Admission Application

101 West Townsend Road
St. Johns, Michigan 48879
(800) 762-3742 or (989) 224-1177
Fax: (989) 224-7078
Facility/Program Info: (517) 896-0045
www.TurningPointYouth.net

Juvenile Name: ______________________ **Age:** ______ **Date of Application:** __________

Referring Agency Information:

Case Worker Name: ______________________ Job Title: __________

Referral Agency: ______________________

Address: ______________________ Phone Number: __________

City: __________ State: ______ Zip Code: ______ Cell Number: __________

Email Address: ______________________ Fax Number: __________

Youth's Personal Information:

Name: ______________________ Social Security Number: __________
First Middle Last

Date of Birth: __________ Place of Birth: ______________________ U.S. Citizen: □ Yes □ No

Address of Primary Residence: ______________________

City: ______________________ State: __________ Zip Code: __________

Lived With Whom: ______________________ Phone Number: __________

Race/Ethnicity: ______________ If Native American, Tribal Affiliation: __________

Religious Preference: ______________________Current Grade Level: __________

Was the Youth Adopted? □ Yes □ No □ Unknown If Yes, Age at Time of Adoption: __________

Axis I Psychiatric Diagnosis: ______________________Full Scale IQ: ______

Height: __________ Weight: __________ Hair Color: __________ Eye Color: __________

Chronic Medical or Substance Abuse Issues: ______________________

Distinguishing Scars, Marks, Tattoos: ______________________

Family Information:

Legal Guardian(s): ______________________ Relationship: __________

Address: ______________________ Date of Birth: __________

City: __________ State: ______ Zip Code: ______ Phone Number: __________

When Was Guardianship Awarded? ______________________ Cell Number: __________

Biological Mother: ______________________ Custody: □ Yes □ Joint □ No
First Middle Last

Address: ______________________ Date of Birth: __________

City: __________ State: ______ Zip Code: ______ Phone Number: __________

Biological Father: ______________________ Custody: □ Yes □ Joint □ No
First Middle Last

Address: ______________________ Date of Birth: __________

City: __________ State: ______ Zip Code: ______ Phone Number: __________

Were Parents Married? ☐ Yes ☐ No ☐ Unknown If Yes, Are They Now Divorced? ☐ Yes ☐ No When? _______

If Parents Were Not Married to Each Other, Was Paternity Legally Established? ☐ Yes ☐ No ☐ Unknown

Siblings/Other Children in Family:

Full Name: ______________________ Date of Birth: ____________ Gender: __________

Full Name: ______________________ Date of Birth: ____________ Gender: __________

Full Name: ______________________ Date of Birth: ____________ Gender: __________

Full Name: ______________________ Date of Birth: ____________ Gender: __________

Court Information:

Committing Offense: ______________________ Date of Offense: ____________

Upcoming Court Date/Time: ____________ Charge: ______________________

Upcoming Court Date/Time: ____________ Charge: ______________________

Registered Sex Offender: ☐ Yes ☐ No Has Applicable Information Been Sent to MSP? ☐ Yes ☐ No ☐ Unknown

Medical Information:

Is Medical Insurance Established? ☐ Yes ☐ No Straight Medicaid Number: ______________________

Allergies (if medications, include specific reaction): ______________________

____

Has the Youth been diagnosed with any of the following?

☐ Asthma
☐ Bladder/Kidney Infection
☐ Bleeding Disorder
☐ Bronchitis
☐ Chicken Pox
☐ Convulsions
Last Episode: __________
☐ Diabetes
*Attach Current Schedule

☐ Heart Disorder
Last EKG: __________
☐ Heart Murmur
Last EKG: __________
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure

☐ HIV Positive/AIDS
☐ Meningitis
☐ Mononucleosis
☐ MRSA
*Attach Treatment Utilized
☐ Muscle Weakness
☐ Poor Circulation
☐ Problem with Joints
☐ Scoliosis

☐ Seizure Disorder
☐ Sickle Cell Trait
☐ Syphilis
☐ Tuberculosis
☐ Last PD: _______
☐ Treated
☐ Tx Completed
*Attach Tx Utilized
☐ Ulcers

If taking Depakote or Lithium, date of last serum level: ____________ Dose of Medication: ____________

Individual Responsible for Medication Authorization:

Name: ______________________ Daytime Phone Number: ____________

Emergency Contact Information:

Emergency Contact: ______________________ Relationship: ____________
First Middle Last

Address: ______________________ Phone Number: ____________

City: ____________ State: ______ Zip Code: ________ Cell Number: ____________

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☐ Accepted ☐ Declined Date Application Received: ____________

Date Caseworker Notified: ____________ Date of Admission: ____________

Admitting Diagnosis: ______________________

Height: ________ Weight: ________ Room Assignment Number: ________ Group Assignment: ________