

**Instructions:** This is an interactive form. Please complete all form fields, save the document and email this document to [info@hughcenter.org](mailto:info@hughcenter.org) or fax to 409-983-6408.

By signing this form, the Department and the CPS worker who signs verify that the child described herein needs emergency care as defined in 40 TAC §700.1322(a), and that the information contained in this form and the written information attached to it contain as much of the information described in 40 TAC § 720.913 as are available to the worker at this time. This application expires 30 days from the date of the signature. Before then, the Department must give to the residential care provider a "Common Application for Placement of Children in Residential Care" or a newly signed Alternative Application with updated information. Application for placement of this child in basic residential care. The provider understands that only Level of Care 1 payments are available.

Child's Name			Date of Birth		Age	Social Security Number	
Sex M F	Ethnicity		Primary Language	Place of Birth (city, state, country)		Child's Person ID No.	
Height	Weight	Religious Preference		Child's Current Location or Placement		Country of Citizenship	

1. Child's immediate needs and problems and reason for emergency or basic placement (if not adequately described below):

**2. Special Needs, Problems and Behaviors**

Is child considered a danger to self? Yes No	Is child considered a danger to others? Yes No	Number runaways from home:	Number runaways from placement:
Any history of setting fires? Yes No	Special Program Needs? Maternity Preparation for Adult Living	Other:	Specify:
Other Significant Problems or Behaviors			

**3. Juvenile Justice History**

Does the child have a history of involvement or current involvement with the juvenile justice system?... Yes No Unknown

**4. Placement History**

Has the child been placed away from home before? ..... Yes No Unknown

Most recent Placement	LOC of current/most recent out-of-home placement:
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Reason for Discharge:

**5. Substance Abuse History**

Does the child have a history of substance abuse? ..... Yes No Unknown

If yes, indicate degree of substance abuse:

Alcohol Unknown None Mild Moderate Severe	Inhalants Unknown None Mild Moderate Severe
Marijuana Unknown None Mild Moderate Severe	Cocaine/Crack Unknown None Mild Moderate Severe
Other Drugs (Specify)	
Mild Moderate Severe	
Is specialized program required? Yes No Unknown	If yes, specify:

**6. History of Abuse and Neglect**

Does the child have a history of abuse or neglect? ..... Yes No Unknown

Physical Unknown None Mild Moderate Severe	Sexual Unknown None Mild Moderate Severe
Emotional Unknown None Mild Moderate Severe	Neglect Unknown None Mild Moderate Severe

Abandonment? ..... Yes No Unknown

**7.-8. Family/Parental Involvement**

Managing Conservator Mother    Father    PRS    Other				Mother's Parental Rights Terminated Yes    No		Father's Parental Rights Terminated Yes    No	
Will family/others participate in treatment or cooperate with others? Yes    No			Can child return home? Yes-Permanently    No-Not At All    For Visits Only    Unknown				

**9. Education**

Highest Grade Completed		Currently Enrolled in School? Yes    No		Educational Needs Regular Classes    Vocational    Resource    Special Education			
History of Truancy? Yes    No    Unknown			On Campus		Other (specify):		
IQ Scores: Full Scale		Verbal		Performance		Date of Most Recent IQ Test	Name of Test
				Unknown			

**10. Physical Health/Disabilities**

Does the child have a diagnosed or suspected health condition or disability?..... Yes    No    Unknown  
If yes, describe the condition and treatment required, if any:

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Condition Acute    Chronic    Unknown			Severity Mild    Moderate    Severe    Unknown				Requires Specialized Treatment Yes    No    Unknown		
List Current Medications					List Allergies				

**11. Mental Health**

Does the child have mental health needs requiring treatment?..... Yes    No    Unknown

Date of most recent psychological or psychiatric evaluation:..... \_\_\_\_\_

DSM III Diagnosis:  
\_\_\_\_\_

Condition Acute    Chronic    Unknown			Severity Mild    Moderate    Severe    Unknown				Requires Specialized Treatment Yes    No    Unknown			
Psychotropic medications prescribed? Yes    No    Unknown			If yes, specify:							
Referring Agency/Organization				Agency Contact Person				Telephone No. (Inc. A/C)		
Agency Address										
Name of Person Signing Form				Title				Date and time of Emergency Placement		
Where Placed--Facility Name and Location										

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Signature, CPS worker\*

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Date

\*Signature required at time of placement.