BDCO SCREENING APPLICATION

Applicant's Name: ____

Full Address: ____

Phone #(s): ____

Full Social Security #: ________-________-________ DOB: ________/________/________ Age: __________

Do you identify as: ☐Male ☐Female ☐Transgendered Female to Male ☐Transgendered Male to Female ☐Gender Non-Conforming

Primary Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Native American or American Indian ☐ Native Hawaiian or other Pacific Islander ☐ Other: ____________________

Secondary Race ***(if applicable):*** ☐ N/A ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Native American or American Indian ☐ Native Hawaiian or other Pacific Islander ☐ Other: ____________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Military Service:
- ☐ No
- ☐ Yes, Active *(currently serving)*
- ☐ Yes, Veteran *(have ever served)*

Type of Discharge: ☐ Honorable ☐ Dishonorable

Language Preference: ☐ English ☐ Spanish ☐ Other: ____________________________

Referral Sources: ____

Parent/Guardian/Worker Name: ____

Section I: Housing and Basic Needs – Current Situation

Do you have any dependents ☐ Yes ☐ No If yes, what is the relationship? ______________________________

Do you have stable housing? ☐ Yes ☐ No

If yes, who do you live with? ☐ Alone ☐ w/Family/Relatives ☐ w/Non-Related Persons ☐ Foster Care ☐ Other

If no, where did you sleep last night: *(select only one)*

Homeless situation:
- ☐ Place not meant for habitation
- ☐ Emergency shelter, incl. hotel/motel paid for w/ ES voucher or RHY-funded Host Home shelter
- ☐ Safe Haven

Institutional situation:
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison, or juvenile detention facility
- ☐ Long term care facility
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

Temporary and permanent housing situation:
- ☐ Residential project or halfway house
- ☐ Staying or living in a friend's room, apartment, or house

☐ Hotel/motel paid for w/o ES voucher
☐ Transitional housing for homeless persons *(incl. homeless youth or Host Home non-crisis)*
☐ Staying or living in a family member's room, apartment, or house
☐ Rental by client, with GPD TIP housing subsidy

If you don't have stable housing, what was the length of stay where you slept last night: ☐1 night or less ☐ 2-6 nights
☐ 1 week or more, but less than 1 month ☐ 1 month or more, but less than 90 days
☐ 90 days or more, but less than 1 year ☐ 1 year or longer

Do you feel safe in your living situation? ☐ Yes, tell me more: ____

☐ No, tell me why: ____

If you don't have stable housing, what is the approximate start date of homelessness: _____/_____/_____

Of times on the streets in the past 3 years *(in emergency shelter ES or street homeless SH)*:

☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

Total # of months in the past 3 years: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months
☐ 6 months ☐ 7 months ☐ 8 months ☐ 9 months ☐ 10 months ☐ 11 months ☐ 12 months
☐ more than 12 months

Do you have needs in the following area? ☐ No needs at this time

☐ food *(access/availability)* ☐ hygiene products ☐ clothing ☐ transportation ☐ other needs: _________________

Do you receive:

☐ I do NOT receive ANY non-cash benefits

☐ WIC- $___________Amount of non-cash benefits

☐ TANF *(Transportation Services)*- $___________Amount of non-cash benefits

☐ TANF *(Child Care Services)*- $___________Amount of non-cash benefits

☐ SNAP/Food Stamps - $___________Amount of non-cash benefits

☐ Other Sources: ___________________________ $___________Amount of non-cash benefits

TOTAL AMOUNT OF NON-CASH BENEFITS: $______________________

Are you covered by Health Insurance? ☐ Yes ☐ No ☐ Need assistance with applying

☐ Medicaid If yes Policy/Medicaid # __________________________________

Policy Holder Name *(as it appears on the insurance card)* __________________________________

☐ Mental Health/Substance Abuse Only ☐ Child Custody Only

☐ Private pay insurance If yes, with whom? __________________________________

Policy Holder Name *(as it appears on the insurance card)* __________________________________

☐ Employer provided insurance If yes, with whom? __________________________________

Policy Holder Name *(as it appears on the insurance card)* __________________________________

☐ Cobra insurance

☐ Indian Health Services

☐ Other: __________________________________

Do you have a Monthly Income: ☐ Yes ☐ No

☐ Alimony or other Spousal Support-Monthly Amount $ ________

☐ Child Support-Monthly Amount $ ________

☐ Earned Income *(currently have a job)*-Monthly Amount $ ________

☐ Pension/Retirement from another job-Monthly Amount $ ________

☐ Private Disability Insurance-Monthly Amount $ _______

☐ SSDI-Monthly Amount $ ________

☐ SSI-Monthly Amount $ ________

☐ TANF-Monthly Amount $ ________

☐ Unemployment Insurance-Monthly Amount $ ________ ☐ Worker's Compensation-Monthly Amount $ ________

