Application for Adult Services – DCYF Transition Aged Youth

STATE OF RHODE ISLAND



Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
BEHAVIORAL HEALTHCARE SERVICES
TEL: (401) 462-3407

6 Harrington Road Cranston, RI 02920

Please send completed application to BHDDH.MentalHealthTreatment@bhddh.ri.gov

1.	Today's	Date
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Please submit application as soon as is possible between the ages of 17 years 4 months and 21.

- 2. Applicant Name:
- 3. Applicant Date of Birth:
- 4. Applicant Contact Phone:
- 5. Current Address:

Note: Family address or address where individual will be living is needed to determine which mental health agency will do eligibility.

- 6. DCYF Status (choose one): Voluntary DCYF Custody
- 7. Name of DCYF contact: .

Phone: Email:

- 8. Insurance:
- 9. Current psychiatric diagnosis(es); select as many as apply.

Diagnosis type	Primary	Secondary	Diagnosis w/in past 2years
Schizophrenia			
Schizoaffective Disorder			
Schizoid Personality Disorder			
Bipolar Disorder			
Major Depressive Disorder, recurrent			
Obsessive-Compulsive Disorder			
Borderline Personality Disorder			
Delusional Disorder			
Psychotic Disorder			
Other			
(Please Describe)			

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10.	Applicant co-morbidities or co-occurring disorders
	a. Does the applicant have any medical problems? Yes No If yes, please describe:
	 b. Does the applicant have co-occurring substance use disorder? Yes c. Does the applicant have developmental or intellectual disabilities (I/DD)? Yes If yes, has an application been submitted for I/DD adult services? Yes
	d. Does the applicant have any medical problems? Yes No If yes, please describe:
11.	Hospitalization and residential treatment history. If yes to either, please attach discharge summaries
	a. Prior hospitalization? Yes No
	If yes, within last 2 years? Yes No
	b. Prior intensive residential treatment? Yes No
	If yes, within last 2 years? Yes No
	Are discharge summaries attached for prior hospitalizations or residential treatment?
12.	Date of most recent psychiatric evaluation:
	If yes, please attach evaluation, psychological assessments, and medication list as applicable.
	Is the evaluation attached? Yes No
	Is the medication profile with list attached? Yes No
	Are psychological assessments including Yes No
	Is a neuropsychological test, including full scale IQ, available? Yes No
13.	DCYF Service History
	Please check all that apply and describe program and location in text field.
	☐ Group home placement
	☐ Therapeutic settings
	☐ Intensive mental health services
	☐ Correctional and/or court related issues (legal involvement)
	If yes to correctional and/or court related issues, please describe current and past
	charges
	Is DCYF service history face sheet included? Yes \square No \square

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4.Does the applicant have any of the following deficits?
If yes to any, please attach psychosocial summaries including family information, $\operatorname{Vocational}$
☐ Activities of daily living
☐ Support network
15. Please provide a brief description of treatment needs (MH, SUD and/or co-occurring):
16. What treatment services or level of care is requested? Check all that apply.
Integrated Health Homes- IHH
Assertive Community Treatment- ACT
General Outpatient programs
Specialty Programs please describe:
Other please describe:
Mental Health Psychiatric Rehabilitative Residences-(MHPRR) Congregate Group
Homes and Supervised Apartments
If group home, please describe what other living arrangements have been explored prior to the referral here: