Thrive Girls Academy Intake Application

Submitted By: _____ **Date**: _____

Client Information

Name: _____
First Middle Last

Gender: _____ DOB: _____ Age: _____

SSN : _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Mobile : _____

Email : _____

Expect to Enroll: _____

School Grade: _____

Emergency Contact (other than Parent/Guardian):

_____

Relationship: _____

Home Phone: _____ Mobile : _____

Address: _____

City/State/Zip: _____

Type of Plan: **Initial** Estimated Length of Stay in Placement: Program Length 12 months

Current Level of Care: **Basic** Effective Date of Plan: _____ Legal Status of Child: TMC

Parent/Guardian/Sponsor Information

Parent/Guardian/Sponsor: (PRIMARY): _____

Please mark all that apply: Parent ☐ Guardian ☐ Legal Custody ☐ Physical Custody ☐ Sponsor ☐ Adoption ☐

Relationship: _____ DOB: _____ SSN : _____

Address: _____ City/State/Zip: _____

Method of contact : _____ Home Phone : _____ Mobile : _____ Home Fax : _____

Home Email : _____ Job title : _____ Work Phone : _____

Employer : _____ Work Email : _____ Work Fax : _____

Parent/Guardian/Sponsor: (SECONDARY): _____

Please mark all that apply: Parent ☐ Guardian ☐ Legal Custody ☐ Physical Custody ☐ Sponsor ☐ Adoption ☐

Relationship: _____ DOB: _____ SSN : _____

Address: _____ City/State/Zip: _____

Method of contact : _____ Home Phone : _____ Mobile : _____ Home Fax : _____

Home Email : _____ Job title : _____ Work Phone : _____

Employer : _____ Work Email : _____ Work Fax : _____

Briefly describe relationships and home environment between the above persons and applicant _____

_____

_____

General Information

Is the applicant fluent in any languages other than English?:_____Specify: _____

Child's Ethnicity: ☐ Hispanic ☐ Other Hair Color:_____Eye:_____Height:_____Weight:_____

Legal status: US Citizen Yes No Other: _____

Child's Race: (Check one)	White ☐	Black ☐	Asian ☐	American Indian/Alaskan Native ☐	Native Hawaiian/Pacific Islander ☐	Unable to Determine ☐

Parent/Guardian Report

Please describe your reasons for wanting to place your child at THRIVE Girls Academy and behaviors:

_____

_____

Comment on any factors that may have contributed to the problems that your child is having: _____

_____

_____

Please describe what steps you have taken so far to help your child: _____

_____

_____

Briefly Describe your child's strength, special skills and interests, talents and personality: _____

_____

Briefly Describe your child's triggers:

_____

_____

Has the applicant been raised by anyone other than her parents: Please explain : _____

Does the child have siblings: Yes or No If Yes, are they in substitute care: Yes or No

If the child has siblings in care that are placed separately, identify placing Agency or Kinship Family Name:

_____

Type of contact approved (such as: letters, email, skype, phone, cell, text) _____ If visitation or contact is not allowed explain why: _____

Efforts to maintain and improve connections with family and other caring adults:

_____

Summary of visitation of contacts (Discuss how visits are going, how often they are occurring, and any barriers to visitation: _____

Identified goals for visits (discuss goals which have been identified such as improve or re-establish relationships improve sibling connections, etc.): _____

Identified needs and plans to address (discuss any issues related to ensuring visitation occurs and what is being done to overcome as well as any other issues that need to be addressed regarding visitation):

_____

_____

Has there been a death of a friend or relative in the past year?_____Please explain: _____

_____

Has there been a divorce in the family: _____

A copy of the divorce decree and custody arrangements will need to be submitted to Teen Challenge with these forms.

Please describe the divorce dynamics that may have had an impact on your child: _____

_____

_____

_____

_____

Is there a separation or divorce pending:_____ Are you currently married? _____

Please describe the conditions of your current marriage: _____

_____

_____

_____

Legal History

Has the student ever been arrested: _____ Describe any history or current juvenile justice involvement:

Please give number of, dates of, city and state, reason for and disposition of arrest(s):

Charges	Adjudication Status

Please provide any pertinent details: _____

_____

_____

Pending charges :_____

Charge :_____

Court Date:_____Has the student ever been convicted : _____

Please provide details:_____

_____

Is the student under a FINS petition: _____

Is the student on probation:_____Probation Officer Name: _____

Address:_____City/State/Zip:_____

Phone :_____Ext.:_____Cell:_____

Email: _____

Please provide information about any other illegal activity that you feel THRIVE Girls Academy should know about your daughter:_____

_____

_____

Does your child have a history of using/abusing over•the•counter substances: _____

Please explain: _____

Insurance Information

Primary Insurance Company:_____Address: _____

Benefits Phone:_____ Group Number: _____

Policy Number:_____Policyholder's Name: _____

Employer:_____Date of Birth :_____Social Security Number:_____

Rx BIN #:_____Rx PCN #:_____Pharmacy Help Desk Phone: _____

Secondary Insurance Company:_____Address: _____

Benefits Phone:_____ Group Number: _____

Policy Number:_____Policyholder's Name: _____

Employer:_____Date of Birth :_____Social Security Number:_____

Rx BIN #:_____Rx PCN #:_____Pharmacy Help Desk Phone: _____

Please list **current information** for your daughters Psychiatrist in Texas:

Psychiatrist Name	Location	Phone	Date Last seen	Email address

If you live **outside** of Texas, please list Psychiatrist in Texas that your medical insurance covers:

Psychiatrist Name	Location	Phone	Date Last seen	Email address

Current Medications Please list ALL medications below;:
Current medications, non-psychotropic & psychotropic medication includingover
The counter and supplements.

Medication Name	**Dose & Frequency**	**Length of Time**	**Prescribing Physician**	**Reason Prescribed/Taking**	**Do you believe the medication is effective?**	**Prescribing Physician and contact information**
Describe any side effect experienced by the child:						
List of Psychotropic Medication Name	**Dose & Frequency**	**Length of Time**	**Prescribing Physician**	**Reason Prescribed/Taking**	**Do you believe the medication is effective?**	**Prescribing Physician and contact information**
Describe any side effect experienced by the child: List DME supplies: _____Is there a DNR? Yes or No						

Medical History

Pregnancy and Early Development
Illness or Complications? ( ) Yes ( ) No
C-section? ( ) Yes ( ) No
Smoking During Pregnancy? ( ) Yes ( ) No
Alcohol? ( ) Yes ( ) No
Drugs/Medications? ( ) Yes ( ) No
Premature Delivery? ( ) Yes ( ) No

If so, length of hospitalization_____

Treatment / Placement History

Please include all previous counseling, inpatient, psychiatric, psychological, or any other professional services received:

Dates - List Recent admission	Dates - List Recent discharge	Agency or Program	Reason for Treatment/Placement	Results of Placement/Treatment

Parent/Guardian Must provide initial evaluation of appropriate placement & ensure that necessary information for service planning is provided with this application for enrollment consideration.

PRE-ASSESSMENT SCREENING Checked by Office Staff (Name):_____

Check all that apply to your daughter's current and past diagnosis (provide diagnosis documentation):

- ☐ ADHD
- ☐ dental problems
- ☐ Allergies/Asthma
- ☐ Trauma
- ☐ Seizures
- ☐ Lung Dysfunction
- ☐ Sexually Transmitted Disease(s)
- ☐ Bruises Easily
- ☐ Heart Dysfunction
- ☐ Vision problems
- ☐ Back Problems
- ☐ HIV
- ☐ Blood Disorder
- ☐ Skin Infections
- ☐ Infectious Disease(s)
- ☐ Chronic Medical Problems
- ☐ Hepatitis
- ☐ Nervous Condition
- ☐ Liver Dysfunction
- ☐ Diabetes
- ☐ Autism
- ☐ Anxiety

Other:

Please provide details about all items indicated above: _____

*Description of Allergies: _____

_____

Is your child able to participate in rigorous physical activities (i.e. sports, rappelling, hiking, running, etc.): _____

