



**LEE & BEULAH MOOR CHILDREN'S HOME**

1100 E. Cliff Drive  
El Paso, Texas 79902  
(915) 544-8777 Fax (915) 532-1368

**APPLICATION FOR ADMISSION**

Date of Application \_\_\_\_\_ *(LBMCH use) Case Number* \_\_\_\_\_

Date of Admission \_\_\_\_\_

1. Name of child being referred \_\_\_\_\_ D.O.B. \_\_\_\_\_

Place of birth (city/state/country) \_\_\_\_\_ Gender  M  F

Social Security number \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt.# City State ZIP

Race:  Hispanic  Anglo  African-American  Native American  Asian

Other Religious Preference \_\_\_\_\_ Referring Agency \_\_\_\_\_

2. What problems is the child presently experiencing? (check all that apply to this child)

- |                                                            |                                                         |
|------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Problems with parents             | <input type="checkbox"/> Problems with brothers/sisters |
| <input type="checkbox"/> Academic school problems          | <input type="checkbox"/> School behavior problems       |
| <input type="checkbox"/> Peer/friend relationship problems | <input type="checkbox"/> Drug/alcohol problems          |
| <input type="checkbox"/> Problems with gangs               | <input type="checkbox"/> Legal problems                 |
| <input type="checkbox"/> Medical problems                  | <input type="checkbox"/> Runaway                        |
| <input type="checkbox"/> Sexual                            | <input type="checkbox"/> Other (Specify) _____          |

3. Briefly describe what is presently happening in the family that is prompting this request for placement at this time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How long do you feel the child you are referring to the program will need to stay at LBMCH if he/she is accepted?

\_\_\_\_\_

5. If this child is placed at LBMCH and is released from the program, what will be the plan for the care of this child?

\_\_\_\_\_ Return to father  
\_\_\_\_\_ Independent living  
\_\_\_\_\_ Other (Specify person(s) name and relationship)

\_\_\_\_\_ Return to mother  
\_\_\_\_\_ Return to relative (*Specify what relative*)

\_\_\_\_\_

6. What needs to change in the family for this child to return to the home?

\_\_\_\_\_  
\_\_\_\_\_

7. Please provide the following information on Parents/Managing Conservators

\_\_\_\_\_  
Mother's Name Social Security number D.O.B. Legal (sole, shared, managing custody of child)

\_\_\_\_\_  
Address (Home) City State ZIP Phone Cell/Beeper

\_\_\_\_\_  
Work (Name of business) Address (Work) Phone and extension

\_\_\_\_\_  
Current Marital Status Previous Marital Status Email Address

\_\_\_\_\_  
Father's Name Social Security number D.O.B. Legal (sole, shared, managing custody of child)

\_\_\_\_\_  
Address (Home) City State ZIP Phone Cell/Beeper

\_\_\_\_\_  
Work (Name of business) Address (Work) Phone and extension

\_\_\_\_\_  
Current Marital Status Previous Marital Status Email Address

\_\_\_\_\_  
Managing Conservator Social Security number D.O.B. Legal (sole, shared, managing custody of child)

\_\_\_\_\_  
Address (Home) City State ZIP Phone Cell/Beeper

\_\_\_\_\_  
Work (Name of business) Address (Work) Phone and extension

\_\_\_\_\_  
Current Marital Status Previous Marital Status Email Address

\_\_\_\_\_  
Other (Stepparent/grandparent) Social Security number D.O.B. Legal (sole, shared, managing custody of child)

\_\_\_\_\_  
Address (Home) City State ZIP Phone Cell/Beeper

\_\_\_\_\_  
Work (Name of business) Address (Work) Phone and extension

\_\_\_\_\_  
Current Marital Status Previous Marital Status Email Address

8. Please provide the following information on this child's brothers/sisters

Name	Address	Phone #	D.O.B.	Place of birth	Grade in school

9. Significant Relatives—List any relatives who have a close relationship to the child and who you may want the child to continue contact with during placement either by phone, mail, or in person.

