Developmental Trauma & Attachment Program (DTAP) Application Packet

Please complete application as thoroughly as possible to allow Chaddock's Admission Team to determine which DTAP treatment plan (in-home, residential, or accelerated residential) is the best fit for the child and family.

205 South 24th Street | Quincy, Illinois 62301
Phone: 217.222.0034 | Fax: 217.222.3865

Chaddock
Attachment & Trauma Services

205 South 24th Street | Quincy, Illinois 62301
Phone: 217.222.0034 | Fax: 217.222.3865

Acknowledgement of DTAP Application for Assessment and Treatment

I/WE UNDERSTAND that this application will not be considered complete until I/WE have submitted the required application materials. Once the application is completed and returned it will be reviewed by the Admissions Team..

IT IS UNDERSTOOD that a completed application does not ensure acceptance into the DTAP program. By signing below, I/WE signify MY/OUR understanding of these terms and MY/OUR acceptance of aforesaid.

Please direct any questions regarding this admissions application to:
Melissa Hess, Admissions Manager | mhess@chaddock.org | 217.592.0402
Holli Fuhrman, Admissions Manager | hfuhrman@chaddock.org | 217.592.0432

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date

DTAP Application Checklist

- ☐ Psychiatric reports/hospitalizations / Psychological reports with full scale IQ and diagnosis / Psycho- social histories/assessments
- ☐ Copy of medical card or private insurance card(s); should include Primary, Secondary and Tertiary Insurance Information
- ☐ Most recent Individualized Education Program (IEP)
- ☐ Medical (vision and hearing information should also be provided, if available)
  - ☐ List of all current medications (including over-the-counter and supplements)
  - ☐ Physical Forms, Physician notes from pediatrician or family practitioner
- ☐ Complete the attached Consent for Release of Information on all professionals who have worked with your child (see form on page 7). Please return with the application. The form can be copied as needed for each professional.

PLEASE NOTE:
Additional education and medical information will be required should the child be eligible for residential placement.

Identifying Information

Person Completing Application

Name: _____Relationship to child: _____

Phone number(s): _____ / _____

E-mail address: _____

Child Information:

Name:_____ Social Security #: _____

Street address: _____ City: _____ State: _____ Zip: _____

County: _____ Ethnicity:_____ Date of birth: _____ Age:_____

Gender: M/F Adopted? Y/N From where? _____ At what age? _____

Height: _____ Weight:_____ Eye color: _____ Hair color: _____

Education

IQ verbal: _____ IQ performance: _____ IQ full scale: _____

Current education status (*Select all that apply*): LD☐BD☐ED☐OHI☐

Most recent IEP date: _____ Location: _____

Current grade level: _____ HS credits earned (*if applicable*): _____

Child's Current Diagnosis

Date: _____ Diagnosing professional: _____

Agency:_____

DSM-V Diagnosis(s) _____

_____

_____

_____

Other Sibling(s) and Children in the Home

Name	Age	Gender M/F	Ethnicity	Currently in home? Y/N	Biological to parent? Y/N	Biological to child? Y/N

Describe your child's interests/activities/hobbies: _____

_____

_____

_____

_____

Parent / Financial Information

Parent 1

Name: _____Spouse (if applicable): _____

Relationship to child:_____ Social Security #: _____

Street address:_____ City: _____ State: _____ Zip: _____

Home number: _____ Cell number: _____ Fax number: _____

Email address: _____ Gender: M ◯ F ◯ Ethnicity: _____

DOB: _____ Religious Preference: _____ Marital status:_____

Employers name: _____ Occupation: _____

Phone: _____ Street address:_____

City: _____ State: _____ Zip: _____

Insurance carrier: _____ Phone: _____

Policy number: _____Policyholder: _____

Parent 2 (if applicable)

Name: _____Spouse (if applicable): _____

Relationship to child:_____ Social Security #: _____

Street address:_____ City: _____ State: _____ Zip: _____

Home number: _____ Cell number: _____ Fax number: _____

Email address: _____ Gender: M ◯ F ◯ Ethnicity: _____

DOB: _____ Religious Preference: _____ Marital status:_____

Employers name: _____ Occupation: _____

Phone: _____ Street address:_____

City: _____ State: _____ Zip: _____

Insurance carrier: _____ Phone: _____

Policy number: _____Policyholder: _____

Responsible party is obligated to check with the insurance carrier prior to placement.
Parent or guardian will be responsible for any medical or pharmacy bills not covered by another funding source.

Name of person(s) legally responsible for child: _____

What funding source will you be pursuing? (check all that apply and include contact person and phone number)

	{h¦w/9	/hat!b¸	CONTACT NAME & PHONE NUMBER
	Primary Medical Insurance:		
	{Ŝ0̂2yŘary Medical Insurance:		
	5Ŝyűl·f insurance:		
	Pharmacy insurance:		
	Vision insurance:		
	State and/or county funds:		
	Medicaid:		
	School or school district funds:		
	Other, (describe):		

Contact Information (complete areas that are applicable.)

