Sunshine Acres
CHILDREN'S HOME

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

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

Name (person filling out this application) _____

Relationship to child _____ Date _____

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 legal guardian Date

_____ _____
Signature of person completing the application (if different) 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 _____

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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? _____

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

- ❑ I am experiencing homelessness
- ❑ I have severe medical conditions
- ❑ I am facing incarceration
- ❑ I lack sufficient financial resources
- ❑ I am unemployed
- ❑ My child has behavioral challenges
- ❑ I do not have a vehicle
- ❑ I need therapy/rehab
- ❑ Other _____

## 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 DCS or CPS?

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

_____

_____

## F. FAMILY INFORMATION

| | Biological Father | Biological Mother | Previous placement and relationship to child if different than parent: |
|---|---|---|---|
| Full Name | | | |
| Birthday | | | |
| Current Address | | | |
| Current Phone | | | |
| Social Security # | | | |
| Marital Status | | | |

## 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. QUESTIONNAIRE

| Childhood Stressors | Yes | No |
|---|---|---|
| Has the child ever lived with an adult family member who has intimidated or threatened them? (Includes often swearing at, insulting, putting down, humiliating, or fear of being physically hurt) | | |
| Has the child ever been physically abused by an adult or household member? (Includes often being pushed, grabbed slapped, or had something thrown at them, or been hit so hard there were marks or injuries) | | |
| Has the child ever been sexually abused? (Includes being touched or touching others in a sexual way, try to or actually had intercourse) | | |
| Has the child often had feelings that they were not loved, important, or special or that the family was not close or supportive? | | |
| Were there times the child did not have enough to eat or had caregivers who were not able to care for them, get them medical attention, or protect them? | | |
| Were the child's parents divorced or separated? | | |
| Has the child ever witnessed adult violence in the home? (Includes someone being pushed, grabbed, hit repeatedly, or threatened with a weapon) | | |
| Has the child ever lived with someone who had a problem with alcohol or drugs? | | |
| Has the child ever lived with anyone who was mentally ill, suicidal, or depressed? | | |
| Has the child lived with someone who has been to jail or prison? | | |
| Has the child experienced the death of a close family member? If | | |
| Has the child experienced financial stress, poverty, homelessness, or frequent moves? (please circle which ones) | | |
| Has the child experienced adoption, out of home placements, or court involvement (including DCS or CPS)? (please circle which ones) | | |

| 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 physical abuse | | | | |
| Coping with emotional abuse | | | | |
| Coping with 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 | | | | |

## L. GRIEF/LOSS HISTORY

| | |
|---|---|
| Name of deceased | |
| Relationship to child | |
| Did the child live with the deceased | |
| Date of death | |
| Cause of death | |

| | |
|---|---|
| Was the death sudden | |
| Did the child witness the death | |
| Did the child attend the funeral | |

## M. SUBSTANCE USE/EXPOSURE

| Child History | Past | Present | Age 1st Use | Last Use | Treatment Facility/Treatment Dates |
|---|---|---|---|---|---|
| Alcohol | | | | | |
| Marijuana | | | | | |
| Other | | | | | |
| Other | | | | | |
| Other | | | | | |

## N. MENTAL HEALTH INFORMATION

| | |
|---|---|
| Psychiatrist/Prescriber | |
| Counselor/Therapist | |
| Diagnosis | |

| Past/Current Medication | Dosage | Start Date | End Date | Reason Prescribed | Prescribing Doctor | Side Effects |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## O. MEDICAL INFORMATION

| | |
|---|---|
| Primary Care Physician Name & Number | |
| Dentist Name & Number | |
| Food Allergies | |
| Medication Allergies/Adverse Drug | |
| Other Allergies | |
| Glasses/Contacts/Hearing Aids | |
| Date of Last Physical | |
| Date of Last Dental Appointment | |
| History of Hospitalizations | |
| Serious Illnesses or Injuries | |
| History of Operations | |

| | |
|---|---|
| History of Eye Surgery | |
| Insurance Policy Number & Company | |
| Medical Diagnosis | |

| Past/Current Medication | Dosage | Start Date | End Date | Reason Prescribed | Prescribing Doctor | Side Effects |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Recurring Health Problems | | | 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 | |
| Difficulty breathing | Yes | No | |
| Constipation | Yes | No | |
| Vomiting | Yes | No | |
| Unusual sweats or chills | 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 | |
| **Past/Current Health Conditions** | | | **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 | |
| Anemia | Yes | No | |
| Hepatitis (if yes, indicate type, treatment & duration) | Yes | No | |
| Hernia | Yes | No | |
| Heart murmur | Yes | No | |
| Kidney problem | 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 | |
| Blow to the head (head trauma) | Yes | No | |
| Seizures or convulsions | Yes | No | |
| Difficulty gaining weight | Yes | No | |
| Recent weigh loss/gain | Yes | No | |
| Complains of feeling tired most of the time | Yes | No | |

