

ONE LOVE DEVELOPMENTAL SERVICES, INC.
SCREENING ASSESSMENT

Date of application: _____

Type Services Requested: __ CBS (Professional/Para) __ Residential __ Counseling

Client Name: _____ Record #: _____

Date of Birth: _____ Social Security Number: _____

Current Address: _____

Guardian/Legally Responsible Person Name, Address/Telephone #:

Referring Agency Name/Address: _____

Person Making Referral: _____ Tel. #: _____

Client current diagnosis (List all, i.e.. Axis I, II, III, IV): _____

(The following information below is being requested to screen the applicant for services) :

a. Application/Referral ____ b. Tx Plan ____ c. Assessment of clients presenting problem

d. Social History ____ e. Psychological Evaluation/Assessment ____ f. Medical Information

Presenting Problems: _____

Circumstances leading to placement: _____

Previous hospitalizations. If yes, please list hospital name/and date(s) admitted:

Needs: _____

Strengths _____

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Clients understanding of the need for placement: _____

Current Living Situation: (i.e. AFL, foster care, rest/nursing, group home, detention/jail, etc.): Please explain in detail.

Do you currently have Medicaid, if yes please give number: _____

Appropriateness of placement: _____

Disposition:

Accepted: _____ **Waiting list:** _____ **Denied: (Give Reasons):** _____

Recommendations to another facility if Agency is unable to provide services :

Comments: _____

This purpose of this form is to assess the applicants needs for services and to determine if the minimum requirements are met to provide therapeutic treatment. This screening does not indicate admissions to One Love Developmental Services, Inc.

Consumer/Legally Responsible Persons Signature

Date

Signature/Title of Person Completing Form

Date