Kentucky IMPACT

Nomination Packet
(Insert Region)

Demographic Information

Child's Name _____ Date of Birth ____/____/____ Sex ❑ Male ❑ Female

Social Security Number ____-____-____

Child's Address (If Different) _____

Name of Legal Guardian _____

Relationship to the Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Pager Number _____

Name of Guardian where Child is living. _____

Relationship to the Child _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Pager Number _____

Name of Father _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Pager Number _____

Name of Mother _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Pager Number _____

Date of Referral _____ Name of Person Making Referral _____

Agency / Organization _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information

❑ No Insurance

❑ Medicaid / Medical Card Card Identification Number _____ Card Name _____

❑ Private Insurance Card Identification Number _____ Card Name _____

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Health Information

What is the child's Mental Health Diagnosis? _____

Is the child currently taking prescribed medication(s)?
- ❑ No
- ❑ Yes, If know please identify below:

Name of Medication	Milligrams	Frequency	Prescribing Doctor

Does the child have a history of Psychiatric Hospitalizations and/or Residential Placements?
- ❑ No
- ❑ Yes, please provide dates and location below:

_____

_____

Does the child have a chronic handicap or significant developmental delay?
- ❑ No
- ❑ Yes, please provide details below

_____

_____

Has the child suffered and/or experiencing any type of trauma?
- ❑ No
- ❑ Yes, please provide details below

_____

_____

Additional Information

What strengths can you identify for this child and family? _____

_____

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Please indicate the severity for each behavior identified by circling the most appropriate number; **one (1) being never** and **five (5) being frequently**:

Behaviors	N				F
1. Physically assaults peers; Comments:_____	1	2	3	4	5
2. Physically assaults adults; Comments:_____	1	2	3	4	5
3. Verbally or physically threatens people; Comments:_____	1	2	3	4	5
4. Damages or destroys property; Comments:_____	1	2	3	4	5
5. Steals; Comments:_____	1	2	3	4	5
6. Lies; Comments:_____	1	2	3	4	5
7. Sets fires; Comments:_____	1	2	3	4	5
8. Engages in inappropriate sexual behavior;	1	2	3	4	5
9. Exhibits strange or bizarre behavior; Comments:_____	1	2	3	4	5
10. Runs away; Comments:_____	1	2	3	4	5
11. Deliberately harms self; Comments:_____	1	2	3	4	5

Behaviors	N				F
12. Attempts suicide; Comments:_____	1	2	3	4	5
13. Fails at self-care/hygiene; Comments:_____	1	2	3	4	5
14. Withdraws from others; Comments:_____	1	2	3	4	5
15. Uses drugs or alcohol; Comments:_____	1	2	3	4	5
16. Gang or occult involvement; Comments:_____	1	2	3	4	5
17. Cruelty to animals; Comments:_____	1	2	3	4	5
18. Other:_____	1	2	3	4	5

Additional Comments:

_____

_____

_____

Educational Information

Does the child attend school?
- ❑ No
- ❑ Yes; School Name:_____

Please identify the child's type of school placement(s):
- ❑ Home Schooled
- ❑ Regular Education
- ❑ Day Treatment
- ❑ 504 Plan
- ❑ IEP
- ❑ EBD
- ❑ MR/DD
- ❑ Need to refer
- ❑ Do not know

Please identify the child's intellectual functioning level:
- ❑ Above Average
- ❑ Average
- ❑ Below Average
- ❑ Borderline
- ❑ Mental Retardation
- ❑ Do not know

Please specify range and IQ scores if known: _____

_____

_____

Please indicate the severity for each behavior(s) and discipline problem(s) identified by circling the most appropriate number: **one (1) being never** and **five (5) being frequently**:

School Behaviors	**N**				**F**
Chronic Tardiness	1	2	3	4	5
Defiant	1	2	3	4	5
Poor Concentration	1	2	3	4	5
Truancy	1	2	3	4	5
Academic Underachievement	1	2	3	4	5

Discipline Problems	**N**				**F**
Suspensions	1	2	3	4	5
Expulsions	1	2	3	4	5

Please provide explanation for discipline problems:

_____

_____

_____

_____

POTENTIAL / CURRENT TEAM MEMBERS

	Contact Information (Address and Phone Number)
Therapist: (Mental Health)	
School Teacher:	
School Counselor:	
DCBS Worker: (Social Services)	
DJJ Worker: (Juvenile Justice)	
CDW: (Court Designated Worker)	
Physician: (Primary Care)	
Psychiatrist (Mental Health)	
Other:	

Additional Comments to Further Support Nomination of the Child

_____

_____

_____

_____