If not, please explain: _____

List any medical strengths: _____

_____

Date of last annual medical exam:_____Next scheduled due date: _____

Date of last annual dental exam:_____ Date of last annual vision exam: _____

Date of last annual hearing exam: _____

Next scheduled dental exam:_____ Date of next scheduled vision exam: _____

Date of next scheduled hearing exam: _____

(Include results of the medical and dental exams)

Name of Clinical Professional:_____Address_____Phone _____

Name of Clinical Professional:_____Address_____Phone _____

** **Vaccine Preventable Disease Policy**: Once this students application is approved for enrollment a Copy of her Immunization shot records or an Affidavit Exemption from Immunizations for Reasons of Conscience must be emailed, faxed or mailed prior to admissions into ATCOT Thrive Girls Academy.

Please list all Hospitalizations and/or ER Visits:

Treated For:	**Date[s]**	**Length of Stay**	**Place of Service/City/State**

What is your religious/denominational preference: _____

Name of church and how often you attend on average: _____

Does your family attend church regularly, or are faith observant: _____

ATCOT THRIVE GIRLS ACADEMY ADMISSIONS INFORMATION

Referral Information

How did you first hear about Thrive Girls Academy?:_____

Family Information

Please provide the following. Do not include extended family (i.e. grandparents or aunts and uncles) unless that Family member has had guardianship or care of the child in the past. Please include adult children who live separately and parents that the child does not live with.

Name	Relationship to Student	Age	Household Status	Substance User	Mental Health Issues	Allowed Contact

Allowed Contacts: Students may receive correspondence from immediate family, pastors, teachers, and/or counselors. Please let us know who you would like your child to receive mail, letters from. After 6 weeks in care/completion of Phase 1 students may receive scheduled phone call, text, Phase 2 family visit. Progress in program is reviewed before scheduling family visits.

Name	Relationship	Address	Phone number

Are there family members that should **not** have contact with your child, explain reason:

Name	Relationship	Address	Phone number
1.			
2.			
3			
4			
5.			

Explain reason for NO contact:

_____

List all family and supportive adult relationships:

_____

_____

Behavior Assessment

- ☐ Drug Abuse Explain:_____
- ☐ Running Away Explain:_____
- ☐ Physical Abuse Explain:_____
- ☐ Alcohol Abuse Explain:_____
- ☐ Aggressive/Violent Behavior Explain:_____
- ☐ Death of Loved One Explain:_____
- ☐ Tobacco/Vaping Explain:_____
- ☐ Abandonment Explain:_____
- ☐ Emotional Stress Explain:_____
- ☐ Emotional/bullied Abuse Explain: _____
- ☐ Anger Explain: _____
- ☐ Fear Explain:_____
- ☐ Family Relationships Explain:_____
- ☐ Arson/Fire Starting Explain:_____
- ☐ Sexual Abuse Explain:_____
- ☐ Self Mutilation/Cutting Explain:_____
- ☐ Pornography Explain:_____
- ☐ Insomnia Explain:_____
- ☐ Forgiveness Explain:_____
- ☐ Guilt Explain:_____
- ☐ Self Image Explain:_____
- ☐ Hearing Voices Explain:_____
- ☐ Hallucinations Explain:_____
- ☐ Paranoia Explain:_____
- ☐ Neglect Explain: _____
- ☐ Other Explain: _____
- ☐ Self-Harm: Has your child ever attempted suicide or had suicidal thoughts: YES or NO

When (Dates Suicide)_____Number of attempts: _____

When (Dates Suicidal thoughts)_____When (dates cutting)_____

Is your child currently suicidal:_____Please explain:_____

If your daughter is accepted/enrolled into Thrive Girl Academy and begins to self-harm and is taken to a Behavioral Health Hospital for evaluation she will not be admitted back into the program. Parents will need to contact Campus Director or Campus Coordinator.

Has someone died by suicide, particularly a family member, friend, peer, or hero that your child is connected to?

_____

Please explain:

_____

Has your child ever been charged with a sexual offense:_____Please explain: _____

_____

_____

Substance Abuse History

Please indicate any and all substances that you know your daughter has used.

Be sure to include all prescription drug abuse.

