Sunshine Acres
CHILDREN'S HOME

This application must be completed in its entirety and returned to Sunshine Acres before the child can be considered for placement.

p: 480-832-2540 · f: 480-832-2041 · web: SunshineAcres.org

Name (person filling out this application) _____

I hereby request that Sunshine Acres consider providing services to my family and the child named below. All information provided is accurate to the best of my knowledge. I understand that any deliberate false information is grounds for denial into the program.

_____ _____
Signature of custody holder Date

_____ _____
Signature of person completing the application Date

Relationship to child _____ Date _____

How did you come to know about Sunshine Acres? _____

A. BIOGRAPHICAL INFORMATION

Child's Name _____
(Last) (First) (Middle) (Nickname)

Current Physical Address _____
(Street) (City) (State) (Zip) (County)

Place of Birth _____ Race _____ Religion _____ Male ❑ Female ❑

Social Security # ___-___-____ Date of Birth ___/___/____ Current Age _____ Current Grade Level _____

Legal Guardian _____ Relationship to Child _____

Adopted ❑ Natural ❑ Other ❑ _____ Email Address _____

Current Address _____
(Street) (City) (State) (Zip) (County)

Home Ph.# (___) _____ Work Ph.# (___) _____ Cell Ph.# (___) _____

With whom is the child living? _____

Please check all reasons that apply to why Sunshine Acres would be of help to you and your child:

- ❑ I am experiencing homelessness
- ❑ My child has behavioral challenges
- ❑ I have sever medical conditions
- ❑ I do not have a vehicle
- ❑ I am facing incarceration
- ❑ I need therapy/rehab

❑ I lack sufficient financial resources ❑ Other _____

❑ I am unemployed

B. EDUCATION (List all schools child has attended **starting with the most current**)

Grade Level	School Name & Address	Phone Number	**STATUS:** Special Education, IEP, Promoted, Retained, etc.

C. OUT OF HOME PLACEMENTS (Residential Treatment Facilities/Psychiatric Hospitalizations/DCS/Relative Placement)

Dates	Name of Facility	Phone Number	Reason for Placement	Reason for Termination

D. COURT INVOLVEMENT

Are there any pending court matters involving your child? No ❑ Yes ❑ *If yes, please explain.*

_____

_____

E. DEPARTMENT OF CHILD SAFETY

Is your family **currently or previously** involved in any capacity with the Department of Child Safety?

No ❑ Yes ❑ *If yes, please explain, including length of time.*

_____

_____

F. CURRENT FAMILY DATA

	Biological Father	Biological Mother	Previous placement and relationship to child if other than parent:
Full Name			
Current Address			
Current Phone			
Social Security #			
Birth Place / Birth Date			
Marital Status			
Name of Spouse			
Deceased?			

G. CHILD'S SIBLINGS

Name	Birth Date	Age

H. UNAPPROVED CONTACTS

Name	Relationship to Child

I. EMERGENCY CONTACTS

Name	Relationship to Child	Phone Number

J. FINANCIAL

Person financially responsible for the child _____ Relationship to child _____

- ❑ Parent/guardian wages monthly $_____
- ❑ Child support monthly $_____
- ❑ Social security monthly $_____
- ❑ Other income monthly $_____
- ❑ Total monthly income $_____

K. PARENT QUESTIONNAIRE

What challenges have existed in this child's biological or adoptive family? *Check all that apply.*

- ❑ Fear of being hurt / threatened
- ❑ Child abuse – physical
- ❑ Child abuse – sexual
- ❑ Child abuse – emotional
- ❑ Child neglect / lack of supervision
- ❑ Divorce / separation
- ❑ Domestic violence
- ❑ Alcohol or drug abuse
- ❑ Mental illness / suicide attempts
- ❑ Incarceration
- ❑ Adoptions
- ❑ Poverty / unemployment
- ❑ Financial stress
- ❑ Homelessness
- ❑ Frequent moves / Out of home placement
- ❑ Parental death
- ❑ Physical illness
- ❑ Witnessed violence
- ❑ Court involvement (including DCS)
- ❑ _____
- ❑ _____
- ❑ _____

School Functioning	Past	Present	Never	Describe
Not getting good grades in school				
Not doing homework				
Difficulty with learning				
Disturbs others in school				
Gets into fights at school				
Skips school / truancy				

