Date of Application:
/ /

Eliada Homes, Inc.
Application for Equine Assisted Therapy Services

Client's Name: _____ **Preferred Name (Optional):** _____

Date of Birth: / / **Race:** Please Select

Ethnicity: Please Select

SSN: - - □ Male □ Female □ Other:

Current Address			
Legal Custodian (if under 18) **Preferred Mode of Contact**	Name: Phone Number: Email: □ Phone Call □ Email □ Text	**Parent (If Different from Legal Custodian)** **Preferred Mode of Contact**	Name: Phone Number: Email: □ Phone Call □ Email □ Text
Case Responsible Agency (if applicable)	Case Responsible Agency: Agency Contact: Email Address: Address: Phone Number:		
MCO □ None (Self-pay client)	MCO: Please Select Care Coordinator (if assigned):		
Primary Care Physician	Physician Name: Phone Number: Email:		

CURRENT STATUS

I. CURRENT BEHAVIORS/PRESENTING PROBLEMS AND REASON FOR REFERRAL

A. Current Diagnoses **(Date of Diagnosis and Name of Diagnosing Professional Required)**	Date	Professional	Diagnosis: (Please indicate which is Primary (R) & Additional (A))
			□ Primary □ Additional
			□ Primary □ Additional
			□ Primary □ Additional
			□ Primary □ Additional
			□ Primary □ Additional
			□ Primary □ Additional
			□ Primary □ Additional
B. Medications □ None	Please list all current medications and dosages		

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II. CURRENT STRESSORS (Please check all that apply)

Legal Problems	□ Yes	□ No	Physical Assault	□ Yes	□ No	Addiction	□ Yes	□ No
Medical Problems	□ Yes	□ No	Relationship Problems	□ Yes	□ No	Abuse History	□ Yes	□ No
Sexual Assault/ Rape	□ Yes	□ No	Separation/Loss	□ Yes	□ No	Other	□ Yes	□ No

III. HEALTH CONCERNS and MEDICAL CONDITIONS

A. Physical Disorders or Diseases □ None	Please describe the nature of the disorder or disease and any necessary accommodations: □ Are any of the above contagious?
B. Disabilities □ None	Please describe the nature of the disability and any necessary accommodations:
C. History of Seizures, Head Injury, or Other Traumatic Injury □ None	Please provide any history of seizure disorder, head injury, or other traumatic physical injury. Are there any ongoing concerns or treatments related to these events?

IV. LEGAL INVOLVEMENT □ Client has never been in trouble with the law

	Charge:	**Date**	**Outcome**
A. Charges: List all past, current, and pending charges			□ Dismissed □ Not Guilty □ Convicted □ Ongoing
			□ Dismissed □ Not Guilty □ Convicted □ Ongoing
			□ Dismissed □ Not Guilty □ Convicted □ Ongoing
B. Probation	Is the client currently on probation? ☐ Yes ☐ No If yes, please describe the length and all applicable terms:		

V. EDUCATIONAL INFORMATION

A. School Information *if under 18 years of age	Current School: Grade: History of Truancy: □ Y □ N
B. Level of Education *if over 18 years of age	Highest Level of Education Completed: Please Select
Please describe any additional academic-related information of which we should be aware (i.e. suspensions, expulsions, IEP, etc.):	

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What are the client's educational and vocational goals? (i.e. diploma, GED, college, career aspirations): If applicable, what are the client's school behaviors?	
C. IQ Information (if known)	Special Ed? □ Y □ N IEP: □ BED □ EMD □ SLD □ OHI □ 504 Plan □ Other: _____ Date IEP/504 Plan expires: Current IQ Score (Optional): FSIQ- VCI- PRI- WMI- PSI- Test Administered: Date Administered:

HISTORY

VI. SOCIAL HISTORY/FAMILY DYNAMICS

Please provide a brief description of the client's social history. Include information on family dynamics, family mental health history, trauma, and any other significant events:

VII. ABUSE HISTORY

Has the client ever been a victim of abuse? □ Yes □ No If yes, □ Physical □ Sexual □ Emotional

Has the client ever been a victim of neglect? □ Yes □ No If yes, □ Physical □ Emotional

Was DSS involved? □ Yes □ No

If investigation was opened, is DSS still involved: □ Yes □ No

If yes: DSS Case Worker:

Phone Number:

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VIII. PAST SERVICES RECEIVED ☐ Client has never received mental health services			
Name of Provider/Level of Care	Reason for Service	Admission Date (mm/dd/yy)	Discharge Date (mm/dd/yy)
☐ Outpatient ☐ Therapeutic Foster Care ☐ Group Home ☐ Level 3 Placement ☐ PRTF Placement ☐ Psychiatric Hospitalization			
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☐ Outpatient ☐ Therapeutic Foster Care ☐ Group Home ☐ Level 3 Placement ☐ PRTF Placement ☐ Psychiatric Hospitalization			
☐ Outpatient ☐ Therapeutic Foster Care ☐ Group Home ☐ Level 3 Placement ☐ PRTF Placement ☐ Psychiatric Hospitalization			

