



Good Shepherd Children's Home
P.O. Box 519 ● Murfreesboro, TN 37130
Phone: (615) 896-1459 ● Office: (615) 900-4698
Email: info@gsch.net ● Website: www.gsch.net

Application for Admission (Overview)

Please print, using black or blue ink.

Date of Application: _____

Name of Child to receive services: _____

Name and relationship of person filling out application:

State of current residence (**If from ANY state other than Tennessee, you must also fill out Form 100A "Interstate Compact for the Placement of Children" located at end of this application**): _____

What are the reasons you want to place your child at the Good Shepherd Children's Home?

- | | |
|--|---|
| <input type="checkbox"/> Lack of Finances | <input type="checkbox"/> Court Order |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> DCS Recommendation |
| <input type="checkbox"/> Incarceration of Parent | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Drugs in the Home | <input type="checkbox"/> Other: _____ |

Comments: _____

How did you hear about the Good Shepherd Children's Home?

- | | |
|---|-------|
| <input type="checkbox"/> Friend: | _____ |
| <input type="checkbox"/> Church/Pastor: | _____ |
| <input type="checkbox"/> Another Children's Home: | _____ |
| <input type="checkbox"/> Government Agency: | _____ |
| <input type="checkbox"/> Internet Search | |
| <input type="checkbox"/> Other: | _____ |

Do you have full legal custody of the child? * Yes No

*Please provide copies of court transcripts where applicable

I understand that by placing this child at the Good Shepherd Children's Home, I am ultimately responsible for the care and well-being of this child. I understand that though the GSCH agrees to the basic care of this child's needs, the laws in the State of Tennessee mandate that I am legally bound to be responsible for unmet financial responsibilities incurred while the child is in the care of the GSCH. I also understand that at such time the child is discharged from the GSCH, it is my responsibility to re-assume care of the child.

Signature of Parent/Guardian

Date



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Application for Admission (Bio-Psychosocial Assessment of Child)

This is a permanent record. All of the entries must be answered completely and truthfully. If information is unknown, every effort should be made to obtain it. If a question is not applicable, please use N/A. This record will be valuable in working with your family. When necessary, you may write on the back or use other paper to give complete information.

Unless otherwise noted, all questions should be answered regarding the child.

Please print, using black or blue ink.

Name of Child to receive services: _____

Address/City/State/Zip: _____

Date of Birth (mm/dd/yyyy): _____ Sex: Male Female

Is this Child a U.S. Citizen? Yes No

Child's Social Security #: _____

Place of Birth (City, State): _____

Other Names Used (Alias, Nicknames): _____

Is this Child your natural-born Child? Yes No

If no, please explain (adopted, etc.): _____

Are you willing to participate in the care of this child when appropriate? Yes No

If no, please explain: _____

Does the child have a cell-phone? Yes No

CURRENT LIVING SITUATION

What is the Child's current living arrangement? _____

What is the number of persons, *other than the Child*, currently living in the home? _____

Please list all household members: (may use back side if necessary)

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any siblings or step siblings living *outside* the home? Yes No



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If yes, please list them below (may use the back side if necessary):

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any of the above is *under* the age of 18, please list reason for residing outside the home:

<u>Name</u>	<u>Reason for Residence outside the home</u>
_____	_____
_____	_____

How many times has this Child's residence changed within the last two years? _____

Please explain: _____

How would you rate the family's Socioeconomic Position (poor, middle, or upper class, etc.)?

- Above Average Average Below Average

Do you currently receive public assistance on behalf of this child? Yes No

Does this Child receive social security benefits? Yes No

If yes, what is the amount? _____ To whom paid? _____

Past Significant Events (Check any/all that apply):

- Does the parent/caregiver have a significant medical condition?
- Does the Child have a medical condition?
- Did the mother have post-partum adjustment problems?
- Is there any mental illness of the parent/caregiver?
- Is there substance abuse of parent/caregiver? (drugs, alcohol, etc.)
- Has there been a separation or divorce of parent/caregiver?
- Has the child gone through an adoption?
- Has the significant adult caregiver abandoned the child at any time?
- Has there been a death of either parent/caregiver?
- Is there mental retardation of either parent/caregiver?
- Is or has there been any incarceration of parent/caregiver?

Comments: _____

Has the Child ever lived in any of the following settings (Check any/all that apply):

- Relative's home Foster Family Therapeutic foster care
- Group home Orphanage Correctional facility
- Emergency shelter Halfway house Residential substance abuse facility
- Detention facility Homeless Residential treatment center
- Hospital Other

Comments: _____



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CHILD'S ATTITUDE

Please give your evaluation of this Child's attitude toward:

1. You, the Parent/Guardian

2. School/Church/Other Authority Figures

3. Correction and Discipline

4. Does the Child habitually lie to you? Yes No

5. Does the Child frequently use illness to miss school or get out out of responsibility? Yes No

6. Has the Child ever run away? _____ How many times? _____

7. Please discuss any other problems the Child has that you feel need to be addressed:

Please check the most appropriate response:

