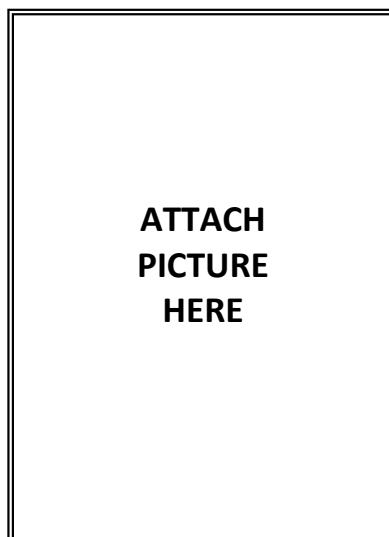


FORM B

MAIL OR FAX TO
House of Hope York, PA
3899 Sticks Rd
Glen Rock, PA 17327
Fax: 717-942-2196



HOHYP RESIDENTIAL APPLICATION & INTAKE ASSESSMENT



Name: _____ **DOB:** _____

Date Received: _____



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RESIDENTIAL APPLICATION

TEEN BIOGRAPHICAL INFORMATION			
Teen's Name		Age	Today's Date
Gender	Date of Birth	Grade in School	
Address			
City		State/Zip	
Home Phone	Work Phone	Cell Phone	
Place of Birth		Social Security No.	
Height	Weight	Hair Color	Eye Color
Who has legal custody of the teen?			
Who has physical custody of the teen?			

PARENT INFORMATION			
Who does the teen live with at this time?			
Are Parent's Divorced or Separated?	If yes, at what age was teen?	Parents ever Married?	
Is there any significant information about the Parent's relationship with the teen which will be beneficial in counseling? If yes, please describe.			
Biological Mother's Name	Age	Occupation	Cell Phone
Where Employed		Social Security No.	
Home Address		City, State, Zip	
Work Phone	Home Phone	Email	
Date of Birth	Education	Is teen living with Biological Mother?	
Is there anything notable, unusual or stressful about teen's relationship to Biological Mother? Explain			



PARENT INFORMATION Continued				
Biological Father's Name		Age	Occupation	Cell Phone
Where Employed		Social Security No.		
Home Address		City, State, Zip		
Work Phone		Home Phone	Email	
Date of Birth	Education		Is teen living with Biological Father?	
Is there anything notable, unusual or stressful about Teen's relationship to Biological Father? Explain				
Step Mother's Name		Age	Occupation	Cell Phone
Where Employed		Social Security No.		
Home Address		City, State, Zip		
Work Phone		Home Phone	Email	
Date of Birth	Education		Is teen living with Step Mother?	
Is there anything notable, unusual or stressful about teen's relationship to Step Mother? Explain				
Step Father's Name		Age	Occupation	Cell Phone
Where Employed		Social Security No.		
Home Address		City, State, Zip		
Work Phone		Home Phone	Email	
Date of Birth	Education		Is teen living with Step Father?	
Is there anything notable, unusual or stressful about teen's relationship to Step Father? Explain				



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RESIDENTIAL APPLICATION

LEGAL GUARDIAN INFORMATION		
Who has custody of teen?	Full or Joint?	Permanent or Temporary?
If Temporary, how long is it ordered?	Court arranged or other?	How long has Guardianship been enforced?
Guardian Name:	Guardian Age:	Guardian Occupation?
Where Employed		Social Security No.
Home Address		City, State, Zip
Cell Phone	Work Phone	Email
Date of Birth	Education	Is teen living with Guardian?
Describe custody and visitation arrangement.		
Is there anything notable, unusual or stressful about teen's relationship to Guardian? Explain.		

SIBLINGS/OTHERS WHO LIVE IN THE HOUSEHOLD									
Name of Sibling/Other	Age	Gender		Live at Home?		Relationship with teen			
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great
		M	F	Y	N	Poor	Average	Good	Great

Are you aware that House of Hope York, PA does not take Insurance? YES NO



Please describe the concerns you have for your teen:

SCHOOL INFORMATION (PAST AND PRESENT)

Grade Level	Name and Address of School (Starting with most recent)	Phone Number	Status

Does teen have an Individualized Education Plan or receive special services at school? NO YES

If yes, please describe:

Is the teen currently expelled from School? No Yes

If yes, what date will the teen be able to return to School?

Briefly describe the circumstances that caused expulsion:

RESIDENTIAL TREATMENT FACILITY CURRENT/PRIOR PLACEMENTS (HOSPITALIZATION/JUVENILE/ETC.)