Emergency Contact

Name: _____Relationship to Child: _____

Street address:_____ City: _____ State: _____ Zip: _____

Home number: _____ Cell number: _____ Fax number: _____

Email address: _____

Current School Information

School Name: _____

Primary contact: _____ E-mail: _____

Phone number: _____ Cell number: _____ Fax number: _____

Consent for release of information: Yes ◯ No ◯

Therapist

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

Psychiatrist

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

Psychologist

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

Pediatrician/Physician

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

OTHER (ex. Orthodontist, Optometrist, etc)

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

OTHER (ex. Orthodontist, Optometrist, etc)

Name: _____Agency: _____

Phone Number: _____ E-mail: _____

Consent for release of information: Yes ◯ No ◯

Placement History (Please list as much information as possible in **chronological** order beginning with most recent.)

Key : B=Birth, BR=Birth Relative, A=Adopt, F=Foster, O=Orphanage, I=Institute, R=Residential, H=Hospital, D=Detention/Jail

Date	Code	Name of caretaker	Reason for move

Medical History of the Child

Is there a history or current problem with hearing? ☐ Yes ☐ No ☐ Hearing aid ☐ Classroom Accommodations

☐ Other _____

Is there a history or current problem with vision? ☐ Yes ☐ No ☐ Glasses ☐ Contacts

☐ Other _____

Describe your child's current state of physical health, concerns, etc.: _____

_____

_____

_____

List any chronic/ongoing health problems(ex. Diabetes, seizures, etc.): _____

_____

_____

_____

List any allergies or intolerances to **medications**:

Drug	Reaction	Treatment if needed

List any allergies to **NON-medications**:

Substance	Reaction	Treatment if needed

List any operations, procedures, and/or medical traumas:

Operation/Procedure/Medical Trauma	Date Occurred	Location/care

Describe special dietary restrictions and reason why: _____

_____

_____

Are there any limitations of physical activity? Yes or No If yes, please describe why: _____

_____

_____

Child's History & Behaviors

	Past Year	History Only	Not Applicable
Trauma Experiences			
History of Physical Abuse	☐	☐	☐
History of Sexual Abuse	☐	☐	☐
History of Neglect	☐	☐	☐
History of Emotional Abuse	☐	☐	☐
Domestic Violence	☐	☐	☐
Extreme Interpersonal Violence	☐	☐	☐
Significant Loss (ie. death of grandparent, friend, teacher…)	☐	☐	☐
Medical Trauma/illness	☐	☐	☐
Serious Injury/Accident	☐	☐	☐
Natural Disaster	☐	☐	☐
Other Significant Events or Traumas (describe):	☐	☐	☐
Child Behavioral/Emotional Needs			
Family Violence	☐	☐	☐
Superficially Charming	☐	☐	☐
Lying that does not benefit the child	☐	☐	☐
Impulsive Behaviors	☐	☐	☐
No Cause and Effect Thinking	☐	☐	☐
Unsuccessful Peer Relationships	☐	☐	☐
Very Demanding	☐	☐	☐
Lack of Empathy	☐	☐	☐
Extreme Control Issues	☐	☐	☐
Low Self-Esteem	☐	☐	☐
Crying	☐	☐	☐
Hyperactivity	☐	☐	☐
Sleep Disturbances	☐	☐	☐
Frequent Mood Changes	☐	☐	☐
Attention Difficulties	☐	☐	☐
Withdrawn	☐	☐	☐
Irritability	☐	☐	☐
Anxiety	☐	☐	☐
Significant Appetite (Weight Change)	☐	☐	☐
Child Risk Behaviors			
Poor Insight/Judgment	☐	☐	☐
Fire Setting	☐	☐	☐
Sexually Active	☐	☐	☐
Sexually Reactive	☐	☐	☐
Self-Harm/Mutilation	☐	☐	☐
Suicidal Ideation/Suicidal Threats	☐	☐	☐
Physically Aggression/Assault	☐	☐	☐
Criminal /Police Involvement	☐	☐	☐
Destructive to self, other, animals and/or property	☐	☐	☐
Homicidal Threats/Homicidal Intentions	☐	☐	☐
Verbal Aggression	☐	☐	☐
History of Running	☐	☐	☐
Encopresis/Enuresis	☐	☐	☐
Substance Usage (Alcohol/Tobacco/Other)	☐	☐	☐

A day in the life of your child:

In the space provided, please tell us about a typical day in your child's life. (250 character maximum each)

- **Describe your child's typical behaviors.**

- **Describe how you would typically respond to these behaviors.**

- **Describe the interaction between your child and siblings.**

- **Which of your child's behaviors bother you the most?**

- **Discuss your child's positive attributes.**

- **Describe your child's school behavior and your child's response to authority.**

- **Describe the community's teachers', neighbors', friends', and family's reactions to your child's behavior and to your parenting interventions.**

A day in the life of your child (continued):

In the space provided, please tell us about a typical day in your child's life. (250 character maximum each)

- **Describe how your child relates to parent(s)/guardian(s)/caregiver(s).**

- **Which of your parenting techniques seems to be the most effective?**

- **Does anyone in your family feel physically threatened?**

- **What are your worst fears?**

- **What are your best hopes?**

- **Describe any spiritual or family traditions:**

- **Describe what impact this child has had on:** (500 character max)
  a) your marriage b) your family c) your lifestyle d) your personal well-being
  (please answer for each member of the family)