IX. HISTORY OF AGGRESSIVE BEHAVIOR ☐ None

Has the client ever displayed any of the following? (If no, please skip ahead to section X)

☐ Verbal Aggression ☐ Physical Aggression ☐ Property Destruction ☐ Fire Setting ☐ Cruelty to Animals

Aggression is: Impulsive Planned Triggered by Fearfulness

Where is the client aggressive:

Known triggers:

Main targets of aggression: ☐ Peers ☐ Authority figures ☐ Family members Please Describe:

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CLIENT NAME: **RECORD NUMBER:**

Please describe the most recent episode of aggression:

X. HISTORY OF SELF INJURIOUS AND SUICIDAL BEHAVIORS (Check all options that apply)	
Self-Injury	**Has the client engaged in self-injury in the past?** □ Yes □ No **Does the client currently self-injure?** □ Yes □ No

Suicidal Characteristics □ None	Check all that apply:	□ Suicidal Ideation □ Current □ Past	□ Suicidal Gestures □ Current □ Past	□ Suicidal Plans □ Current □ Past
		□ Suicide Attempts	□ Number of previous attempts:	
	Date of Last Attempt:			
	Were attempts planned? □ Yes □ No □ Sometimes			

**XI. History of Running ***if under 18 years of age □ None

□ Runs away from home or placements

In the past year, How many times has the client run? ____ □ Impulsive □ Planned

Average duration:

Where does the client go and what do they do?

How do they return home/placement?

XII. Substance Abuse History □ None

Type of Substance used	**Frequency**	**Last Use**	**Type of Substance used**	**Frequency**	**Last Use**
□ Marijuana		Select If Applicable	□ Inhalants		Select If Applicable
□ Cocaine		Select If Applicable	□ Hallucinogens		Select If Applicable
□ Crack		Select If Applicable	□ Alcohol		Select If Applicable
□ Heroin/Opiates		Select If Applicable	□ Tranquilizers		Select If Applicable
□ Amphetamines		Select If Applicable	□ Other		Select If Applicable

Has the client received Substance Abuse treatment? □ Yes □ No

XIII. Sexualized Behaviors □ None

Please describe any sexualized behaviors exhibited by the client (i.e. premature exposure, compulsions, aggression, etc.):

XIV. Psychosis □ None

Has the client ever experienced any hallucinations or paranoia: Y N

If yes, what type? □ Auditory □ Visual □ Tactile (Touch) □ Olfactory (Smell) □ Other:

Please describe the nature of the hallucinations and/or paranoia:

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XV. STRENGTHS & INTERESTS

Please describe the strengths and interests of the client:

What are the client's informal supports (i.e. family, friends, social groups):

XVI. CULTURAL NEEDS

Please describe any cultural needs of which we should be sensitive to when working with the client (i.e. racial, ethnic, cultural, religious, linguistic, dietary, etc.):

XVII. DISCHARGE PLAN/ PERMANENCY PLAN

Please describe your current thoughts, plans and/or goals for the client upon discharge:

XIX. FUNDING:

Please check all applicable funding sources available for the client. Include all applicable numbers (subscriber, group, etc.) associated with each funding source. For private insurance, please include the SSN and DOB of the policy holder.

□ Medicaid:

Policy Number: Subscriber/ Group #:

Policy Holder SSN: - -

□ Private Insurance:

Policy Holder Name:

Policy Holder DOB:

If possible, please attach a copy of the front and back of the client's insurance card. If you do not have access to a scanner, please bring your insurance card to your first appointment.

Client Signature | Client Name | Date

For clients under 18: I hereby apply for services on behalf of the child for whom I hold legal custody and/or placement authority. I certify that the information contained in this application/assessment is true and accurate to the best of my knowledge.

Custodian Signature | Custodian Name | Date

Referring Professional/Agency (if applicable) | Date

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CLIENT NAME: **RECORD NUMBER:**

How did you hear about us? (Please check all that apply)

- □ Office/Co-Workers
- □ Community Agencies
- □ MCO/LME (Please Specify):
- □ Eliada Homes Flyer
- □ Eliada Homes Website
- □ Eliada Homes Facebook page
- □ Eliada Homes Equine Assisted Therapy Facebook Page
- □ Email
- □ Family or Friends
- □ Media
- □ Other:

Please also include a copy of the client's most recent CCA and/or psychological assessment with this application if possible to speed up the intake process.