PRTF APPLICATION CHECKLIST

APPLICATIONS THAT ARE RECEIVED INCOMPLETE WILL NOT BE PROCESSED.

PLEASE FOLLOW THE CHECKLIST BELOW WHEN COMPLETING THE ENCLOSED PRTF APPLICATION.

___________ PLEASE COMPLETE APPLICATION IN FULL.

___________ PLEASE ATTACH ALL OF THE FOLLOWING INFORMATION FOR APPLICATION TO BE PROCESSED.

___________ CURRENT IEP, FINAL GRADES FROM PREVIOUS SCHOOL YEAR,SUSPENSIONS.

____________ IMMUNIZATION RECORD

____________ PSYCHOLOGICAL TESTING

____________ HISTORY AND PHYSICAL

____________ CURRENT TREATMENT PLAN

PLEASE RETURN ALL INFORMATION TO:
The Brynn Marr Helpline at (910)-577-2767 (fax) or call (800)-822-9507.

PRTF APPLICATION

1. PERSON/AGENCY MAKING APPLICATION

NAME:____________________________________

ADDRESS: _________________________________

TELEPHONE: _______________________________

FAX: ______________________________________

2. CLIENT

NAME: _____________________________________

ADDRESS: __________________________________

CITY: ______________________________________

STATE:_______________________ ZIP: ___________

TELEPHONE #: ______________________________

DOB: ___________ AGE: ______________ SEX: _____

SSN #: ___________________ RACE: _______________

MEDICAID #: __________________________________

3. CUSTODY

LEGAL CUSTODIAN: ___________________________

RELATIONSHIP: _______________________________

ADDRESS: _______________________________________

CITY: ______________________ STATE: ______________

ZIP: __________ TELEPHONE #: ____________________

HAVE PARENTAL RIGHTS BEEN TERMINATED?

Y_________ N____________ WHEN ________________

HAS CLIENT BEEN ADOPTED? Y________ N_________

DATE OF FINAL ADOPTION ORDER: _________________

CLIENT'S SIBLINGS

NAME	AGE	RELATIONSHIP	PRESENTLY LIVES WITH
______________________	_______	__________________	________________________
______________________	_______	__________________	________________________
______________________	_______	__________________	________________________

4. MEDICAL

MEDICAL PROBLEMS/PAST SURGERIES (INCLUDE DATES)

____

ALLERGIES.ADVERSE DRUG REACTIONS

____

CLIENT'S PHYSICIAN

NAME:_________________________ ADDRESS: ________________________

TELEPHONE: __________________________

CLIENT'S DENTIST

NAME: ________________________ ADDRESS: __________________________

TELEPHONE: _____________________________

CURRENT/PAST SYMPTOMS

PAST/PRESENT SUICIDAL/HOMICIDAL IDEATION/GESTURE/ATTEMPT

____

____

____

PAST/PRESENT HISTORY OF PSYCHOSIS

____

____

____

HISTORY OF PHYSICAL/SEXUAL ABUSE/NEGLECT

____

____

____

HISTORY OF RUNAWAYS

____

____

____

HISTORY OF CHEMICAL DEPENDENCY

TYPE	AMOUNT	FREQUENCY	LAST USE

CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY

5. LEGAL ISSUES

CHARGES	OUTCOME

PROBATION OFFICER	TELEPHONE #

INPATIENT HOSPITALIZATION (S) WITHIN THE LAST YEAR

HOSPITAL	DATES

OUTPATIENT TREAMENT

NAME	AGENCY	TELEPHONE #

GROUP HOME PLACEMENT (IN LAST TWO YEARS)

GROUP HOME	ADDRESS	DATES

RESIDENTAL PLACEMENT (IN LAST TWO YEARS)

CENTER NAME	ADDRESS	DATES

OTHER AGENCY INVOLVEMENT (GAL,DSS,ETC)

AGENCY CONTACT PERSON TELEPHONE #

______________________ ______________________ ________________

______________________ ______________________ ________________

6. ACADEMICS

ASSIGNED SCHOOL GRADE _____ RETANINED AND IN WHAT GRADE ________

EDUCATIONAL SETTING

REGULAR CLASS _______ SPECIAL ED _____ OTHER ______

HAS CLIENT BEEN CLASSIFIED AS SPECIAL NEEDS UNDER PL 105-17

AU BED C/B HI EMD TMD SPD MU OI OHI SLD SLI VI

HAS CLIENT BEEN SUSPENDED/EXPELLED IN LAST SCHOOL YEAR?

PLEASE LIST AND EXPLAIN INCIDENTS

____

____

____

7. PLEASE LIST OTHER RESIDENTIAL FACILITIES APPLIED FOR

1. ____

2. ____

3. ____

8. CURRENT SYMPTOMS AND FUNCTIONING REQUIRING TREATMENT IN PRTF.

____

____

9. CHRONIC BEHAVIORS

____

____