Dates	Name of Facility & Location	Phone Number	Reason for Placement	Reason for Termination



CURRENT/PRIOR JUVENILE COURT INVOLVEMENT		
Has teen ever had charges filed against him? NO YES		If YES, please answer the following:
What were the charges?		What was the determination? NOT GUILTY GUILTY
If other outcome, please explain:		
Is teen currently on Probation? NO YES		If YES, please answer the following:
County of Probation:	Start Date:	End Date:
Probation Officer:		Phone #:
Is your application to House of Hope York, PA in response to a court order or recommendation? NO YES		
If teen has a history of Probation, please complete the following for each previous period of probation:		
County of Probation:	Start Date:	End Date:
Probation Officer:		Phone #:
County of Probation:	Start Date:	End Date:
Probation Officer:		Phone #:
Are you, the parent/guardian, currently involved in any type of legal action? NO YES (i.e. custody, child support, civil, criminal, etc.) If YES, please briefly explain:		

CURRENT/PRIOR DEPARTMENT OF FAMILY/CHILD SERVICES/PROTECTIVE SERVICES		
Is your family currently involved in any capacity with Family/Child Services or Child Protective Services? NO YES		
If YES, please answer the following:		
Name of Agency:	Start Date:	End Date:
County:	Case Worker:	Phone #:
Briefly describe the circumstances of the involvement:		
Has your family ever had any past involvement in any capacity with the Department of Family/Child Services or Child Protective Services? NO YES If YES, please answer the following:		
Name of Agency:	Start Date:	End Date:
County:	Case Worker:	Phone #:
Briefly describe the circumstances of the involvement:		



CURRENT MEDICAL INFORMATION			
Specialist	Name	Phone	
Family Physician			
Dentist			
Psychologist			
Psychiatrist			
Counselor/Therapist			
Other			
Is teen currently on psychotropic medication? NO YES		Has teen taken psychotropic medication in the past? NO YES	
Medication	Dosage	Medication	Dosage
Does teen have any significant medical problems? NO YES			
Describe:			

FAMILY PSYCHIATRIC HISTORY	
Has anyone in teen's family had mental health problems? NO YES	
If YES, describe:	
Has anyone in teen's family had Alcohol or Drug problems? NO YES	
If YES, describe:	
Has anyone in teen's family attempted or committed suicide? NO YES	
Has teen ever attempted suicide? NO YES	
If YES, describe (times, how, last attempt):	
Has teen ever done any self-mutilating (i.e. cutting or burning)? NO YES	
If YES, describe:	
Does teen have any tattoos? NO YES	
If YES, describe (number, place, type):	
Does teen have any body piercing? NO YES	
If YES, describe location on body:	



DRUG AND ALCOHOL USE (PAST AND PRESENT)

Has teen ever used illegal drugs? NO YES DON'T KNOW

If YES, describe (type, frequency of use, amount used, date of last use):

What is teen's drug of preference?

Has teen ever done any Huffing (i.e. inhaling glue, gas, NO2, etc.)? NO YES DON'T KNOW

If YES, describe:

Has teen ever misused over the counter drugs (i.e. cough syrup, ephedrine, etc.)? NO YES DON'T KNOW

If YES, describe:

Has teen ever misused prescription drugs? NO YES DON'T KNOW

If YES, describe type and amount of use:

Has teen ever used alcohol? NO YES DON'T KNOW

If YES, describe when he started to drink, frequency of drinking, and preferred drink:

CHURCH PARTICIPATION

Are you currently attending a church? YES NO

If yes, describe how often you attend and how long you have been attending. Does your teen attend with you?

Church Name:

Pastor Name:

Church Address:

Church Telephone:

Does teen attend youth group at this church? YES NO

If yes, describe how often and for how long.



CHECK THE FOLLOWING BEHAVIORS/SKILLS THAT DESCRIBE POSITIVE CHARACTERISTICS OF TEEN

Accepts Praise	Writing	Insightful	Grooming/hygiene
Assertive	Safety Skills	Motivated	Honesty
Cooperative	Survival Skills	Respects Others	Listening Skills
Dependable	Affectionate	Sense of Humor	Polite
Friendly	Cleanliness (Household)	Verbal Expression	Responsible
Helpful	Courteous	Apologizes	Shares
Independent	Emotional	Community Skills	Works Hard
Money Management	Leader	Musical	Athletic
Reading	Hobbies/Crafts	Organized	

Comments on any of the above:

CHECK THE FOLLOWING THAT ARE TYPICAL OF TEEN

Affectionate	Head Banging	Sexual Acting Out	Excessive Masturbation
Aggressive	Hopelessness	Shares	Expects Failure
Alcohol	Hurts Animals	Sick Often	Fatigue
Angry	Imaginary Friends	Short Attention Span	Psychiatric Problems
Anxiety	Impulsive	Shy, Timid	Moody
Avoids Adults	Irritable	Sleeping Problems	Nightmares
Bed-wetting	Lazy	Slow Moving	Obedient
Bizarre Behavior	Learning Problems	Speech Problems	Over weight
Bullies, Threatens	Lies Frequently	Steals	Panic Attacks
Clumsy	Listens to Reason	Stomach Aches	Phobias
Confident	Loner	Suicidal Threats	Poor Appetite
Cooperative	Low Self-Esteem	Suicidal Attempts	Frequent Injuries
Cyber Addiction	Messy	Depression	Disrespectful
Defiant	Sad	Destructive	Unsafe Thinking
Frustrated Easily	Selfish	Dizziness	Weight Loss
Gambling	Separation Anxiety	Drug Dependence	Withdrawn
Generous	Sets Fires	Eating Disorder	Worries Excessively
Hallucinations	Sexual Addiction	Enthusiastic	

This Residential Application has been completed to the best of my knowledge. I understand that any deliberate false information is grounds for denial of acceptance/consideration into the House of Hope York, PA Program. I hereby request that House of Hope York, PA consider providing services to my family and the teen named in this Residential Application.

Signature

Date

Print Name

Relationship to Teen