Name	Address	Phone number	Relationship to child	Maternal/Paternal

10. Life Experiences

Has your child experienced a significant trauma or event of which we need to be made aware (physical or sexual abuse, death of someone close, gangs, violence, arrested by police, etc?)  Yes  No  
 If yes, please explain \_\_\_\_\_

11. School

Name of School	Address	City	State	ZIP	Phone number

Grade level \_\_\_\_\_ Has the child ever been suspended or expelled from school?  Yes  No

What subject does this child like the best? \_\_\_\_\_ least? \_\_\_\_\_

Does this child attend any special classes in school? \_\_\_\_ Yes \_\_\_\_ No If yes, please list classes attending.

\_\_\_\_\_

Has this child ever repeated a grade level? \_\_\_\_ Yes \_\_\_\_ No If yes, what grade? \_\_\_\_\_

Has this child had behavior problems in school? \_\_\_\_ Yes \_\_\_\_ No If yes, please describe the kind of problems \_\_\_\_\_

\_\_\_\_\_

Is your child involved in extracurricular activities? If yes, describe \_\_\_\_\_

\_\_\_\_\_

12. Please list all agencies that you are currently involved with or who have been involved with your family previously

Name of agency	Services received/purpose of involvement	Dates of involvement
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. Previous placements outside of applicant's home - Please list occasions this child has not lived with you (such as times he/she lived with grandparents, other relatives, other parent, or residential facility).

Home or Facility	Address	Date lived at this location
_____	_____	_____
_____	_____	_____

Reason for placement \_\_\_\_\_

Reason for placement \_\_\_\_\_

14. Identification of the child's treatment needs, if applicable, and any additional treatment services or programmatic services the child is receiving.

\_\_\_\_\_

\_\_\_\_\_

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**I am stating the above statements are true and correct to the best of my knowledge.**

\_\_\_\_\_  
*Father/Managing Conservator*

\_\_\_\_\_  
*Mother/Managing Conservator*

# LEE & BEULAH MOOR CHILDREN'S HOME

## DEVELOPMENTAL/MEDICAL HISTORY

Name of Child: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Gender: \_\_\_\_\_

### 1. Medical

List this child's current medical problems \_\_\_\_\_  
\_\_\_\_\_

List any medications this child is currently taking \_\_\_\_\_  
\_\_\_\_\_

What physician and/or medical clinic does this child use? \_\_\_\_\_  
Name of Clinic/Doctor

Street Address City ZIP Phone Number

Date of last physical exam \_\_\_\_\_

What dentist and/or dental clinic does this child use? \_\_\_\_\_  
Name of Clinic/Doctor

Street Address City ZIP Phone Number

Date of last dental exam \_\_\_\_\_

What optometrist/ophthalmologist and/or eye clinic does this child use? \_\_\_\_\_  
Name of Clinic/Doctor

Street Address City ZIP Phone Number

Date of last eye exam \_\_\_\_\_ Does this child wear glasses or contacts? \_\_\_ Yes \_\_\_ No

List any specialist doctors your child may be seeing and reason they are seeing this doctor:  
\_\_\_\_\_  
\_\_\_\_\_

Does this child have medical coverage? \_\_\_ Yes \_\_\_ No If yes, name the insurance and policy number including Medicaid plan \_\_\_\_\_  
\_\_\_\_\_

### 2. Current Physical Description

a. Height \_\_\_\_\_ Weight \_\_\_\_\_

b. Color of hair \_\_\_\_\_ Color of eyes \_\_\_\_\_

c. Please list/describe any physical marks (tattoos, piercings, scars) \_\_\_\_\_

**3. Birth**

- a. Was birth full term \_\_\_\_\_ or premature \_\_\_\_\_? If premature, how many months at time of birth \_\_\_\_\_.  
 Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ Birth defects? \_\_\_\_ Yes \_\_\_\_ No
- c. Did you have prenatal care? \_\_\_\_ Yes \_\_\_\_ No
- d. Were there any complications during the pregnancy? \_\_\_\_ Yes \_\_\_\_ No If yes, explain \_\_\_\_\_
- e. List any complications during labor and/or delivery \_\_\_\_\_
- f. How long did the child stay in the hospital after birth? \_\_\_\_\_
- g. Did you experience any accidents, falls, abuse, etc. during pregnancy? \_\_\_\_ Yes \_\_\_\_ No If yes, explain \_\_\_\_\_
- h. Did the father of this child use drugs/alcohol at time of conception? \_\_\_\_ Yes \_\_\_\_ No
- i. Did the mother of this child use drugs/alcohol prior to or during pregnancy? \_\_\_\_ Yes \_\_\_\_ No  
 If yes was checked on **h** or **i**, list what drugs, including those prescribed by a doctor and frequency of alcohol consumption. \_\_\_\_\_

