intermountain Residential
Hope + Healing for Children + Families
www.intermountainresidential.org
Admissions Line: 406-457-4778
Fax: 406-513-1165 (Attn: Residential Admissions)

Please type or print clearly. All fields must be entered.

Submitted By: (Placing Person or Agency or Legal Guardian Please specify)	
Name and Role:	
Date Submitted:	

Client/Child Information	
Name:	Preferred Name:
Gender:	Ethnicity:
Preferred Pronouns:	Race:
Date of Birth:	Height:
Age:	Weight:
SSN:	School Grade:
Address:	Religious Pref.:
City/State/Zip:	Identifying Charact./Scars:
Country:	Tribal Affiliation/Enrollment #:
Phone:	Eye Color/Hair Color:

Parent/Guardian Information	
Parent/Guardian	
Name:	Preferred Contact Method:
Relationship:	DOB:
Address:	SSN:
City/State/Zip:	Job Title:
Home Phone:	Employer:
Mobile Phone:	Work Phone:
Email:	Work Email:
Parent/Guardian	
Name:	Preferred Contact Method:
Relationship:	DOB:
Address:	SSN:
City/State/Zip:	Job Title:
Home Phone:	Employer:
Mobile Phone:	Work Phone:
Email:	Work Email:

Referral Source Information

How did you first hear about Intermountain?
Name(s) of the referral source:
Phone:
Address:
City/State/Zip:
Email:

Current Location or Placement of Child

Name:
Contact Person:
Phone:
Address/City/State/Zip:
Duration at Current Placement:
May we contact? Yes ☐ No ☐

Referral Information

Describe in detail the child's presenting problems and what is occurring.
Thoroughly describe the child's relevant family/social/early history:
Describe the child's strengths:
Diagnosis: (Include current and previous)
Who made the above diagnosis and when was it established?
Parent(s) goal(s) in treatment:
Child's goal(s) in treatment:
Discharge Plan:

Custody Status

Who has custody of this child?

If DPHHS or other social service agency, is it permanent or temporary?

Name of agency:

Have parental rights been terminated? (If yes, include when)

Mother: Yes ☐ No ☐ When:

Father: Yes ☐ No ☐ When:

Will family members participate in therapy? Yes ☐ No ☐

Can this child return home? Yes ☐ No ☐

Does this child have a Guardian ad Litem and/or CASA? If yes, provide contact information (Name, address, phone number)

Family/Contacts Section

Parents:

Name:	Relationship:	Address:	Phone:

Siblings:

Name:	Relationship:	Residence:	DOB/Age:

Other Significant Individuals:

Name:	Relationship:	Address:	Phone:

Education

Current Grade:

Current School:

District of current enrollment (if different):

Is this child a Special Ed student? If yes, please explain:

Is this child on an IEP? If yes, Label:

If on an IEP, what is the date of the IEP?

Describe, in detail, educational history:

Describe, in detail, behaviors in school?

Does this child receive Occupational therapy? If yes, through IEP or private? IEP ☐ Private ☐

Does this child receive Speech and Language therapy? If yes, through IEP or private? IEP ☐ Private ☐

Juvenile Justice History

Does this child have a history of involvement with the juvenile justice system? If yes, please describe:

Abuse/Neglect History

Does this child have a history with Child Protective Services or Social Services? If yes, how long?

Does this child have a history of abuse/neglect? If yes, please explain:

Placement History

Has the child been placed away from home before?
This section is designed to reflect disruptions or changes in the child's living situation. Include all agency out of home placements, independent placements, kinship or relative placements, adoptive placements and breakdowns. If the information is available in the social history, make that notation. You do not have to complete this section if the information is available on another document. Make the notation that the document is attached. End with most current.

Name of placement/ provider/ relative/ other	Dates From/To	Reason for Termination

Health and Medications

Allergies: (please include allergies to food, medications, other)

Reaction:

Current Medications: (include dose, frequency, start date, etc.)

