Skill Builders
Independent Living
www.skill-builders.net
757-233-2896 Office
757-222-1973 Fax

Application for Independent Living Program

Referring/Placing agency: ____

Address: ____
Street City State Zip Code

Referring/Placing agency worker: ____

Telephone #: ______________________ Fax #: __________________________

Email: ____

Emergency telephone #: ____

Funding Source: ____

Youth's name: _____________________________ DOB: __________ Age: ________

National origin: _______________________ Medicaid #: _________________________

MCO provider and number: ____

SSN #: ______________________________ Place of birth: ______________________

Anticipated date of placement: _______________ Anticipated length of stay: _______________

Reasons for referral: ____
____
____

Presently Residing: Check Only One

Emergency Placement Home	□	Treatment Foster Care Home	□
Independent Living Program	□	Residential Program	□
Detention Center	□	Biological Parent(s) or Relative	□
Other	□		

1400 18th Street—Chesapeake—Virginia—23324

Initial Plan of Care Services requested by placing agency (completed within 30 days of placement)

Case Management Services	☐	Medical Follow up	☐
Contact with Probation Officer	☐	Meeting with Attorney	☐
Court Hearing	☐	Outpatient Therapy	☐
Dental Examination	☐	Physical Examination	☐
Educational Testing	☐	Psychological Evaluation/Testing	☐
Eye Examination	☐	School Enrollment	☐
GED Course Enrollment	☐	School Meetings/IEP	☐
Independent Living Skills	☐	Vocational Enrollment	☐
Medication Management	☐	Other _______________________	☐

Identify Family visitation and involvement needs: ____
____
____

Biological Parent(s):

Mother:	____________________________	Father:	___________________________________
Address:	____________________________	Address:	___________________________________
City, State, Zip:	____________________________	City, State, Zip:	___________________________________
Cell Phone:	____________________________	Cell Phone:	___________________________________
Email address:	____________________________	Email address:	___________________________________

Sibling(s):

Name:	____________________________	Relationship:	___________________________________
Address:	____________________________		
City, State, Zip:	____________________________		
Cell Phone:	____________________________		
Email address:	____________________________		
Name:	____________________________	Relationship:	___________________________________
Address:	____________________________		
City, State, Zip:	____________________________		
Cell Phone:	____________________________		
Email address:	____________________________		
Name:	____________________________	Relationship:	___________________________________
Address:	____________________________		
City, State, Zip:	____________________________		
Cell Phone:	____________________________		
Email address:	____________________________		

(Attach any additional known family member information to application)

Involvement of biological parents and extended family:
____
____
____
____

Behavior Support Needs: Please describe the following:

Behavior triggers:
____

Successful intervention strategies used in the past:
____

Emotional and behavioral management techniques:
____

Techniques which have been used for self-management:
____

Have any behaviors led to or are likely to lead to emergency safety interventions, including psychiatric hospitalizations: If yes, indicate:
Behaviors: ____

Permanency planning goals:
1. Goal: ____
   Achievement date: ____

2. Goal: ____
   Achievement date: ____

Youth's skills, interests, strengths and talents: ____
____
____

Describe the youth's behavior in the current living situation: ______________________________
____
____

Level of education: High School Graduate Y/N Received: Diploma/GED N/A

Current school: ____ Grade: ______________________

Adjustment to school (include previous behaviors and retentions):______________________________
____
____

Special Education (circle if applicable) LD ED ID (attach IEP)

Employment past and current employer: ____

Length of time employed: ________________________ Position: ____________________________

Name of primary care physician: ____

Address: ____ Telephone#: ______________

Date of last physical examination: ___________ (attach a copy, including immunization records)

Name of dental provider: ____

Address: ____ Telephone#: ______________

Date of last dental examination: ____________ (attach a copy)

Current medical or mental health issues: ____
____

Currently participating in outpatient counseling: Yes □ No □ If yes, agency name and address:
Agency Name: ____________________________ Address: ____________________________

Individual: □ Therapist: ____
Telephone Number: ______________________________________

Family: □ Therapist: ____
Telephone Number: ______________________________________

