

MARIE'S HOUSE OF HOPE
CHILD APPLICATION



- Group Home
- Independent living

Date ____ / ____ / ____

CHILD'S NAME _____ Male Female
FIRST MIDDLE NAME LAST SOCIAL SECURITY No. ____ - ____ - ____

AGE _____ GRADE _____ BIRTH DATE ____ / ____ / ____ IS THIS CHILD ADOPTED? _____

OHIO MEDICAID, TYPE: Healthy Start Amerigroup Molina CareSource or IF PRIVATE INS., PLAN NAME: _____

(FAX OR MAIL COPY OF HEALTH INSURANCE PLAN WITH APPLICATION) RELIGION _____ ACTIVE? _____

CHILD'S ROUTINE (SCHOOL HOURS, STANDING APPOINTMENTS, ETC.) _____

NAME OF PERSON MAKING APPLICATION _____ RELATIONSHIP _____

ADDRESS _____ PHONE (____) ____ - ____
STREET CITY STATE ZIP FAX (____) ____ - ____

EMAIL: _____ CELL (____) ____ - ____

FAMILY INFORMATION ON APPLICANT:

NAME OF MOTHER _____ SS# ____ - ____ - ____ AGE _____ DOB ____ / ____ / ____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) ____ - ____ WORK PHONE (____) ____ - ____ CELL PHONE (____) ____ - ____

NAME OF FATHER _____ SS# ____ - ____ - ____ AGE _____ DOB ____ / ____ / ____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) ____ - ____ WORK PHONE (____) ____ - ____ CELL PHONE (____) ____ - ____

WHO HOLDS CUSTODY OF CHILD? _____

WITH WHOM DOES THE CHILD RESIDE? _____

COMPLETE NEXT ITEM IF PERSON OTHER THAN PARENT HAS CUSTODY:

NAME _____ SS# ____ - ____ - ____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) ____ - ____ WORK PHONE (____) ____ - ____ CELL PHONE (____) ____ - ____

EXPLANATION: _____ FAX (____) ____ - ____

PERSON HOLDING LEGAL CUSTODY IS EMPLOYED BY: COMPANY _____

ADDRESS _____

REASONS FOR APPLYING TO MARIE'S HOUSE OF HOPE: _____

DESCRIBE "NON-CUSTODIAL PARENT (S)" ATTITUDE TOWARD CHILD ENTERING MHOH: _____

DESCRIBE CHILD'S CURRENT FAMILY LIFE: _____

NUMBER OF SIBLINGS AT HOME _____ AGES _____

IN YOUR OWN WORDS, WHAT ARE THE PROBLEMS OR DIFFICULTIES THIS CHILD IS HAVING?

WHEN DID THESE PROBLEMS FIRST BEGIN? _____

WHAT HELP HAVE YOU TRIED AND HOW WAS IT BENEFICIAL? _____

_____ WHAT CHANGES HAVE YOU NOTICED RECENTLY IN THE CHILD'S BEHAVIOR AND MOODS OR IN OTHER FAMILY MEMBERS? _____

HAVE ANY OF THE FOLLOWING EVENTS OR CHANGES HAPPENED TO THE CHILD OR THE CHILD'S FAMILY IN THE LAST YEAR?

- | | | | |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> LOSS OF ACCEPTANCE BY PEERS | _____ COMMENT _____ | <input type="checkbox"/> PARENTS DIVORCED OR SEPARATED | _____ COMMENT _____ |
| <input type="checkbox"/> PARENT REMARRIED | _____ | <input type="checkbox"/> MAJOR ILLNESS OF FAMILY MEMBERS | _____ |
| <input type="checkbox"/> UNWED PREGNANCY | _____ | <input type="checkbox"/> ACQUIRED A VISIBLE DEFORMITY | _____ |
| <input type="checkbox"/> SCHOOL FAILURE | _____ | <input type="checkbox"/> DRUG, ALCOHOL INVOLVEMENT | _____ |
| <input type="checkbox"/> DEATH OF CLOSE FRIEND | _____ | <input type="checkbox"/> HOSPITALIZATION | _____ |
| <input type="checkbox"/> DEATH OF PARENT | _____ | <input type="checkbox"/> MOVED | _____ |
| <input type="checkbox"/> DEATH OF SIBLING | _____ | <input type="checkbox"/> CHANGED SCHOOL | _____ |
| <input type="checkbox"/> FAMILY MEMBER IN JAIL | _____ | <input type="checkbox"/> BEGINNING SCHOOL | _____ |

IF ANY OF THE FOLLOWING EVENTS OR CHANGES HAPPENED TO THE CHILD OR THE CHILD'S FAMILY IN THE LAST YEAR?