Contact information for prescribing physician:

Name:

Address/City/State/Zip:

Phone:

Contact information for Primary physician or MT Passport Provider:

Name:

Address/City/State/Zip:

Phone:

Last Medical Exam and MD:

Contact information for Dentist:

Name:

Address/City/State/Zip:

Phone:

Last Dental Exam:

Contact information for Eye Dr:

Name:

Address/City/State/Zip:

Phone:

Last Eye Exam:

Health Information:		
Please check if any of the following and explain below:		
☐ Heart Condition	☐ Ear Infections (ear tubes and date placed)	☐ Congenital defects (i.e. cleft palate, etc.)
☐ Asthma	☐ Epilepsy (date of onset):	☐ Chicken Pox:
☐ Diabetes:	☐ Injuries:	☐ Surgery:
Explain:		
Significant family health history: – diabetes, TB, mental illness, etc.		
Physical restrictions or health problems that may require special seating, bathroom privileges, etc.:		
Special diet or food restrictions:		

Financial Information

Person, Agency, County, or Insurance Company of financial responsibility: (please list all that apply)
Does the child receive SSI? If yes, amount:
Payee Name and Address:

Additional Information

Please provide any other additional information you feel is pertinent:

Significant Emotional/Behavioral Indicators

Please select any significant emotional/behavioral indicators and **describe:**

- ☐ Holdings:
- ☐ Behaviors endangering/injuring self:
- ☐ Behaviors endangering/injuring others:
- ☐ Suicidal ideation/intent/attempt:
- ☐ Homicidal ideation/intent/attempt:
- ☐ Sexually inappropriate behaviors (e.g., exposing self, public masturbation, sexual touching):
- ☐ Running away:
- ☐ Fire setting/preoccupation with fire:
- ☐ Cruelty to animals:
- ☐ Destructive to property:
- ☐ Stealing:
- ☐ Lying:
- ☐ Bladder/bowel difficulties:
- ☐ Self-loathing, self-dislike:
- ☐ Poor social skills, poor ability to understand social or nonverbal cues:
- ☐ Difficulty with ADL's (hygiene, dressing, etc.):
- ☐ Poor peer relationships (e.g., controlling, bullying, avoidance):
- ☐ Indiscriminately affectionate or resistant to nurture:
- ☐ Over-dependence on adults (e.g., clinging, shadowing, and helplessness):
- ☐ Withdrawn/detached/isolated:
- ☐ Hypervigilant:
- ☐ Lack of anger control (e.g., tantrums, profanity, yelling):
- ☐ Noncompliance/Oppositionality/Manipulative:
- ☐ Low frustration tolerance or difficulty with transitions:
- ☐ Poor impulse control:
- ☐ Poor attention span/lack of concentration:
- ☐ Extreme activity level, fidgetiness, restlessness:
- ☐ Lethargic, underactive, slow moving:
- ☐ Eating disturbance (e.g., under eats, over eats, hoards food):
- ☐ Sleep disturbance (e.g., nightmares, insomnia, sleepwalking):
- ☐ Somatic complaints/accident prone:
- ☐ Self-stimulating/self-soothing behaviors (e.g., thumb sucking, rocking, touching genitals):

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☐	Impaired case and effect thinking/lack of regard for consequence:
☐	Lack of regard or empathy for others:
☐	Anxious behaviors (picking at self, biting nails, etc.):
☐	Hypersensitivity to stimulus (e.g., sound, touch, visual):
☐	Obsessive/compulsive thoughts and behaviors:
☐	Dissociative episodes:
☐	Disturbed thinking (e.g., tangential, flight of ideas, loose associations, poor reality testing):
☐	Paranoid/delusional thinking:
☐	Auditory or visual hallucinations/illusions:
☐	Mood disturbance (e.g., depressed, anxious, manic):
☐	Affect disturbance (e.g., inappropriate, labile, flat, brittle):
☐	Other, please explain:

Sexual Assessment (If Applicable)
What type of sexual behaviors has your child engaged in?
How often? History (where began, etc.):
Age of person the child engages in sexual activities with:
Relationship to the child:
Was any trickery, bribery, emotional or physical force used? If yes, please explain:
Motivation for child's sexual behavior (list any precipitating factors):
Affect when confronted:
Response when confronted:

In addition to the completed application, please include documentation in the following areas in order to be considered for acceptance.

- Medical – include Immunization Records, last well child exam, and any significant medical history.
- Educational – include IEP/504 plan, any educational records, behavior documentation, testing, etc.
- Clinical – include clinical assessments, neuropsychological/psychological testing, treatment plans, discharge reports, etc.

X

Parent/Legal Guardian