Do you have a disability? ☐ Yes ☐ No

If yes, is it expected to be long continued & indefinite duration & substantially impairs ability to live independently? ☐ Yes ☐ No

If you have a disability, do you receive SSI or SSDI for that disability? ☐ Yes ☐ No

If yes, how much monthly? $______________________________ Start date of disability: _________________________

Disability type: ☐ Alcohol Abuse ☐ Both Alcohol and Drug Abuse ☐ Chronic Health Condition ☐ Developmental ☐ Drug Abuse ☐ Dual Diagnosis ☐ Hearing Impaired ☐ HIV/AIDS ☐ Mental Health Problem ☐ Physical ☐ Physical/Medical ☐ Vision Impaired ☐ Other: Cognitive ☐ Other: Learning ☐ Other: Speech

Section II: Education

Reading ability? ☐Yes ☐ No Does client read on grade level? ☐ Yes ☐ No If no, what grade level? _________

Last/highest grade completed: ______________________

Is client currently in school? ☐ Yes ☐ No ☐ N/A

If yes, where? ____ Current grade: _____________

Current school status: ☐ attending school regularly ☐ attending school irregularly ☐ graduated high school ☐ obtained GED ☐ dropped out ☐ suspended ☐ expelled

How many different schools have they attended? _________________

Is client passing all classes? ☐ Yes ☐ No If no, which are you not passing? ____

Are they on an IEP? ☐ Yes ☐ No If yes, what for? ____

Are they experiencing any barriers? ☐ Behind on credits ☐ Other: ____

If not in school, what is their educational plan? ____

What are their future educational goals? ☐ College ☐ Trade School ☐ Career-tech ☐ Other _____________________________

Other educational issues: ____

Section III: Employment/Vocational

Are you of job age *(i.e., 16 or older)*? ☐ Yes ☐ No

If yes, which of the following best describes your situation? ☐ In need of employment ☐ Employed, full-time ☐ Employed, part-time ☐ Actively looking ☐ Seasonal/sporadic *(including day labor)* ☐ Retired

If not employed, why: ☐ Unable to work, reason: ____________________ ☐ Not looking, reason: ___________________ ☐ other: _______________

What are your employment goals? ____

Tell me about the jobs you have had in the past: ____

What barriers do you feel you face in achieving employment goals? ____

Section IV: Health and Wellness

Physical Health

Do you have any specific medical conditions/diagnosis/injuries/illnesses/allergies? ☐ Yes ☐ No

If yes, describe description of problem(s) and client's ability to adjust to reported disorders or disabilities:

Are there any conditions in the environment that have affected your wide range of health, functioning, or quality of life? ☐ Yes ☐ No

(Social determinants of health - i.e., lack of economic stability, lack of quality education, lack of access & quality of healthcare, lack of food, lack of safe affordable housing, lack of transportation, neighborhood violence, different kinds of pollution or exposure to toxins like 2nd hand smoke or loud noises)

If yes, describe: ______

Does client report any medication allergies or adverse reactions? ☐ Yes ☐ No

If yes, note what medication & the reaction it causes: ______

If client has allergies or adverse reactions, do they have an EpiPen *(auto injector)* in their possession? ☐ Yes ☐ No ☐ N/A

If client has asthma, do they have an inhaler? ☐ Yes ☐ No ☐ N/A

Does client have an official advanced directive document: ☐ Yes ☐ No

If yes, describe: ______

Please list any food allergies: ______

Please list any dietary requirements: ______

Do you have regular eating habits? ☐ Yes ☐ No If no, please describe: ______

In the past 90 days, how often have you had access to an adequate amount of food from the major food groups approximately?

☐ 25% of the time ☐ 50% of the time ☐ 75% of the time ☐ Over 75% of the time

How often do you exercise or do something physical at least 20 minutes a day?

☐ Daily ☐ Every other day ☐ Sometimes ☐ Never ☐ Other: ______

How would you describe the following areas?

Overall Health:	*Mental Health:*	*Oral (dental) Health:*
☐ Excellent	☐ Excellent	☐ Excellent
☐ Very Good	☐ Very Good	☐ Very Good
☐ Good	☐ Good	☐ Good
☐ Fair	☐ Fair	☐ Fair
☐ Poor	☐ Poor	☐ Poor

Do you have any needs in the following health areas?

