AFFINITI CARE L.L.C

610-977-1045
www.afincare.org
affiniticare@gmail.com
26 Marple Avenue,
Clifton Heights, PA 1901

Affiniti Care LLC Placement intake form:

Please fill the form to the best of your knowledge. Please write N/A if not applicable. Send via email to the email below

Date of referral:

Time of Referral:

Referral Information:

Person Making Referral:

Phone Number:

Email Address:

Fire

Relationship to Client:

- [ ] OCY Staff
- [ ] Detention Staff
- [ ] Other

County Agency:

Case Worker

Phone:

Email:

Supervisor Name:

Phone:

Email:

GAL:

Phone:

Email:

Reason For Referral:

- [ ] Parent/Child Conflict
- [ ] Disruptive Behavior
- [ ] Repeated Arrests
- [ ] School Conflict
- [ ] Sexually Acting Out
- [ ] Truancy
- [ ] Breaking Curfew
- [ ] Abuse/Neglect
- [ ] Poor relationship with Parents, siblings
- [ ] Repeated Arrests
- [ ] Not wanting to live a t home
- [ ] Poor Grades
- [ ] Stealing
- [ ] Other

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Client Information:

County Case Number:

Master Client Index Number:

First Name:

Middle Name:

Last Name:

Youth's Most Recent Address:

Youth Phone:

Youth Email:

Youth Social Media:

DOB:

SSN:

Current Age:

Primary Language•

Race:

Ethnicity:

- [ ] Non-Hispanic
- [ ] Hispanic

Religion:

Identified Gender:

Transgender:

- [ ] No
- [ ] Yes

Sexual Orientation:

Pregnant:

- [ ] Yes
- [ ] No
- [ ] N/A

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Education Information:

Current Enrollment Status:

☐ Enrolled ☐ Not Enrolled ☐ Unknown

Name of School

School Address:

Current Grade:

IQ:

Special Education:

☐ Yes ☐ No ☐ Unknown

Any limitations on intellectual functioning:

☐ Yes ☐ No

Plan for schooling if accepted

Allergy (s)	Type of Reaction:

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Medical Information:

Does child have a physical diagnosis:

☐ Yes ☐ No ☐ Unknown

If yes, indicate diagnosis:

Is youth taking prescribed medcations:

☐ Yes ☐ No ☐ Unknown

If yes, does youth have meds:

☐ Yes ☐ No ☐ Unknown

If yes, please list medications, along with prescribing physician:

Does medication require blood level monitoring:

☐ Yes ☐ No

If yes, will parent/guardian or referring agency arrange for monitoring:

☐ Yes ☐ No

What other important medical information/concerns we need to know:

Medication Name/Doseage, frequency, rout, time:	Prescribing Physician:

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Medication Name/Doseage, frequency, rout, time:	Prescribing Physician:

Behavioral Health Information:

Does child have a mental health diagnosis:

☐ Yes ☐ No ☐ Unknown

If yes, indicate diagnosis:

Autism Diagnosis:

☐ Yes ☐ No ☐ Unknown

Does youth have a history of substance abuse?

☐ Yes ☐ No

If Yes please indicate the substance:

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If appropriate, please indicate the level of mental health treatment the youth has:

- [ ] Outpatient Therapy
- [ ] Intensive Outpatient Therapy
- [ ] Partial Hospitalization
- [ ] Inpatient Hospitalization
- [ ] Other

Number of Times Attended:

Number of Times Attended:

Does youth have a history of fire setting or fire alarm pulling:

- [ ] Yes
- [ ] No

If yes, please elaborate

Does youth have a history of sexually inappropriate behavior:

- [ ] Yes
- [ ] No

If yes, please elaborate

Current or history of aggressive behavior

- [ ] Yes
- [ ] No

If yes, please elaborate

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Health Insurance Information:

Does child have health insurance:

☐ Yes ☐ No

Insurance Name: **Member ID:** **Phone:**

PCP Name: **Phone:**

Address:

Criminal History:

Has youth ever been involved with juvenile or criminal justice system:

☐ Yes ☐ No

If yes, please list past and current criminal charges and status (adjudicated, misdemeanor or felony):

JPO Supervisor Name: **Phone:** **Email:**

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Miscellaneous Information:

Upcoming Appointments:

Date	Time	Location	Purpose	Who will transport?

Emergency Contact:

First Name:

Last Name:

Relationship to Client:

Aware of Client Situation:

☐ Yes ☐ No

Phone number:

Email Address:

Address:

Form Completed By:

Signature

County Client ID:

County Staff signature: