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

Section V: Permanent Connections

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_____