## P. PRENATAL HEALTH HISTORY

| **Mother During Pregnancy** | | | **Child Development** | | |
|---|---|---|---|---|---|
| Receive prenatal care | Yes | No | Sat up by age 1 | Yes | No |
| Drink alcohol | Yes | No | Crawled by 18 months | Yes | No |
| Use any illegal drugs | Yes | No | Walked by age 3 | Yes | No |
| Use any medications | Yes | No | Talked in real words by age 3 | Yes | No |
| Exposed to domestic violence | Yes | No | Fed self with a spoon by age 3 | Yes | No |
| Inadequate nutrition | Yes | No | Became completely toilet trained by age 5 | Yes | No |
| Experienced homelessness | Yes | No | Talked in sentences by age 5 | Yes | No |
| Experienced medical problem | Yes | No | Learned to ride a tricycle by age 5 | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| Healthy pregnancy | Yes | No | Evaluated for failure to thrive | Yes | No |
| Birth complications | Yes | No | Evaluated for developmental delays | Yes | No |
| Normal birth weight | Yes | No | Diagnosed with autism | Yes | No |
| Breathing problems at birth | Yes | No | Diagnosed with learning disabilities | Yes | No |
| Congenital problem | Yes | No | Had difficulty with speech | Yes | No |
| Drug addicted at birth | Yes | No | Unusually sensitive to touch | Yes | No |

| **Is there a family history of:** | | | **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 | |
| Immune condition | Yes | No | |
| Nervous breakdowns | Yes | No | |
| Convulsive disorders | Yes | No | |
| Depression | Yes | No | |
| Emotional problems | Yes | No | |

Sunshine Acres
CHILDREN'S HOME

# AUTHORIZATION TO EXCHANGE INFORMATION

Child's Name: _____ DOB: _____

I authorize Sunshine Acres Children's Home to exchange information with:

Phone: _____

_____ Fax: _____

Name of Most Recent School

_____

Address City, State Zip

A. INFORMATION TO BE DISCLOSED

| | | | |
|---|---|---|---|
| __X__ | MET Evaluation Report | __X__ | Test Results/AIMS Scores |
| __X__ | Individual Education Report (IEP) | __X__ | Discipline Records |
| __X__ | 504 Plan | __X__ | Current Report Card |
| __X__ | Copy of Immunizations Record | __X__ | Attendance Record |
| __X__ | Copy of Birth Certificate | Other | _____ |

B. PURPOSE OF DISCLOSURE: Possible Placement

C. PLEASE RELEASE THE INFORMATION TO:

Academic Services Department
Sunshine Acres Children's Home
3405 N. Higley Road
Mesa, Arizona 85215-9741

**academics@sunshineacres.org**
Fax: 1-866-491-5380
Phone: 480-981-4112

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has already been taken. This release will expire one year from today or upon the client leaving Sunshine Acres Children's Home.

_____

Signature of Parent/Legal Guardian Date

_____

Signature of Witness Date

RELEASE OF INFORMATION

Child's Name:_____ DOB: _____

I authorize the exchange of records and information, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use. I understand that there is potential for information disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.

Phone: _____

_____ Fax: _____

Name of Agency/Person

_____

Address City, State Zip

A. INFORMATION TO BE DISCLOSED

__X__ Intake/Assessment
__X__ Treatment Recommendations
__X__ Medication (Past/Current)
__X__ Substance Use (Past/Current)
__X__ Other_____

__X__ Treatment/Progress Summary
__X__ Psychological/Psychiatric Evals
__X__ Discharge Summary
__X__ Probation/Court Status

B. PURPOSE OF DISCLOSURE: Continuity of care

C. PLEASE RELEASE THE INFORMATION TO:

Sunshine Acres Children's Home
3405 N. Higley Road
Mesa, Arizona 85215-9741

**connieh@sunshineacres.org**
Fax: 1-866-491-5380
Phone: 480-832-2540

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has already been taken. This release will expire on year from today or upon the client leaving Sunshine Acres Children's Home.

_____

Signature of Parent/Legal Guardian Date

_____

Signature of Witness Date