

APPLICATION FOR RE-ENTRY TO ADOLESCENT SERVICES PROGRAM

Please fill out completely and return to:

DEMOGRAPHIC INFORMATION

Youth's Name: _____

Address: _____ **Street** _____ **City** _____ **State** _____ **Zip Code** _____

Phone #: _____ **Social Security #:** _____

D.O.B. _____ **Age:** _____ **Sex:** _____ **Race:** _____

	Name	Phone Number
Medical Provider	_____	_____
Dental Provider	_____	_____
Attorney	_____	_____

DCF INVOLVEMENT

Most Recent DCF Worker or Office: _____ **Phone #:** _____

Reason for Re-Entry Request: Please explain why you are requesting to re-enter DCF services and why you should be considered for re-entry.

EDUCATION

School: _____ Grade: _____

School Type: College Vocational High School

Other (Please explain): _____

Education Plans after Completing High School

Have You Completed a Life Skills Program? Yes No If yes, which program? _____

In the past 12 months have you: (Please check all that apply.)

- Attended school regularly
- Received passing grades
- Been suspended from school
- Performed to your potential
- Been truant from school
- Been expelled from school
- Received poor grades
- Been disruptive in school

FAMILY/FRIENDS

What family, friends or other adult supports do you have in place?

	Name	Telephone Number
Parent/Guardian:	_____	_____
Parent/Guardian:	_____	_____
Spouse:	_____	_____
Sibling:	_____	_____
Adult Support:	_____	_____
Other:	_____	_____
Other:	_____	_____

COMMUNITY INVOLVEMENT

- Clubs/Organizations
- Volunteer
- Participates in Religious Activities
- Mentoring
- Paid Employment
- Other (please specify): _____

MEDICAL AND MENTAL HEALTH

Do you have any unmet medical or dental needs? Yes No If yes, please explain: _____

I agree to a substance use/abuse evaluation. Yes No
Signature: _____ Date: _____

I agree to a mental health evaluation. Yes No
Signature: _____ Date: _____

I agree to a physical health evaluation. Yes No
Signature: _____ Date: _____

Are you in therapy? Yes No If yes, where? _____

Name of Therapist: _____ Phone: _____

Purpose of Therapy: _____

If no, have you ever been in therapy? Yes No If yes, please detail when, where, and the reason for therapy.

Are you currently on prescription medication? Yes No If yes, please complete.

Medication

Purpose of Medication

Are you pregnant? Yes No If yes, please specify expected delivery date. _____

If pregnant, where have you been receiving pre-natal care? _____

Are you a parent? Yes No If yes, please complete.

Child's Name

Child's Age

Child Lives With Me

Yes No
 Yes No
 Yes No
 Yes No

LEGAL/COURT INVOLVEMENT

Court History: Not Applicable Currently on Probation Probation Completed

Probation Officer: _____ Phone: _____

Attorney: _____ Phone: _____

Reason for Court Involvement: _____

Criminal Charges, if any: _____

Do you have any pending criminal charges? Yes No If yes, please explain:

WORK EXPERIENCE

Currently Employed?: Yes No If yes, please complete.

Name of Employer: _____ Hours Worked Weekly: _____

Previous Employment History: Yes No If yes, list employer(s) and dates.

Employer	Dates Employed	
	From:	To:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RESIDENCE HISTORY

Please list the last five places you have lived, beginning with the most current residence.

Name and Type of Residence (Family, Friend, DCF Placement, etc.)	Dates of Placement	
	From:	To:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that DCF will review this application within the next 30 days to assess whether or not I will be able to re-enter the DCF Adolescent Services Program. I understand that failure to answer these questions truthfully may result in delay, further review or denial of the application.

Signature

Date