CHECK AND EXPLAIN:

	PROBLEM AREA	EXPLANATION (PAST, PRESENT)
<input type="checkbox"/>	STEALING	
<input type="checkbox"/>	LYING	
<input type="checkbox"/>	ACADEMIC UNDER ACHIEVEMENT OR FAILURE	
<input type="checkbox"/>	RUNNING AWAY	
<input type="checkbox"/>	TOILET PROBLEMS (BED WETTING, SOIL PANTS, ETC.)	
<input type="checkbox"/>	TEMPER TANTRUMS	
<input type="checkbox"/>	SLEEP DISORDERS (TOO MUCH, TOO LITTLE, NIGHTMARES, SLEEPWALKING)	
<input type="checkbox"/>	NERVOUSNESS/ANXIETY (WORRY, APPREHENSION, TENSION, FEAR, PHOBIAS)	
<input type="checkbox"/>	TIREDDNESS/FATIGUE (LACK OF ENERGY)	
<input type="checkbox"/>	EATING PROBLEMS (TOO MUCH, TOO LITTLE, PHOBIAS, ANOREXIC, ETC.)	
<input type="checkbox"/>	SEXUAL MISBEHAVIORS, ACTIVITIES	
<input type="checkbox"/>	SHYNESS (WITHDRAWAL, ISOLATION, AVOIDANCE, DISCOMFORT WITH PEOPLE)	
<input type="checkbox"/>	EXTREME FEARS/PHOBIAS (DARKNESS, ANIMALS, HEIGHTS, ETC.)	
<input type="checkbox"/>	OVERLY DEPENDENT (UNABLE TO COPE WITHOUT ASSISTANCE, REASSURANCE)	
<input type="checkbox"/>	JEALOUSY (EXTREME SIBLING RIVALRY, ENVY, ETC.)	
<input type="checkbox"/>	CRUELTY/DESTRUCTIVENESS (CRUELTY TO PEOPLE OR ANIMALS, DESTRUCTIVE)	
<input type="checkbox"/>	OVERLY SENSITIVE (EASILY UPSET, FEELS MISTREATED FREQUENTLY)	
<input type="checkbox"/>	CLUMSY (ACCIDENT PRONE)	

CHECK AND EXPLAIN:

<input type="checkbox"/>	OVER OR UNDER ACTIVE (FIDGETY, INABILITY TO SIT STILL; SLOWED SPEECH OR MOVEMENT)	
<input type="checkbox"/>	DEPRESSION/SADNESS	
<input type="checkbox"/>	GUILT FEELINGS	
<input type="checkbox"/>	DRUG USAGE	
<input type="checkbox"/>	ALCOHOL USAGE	
<input type="checkbox"/>	TOBACCO USAGE	
<input type="checkbox"/>	MISCONDUCT IN SCHOOL	
<input type="checkbox"/>	TRUANCY	
<input type="checkbox"/>	SPEECH/HEARING (ARTICULATION, STUTTERING, LACK OF HEARING, ETC.)	
<input type="checkbox"/>	SUICIDAL TENDENCIES (THOUGHTS, ACTS, THREATS TO LIFE)	
<input type="checkbox"/>	FIGHTING (AGGRESSION, ASSAULTIVE ACTS)	
<input type="checkbox"/>	ANGER/NEGATIVISM (FREQUENTLY SEEMS ANGRY, HOSTILE TOWARD OTHERS)	
<input type="checkbox"/>	PREOCCUPATION WITH PHYSICAL COMPLAINTS (HEADACHES, STOMACH ACHES, ETC.)	
<input type="checkbox"/>	SEIZURES, CONVULSIONS, BLACKOUTS	
<input type="checkbox"/>	DIFFICULTY CONCENTRATING (MENTAL CONFUSION, MEMORY IMPAIRMENT)	
<input type="checkbox"/>	OBSESSIONS/COMPULSIONS (UNWANTED, REPEATED ACTS, SEEMINGLY SENSELESS THOUGHTS OR ROUTINES)	
<input type="checkbox"/>	MOOD SWINGS	
<input type="checkbox"/>	OPPOSITIONAL/DISOBEDIENT (REFUSES TO OBEY FAMILY AND SOCIETAL RULES, DEFIES AUTHORITY)	

SOCIAL AND DEVELOPMENTAL HISTORY:

DESCRIBE CHILD'S HEALTH: _____

WHAT ACHES, PAINS, OR PHYSICAL DISCOMFORTS DOES THE CHILD CURRENTLY HAVE? _____

DOES THIS CHILD HAVE ANY OF THE FOLLOWING PROBLEMS?:

