

**Application for Way Station, Inc. Child and Adolescent Services
CAMP JOURNEY RESPITE PROGRAM**

Child's Full Name			Birth Date
Child's Social Security #			
Parent(s)/Guardian(s) Name(s) and relationship to child			
Address			
County			
Child resides with:	<input type="checkbox"/> Parent(s)/Guardian(s) <input type="checkbox"/> Foster Parents(specify regular or therapeutic placement) <input type="checkbox"/> Other: _____		
Phone (home)		Cell Phone:	
Phone (work)		Email Address:	

Prescribed Medications	Dosage and Frequency

Please tell us why you are requesting services and how it would be helpful for your family:

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Please have your child's therapist/clinician fill out this portion.

Most Recent DSM IV Diagnosis and Code:

Axis I: _____() _____()

_____ () _____ ()

Axis II: Mental Retardation: () Mild () Moderate () Severe

Axis III: _____

Axis IV: _____

Axis V: GAF current _____ Past year _____

Diagnosed by: _____ on _____

**** THERAPIST/ TREATMENT PROVIDERS: If you are making this referral, we would like to request the most recent treatment plan and psycho-social assessment for this client. This will not only allow us to be more efficient with our intake process but also allow us to be consistent with the treatment plan of this individual. Additionally, please complete the attached Release of Confidential Information Form including the parent/guardian signature. Return the Release of Confidential Information Form along with this page and/or the fully completed application for respite services.**

If you have any questions regarding this referral, please feel free to contact me at:
301-682-5886 or toll free at (888) 878-5066 x6149

You may fax this to my office at (301) 682-6151 or have the parent(s)/guardian(s) return it with the referral.

Thank you for your time.

Dave Evason
Respite Intake Specialist
Way Station, Inc.

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Funding:

- Medical Assistance # _____
- Self Pay
- Other Funding Source: _____

Living Arrangements:

- Siblings: _____ Age: _____
 _____ Age: _____
 _____ Age: _____
- Others: _____ Age: _____

Education:

- School _____ Grade: _____
- Public-mainstream
- Hours of Special Ed. Services: _____
- Special Ed. Services Provided: _____
- IQ: _____
- Disability Code: _____

Out of Home Placements:

- Hospitalizations _____ Date: _____ Duration: _____
 _____ Date: _____ Duration: _____
 _____ Date: _____ Duration: _____
- Residential Treatment Center:
- Day Programs: Respite Care Foster Care
- Other: _____

Services Currently receiving:

- Dept. of Social Services: Caseworker _____
- Dept. of Juvenile Justice: Caseworker _____
- Rehab. (Institute for Family Centered Services, Family Pres, Community Kids etc.)
- Therapy: _____

Problematic/Risk Behaviors at home/school:

- | | |
|--|---|
| <input type="checkbox"/> Aggression to self | <input type="checkbox"/> Peer Problems |
| <input type="checkbox"/> Aggression to Others | <input type="checkbox"/> Sibling Problems |
| <input type="checkbox"/> Destruction of Property | <input type="checkbox"/> Parent Problems |
| <input type="checkbox"/> Oppositional Behavior | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> History of Abuse |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Running Away | |