

ADOLESCENT ASSESSMENT / PLACEMENT STABILIZATION CENTER ADMISSION

Use of form: Provision of the child's social security number is voluntary. However, providing the social security number will aid in determining Title IV-E eligibility.

Name – Adolescent Assessment / Placement Stabilization Center

Date – Admission

Division of Milwaukee Child Protective Services Case Number

Time – Admission
 A.M. P.M.

Name – Child (Last, First, MI)

Date – Mandatory Removal

Birthdate – Child (mm/dd/yyyy)

Date – First Extension

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race / Ethnicity
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Date – Second Extension

Height	Weight	Hair Color	Eye Color
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Date – Discharge

Identifying marks on child – Describe.

Time – Discharge

Name – School (if attending)	Current Grade Level
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Destination

Address – School (Street, City, State, Zip Code)

Court status: Division of Milwaukee Child Protective Services custody pending TPC TPC CHIPS

Child's prior living arrangement (Check all that apply and circle the most recent arrangement.)

- | | | | |
|--|--|-------------------------------------|---|
| <input type="checkbox"/> Parental home | <input type="checkbox"/> Foster home | <input type="checkbox"/> Group home | <input type="checkbox"/> Adolescent Assessment / Placement Stabilization Center |
| <input type="checkbox"/> Relative home | <input type="checkbox"/> Treatment foster home | <input type="checkbox"/> CCI / RTC | <input type="checkbox"/> Homeless |

List names of siblings being placed with this child.

If siblings are being placed at other Adolescent Assessment / Placement Stabilization Centers, list their names and the facility names.

List child's medical conditions.

List any medication the child is currently taking and indicate if it has been provided to the center.

Medication	Provided to Center
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medication	Provided to Center
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Child has allergies – Specify.

Special dietary needs – Specify.

Name – Health Insurance Agent

Health Insurance Account Number

Name – Primary Physician

Telephone Number

Check characteristics and behaviors below that apply to the child.

- | | | |
|--|---|---|
| <input type="checkbox"/> Abused | <input type="checkbox"/> Open to change | <input type="checkbox"/> Delinquent peer group |
| <input type="checkbox"/> Neglected | <input type="checkbox"/> Highly motivated | <input type="checkbox"/> Gang affiliation |
| <input type="checkbox"/> Has a supportive family | <input type="checkbox"/> Poor motivation / lacking goals | <input type="checkbox"/> Runaway history |
| <input type="checkbox"/> Outgoing and communicative | <input type="checkbox"/> Independent in peer relationship | <input type="checkbox"/> AODA |
| <input type="checkbox"/> Withdrawn / non-communicative | <input type="checkbox"/> Immature personality | <input type="checkbox"/> Suicide threats |
| <input type="checkbox"/> A leader | <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Psychiatric / emotional difficulties |

Explain any items checked above.

Name – Parent 1 (Last, First, MI)

Telephone Number – Home

Telephone Number – Work

Address – Parent 1 (Street, City, State, Zip Code)

Social Security Number

Name – Parent 2 (Last, First, MI)

Telephone Number – Home

Telephone Number – Work

Address – Parent 2 (Street, City, State, Zip Code)

Social Security Number

Name – Guardian (Last, First MI)

Telephone Number – Home

Telephone Number – Work

Address – Guardian (Street, City, State, Zip Code)

Social Security Number

Name – Admitting Worker

Telephone Number

Site

- After hours initial assessment Business hours initial assessment Ongoing case manager

Name – Supervisor

Telephone Number

Name – Assigned Worker

Telephone Number

Site

- After hours initial assessment Business hours initial assessment Ongoing case manager

Name – Supervisor

Telephone Number