☐ Vision ☐ Dietary ☐ Sexual health *(birth control, STD testing, education, etc.)*

☐ Hearing ☐ Exercise

Do you have any other health needs? ☐ Yes ☐ No If yes, explain: ______

If yes, what referrals need to be made? ______

Do you have a Dr.? ☐ Yes ☐ No If yes, who & phone #: ______

If not, what do you do when you are sick? ______

Will you pass a drug test? ☐ Yes ☐ No If No, What do you have in your system? ______

Are you now or have you ever been sexually active? ☐ Yes ☐ No

If sexually active, do you use protection? ☐ Yes ☐ No If yes, what kind? ______

Are you currently pregnant? ☐ Yes ☐ No If yes, due date: ______

Do you have any children? ☐ Yes ☐ No If yes,

Name: ____ Sex: ☐ M ☐ F Age: __________ Live with you? ☐ Yes ☐ No

Name: ____ Sex: ☐ M ☐ F Age: __________ Live with you? ☐ Yes ☐ No

What is your sexual preference? ☐ Bisexual ☐ Heterosexual ☐ Homosexual ☐ Gay ☐ Lesbian

☐ Pansexual ☐ Demisexual ☐ Asexual ☐ Questioning/Unsure ☐ Other: ___________________________

Has your gender identity or sexual orientation caused any difficulties/discrimination? *(i.e., housing, family or peer conflict, employment, etc.)*

☐ Yes ☐ No If yes, how? ____

Have you ever received anything in exchange for having sexual relations with another person, such as money, food, drugs, or shelter?

☐ Yes ☐ No If yes, has it been within the past three months? ☐ Yes ☐ No How many times? ____________

Were you ever made or persuaded to have sex in exchange for something? ☐ Yes ☐ No

If yes, has it been in the past three months? ☐ Yes ☐ No

Suicide Assessment

Are you thinking about suicide? ☐Yes ☐ No

If yes, take immediate action by following agency procedures and document steps taken below:

____

____

Homicidal (harm to others) Assessment

Are you thinking about homicide or hurting someone else? ☐Yes ☐ No

If yes, take immediate action by following agency procedures and document steps taken below:

____

____

Mental Health

	Lies, cheats, or steals		Eating Difficulties/Change in appetite
	Stubborn, Negative or Defiant		Weight loss/gain
	Shows lack of consideration for others		Displays self-abusive/self-injurious behavior (i.e., cutting)
	Defiant of authority figures		Engages in inappropriate sexual behavior
	Defiant of parent		Overly active
	Unresponsive to redirection by caregiver/parent		Overly impulsive
	Temper Tantrums		Obsessive/compulsive behavior
	Intentionally destroys property of own/others		Appears sad, unhappy, depressed
	Physically aggressive toward others		Exhibits anxiety/Panic attacks
	Kicked out of home		Mood Swings
	Runs away - If yes, # of times______		Exhibits facial/body tics
	Exhibits peculiar mannerisms /habits, stereotypical behavior		Intentionally setting fires
	Difficulty completing class work		Intentionally harming animals
	Inability to follow simple instructions		Enuresis/Encopresis (bed-wetting/bed soiling)
	Poor attention span		Unaware of happenings in immediate environment
	Isolation/Classroom withdrawal		Expresses thoughts that are not sensible/Delusional
	Disruptive classroom behavior		Appears to be attending/responding to internal stimuli, (e.g., hallucinatory)
	Refusal to do work or homework assignments		Sexual abuse victim
	Conflicts/fights with peers		Sexual abuse/rape perpetrator
	Conflicts/fights with school personnel		Physical abuse
	Teases/Bullies others		Emotional abuse
	Violation of school rules		Domestic violence victim
	Poor eye contact		Domestic violence witness
	Withdraws from contact with others/isolates		Family history of mental illness and/or substance abuse
	Refuses scheduled activities		Neglect/Abandonment
	Sleeping Disturbances/Insomnia/Hypersomnia		Significant loss/trauma/grief issues
	Nightmares		CPS involvement/placement to include foster care

Grinds Teeth		

Are you currently receiving mental health services anywhere else? ☐ Yes ☐ No

If yes, where? ______________________________

Any history of receiving mental health services elsewhere? ☐ Yes ☐ No

If yes, where? ______________________________

Emotional Indicators Behavior Checklist – CHECK ALL THAT APPLY ☐ None

Substance Abuse Screening

Any history of drug/alcohol use, risk? ☐ Yes ☐ No If yes,

Drug of Choice	Amount Used	Frequency	Age of 1st Use	Last Used Date
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