_____ HEARING _____ VISION _____ SPEECH _____ IMPAIRMENT OF LIMBS _____ ASTHMA _____ ALLERGIES

_____ HYPERACTIVE _____ NIGHTMARES _____ SLEEPWALKING _____ OTHER (PLEASE EXPLAIN BELOW)

ALLERGIES (LIST): _____

OTHER EXPLANATION: _____

HOW DO THESE PROBLEMS AFFECT THE CHILD? _____

HOW DOES THE CHILD HANDLE THE PROBLEMS? _____

WHAT HAS THE CHILD BEEN HOSPITALIZED FOR IN THE PAST? _____

WHAT MEDICINE(S) IS THE CHILD CURRENTLY TAKING AND WHY WERE THESE PRESCRIBED? _____

HAS THE CHILD BEEN ON ANY MEDICATION PRIOR TO THIS? IF SO, PLEASE EXPLAIN WHY THEY WERE PRESCRIBED. _____

WHAT SERIOUS ACCIDENTS HAS THIS CHILD HAD? _____

WHAT SERIOUS ILLNESSES HAS THIS CHILD HAD? _____

WHEN WAS THE CHILD'S LAST MEDICAL EXAMINATION? _____

WERE THERE ANY ABNORMAL FINDS? _____ IF SO, PLEASE EXPLAIN: _____

NAME OF CHILD'S PHYSICIAN _____ PHONE () _____

ADDRESS _____

PLEASE LIST NAMES AND ADDRESSES OF ANY OTHER HEALTH PROFESSIONAL (i.e., SPEECH PATHOLOGIST, NURSE, PHYSICAL THERAPIST, COUNSELOR, ETC.) THAT THE CHILD HAS BEEN UNDER THE CARE OF: _____

WHAT, IF ANY, PROBLEMS WERE THERE DURING PREGNANCY AND BIRTH WITH THIS CHILD? _____

IN ORDER OF SIBLINGS, WHAT NUMBER IS THIS CHILD IN THE FAMILY? _____

SCHOOL HISTORY:

PLEASE LIST ALL THE SCHOOLS THIS CHILD HAS ATTENDED STARTING WITH THE CURRENT ONE:

SCHOOL	MAILING ADDRESS	GRADE	YEAR(S)

WHAT GRADE IS THIS CHILD IN NOW? _____ WHAT GRADE(S) HAS THIS CHILD REPEATED? _____

LIST ANY HONORS THIS CHILD HAS RECEIVED: _____

WHAT, IF ANY, PROBLEMS DOES (OR HAS) THIS CHILD HAD WITH SCHOOL? _____

IS THIS CHILD'S SCHOOL WORK: _____ ABOVE AVERAGE _____ AVERAGE _____ BELOW AVERAGE _____ FAILING

IN WHAT 3 SUBJECTS DOES THIS CHILD EARN THE BEST GRADES?

IN WHAT 3 SUBJECTS DOES THIS CHILD EARN THE LOWEST GRADES?

IN WHAT EXTRA CURRICULAR ACTIVITIES DOES THIS CHILD PARTICIPATE? _____

WHAT PSYCHOLOGICAL OR ACHIEVEMENT TESTS HAS THIS CHILD HAD AND WHAT WERE THE RESULTS? _____

WHO SHOULD WE CONTACT TO GET A COPY OF THE TEST REPORTS?:

NAME _____ ORGANIZATION _____

ADDRESS _____

DURING THE LAST 12 MONTHS: DAYS ABSENT _____ TIMES SUSPENDED _____

HOME HISTORY:

IF THIS CHILD HAS ANY FAMILY MEMBERS LIVING OUTSIDE THE HOME, PLEASE PROVIDE INFORMATION ON THEM IN THE SPACE PROVIDED BELOW:

NAME	RELATIONSHIP	AGE	EDUCATION LEVEL	OCCUPATION	REASON FOR LEAVING

PARENTS MARITAL STATUS:

- CURRENTLY MARRIED TO EACH OTHER HOW LONG? _____
- CURRENTLY SEPARATED HOW LONG? _____
- DIVORCED HOW LONG? _____ MOTHER REMARRIED HOW LONG? _____
- WIDOWED HOW LONG? _____ FATHER REMARRIED HOW LONG? _____
- NEVER MARRIED TO EACH OTHER