**4. Developmental Stages**

Activity	Age in Months or Years
Sit up	
Crawl	
Walk	
Speak words	
Speak sentences	
Toilet trained	

**5. Feeding History**

- a. Was this child breast fed \_\_\_\_\_ or formula fed \_\_\_\_\_? Were there any problems in infancy with feeding? \_\_\_\_\_
- b. Does this child have any food allergies? \_\_\_\_ Yes \_\_\_\_ No If yes, list \_\_\_\_\_
- c. What are this child’s favorite foods? \_\_\_\_\_
- d. What foods does this child dislike? \_\_\_\_\_

**6. Behaviors/Habits (Check all that apply)**

- |                                            |                                |
|--------------------------------------------|--------------------------------|
| _____ has problems going to sleep/insomnia | _____ short attention span     |
| _____ wakes up early                       | _____ overly active            |
| _____ has problems staying asleep          | _____ bites nails              |
| _____ has nightmares                       | _____ sucks on thumb, clothing |
| _____ enuresis (wets the bed, pants)       | _____ eats very little         |
| _____ encopresis (bowel movement in pants) | _____ throws up (vomits) food  |
| _____ walks in sleep                       | _____ overeats                 |
| _____ physically aggressive                | _____ masturbates              |
| _____ verbally aggressive                  | _____ sexually acts out        |
| _____ appears depressed                    | _____ uses drugs/alcohol       |
| _____ talks about suicide                  | _____ sets fires               |
| _____ has attempted suicide                | _____ quiet/likes to be alone  |
| _____ cruelty to animals                   | _____ destroys property        |

**7. Mental Health Issues**

Has child received outpatient counseling? \_\_\_\_ Yes \_\_\_\_ No If yes, with what clinician/agency?  
 \_\_\_\_\_ Treatment dates from \_\_\_\_\_ to \_\_\_\_\_

Was this child hospitalized for psychiatric reasons in the past? \_\_\_\_ Yes \_\_\_\_ No If yes, give dates and name of hospital \_\_\_\_\_

Has this child had a psychological evaluation? \_\_\_\_ Yes \_\_\_\_ No If yes, date \_\_\_\_\_

Has this child had substance abuse counseling/treatment? \_\_\_\_ Yes \_\_\_\_ No If yes, date \_\_\_\_\_

**8. Please check any of the following medical conditions this child and/or family members may have currently or in the past**

Condition	Child Applying	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brother /Sister
Allergies to plants, dust						
Allergies to medication (name)						
Asthma						
Heart problems						
High blood pressure						
Diabetes						
Cancer						
Hepatitis						
Stomach problems						
Hearing loss						
Eye problems						
Depression						
Schizophrenia						
ADHD/ADD						
Other psychiatric disorders						
School learning problems						

Condition	Child Applying	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brother /Sister
Scarlet fever						
Measles						
Chicken pox						
Mumps						
Frequent colds/Flu						
Convulsions/Epilepsy						
Drug/alcohol use						
Cigarette smoking						
Multiple Sclerosis						
Anemia						
Sexually transmitted infections						
Hospitalizations for illness, surgery/accidents (type/date)						
Other condition(s) not listed						
Known contraindications (inadvisable) to the use of containment/restraint						
List any immediate family members who have died, their age and cause of death						

I give my permission for the medical information listed in this form to be released to any medical doctor, hospital, and/or mental health professional my child may see while placed with Lee & Beulah Moor Children's Home.

\_\_\_\_\_  
Signature/Relationship to Child

\_\_\_\_\_  
Date



## LEE & BEULAH MOOR CHILDREN'S HOME

### MONTHLY BUDGET FORM

Please fill in all areas applicable to you. From this form, a reasonable monthly child care fee for your child(ren) will be determined.