Group: □ What Type: ____

Psychiatrist: ____________________________ Telephone Number: ________________

Psychological Evaluation: Yes □ (Date ________________) No □ (Attach a copy)

DSM V Diagnosis:
Axis I: ____
Axis II: ____
Axis III: ____
Axis IV: ____
Axis V: GAF Score____

Current Medications:
1. Name: ______________________________ Dosage: ___________ Frequency: ______________

Reason for medication: ____

2. Name: ______________________________ Dosage: ___________ Frequency: ______________

Reason for medication: ____

3. Name: ______________________________ Dosage: ___________ Frequency: ______________

Reason for medication: ____

Please Check All That Apply That Describes The Individual:

- □ Depressed Mood
- □ Low Self-Esteem
- □ Suicidal Ideation
- □ Sexual Perpetrator
- □ Destroys Property
- □ Temper Outbursts
- □ Homicidal Ideation
- □ Lacks Self-Confidence
- □ Physically Challenged
- □ Preoccupied With Self
- □ Hostility towards Others
- □ Non-Compliant with Curfew
- □ Displays Oppositional/Defiant Behaviors
- □ Disrespectful towards Authority Figures
- □ Requires Assistance with Bathing and Dressing
- □ Poor Social Interactions
- □ Poor Communication Skills
- □ Poor Decision Making Skills
- □ Difficulty Following Directions
- □ Difficulty Completing Homework
- □ Difficulty Completing Assigned Chores
- □ History of Lying
- □ History of Assault
- □ History of Stealing
- □ History of Petty Larceny
- □ History of Substance Abuse
- □ History of Disorderly Conduct
- □ History of Runaway Behaviors
- □ History of Aggressive Behaviors
- □ History of Being Physically Abusive towards Others

List last three emergency foster care placements:

1. Placement: ______________________________
   Dates: ______________________________
2. Placement: ______________________________
   Dates: ______________________________
3. Placement: ______________________________
   Dates: ______________________________

List last three foster home placements:

1. Home: ______________________________
   Dates: ________________ Reason for Discharge: ________________
2. Home ______________________________
   Dates: ________________ Reason for Discharge: ________________
3. Home ______________________________
   Dates: ________________ Reason for Discharge: ________________

List last three psychiatric hospitalizations: (attach discharge summaries)

1. Hospital: ______________________________
   Dates: ______________________________
2. Hospital: ______________________________
   Dates: ______________________________
3. Hospital: ______________________________
   Dates: ______________________________

Probation/Parole Officer: Yes □ No □ (Attach rules of probation/Parole/ upcoming court dates)

Name: ______________________________ Telephone Number: ______________________________

List all charges: ______________________________

____

Please attach a copy of the following items for placement consideration:

- □ Custody Order
- □ Medicaid Card/Number
- □ MCO Provider Card/Number
- □ DSM V Diagnosis
- □ Certification by the FAPT or CPMT for placement (attach most recent report)
- □ Recent CAFAS/CANS
- □ Psychological Evaluation
- □ Social History
- □ Birth Certificate
- □ Social Security Card/Number
- □ Physical Examination (within the last 12 months)
- □ Dental Examination (within the last 12 months)
- □ Service Plans and Monthly Summaries from previous placements
- □ IEP and any educational information (within the last 12 months)
- □ Admission Note and Discharge Note from Previous Placements and hospitalizations
- □ Copy of previous Independent Living Assessments (within the last 3 months)
- □ Previous DJJ Reports/Rules of Probation

Rate youth on ability of independence:

Skill	Independent	Some Assistance	Total Assistance
Money Management			
Community Resource			
Legal Plans			
Educational Planning			
Personal Appearance/Hygiene			
Housekeeping			
Transportation			
Interpersonal Skills			
Leisure Activities			
Food Management			
Health			
Job Maintenance Skills			
Job Seeking			
Housing			

Suitability of resident's admission determined by: ____

What are the protection needs of the resident? ____
____
____

Would resident's admission to the program pose a potential risk to self, other residents and/or staff?
If yes, explain: ____
____
____

______________________________ ___________________
Signature of Referring Worker Date