Substance	Current Usage Past 30 Days	If yes, pattern of use last 30 days (include amount and frequency)	Age of 1st Use	Age this became a problem?	Pattern of use for at least last 6 months (include amount and frequency)	Primary Route	Date, Time, and amount
Alcohol							
Amphetamines							
Barbiturates							
Crack							
Cocaine							
Ecstasy							
Heroin							
Huffing/Snuffing							
LSD							
Marijuana							
Methadone							
Methamphetamine							
Morphine							
Mushrooms							
Opioids							
Oxycontin							
PCP							
Tobacco							
Vape							
Fentanyl							
Other							

Medical & Developmental History

Were any of the following present during child's early childhood? Please circle below the appropriate:

_____Did not enjoy cuddling _____Difficult to comfort _____Colic Irritability

_____Diminished ____Excessive Sleep ____Head Banging_____Illness

Testing & Diagnosis

Has your child ever received? Psychiatric Evaluations ☐ When:_____

☐ Medical ☐ Psychological Evaluations ☐ Psychoeducational assessments ☐ IQ testing

Comments/Additional information if applicable:

_____

Location:_____ Phone#_____

Has your child ever been in any resource classes:_____Please explain:_____

_____

Has your child ever been tested for learning disabilities (list dates): _____

Please explain_____

Recommendations for further testing assessments:_____

Has your child been diagnosed by a Physician with a psychological, behavioral, or development disorder:

_____

What were the resulting diagnosis: _____

Parents/Guardians must provide initial evaluation of appropriate placement & ensure that necessary information for service planning is provided.

Academic Information

Previous Schools *List most recent schools first:*

Information	School 1	School 2	School 3
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades earned			

Information	School 4	School 5	School 6
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades Earned			

Information	School 7	School 8	School 9
School Name:			
Dates Attended:			
Address:			
City:			
State:			
Zip Code:			
Work Phone:			
FAX:			
Contact:			
Email (if known):			
Grades Earned			

Has your child received any disciplinary actions at school? Please explain: _____

How would you rate her overall performance throughout her school years? _____

Has your child received any special achievements? _____

Describe any IEP goals and/or 504 plans: _____

Childs Distinguishing Marks: Scars or Tattoos/Other (Describe)

_____

__ _____

Shirt Size:_____Shoe Size:_____Waist:_____Length:_____

* Please include your daughters most current psychological diagnosis and/or therapist assessments. Medical exam, dental exam, eye exam, hearing exam and the attached THRIVE medical form must be completed at least 30 days prior to admissions into the THRIVE Girls Academy.

PLANNING FACTORS

Tentative date and time you would like to admit applicant _____

Means of transportation_____

UNDERSTANDING OF FINANCIAL OBLIGATION

I/we understand ALL fees and tuition payments are Non-Refundable, regardless of length of stay.

Parent/Guardian Name &Signature:_____Date: _____

Parent/Guardian Name &Signature:_____Date: _____

FINANCIAL OBLIGATION

Pre-Admissions Intake Fee: $1000 To reserves your daughter's Intake date into our program. A date for her intake cannot be scheduled until this fee has been received. (This can be paid by credit card)

PROGRAM COSTS ON ADMISSIONS DATE:

Monthly Tuition: $4150 x 2 = $8,300 (First and Last Month's tuition)

Education/Curriculum Fee: $1200 covers first 2 full credit courses

Damage Fee: $500 Fee for transport for medical, dental, or legal needs and/or any damage to property(In the event a student maliciously destroys property, the damage incurred will be covered by the parent in as fast a means as necessary)

***Student Account $575 Limits of $45 every month is placed on this, all receipts for anything purchased (recreation membership, haircuts, over the counter allergymedication, new shoes she grows into, etc.), and Bookkeeper will keep you informed if she is low on these particular funds.

GPS Ankle monitor $250 As needed, will be monthly only if student continues to be a flight risk after 30 days

Total Admissions Program costs due on or before day of Intake is $10,575.
Admissions/Intake Payment is accepted before or on Admissions date in the form of a cashiers check made to: Thrive Girls Academy

***All fees and tuition payments are Non-Refundable regardless of length of stay.**

Application & forms can be emailed to: tga.admissions@tctexas.org OR fax application & forms to FAX# 512-584-8535

MEDICAL FORM

Please fill out completely.

