

Is child/youth at risk of removal from preferred childcare or education setting? Yes No

If yes, please explain: _____

Is child/youth at risk of disruption to preferred living situation? Yes No

If yes, please explain: _____

Does the child/youth have any physical challenges or limitations? Yes No

If yes, please explain: _____

Does the child have any special needs or delays? Yes No

If yes, please explain: _____

List child and family strengths: _____

What help does your family need (use family's voice): _____

Household Demographic Information

Income of Family: Monthly: _____ or Annual: _____

SSI: _____ TANF: _____ Child Support: _____ Other: _____

Insurance of Child/Youth: Medicaid (Medicaid Provider: _____)

CHIP MAP Private Insurance (Name of Company): _____

No Insurance Coverage

Living Arrangement of Child/Youth (check all that apply): Adoptive Home Biological Father

Biological Mother Biological Parents Camp Drug/Alcohol Treatment Center Emergency Shelter

Foster Care Group Home Home of Friend Home of Relative Independent/Lives by Self

Independent/Lives with friend or partner Emergency Shelter ICF/IID Jail/Prison Juvenile

Detention Center Living with a Non-Parent Relative Psychiatric Hospital Residential Treatment

Center Two Parent/Caregiver Home

Household Members:

Parent/Caregiver:

Name: _____ Relationship to child/youth: _____

Name: _____ Relationship to child/youth: _____

Marital Status of parents/caregivers: _____

List any Parent residing out of the home:

Name: _____ Relationship to child/youth: _____

Name: _____ Relationship to child/youth: _____

List siblings residing in the home:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

List any siblings residing out of the home:

Name: _____ Age: _____ Living where: _____
Name: _____ Age: _____ Living where: _____
Name: _____ Age: _____ Living where: _____

Other household members:

Name: _____ Relationship to Child/Youth: _____
Name: _____ Relationship to Child/Youth: _____
Name: _____ Relationship to Child/Youth: _____

Mental Health Status

Current Diagnosis: DSM V

Date of Evaluation: _____ Diagnostician: _____ (Attach Evaluation)
Code: _____ Diagnosis: _____
Code: _____ Diagnosis: _____

Prior or DSM IV Diagnosis (if applicable):

Date of Evaluation: _____ Diagnostician: _____ (Attach Evaluation)
Axis I Code: _____ Diagnosis: _____
Code: _____ Diagnosis: _____
Code: _____ Diagnosis: _____
Axis II Code: _____ Diagnosis: _____
Axis III Code: _____ Diagnosis: _____
Axis IV Code: _____ Diagnosis: _____
Axis V Code: _____ Diagnosis: _____

Has your child/youth been diagnosed with a developmental disability: Yes No?

Current Prescribed Medication:	Amount:	Year/Date Prescribed:	Prescribing Physician:

Prior Prescribed Medication:	Amount:	Year/Date Prescribed:	Prescribing Physician:

Education Information

School District Child/Youth Attends: _____ Grade: _____
 Name of School: _____
 School Contact Person & Info: _____
 Has Child/Youth Been Suspended: Yes No?
 Placed in Alternative Program? Yes No Program Name: _____
 Special Education: Yes No Referred 504 Accommodations _____
 Classification: ED LD OHI Other _____
 Services Provided by Special Education: Yes No Date of last ARD: _____
 Classroom Status of Child/Youth: Self-Contained Inclusion Resource Classes
 Services Provided by the School: OT PT Speech Assisted Technology 1:1 Aid Services
Behavior Specialist Special Ed Counseling SCORES Other: _____

Agency Involvement

Please list ALL PAST and PRESENT involvement with below agencies:
Juvenile Justice Involvement (Past & Present): Yes No
 Most Recent Contact Person/Phone#: _____
 Disposition Date: _____ Expiration Date: _____
 Next Court Date: _____
 Court Status: Pending Court Deferred Prosecution On Probation On Parole C.O.P.E. S.N.D.P.
Other: _____
 History with Agency (List current & prior reason for referral w/ dates and outcomes):

Dept. of Family & Protective Services (Past & Present): Yes No
 Most Recent Referral Date: _____ Most Recent Contact Person/Phone#: _____
 History with Agency (List current & prior reason for referral w/ dates and outcomes):

Integral Care Involvement (Past & Present): Yes No

- Child & Family Services:** Enrollment Date: _____ Current Level of Care: _____
Contact Person/Phone#: _____ Services Provided: Therapy
 School Based Psychiatric/MEDS YES Waiver TACOOMMI Case Mgmt FPP
 Other: _____

And/Or

- Intellectual & Developmental Disabilities:**
Enrollment/Intake Date: _____ ICAP Level of Need: _____
Contact Person/Phone#: _____
Services Provided: Service Coordination Behavior Therapy Respite Community First
Choice Texas Home Living PACE Crisis Intervention Services CBS (Community Based
Services) Other: _____

History with Agency (List current & prior involvement w/ dates and outcomes):

Travis Co. Health & Human Service Programs (Past & Present): Yes No

Emergency Services (Food, Rent Asst) Deaf Services Neighborhood Conference Centers

Community Center (list location): _____

Healthy Families Children F.I.R.S.T. YFAC/CIS CPC Meeting TRIAD The Children's
Partnership/Bridge Coordination CPS Reintegration

Other Counseling/Psychiatric Agencies or Programs (Past & Present): Yes No

If yes please list agency(s) w/ dates of involvement: _____

Please list ALL Community Resource(s) this family has utilized with dates of involvement:

(Examples: Faith-Based, Recreation Programs, Support Groups, Mentors, Coaches, Non-Profits, etc.)

Placement History of Child/Youth

Residential Placement(s)/Hospitalization(s): *include PHP and IOP Programs*

1. Facility: _____ Admit Date: _____ End Date: _____
Reason for Admission: _____
Discharge Status: Successful Unsuccessful Funding Constraints Other: _____
2. Facility: _____ Admit Date: _____ End Date: _____
Reason for Admission: _____
Discharge Status: Successful Unsuccessful Funding Constraints Other: _____
3. Facility: _____ Admit Date: _____ End Date: _____
Reason for Admission: _____
Discharge Status: Successful Unsuccessful Funding Constraints Other: _____
4. Facility: _____ Admit Date: _____ End Date: _____
Reason for Admission: _____
Discharge Status: Successful Unsuccessful Funding Constraints Other: _____

Other (i.e. foster, non-profit placement, relative placement, shelter):

1. Agency/Person Name: _____ Begin Date: _____ End Date: _____
Type of Service: _____ Outcome: _____
2. Agency/Person Name: _____ Begin Date: _____ End Date: _____
Type of Service: _____ Outcome: _____
3. Agency/Person Name: _____ Begin Date: _____ End Date: _____
Type of Service: _____ Outcome: _____
4. Agency/Person Name: _____ Begin Date: _____ End Date: _____
Type of Service: _____ Outcome: _____

**Please remember to have the child or youth being referred
complete the
CPC Child/Youth Interest Form**