#### **PARENTS/MANAGING CONSERVATORS**

##### **Father/Managing Conservator:**

Employer's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address: \_\_\_\_\_ Position: \_\_\_\_\_

##### **Mother/Managing Conservator:**

Employer's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address: \_\_\_\_\_ Position: \_\_\_\_\_

Enter the amount you receive monthly from each of the categories below. If you do not receive any money from the item, enter \$0.

Monthly Income	Mother/Managing Conservator	Father/Managing Conservator
Pay from employment	\$	\$
Worker's compensation	\$	\$
Unemployment benefits	\$	\$
Retirement	\$	\$
VA	\$	\$
Social Security	\$	\$
Child support	\$	\$
TANF	\$ Case #:	\$ Case #:
Food stamps	\$ Case #:	\$ Case #:
Other (Specify)	\$	\$
Other (Specify)	\$	\$
<b>TOTAL</b>	<b>\$</b>	<b>\$</b>

**MONTHLY EXPENSES:**

Utilities	\$ _____
Car payment	\$ _____
Car expense [fuel, maintenance]	\$ _____
Home payment or rental	\$ _____
Insurance [car, home, life, etc]	\$ _____
Medical/Dental	\$ _____
Clothing	\$ _____
Food	\$ _____
Installment payments other than home & car [credit cards, cell phone, loans]	\$ _____
Other, please specify _____	\$ _____
Other, please specify _____	\$ _____
<b>TOTAL MONTHLY EXPENSES</b>	<b>\$ _____</b>

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**I am stating the above financial statements are true and correct to the best of my knowledge.**

\_\_\_\_\_  
*Mother/Managing Conservator & Date*

\_\_\_\_\_  
*Father/Managing Conservator & Date*

**LEE & BEULAH MOOR CHILDREN'S HOME**

1100 Cliff Drive  
El Paso, Texas 79902-4699  
(915) 544-8777  
FAX (915) 532-1368

**EDUCATIONAL HISTORY**

(To be completed by school personnel only)

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of School	Address	City	ZIP	Phone
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**TYPE OF INSTRUCTIONAL PROGRAM:** Please check all that apply:

- All Regular Classes
- Self Contained Spec. Ed.
- Combination Regular/Resource Special Ed. Classes: List Res. Spec. Ed. Classes attending
  - 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
- A.I.M. List Subject Areas
  - 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
- B.I.C. List Subject Areas
  - 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
- Alternative
  - a. Self contained class at \_\_\_\_\_ School.
  - b. Specialized School, Academy \_\_\_\_\_
- Vocational Program
- Special Reading Programs
  - a. SRD
  - b. Other \_\_\_\_\_
- Special Considerations:
  - ADD/ADHD
  - Other \_\_\_\_\_
- Bilingual Program
  - a. ESL \_\_\_\_\_
  - b. Other \_\_\_\_\_
- Related Services
  - a. Content Mastery \_\_\_\_\_
  - b. P.L. 504  Reason qualified for 504 \_\_\_\_\_
  - c. Speech Therapy \_\_\_\_\_
  - d. Occupational Therapy \_\_\_\_\_
  - e. Special Education Counseling \_\_\_\_\_
- Extra Curricular Activities-List: \_\_\_\_\_

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The Cumulative Folder for this child is located: \_\_\_\_\_

Date Last ARD was held (if applicable): \_\_\_\_\_

**Please attach the following to this form:**

- Transcript (Must be updated for all high school students. Required for student to register at new school)
- IEP attached
- Reports on any educational, psychological testing, TASS, I.Q. score are attached.
- Child was retained in grade(s) \_\_\_\_\_
- Transcript not available currently but will be sent on \_\_\_\_\_.

This student has earned the following grades this year:

Course Name	Grade	Comments on Behavior

Are there any recommendations you have at this time for further testing of this child? No  Yes   
 If yes, what testing do you recommend?

