

**FLORENCE CRITTENTON HOME & SERVICES**

901 N Harris St

Helena, MT 59601

Phone: 406-442-6950

Fax: 406-442-6571



**Checklist for admission to FCHS. The following items must be received prior to admission. If these items aren't received, the admission process will be delayed:**

- Birth Certificate (Copy of yours and any child's)
- Social Security Card (Copy of yours and any child's)
- Medicaid/Insurance Card (Copy of yours and any child's)
- Immunization Records (Copy of yours and any child's)
- Medical Records (Your child(ren)'s)
- Current and Past Court Documents (If applicable)
- Documentation of Services child(ren) is/are enrolled in
- Verification of Pregnancy or Parenting Status
- Placement Agreement
- SNAP/TANF/WIC Documents (if applicable)
- Current Clinical/Psychological Evaluation
- Chemical Dependency Evaluation

The following information is required to determine appropriateness of placement, facilitate admission, and provide appropriate services. Please provide accurate information since our ability to adequately meet your needs is dependent on the information we receive. This information is privileged and confidential and will be released only if necessary for continuity of care and as required by law.

**Identifying Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

First Last Maiden/Other

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

State County

Race (optional): \_\_\_\_\_ Tribal Affiliation: \_\_\_\_\_

Current Address: \_\_\_\_\_

City State Zip Code

County: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Permanent Address (if different): \_\_\_\_\_

City State Zip Code

County: \_\_\_\_\_ Phone Number: \_\_\_\_\_

What type of identification do you currently have?  Birth certificate  Social security card

State-issued photo I.D./driver's license  Tribal I.D.  Other: \_\_\_\_\_

Are currently covered by: Medicaid  Yes  No Private Insurance:  Yes  No

**Current Living Situation**

Are you currently homeless?  Yes  No

Are you currently in a potentially unsafe living situation?  Yes  No

**Family Information**

Marital Status:  Single  Married  Separated  Divorced  Widowed  Living with someone

If in a relationship, is significant other supportive?

\_\_\_\_\_

Are you currently pregnant?  Yes  No

If yes, what is your due date: \_\_\_\_\_ If yes, what trimester are you in? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Are you the legal guardian of your child(ren)?  Yes  No

How many children do you have custody of at least 51% of the time? \_\_\_\_\_

How many children would be coming with you to Florence Crittenton? \_\_\_\_\_

Is the father of the child involved in parenting:  Yes  No

If yes, does the father of the child have any legal custody? \_\_\_\_\_

Please list the full name, gender, date of birth (DOB), age, and social security number(SSN) of each child:

Child #1: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Child #2: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Child #3: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Child #4: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Do any of your children have special needs?  Yes  No If yes, please explain:

\_\_\_\_\_

Please list primary family members or significant others:

Person #1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person #2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person #3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Person #4: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Educational and Employment History**

Are you currently enrolled in school?  Yes  No

Do you currently or have you had an IEP?  Yes  No

Are you currently employed?  Yes  No

If yes, where? \_\_\_\_\_ How long? \_\_\_\_\_

**Department of Family Services Information**

Describe any current or past involvement with the Department of Family Services and the current legal status regarding your child/children (TLC, TIA, or termination of rights):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any current or past DFS involvement?  Yes  No

County #1: \_\_\_\_\_ Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_

County #2: \_\_\_\_\_ Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_

County #3: \_\_\_\_\_ Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all years that DFS has been involved with your family: \_\_\_\_\_

**Office of Public Assistance Information**

Are you currently or have you ever received financial assistance?  Yes  No

If yes, which of the following are you receiving/have you received?  Medicaid  Food stamps

SSI  SSDI  TANF (Months used: \_\_\_\_\_)

Receive Child Support (amount per month): \_\_\_\_\_  Pay Child Support (amount per month): \_\_\_\_\_

**Chemical Dependency Information**

Have you recently had a chemical dependency assessment?  Yes  No

If yes, when and where? \_\_\_\_\_ What was your diagnosis? \_\_\_\_\_

What is your drug of choice? \_\_\_\_\_ What other drugs have you used? \_\_\_\_\_

What is your last date of use? \_\_\_\_\_ Which drug was it? \_\_\_\_\_

Are you currently in chemical dependency treatment?  Yes  No

If yes, where? \_\_\_\_\_

Please list contact information of current treatment facility:

\_\_\_\_\_

Please list the following information about your treatment history:

Program #1: \_\_\_\_\_

Date: \_\_\_\_\_ Discharge Type: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Program #2: \_\_\_\_\_

Date: \_\_\_\_\_ Discharge Type: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Legal/Criminal History**

Are you a violent and/or sexual offender?  Yes  No If yes, please list the details of the offense(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently on probation or parole?  Yes  No

Probation/Parole Officer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been on probation or parole?  Yes  No If yes, please list the years: \_\_\_\_\_

Probation/Parole Officer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Explain** the charges that led to current or past probation/parole and specify felony or misdemeanor:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the extent of your legal history/criminal charges?

---

---

---

Are you involved with a drug court? If so, where? \_\_\_\_\_

### Mental Health Information

Have you ever been treated for mental health issues?  Yes  No

If yes, when and where? \_\_\_\_\_ What was your diagnosis? \_\_\_\_\_

Therapist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you currently receiving mental health services?  Yes  No

If yes, list contact information for your provider: \_\_\_\_\_

Have you ever had a neuropsychological evaluation?  Yes  No

If yes, when was your evaluation? \_\_\_\_\_ Who completed your evaluation?

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is there a history of mental illness in your family?  Yes  No If yes, please explain:

---

---

### Medical History

Do you or your child/children have any major medical problems?  Yes  No

If yes, please explain: \_\_\_\_\_

---

Are you currently taking any prescribed or non-prescribed medications?  Yes  No

If yes, please provide the following information for prescribed medications:

Medication #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribed For: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribed For: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribed For: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication #4: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribed For: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any other medications you are currently taking (names, dosages, reason for taking and whether prescribed or not): \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

If yes, please list the year(s) and reason(s) you were hospitalized: \_\_\_\_\_

Please list diagnosed illnesses, health conditions or surgeries you have had (e.g., diabetes, TB, STI's, etc):

If you are pregnant do you see a doctor?  Yes  No Would you say your pregnancy has been:

poor  ok  good  excellent

Do you have a primary doctor?  Yes  No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have a pediatrician for your child/children?  Yes  No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### History of Trauma and Loss

Have you ever been emotionally abused?  Yes  No If yes, when and by whom?

\_\_\_\_\_

Have you ever been physically abused?  Yes  No If yes, when and by whom?

\_\_\_\_\_

Have you ever been sexually abused?  Yes  No If yes, when and by whom?

\_\_\_\_\_

If you were sexually abused in any way, what has been the ongoing impact of that experience? Please briefly describe: \_\_\_\_\_

\_\_\_\_\_

Do you have a history of violent behavior?  Yes  No If yes, please explain:

---

---

Please describe any significant losses you have experienced: \_\_\_\_\_

---

---

List any additional information that may be beneficial for us to know: \_\_\_\_\_

---

---

If you or your child has been the victim of a crime, you may be eligible for compensation that can be used toward medical costs, including mental health services, that aren't or haven't been covered some other way. If you'd like a form or more information, please let us know.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_