In-school suspensions				
Out of school suspensions/expulsions				

Emotional Functioning	**Past**	**Present**	**Never**	**Describe**
Cries easily / often				
Unusually long temper tantrums				
Moods change quickly / drastically				
Easily frustrated				
Easily angered				
Basically unhappy				
Feels/complains no one loves him/her				
Feeling anxious				
Worries more than others				
Feeling lonely				
Wishing he/she were dead				
Hurts self on purpose (i.e. cutting)				
Feeling down or depressed				
Not motivated to do anything				
Stuffing anger				
Exploding with anger				
Suicidal thoughts / attempts				
Has nightmares				
Often confused / in a daze				
Frequent daydreams				
Behaves like the opposite sex				
Sees or hears things that others don't				
Night or day wetting				
Soiling or plays with excrement				
Trusts new people too easily				

Self Esteem	**Past**	**Present**	**Never**	**Describe**
Self-critical / perfectionistic				
Feels worthless or inferior				
Self-body image problems				
Weight problems				
Poor hygiene				

Hyperactivity	Past	Present	Never	Describe
Can't sit still / squirmy				
Acts without thinking				
Doesn't finish things				
Impulsive				
Easily distracted / short attention span				

Conduct Symptoms	Past	Present	Never	Describe
Lies				
Steals				
Runs away				
Gang involvement				
Being arrested or detained by police				
Using drugs				
Using alcohol				
Dealing drugs				
Destruction of property				
Setting fires				
Shows cruelty to animals				
Physically/sexually acting out w/others				
Inappropriate sexual behaviors				
Gets into more trouble than others of same age				
Denies mistakes / blames others				
Picks on other children				
Disobedient / or obeys resentfully				
Is disrespectful to parents				
Has difficulty getting along with other adults / authority figures				
Pornography				
Sexually active				

Peer Relations	Past	Present	Never	Describe
Provokes fights / quarrelsome				
Gets into others' personal space				
Feels others are out to get him / her				
Threatens others				
Would rather be alone than w/others				
Not making or keeping friends				

Having friends who are a bad influence				
Is picked on by other children				
Acts younger than actual age				
Doesn't get along well with siblings				

Coping	**Past**	**Present**	**Never**	**Describe**
Coping with a divorce of parents / guardians				
Coping with a family member's drinking / drug use				
Coping with past physical abuse				
Coping with past emotional abuse				
Coping with past sexual abuse				
Coping with feelings of being adopted				
Dealing with a break-up				
Difficulty handling the death of someone close to him/her				
Loss of an important relationship due to move or death				

Prosocial Behaviors	**Past**	**Present**	**Never**	**Describe**
Makes and maintains friendships				
Expresses thoughts or feelings appropriately				
Feels guilty for doing wrong				
Generally cooperative with adults				
Shows leadership skills				

What drug, alcohol, or tobacco experience has the child had? _____

_____

Child's age at first use? _____ Current use? _____ Last use? _____

Is there a family history of substance abuse problems? If so, please describe. _____

_____

L. MENTAL HEALTH INFORMATION

Psychiatrist/Prescriber	
Counselor/Therapist	
Diagnosis	

M. MEDICAL INFORMATION

Child's Name _____

Primary Care Physician (Name and Phone) _____

Dentist (Name and Phone) _____

Allergies (List all known of the following)

Medications _____

Foods _____

Others _____

Has your child had any adverse drug reactions? _____

Does your child wear glasses, contacts, or hearing aids? _____

Date of last physical _____ Date of last dental appointment _____

History of hospitalization(s) _____

History of operation / surgery(s) _____

Has your child been tested for TB? No ❑ Yes ❑

Insurance Policy Company _____ Number _____

Has your child been diagnosed with any medical conditions? _____

_____

List medications (including over the counter) your child takes currently or previously, when started, and why:

Medication Name	**Dosage**	**Date Started**	**Date Ended**	**Reason Prescribed**

Describe any side effects that you find troublesome from any of the medications the child is taking _____

_____

Does your child have any of the following problems on a recurring or continual basis?