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**BEHAVIOR:** Please check any of the following which apply to the child’s school-related behavior:

- |                                                                    |                                                              |
|--------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Considerate/helpful                       | <input type="checkbox"/> Bright, intelligent                 |
| <input type="checkbox"/> Leader of peers                           | <input type="checkbox"/> Alert, interested                   |
| <input type="checkbox"/> Follower of peers                         | <input type="checkbox"/> Has few/no friends                  |
| <input type="checkbox"/> Friendly to peers                         | <input type="checkbox"/> Works for compliments/praise        |
| <input type="checkbox"/> Ignores or refuses to comply with rules   | <input type="checkbox"/> Poor gross motor skills             |
| <input type="checkbox"/> Forgets rules                             | <input type="checkbox"/> Poor fine motor skills              |
| <input type="checkbox"/> Seems sad, cries frequently               | <input type="checkbox"/> Withdrawn, prefers to be alone      |
| <input type="checkbox"/> Feels helpless                            | <input type="checkbox"/> Suicide attempts or threats         |
| <input type="checkbox"/> Complains of illness frequently           | <input type="checkbox"/> Poor hygiene skills                 |
| <input type="checkbox"/> Verbally aggressive to peers              | <input type="checkbox"/> Is victimized frequently            |
| <input type="checkbox"/> Verbally aggressive to adults/authority   | <input type="checkbox"/> Criticizes others                   |
| <input type="checkbox"/> Physically aggressive to peers            | <input type="checkbox"/> Uses abusive language               |
| <input type="checkbox"/> Physically aggressive to adults/authority | <input type="checkbox"/> Plays with fire                     |
| <input type="checkbox"/> Drug/alcohol abuse                        | <input type="checkbox"/> Inappropriate sexual behavior       |
| <input type="checkbox"/> Prone to tell untruths                    | <input type="checkbox"/> Steals “borrows” without permission |
| <input type="checkbox"/> Does not accept responsibility for self   | <input type="checkbox"/> Truant/cuts class                   |
| <input type="checkbox"/> Overactive, unable to sit still           | <input type="checkbox"/> Low impulse control                 |
| <input type="checkbox"/> Clowns in class                           | <input type="checkbox"/> Demands attention                   |
| <input type="checkbox"/> Difficulty completing tasks               | <input type="checkbox"/> Child has no behavior problems      |
| <input type="checkbox"/> Speech difficulties                       | <input type="checkbox"/> Panics or has problems taking tests |

**Comments:** Please describe any special problems or needs you feel this child has that are not listed above:

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*Signature*

*Date*

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*Please print name and title of person completing form*

## LEE & BEULAH MOOR CHILDREN'S HOME

### INTAKE CHECKLIST FOR PARENTS AND/OR AGENCIES

CHILD'S NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

\_\_\_\_\_ Application for Admission

\_\_\_\_\_ Child's Developmental/Medical History

\_\_\_\_\_ Birth Certificate

\_\_\_\_\_ Social Security Card

\_\_\_\_\_ Monthly Family Budget Form

\_\_\_\_\_ Medical Insurance Card or Medicaid Form      \_\_\_\_\_ Health Plan Card

\_\_\_\_\_ Immunization (shot) Record

\_\_\_\_\_ T.B. Checklist

\_\_\_\_\_ Physical Examination Form (Signed by Physician)

\_\_\_\_\_ Dental Examination Form (Signed by Dentist)

\_\_\_\_\_ Proof of Custody (if applicable) - Court Order, Divorce Decree, etc.

\_\_\_\_\_ Copy of School Report Card for this year and last year

\_\_\_\_\_ School History Report (Completed by School Personnel)

\_\_\_\_\_ School-Teacher Report of Child's Behavior (Completed by Teacher)

\_\_\_\_\_ Religious Documents if Applicable (Baptismal, Communion - if needed for child to attend a religious training program or class)

\_\_\_\_\_ Release of information specific to individual/agency (if applicable)

#### AT TIME OF PLACEMENT INTO LEE & BEULAH MOOR CHILDREN'S HOME PROGRAM

\_\_\_\_\_ School Transfer Form (Drop slip from school to enroll in school near Lee Moor)

\_\_\_\_\_ School Transcript (required for all high school students to re-enroll)

**CPS**

\_\_\_\_\_ Level of Care Report

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ CPS Service Plan

\_\_\_\_\_ Court Order

\_\_\_\_\_ School Transfer Slip

**Notes/Comments**