Legal Issues / Legal Status

Ever been to county jail? ☐ Yes ☐ No If yes, how many times__________

Has client been arrested in the past 30 days? ☐ Yes ☐ No If yes, how many times? __________

What were they arrested for? ______________________________

Has client been arrested in the past 12 months? ☐ Yes ☐ No If yes, how many times in the past 12 months? __________

What were they arrested for? ______________________________

Are you court involved? ☐ Yes ☐ No If yes, with: ☐ DHS ☐ Juvenile Bureau ☐ Office of Juvenile Affairs ☐ Municipal Court

If yes, Worker Name & Phone#: ______________________________

Have you ever been in CPS custody? ☐ Yes ☐ No If yes, when *(what year)* and why? ______________________________

Time involved: ☐ less than 1 year, if less than 1 year how many months: __________ ☐ 1 – 2 years ☐ 3-5 or more

Have you ever been in Juvenile Detention custody? ☐ Yes ☐ No If yes, when, and why? ______________________________

Time involved: ☐ less than 1 year, if less than 1 year how many months: __________ ☐ 1 – 2 years ☐ 3-5 or more

Has the state/CPS ever come to your house to check on you and your family? ☐ Yes ☐ No

How many different homes, shelters or group homes have you stayed in? *(Must be a # i.e., 3)* ______________________________

Have any of your family members ever been incarcerated? ☐ Yes ☐ No

If yes, who and why? ______________________________

Are you now or have you ever been gang involved or gang associated? ☐ Yes ☐ No

If yes, what gang? ______________________________

Are you currently considered a runaway? ☐ Yes ☐ No

<u>Section V: Permanent Connections</u>

What are your sources of support? *(client's supports that assist in achieving goals of independence & productivity and facilitate integration into the community)*

☐ Parent ☐ Guardian ☐ Other family ☐ Friends ☐ Self ☐ Other: ______________________________

Who do you rely on the most for support? ______________________________

Family critical issues: has your family experienced any of the following *(check all that apply)*: ☐ None

☐ Unemployment ☐ Incarcerated parent ☐ Mental health issues ☐ Physical disability

☐ Alcohol or other SA ☐ Insufficient income

Are you involved in any activities, groups, organizations? *(i.e., band, sports, clubs at school, church youth group, etc.)*

☐ Yes ☐ No If yes, what activities/groups/organizations? ______________________________

Strengths, Needs, Abilities (and/or Interest), Preferences, & Liabilities

Describe the client's perceptions concerning their personal strengths, needs, abilities, & preferences as they relate to their overall functioning in the community. Include any liabilities in these areas that needs to be addressed in the client's treatment, as well as preferences for treatment.

Strengths: ______________________________
(i.e., personality characteristics – i.e., trustworthy, caring, giving, confident, etc.)

Needs: ______________________________
(i.e., what they need to work on or need in their life)

Abilities: ______________________________
(i.e., talents/skills – i.e., sports, singing, dancing, video games, etc.)

Preferences: ______________________________
(i.e., preferences towards treatment – i.e., male/female provider, race of therapist, individual, group, family, etc.)

Liabilities: ______________________________
(i.e., things that hold them back or stand in the way – i.e., being on probation, neg. peers, etc.)

You will have 1-2 roommates. Will you have problems living and getting along with roommates? Yes ____ No ____ What might prevent you from getting along? __________________________

You will need to keep your room and bathroom clean, learn and prepare meals and clean up afterwards, and perform daily/weekly chores. Will you be willing to do that? Yes ____ No ____

A plan will be developed with and for you. You will meet with your Case Manager to discuss your progress and be given suggestions to help you achieve your goals. Will you be willing to follow this guidance provided to move forward? Yes ____ No ____

What qualities do you bring that will help you stay on track? ______________________________

PERSONAL CHARACTERISTICS, STRENGTHS, GOALS AND NEEDS

How would you describe yourself? ______________________________

Besides educational and employment goals, what else can we help you with? ______________________________

What are some things that are getting in the way of your goals? ______________________________

What are your greatest strengths that would help you be successful in our program? ______________________________

How did you hear about BDCO? ____________________

What else should we know about your situation in considering your application? ______________________________

Who helped you complete this application? ______________________________

Applicant Signature______________________________ Staff Signature______________________________