



Medina Children's Home

Linking Hearts Together Since 1958

21300 St. Hwy 16 N Medina, TX 78055-3808

Telephone: 830-589-2871 Fax: 830-589-7140 or 830-589-7129

Application For Placement

(Form Revised 3/07)

Date of Application: _____ Person completing application: _____

I. CHILD'S INFORMATION

Last Name:		First:		Middle:	
Street Address:				Apt/Unit #:	
City:		State:		ZIP	
Soc. Sec. No. :		Sex:		Age:	
Place of Birth:	City:		County:	State:	Country:
Hair Color:		Eye Color:		Weight:	
				Height:	
Brief description of need for placement					

List child's problems as you see them (use additional paper if necessary)

Please list any marks, tattoos, etc.

II. LEGAL CUSTODY

Identify all who have current legal custody of applicant and by what right (Indicate such as biological parents, adoptive parents, managing conservator, possessory conservator, etc.):

Child's Name: _____

III. FAMILY INFORMATION			
A. Biological/ Adoptive Mother:			
Name:	Telephone # (Home):	Work:	
Address:	Soc. Sec. #:	Age:	
Marital Status (Explain):			
B. Biological/ Adoptive Father:			
Name:	Telephone # (Home):	Work:	
Address:	Soc. Sec. #:	Age:	
Marital Status (Explain):			
C. Stepparent:			
Name:	Telephone # (Home):	Work:	
Address:	Soc. Sec. #:	Age:	
D. Stepparent:			
Name:	Telephone # (Home):	Work:	
Address:	Soc. Sec. #:	Age:	
E. Significant Others:			
Name:	Telephone # (Home):	Work:	
Address:	Relationship:		
F. Significant Others:			
Name:	Telephone # (Home):	Work:	
Address:	Relationship:		
G. Siblings	Please provide the names, addresses and telephone numbers of any of the child's siblings.		
H. Additional information to help clarify child's family and/or living situation			

Child's Name: _____

IV. BACKGROUND INFORMATION

A. Has the child resided outside of the home previously? If so, explain why, where and for how long.

B. Has the child been arrested before? If so, explain. Is the child on probation? (If so include JPO contact information)

C. Has the child been in the custody of the courts? If so, explain why and where (give dates):

D. Has the child spoken about or attempted suicide? If so, explain (List examples, include dates and if the child was hospitalized)

E. Has the child been hospitalized for suicidal statements or acts or for any psychological reason(s)? If so, please list dates and reasons for hospitalizations as well as length of stay in hospital.

F. Does the child have any psychological diagnoses? If so, please list below (ex. ADHD, Depression, Anger Management, Bipolar Disorder, Reactive Attachment Disorder, etc).

G. Does the child have problems with bedwetting please list how recently and often. Is the child on any medication for this?

Child's Name: _____

VI. MEDICAL INFORMATION

A. If child is currently on medications provide following

All medicine and dosages (please list what the medication was prescribed for).

Prescribing doctor's name:

Telephone #:

B. List allergies to medicines or other severe allergies:

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C. List medical/physical impairments (glasses, hearing aids, etc.)

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D. Is your child under orthodontic care (braces, retainers, etc) If so, for what and how long.

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VII. RELIGIOUS INFORMATION

Child's church preference:

Church Name and Location:

Minister's Name:

Telephone Number:

Is the child baptized? If so, when and where was the baptism?

VIII. OTHER INFORMATION

Please note any other information that would help in serving this child (use additional pages as needed.)

Has the child had a psychological evaluation? If so, when was last evaluation done? (Please attach a copy with the application).

If your child is accepted at MCH, what are your expectations? What are some things that you would like to see your child work on?

How did you hear about MCH? Please list any referrals.

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Child's Name: _____

IX. FAMILY FINANCIAL INFORMATION

This information must be provided and is kept in confidence. Failure to complete this information could delay or prevent placement.

Note: Please send pages 1 and 2 of your IRS Form 1040 (or page 1 of IRS Form 1040EZ) for the last two years.

A. Primary Financially Responsible Person

Name:	SS #:	Relationship to Child:
Address: Street	City	State/Zip
Phone: Work:	Home:	
Company:	Position:	
Supervisor:	Net Salary: \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
If unemployed, please state reasons:		

B. Secondary Financially Responsible Person

Name:	SS #:	Relationship to Child:
Address: Street	City	State/Zip
Phone: Work:	Home:	
Company:	Position:	
Supervisor:	Net Salary: \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
If unemployed, please state reasons:		

X. OTHER FINANCIAL AID

All financial aid provided by governments or by court order must be assigned to Medina Home upon placement. If other financial aid is being received or is entitled please complete following: Please list amounts received for each.

Child Support:	Social Security:	Medicaid:
Other: (explain)		

Child's Name: _____

XI. MEDICA, DENTAL, EYE CARE INSURANCE

Note: Upon admission to Medina Children's Home, the child being placed must immediately be dropped off of your family's insurance and/or Medicaid program. The child will be picked up on Medicaid by MCH. Any delay in doing so, can cause unpaid medical bills which will be your responsibility to pay. If the child is covered under insurance plans please complete the following information as applicable.

A. Medical

Company Name:

Policy Holder's Name:

Policy Number:	Is pretreatment authorization needed for certain procedures? Telephone Number to Call: ()
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B. Dental

Company Name:

Policy Holder's Name:

Policy Number:	Is pretreatment authorization needed for certain procedures? Telephone Number to Call: ()
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C. Eye Care

Company Name:

Policy Holder's Name:

Policy Number:	Is pretreatment authorization needed for certain procedures? Telephone Number to Call: ()
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FINANCIAL RESPONSIBILITY STATEMENT

Notice: There will be an initial startup fee of \$300.00 to be paid at time of placement.

I/we agree to provide:

- | | | | | | |
|----|---|--------------------------|-----|--------------------------|----|
| 1. | All medical costs not covered by family insurance | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 2. | All dental costs not covered by family insurance | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 3. | All eye care not covered by family insurance | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 4. | All clothing & personal items required | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

5. **Regular monthly support in the amount of** \$ _____

NOTE: There will be no refund of startup fee or support!

I understand and agree that failure to meet my pledged monthly support may result in the immediate dismissal of my child unless written permission is received from Medina Home prior to payment date.

I understand and agree that if my child contracts and/or suffers a catastrophic illness or injury that my child will be immediately dismissed from Medina Children's Home. I agree to be responsible for all medical costs incurred from beginning of said illness or injury.

I understand and agree unequivocally to pay any vandalism caused by my child while in care at Medina Children's Home.

Signature (Primary Responsible Person)

Date