



Summit Academy OIC Connections Program
Intake Form

DATE OF INTAKE: _____

SOCIAL WORKER'S NAME: _____

SOCIAL WORKER'S PHONE: _____ Email: _____

YOUTH NAME: _____

DATE OF BIRTH: ___/___/___ AGE: _____ SEX: _____ Female _____ Male

CASE# _____ SSIS# _____ SSN# _____

RACE: Check all that apply

_____ CAUCASIAN _____ AFRICAN AMERICAN _____ HISPANIC _____ ASIAN

_____ NATIVE AMERICAN _____ BI RACIAL _____ OTHER

PLACEMENT INFORMATION:

Status of Care: LTFC _____ State Ward _____ Other (explain) _____

How long has youth been in Hennepin County's Care? _____

Reason for youth being placed in care: _____

Is youth allowed to have contact with biological parents? Yes _____ **No** _____

Does youth have siblings? Yes _____ **No** _____ **If yes, are siblings in care? Yes** _____ **No** _____

Is youth allowed to have contact with biological siblings: Yes _____ **No** _____

Number of disruptions in placements: _____

Number of placements: _____

Please attach listing of all placements outside of current placement.

Current Placement:

Type of Residence: Foster Home ___ RTC ___ Group Home ___ Other (explain) _____

Street Address _____

City, State, Zip Code _____

Home Phone _____ Work Phone _____

Name of Adult Contact Last Name _____ First Name _____

Relationship of Adult Contact at the home _____

CLIENT PERSONAL INFORMATION:

EDUCATION:

Current School Name: _____

Address: _____

Grade Level: _____ Is youth on track to graduate on time? ___ YES ___ NO

Time school starts: _____ Time school ends: _____

School Case Worker's Name: _____

Phone: _____ Email: _____

Other School Contacts: _____

Position: _____ Phone: _____

Email: _____

MEDICAL:

Emergency Contact: _____

Number: _____ Relationship to youth: _____

Does youth have ANY known allergies? Yes ___ No ___

If yes, please explain: _____

Does youth have any special dietary needs/restrictions: _____

Does youth have any physical limitations: Yes ___ No ___

If yes, please explain: _____

Is youth taking any medication(s): Yes _____ No _____

If yes, please complete the information below.

Medication: _____

Reason: _____

How many times a day: _____ Time meds are taken: _____

Medication: _____

Reason: _____

How many times a day: _____ Time meds are taken: _____

Medication: _____

Reason: _____

How many times a day: _____ Time meds are taken: _____

Please explain any other medical or mental health conditions Connections staff should be aware of?

Social worker, provider and Connections staff must sign this document to verify all information has been reviewed and is correct.

Social Worker

Date

Permanent Placement Provider

Date

SAOIC Connections Program

Date