or have you had any of the following:

	Yes	No	Past	Present
Cardiovascular Disease (*hypertension, blood clots, Migraine, varicose veins*)	❍	❍	☐	☐
Hematologic (*anemia, sickle cell, Rh*)	❍	❍	☐	☐
Metabolic (*diabetes, thyroid disease, gallbladder, hepatitis*)	❍	❍	☐	☐
Genitourinary (*STD's, vaginal infections*)	❍	❍	☐	☐
Cancer (*breast, skin, specific organ, lymph node*)	❍	❍	☐	☐
Neurologic (*depression, epilepsy, nervousness*)	❍	❍	☐	☐
Respiratory (*T.B., asthma, other chronic respiratory disease*)	❍	❍	☐	☐
Diabetes (Type I, Type II, gestational)	❍	❍	☐	☐

If Yes, specify condition and describe

	Yes	No
Have you stayed in a place where you think you have been exposed to bed bugs, lice, or scabies in the past three months?	❍	❍
Has anyone in your family been bitten by bed bugs, or do they have bites or blisters that you are concerned about?	❍	❍

(Following the first question:) If yes, which, and how long ago did you stay there? ______________________

(Following the second question:) If yes, please explain ______________________

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MEDICAL/HEALTH INFORMATION (CONT.):

	Name of Medications currently being taken	Dosage		Name of Medications taken in the past	Dosage
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		

Name of Your Primary Care Physician: ____________________

Street Address: ____________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Date of Last Visit: __________

Reason for Last Visit: ____________________

BEHAVIOR REQUIRING JUVENILE INTERVENTION:

	Charges Filed (theft, truancy, etc.) other than runaway	Date	Juvenile Officer	Phone
1.				
2.				
3.				

EMOTIONAL/PHYSICAL/SEXUAL TRAMA:

	If Yes, Explain in Social History
Has child incurred any emotional abuse?	❍ Yes ❍ No
Has child incurred any physical abuse?	❍ Yes ❍ No
Has child ever been the victim of known/suspected sexual molestation?	❍ Yes ❍ No
Has child ever sexually molested anyone?	❍ Yes ❍ No
Has child had any known or suspected sexual activity?	❍ Yes ❍ No

If Yes, with what age and gender? ____________________

Any known pregnancies? ❍ Yes ❍ No

If Yes, what were results? ____________________

DRUG/ALCHOHOL HISTORY:

Please provide a summary of this child's drug/alcohol use to date. Which drugs, how often, how long, etc.?

CHILD'S BEHAVIORS:

Has child ever run away? ❍ Yes ❍ No If, Yes, how many times? ________ With Others? ❍ Yes ❍ No

How long is child generally gone? ____________________

How does child survive when gone? ____________________

* If Yes, Explain in Social History

Does child turn self in? ❍ Yes ❍ No

Has child ever attempted suicide? ❍ Yes ❍ No *

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Has child had a history of self-mutilation? ❍ Yes ❍ No *
Any history of setting fires? ❍ Yes ❍ No *
Any history of aggressive physical behavior? ❍ Yes ❍ No *
If Yes, to whom? ______________________
Any history of aggressive verbal behavior? ❍ Yes ❍ No
If Yes, to whom? ______________________
What kinds of things make child angry, and how does child react?

HABITS OR PROBLEMS

☐ Overactive	☐ Short Attention Span	☐ Tobacco
☐ Withdrawn	☐ Fearful of Others	☐ Hypochondria
☐ Nightmares *	☐ Temper Tantrums	☐ Truancy (skipping school)
☐ Soils Pants or Bed	☐ Sudden Mood Swings	☐ Follower ❍ Positive ❍ Negative
☐ Eating Disorders *	☐ Wets Pants or Bed	☐ Leader ❍ Positive ❍ Negative
☐ Flashbacks *	☐ Rebellious	☐ Other ______________

***If selected, explain in Social History**

SOCIAL HISTORY QUESTIONS:

Describe specific behaviors (i.e. runaway, theft, discipline problems) that are **presently** prompting placement.

Describe a **history** of the child's behavioral problems, as well as a history of family problems, that may be leading to reason for placement (including when problems began, stress at that time, how problem has progressed.)

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What have you done to handle the problem? (Personally or through agencies)

What changes are expected in order for the child to return home? Include any changes that need to be contributed by other family members.

Do you believe these changes can be made? ❍ Yes ❍ No
How long do you think it will take? ❍ Yes ❍ No
Are you willing to be personally involved? ❍ Yes ❍ No
Do you have alternative plans for your child? ❍ Yes ❍ No If Yes, what are they?

PLACEMENT AND TREATMENT HISTORY:

Please list all placements outside of your home: (include family, relative, adoptive, agencies, hospitals, etc.)

On a scale from one to ten, please rate the helpfulness of the placements (1 is not helpful, 10 is very helpful)

CHRONOLOGICAL PLACEMENT HISTORY PLACEMENT			BEGAN MONTH / YEAR	ENDED MONTH / YEAR	REASON FOR ENDING PLACEMENT	RATING
1.	**Current**					
2.	**Previous**					
3.	**Previous**					

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4.	**Previous**					
5.	**Previous**					

LIST ANY ADDITIONAL SERVICES THE CHILD AND/OR FAMILY HAVE RECEIVED IN THE PAST:
(include hospitalizations, psychological, psychiatric, social services – public or private, etc.)

	AGENCY	CONTACT PERSON	PHONE
1.			
2.			
3.			
4.			
5.			

FINANCIAL INFORMATION:
Please include documentation to show gross income.

Father/Guardian's Employer: ____________ Occupation: ____________
Employer's Street Address: ____________ Telephone: ____________
City: ____________ State: ______ Zip: ____________

Mother/Guardian's Employer: ____________ Occupation: ____________
Employer's Street Address: ____________ Telephone: ____________
City: ____________ State: ______ Zip: ____________

Total Household Income: $ ________ **Child Support:** $ ________ **SSI/VA:** $ ________

How much can you contribute to your child's support while at MBCH Children and Family Ministries? $ ________
Final amount will be determined at intake.
Proof of income (last year's W2) and proof of medical insurance to be submitted at time of placement.

INSURANCE INFORMATION
Do you have medical or dental insurance? ❍ Yes ❍ No
Type of Coverage: ____________
Insurance Company Name: ____________

MISCELLANEOUS INFORMATION:
Can you provide clothing? ❍ Yes ❍ No
Transportation for family contacts? ❍ Yes ❍ No

I verify that all information provided is accurate to the best of my knowledge. I understand that it is my responsibility to provide relevant information as a basis for receiving services and participating in service decisions.

____________________ Signature

____________________ Date

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