WHAT MARRIAGE PROBLEMS HAVE THERE BEEN WITHIN THE HOME? _____

HAS EITHER PARENT BEEN MARRIED BEFORE? YES NO IF YES, WHO AND FOR HOW LONG? _____

HOW DID THE PREVIOUS MARRIAGE END? _____

WHAT PROBLEMS DOES THIS CHILD HAVE AT HOME? _____

WHEN ARE THESE PROBLEMS BETTER? _____

WHEN ARE THEY WORSE? _____

WHO DISCIPLINES THE CHILDREN AND HOW? (PLEASE BE SPECIFIC) _____

DO THE PARENTS AGREE ON DISCIPLINARY METHODS? _____ IF NO, HOW ARE THE DIFFERENCES OF OPINION HANDLED? _____

WHAT ARE THIS CHILD'S STRONG POINTS OR FAVORABLE CHARACTERISTICS? _____

WHAT, IF ANY, TROUBLES HAS THIS CHILD'S **FAMILY** HAD WITH THE LAW? (PLEASE DESCRIBE) _____

WHAT, IF ANY, TROUBLE HAS THIS **CHILD** HAD WITH THE LAW? (PLEASE DESCRIBE) _____

SOCIAL HISTORY:

DESCRIBE THE CHILD'S BEHAVIOR. (DEGREE OF COOPERATION, EXTENT OF OBEDIENCE, GENERAL ATTITUDE, NATURE OF ANY PROBLEMS, ETC.)

DESCRIBE HOW APPLICANT GETS ALONG WITH THOSE HE/SHE LIVES WITH: _____

HOW OFTEN DOES THIS CHILD INTERACT WITH CHILDREN OUTSIDE OF SCHOOL/HOME? _____

HOW DOES THIS CHILD GET ALONG WITH INDIVIDUALS OUTSIDE THE HOME? _____

HOW MANY FRIENDS DOES THIS CHILD HAVE? _____

DOES THIS CHILD LIVE NEAR OTHER CHILDREN IN HIS/HER AGE GROUP? _____

HOW DOES HE/SHE GET ALONG WITH BOYS AND GIRLS IN SAME AGE GROUP? _____

HOW DOES HE/SHE GET ALONG WITH OLDER AND YOUNGER CHILDREN? _____

WHAT PEOPLE HAS THIS CHILD FELT CLOSE TO IN HIS/HER LIFE? _____

DOES HE/SHE GET ALONG WITH TEACHERS AS COMPARED WITH HIS /HER PARENTS? _____

WHAT GAMES, INTERESTS AND/OR HOBBIES DOES THIS CHILD HAVE? _____

WHAT ORGANIZED SOCIAL GROUP(S) DOES THIS CHILD BELONG? (i.e., GIRLS SCOUTS, BOY SCOUTS, LITTLE LEAGUE, ETC.) _____

DOES THIS CHILD ENJOY SOCIAL OUTINGS? _____ WHAT KINDS? _____

WOULD THIS CHILD RATHER PLAY WITH OTHERS? _____ OR PLAY ALONE? _____

OBSERVATIONS/COMMENTS:

Physical Location
Marie's House of Hope
468 E Main Street
Trotwood, OH 45426

Business Address
Marie's House of Hope
P.O. Box 219
Dayton, OH 45405

Phone: 937.305.5119 Fax: 937.278.0474

Date: ____ / ____ / ____

Dear _____:

Regarding: _____ DOB: ____ / ____ / ____ DOP: ____ / ____ / ____

I just wanted to remind you of some things needed for the new placement at Marie's House of Hope. I need the following:

- copy of birth certificate; adoption decree if relevant
- copy social security card
- state photo ID if age 16 or over
- Medicaid card or parent insurance card info. (fax copy with application)
- Immunization records
- Legal custodian/guardian document/or certified copy of child custody order
- Copy of any court ordered placement
- Contract from placing agency to MHOH
- Our contract to placing agency
- Copy of Case Plan or most recent Amended Case Plan and most recent SAR
- School: IEP and other required documents
- ICCA—Individual Child Care Agreement
- Last official place of residency—for school district billing or parent residency
- Medical history needed when we take child to Clinic for physical
- *Important***—Copy of Ohio Medicaid card or parent health/dental/eye insurance card & claim forms for doctor visits—**submit health ins. card when making application so we can make arrangements with the acceptable doctors within that plan for the 5-day placement exam and for the other medical exams that we will schedule in first 30 days**
- Proof of dental exam (if within 6 months prior to placement or will have to have exam within six months of placement) (MHOH likes to get within 30 days of placement)
- Proof of last eye exam (if within last year)
- Proof of comprehensive health care screening or examination/physical (if occurred within three months prior to placement). **Otherwise what was the date of the last full physical so we can maintain annual anniversary date?**
- List of visitors allowed (can be listed on the Master Care Plan Ideas Sheet)
- List of Medications currently taking with pharmacy instruction sheet with drug profile for the remaining pills of old prescription
- For counseling verification of residency and consent forms and medical history-- need to be signed by legal custodian