Blood test results must be provided before your child will be entered into our program.

PHYSICIAN'S STATEMENT

Upon examination of_____, I have , her, in my medical opinion, to be **free** from communicable diseases including: TB ◯ HIV ◯ Hepatitis A, B and C ◯

◯ Pregnancy Test: ◯ positive ◯ negative

Has had recent travel outside of the U.S.? Explain:_____

Her overall **physical health** is: Good Average Poor

Her overall **mental health** is: Good Average Poor

Her overall **emotional health** is: Good Average Poor

Handicaps (Physical, Mental, Emotional): _____

_____

Specific treatment: _____

_____

Drug Allergies or ANY known allergies: _____

_____

Prescriptions: _____

_____

Recommended Treatment or Follow up needed:_____

In my opinion, the person is stable enough physically, mentally and emotionally to participate in a long-term group program involving teaching, learning, taking of responsibilities and strict discipline to help produce a self-disciplined life.

Physicians Signature:_____**Date:**_____
Office Address:_____**Phone:**_____
City:_____**State:**_____**Zip:** _____

** Vaccine Preventable Disease Policy: Once this students application is approved for enrollment a Copy of her Immunization shot records or an Affidavit Exemption from Immunizations for Reasons of Conscience must be emailed, faxed or mailed prior to admissions to ATCOT Thrive Girls Academy.

Please send email records of immunizations to tga.admissions@tctexas.org **or mail to Adult & Teen Challenge of Texas, Thrive Girls Academy, Rev. Rodger Anderson, Executive Director, PO Box 1054, Hutto, TX 78634**

*I understand that incomplete testing **will** delay the processing of my child's application.

Parent's or Legal Guardians Name: _____ Signature:_____Date: _____

MEDICAL FORM

Parent/Legal Guardian please answer the following below to the best of your ability for your daughter

Student Name (print): _____

In the past 3 weeks, has your daughter experienced the following symptoms: fever, cough, difficulty breathing and respiratory congestion? Yes or No If yes, explain:

_____
_____
_____

In the past 30 days, has your daughter traveled, lived or been in contact with someone that has traveled outside of the US? Yes or No If yes, explain:

_____
_____
_____ I

In the past 3 weeks, has your daughter been on a cruise ship, or traveled outside of your state?
Yes or No If yes, explain:

_____
_____
_____

If it becomes evident for medical reasons that your daughter cannot be in the general population within our campus, where would you like her to be discharged to?

_____
_____
_____

STUDENT TEMP: _____

Parents/Legal Guardian Name & Signature:_____

Date:_____

AUTOMATIC CREDIT CARD BILLING AUTHORIZATION

For automatic billing, simply complete the information below and sign the form. All **requested information is required.** Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear monthly on your credit card statement. You may cancel this automatic billing authorization at any time by contacting us in writing or by email at least ten (10) days prior to **billing date.**

Student Information

Student's name:_____Enrollment Date: _____

Payment Information

I, authorize THRIVE Girls Academy and Adult & Teen Challenge of Texas Inc. to automatically bill the card listed below as specified **(Monthly billing - All Fields are required):**

Monthly Tuition Amount: $_____ Day of Month to Bill:_____*(*At least 5 days before Tuition Due Date)

Month to Start billing On (MM/*YY):*_____End billing when: ☐ End Date (M*M*/DD/*YY*)_____.

☐ Cardholder p**rovides written cancellation**
(At least 10 business days prior to monthly billing date)

Credit Card Information

The following credit cards are accepted ***(Check One):*** ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Credit Card Number: Expiration Date:

Cardholder's Name (**as shown on credit card)** _____

Card Verification Code_____ Credit Card Billing Zip Code: _____

Credit Card Billing Address:_____Cardholder's Phone Number: _____

Cardholder's Signature:_____**Date:** _____

☐ **Notify me via email or text when my credit card is charged. Email Address:** _____