			If yes, please explain.
Nausea	Yes	No	
Diarrhea	Yes	No	
Dizziness	Yes	No	
Persistent cough	Yes	No	
Passing out / fainting	Yes	No	
Urinary discomfort	Yes	No	
Respiratory infection	Yes	No	
Constipation	Yes	No	
Vomiting	Yes	No	
Unusual sweats or chills	Yes	No	

Shortness of breath	Yes	No	
Self-induced vomiting	Yes	No	
Severe dry mouth	Yes	No	
Persistent sore throat	Yes	No	
Bed wetting	Yes	No	
Poor appetite	Yes	No	
Inappropriate defecation	Yes	No	
Sleep disturbances	Yes	No	
Stomach aches	Yes	No	
Facial or muscle twitching / jerk	Yes	No	
Recurring pain	Yes	No	
STDs	Yes	No	
Bleeding anywhere (mouth, urine, stool)	Yes	No	

Has the child ever had:			**If yes, please give an approximate date and indicate if diagnosed by a doctor.**
Migraine headaches	Yes	No	
Sinus trouble	Yes	No	
Asthma	Yes	No	
Scarlet fever	Yes	No	
Rheumatic fever	Yes	No	
Whooping cough	Yes	No	
Valley fever	Yes	No	
Mononucleosis	Yes	No	
Tuberculosis (if yes, indicate treatment & duration)	Yes	No	
Polio (if yes, indicate treatment & duration)	Yes	No	
Anemia	Yes	No	
Hepatitis (if yes, indicate type, treatment & duration)	Yes	No	
Hernia	Yes	No	
Heart murmur	Yes	No	
Kidney problem	Yes	No	
Menstrual cramps	Yes	No	
Hearing problems	Yes	No	
Eczema	Yes	No	
Scoliosis / spine trouble	Yes	No	
Broken bones, sprains, dislocations	Yes	No	
Eating disorder	Yes	No	
Mumps	Yes	No	

Measles	Yes	No	
Chicken pox	Yes	No	
Ear infections	Yes	No	
Tubes in ears	Yes	No	
Fever 104 or higher more than 3 days	Yes	No	
Blow to the head (head trauma)	Yes	No	
Seizures or convulsions	Yes	No	
Difficulty gaining weight	Yes	No	
Recent weigh loss/gain	Yes	No	
Complained of aches and pains often	Yes	No	
Unable to speak well	Yes	No	
Complained of feeling tired most of the time	Yes	No	
Difficulty with coordination	Yes	No	

During pregnancy, did the child's mother:

Receive prenatal care	Yes	No
Drink alcohol	Yes	No
Use any illegal drugs	Yes	No
Use any medications	Yes	No

What physical/mental/emotional problems did mother have from conceptions to birth of the child?

_____

_____

Please describe any complications mother or child had during labor and delivery (stress, cord around neck, jaundice, seizures, oxygen, hours of labor, "blue baby", type of delivery)

_____

_____

By 0-1 years of age, had this child:

Sat up	Yes	No
Crawled	Yes	No

By 1-3 years of age, had this child:

Walked	Yes	No
Talked in real words	Yes	No
Fed self with a spoon	Yes	No

By 3-5 years of age, had this child:

Become completely toilet trained	Yes	No
Talked in sentences	Yes	No
Learned to ride a tricycle	Yes	No

Other developmental issues:

Evaluated for failure to thrive	Yes	No
Evaluated for developmental delays	Yes	No
Had difficulty with speech	Yes	No
Victimized by physical or sexual abuse	Yes	No
Unusually sensitive to touch	Yes	No

Is there a family history of:	Yes	No	**If yes, please explain (which family member)**
Heart problems	Yes	No	
Thyroid problems	Yes	No	
Asthma	Yes	No	
Kidney disease	Yes	No	
Sinus/allergy problems	Yes	No	
Epilepsy	Yes	No	
Addictions / substance abuse	Yes	No	
Arthritis	Yes	No	
Stroke	Yes	No	
Cancer	Yes	No	
High/low blood pressure	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Ulcers	Yes	No	
Immune condition	Yes	No	
Nervous breakdowns	Yes	No	
Convulsive disorders	Yes	No	
Depression	Yes	No	
Emotional problems	Yes	No	

What injuries not mentioned or explained above has this child had since birth? Date? Healed?

_____

_____

I _____, affirm that to the best of my knowledge, the data given in
(Print Name)

this application is true, complete, and current.

_____	_____
Parent / guardian signature & date	Witness signature & date