- | | | | |
|-----------------------------|--|--|---|
| <i>PERSONALITY:</i> | <input type="checkbox"/> Shy | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Personable |
| <i>MORALS:</i> | <input type="checkbox"/> Low | <input type="checkbox"/> Average | <input type="checkbox"/> Above Average |
| <i>APPEARANCE:</i> | <input type="checkbox"/> Sloppy | <input type="checkbox"/> Average | <input type="checkbox"/> Neat |
| <i>MENTAL ALERTNESS:</i> | <input type="checkbox"/> Dull | <input type="checkbox"/> Average | <input type="checkbox"/> Sharp |
| <i>TACT:</i> | <input type="checkbox"/> Immature | <input type="checkbox"/> Average | <input type="checkbox"/> Keen |
| <i>COOPERATION:</i> | <input type="checkbox"/> Indifferent | <input type="checkbox"/> Self-Centered | <input type="checkbox"/> Socially Concerned |
| <i>DEPENDABILITY:</i> | <input type="checkbox"/> Immature | <input type="checkbox"/> Questionable | <input type="checkbox"/> Reliable |
| <i>CHARACTER:</i> | <input type="checkbox"/> Weak/Up or Down | <input type="checkbox"/> Average | <input type="checkbox"/> Consistent |
| <i>MOTIVATION:</i> | <input type="checkbox"/> Purposeless | <input type="checkbox"/> Usually Purposeful | <input type="checkbox"/> Highly Motivated |
| <i>INFLUENCE:</i> | <input type="checkbox"/> Negative | <input type="checkbox"/> Limited Contributions | <input type="checkbox"/> Respected |
| <i>LEADERSHIP:</i> | <input type="checkbox"/> Retiring | <input type="checkbox"/> Dependable | <input type="checkbox"/> Seeks Responsibility |
| <i>EMOTIONAL STABILITY:</i> | <input type="checkbox"/> Excitable | <input type="checkbox"/> Well-Balanced | <input type="checkbox"/> Stable |

TRAUMATIC EVENTS

- Is there current or past experience of being abused or neglected? Yes No

If yes, please explain: _____

Please list any other traumatic experience: _____

- Has the Child received counseling for any past abuse? N/A Yes No



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PAST MENTAL HEALTH TREATMENT

- Has the Child ever been in the hospital for mental health treatment? Yes No
Has the Child ever been in outpatient care for mental health treatment? Yes No
Has the Child ever been in an in-school treatment program? Yes No
Has the Child ever been in a residential treatment center? Yes No

List any/all Treatment Facilities (use back if necessary):

Name of Facility _____ Location _____

Reason for Treatment _____ Start/End Dates _____

How did the Child do? _____

Was treatment completed? Yes No

Name of Facility _____ Location _____

Reason for Treatment _____ Start/End Dates _____

How did the Child do? _____

Was treatment completed? Yes No

Did the Child have a positive experience in treatment? Yes No

Was the Child compliant with treatment recommendations? Yes No

Comments regarding treatment history:

Do you feel that the Child is at risk for dangerous behaviors? Yes No

What situations increase the risk for dangerous behaviors?

What does the Child do to cope with these risks?

Describe any warning signs for the dangerous behaviors:

LEGAL HISTORY OF CHILD

If there is a history of legal issues, please explain:

Are there any arrest charges pending against this Child? Yes No

If yes, please explain: _____



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- Have there been any previous arrests? Yes No
If yes, please explain: _____
- Is/has the Child been on probation? Yes No
If yes, please explain: _____
- Is/has the Child been under Court supervision? Yes No
If yes, please explain: _____
- Does this Child have a history of violence toward self or others? Yes No
If yes, please explain? _____

DEVELOPMENTAL HISTORY

- Did the mother sustain any major injury/illness while pregnant? Yes No
If yes, please explain: _____
- Did the mother use tobacco, alcohol, marijuana, street, or prescription drugs during pregnancy? Yes No
If yes, please explain: _____
- Was the delivery premature or overdue? Yes No

SUBSTANCE ABUSE HISTORY

- Has the Child used drugs or alcohol? Yes No
If yes, please explain and list them by preference, with the most preferred listed first:

- Is the Child currently using drugs or alcohol? Yes No
- Does the Child use tobacco products? Yes No
- Has the Child been exposed to substance abuse? Yes No
- Does the Child currently live with a person using substances? Yes No
If yes, please describe: _____



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FAMILY HISTORY

Have any family members had a history of mental illness? Yes No

If yes, please list family relation and describe illness (give diagnosis if known):

Is there a family history of substance abuse? Yes No

If yes, please explain: _____

Is there a family history of criminal activity? Yes No

If yes, please explain: _____

Is there a family history of violent behavior? Yes No

If yes, please explain: _____

Is there a family history of medical problems? Yes No

If yes, please explain: _____

Are there family issues that need to be addressed in treatment? Yes No

If yes, please explain: _____

Does the Child have a positive relationship with his/her parents? Yes No

Does the Child have a positive relationship with his/her siblings? Yes No

Is there current DCS involvement? Yes No

If yes, please explain: _____

Has there been past DCS involvement? Yes No

If yes, please explain: _____

Has the court appointed a legal guardian? Yes No

If yes, whom? _____

Have you made application to another institution? Yes No

If yes, where? _____



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QUESTIONS IN THIS SECTION ARE REGARDING THE FATHER:

Father's Name: _____

Address: _____

Employer: _____

Employer phone number: _____

Social security number: _____ Race: _____

Birth Date: _____

May the Child have contact with the Father? Yes No

Is the Father a member at any church? Yes No

Does he attend regularly? Yes No

If yes, where? _____

Is the Father divorced? Yes No

If divorced, is he remarried? Yes No

Does the Father have any mental or physical handicaps? Yes No

If yes, please explain: _____

If deceased, what is the date/cause of death: _____

QUESTIONS IN THIS SECTION ARE REGARDING THE MOTHER:

Mother's Name: _____

Address: _____

Employer: _____

Employer phone number: _____

Social security number: _____ Race: _____

Birth Date: _____

May the Child have contact with the Mother? Yes No

Is the Mother a member at any church? Yes No

Does she attend regularly? Yes No

If yes, where? _____

Is the Mother divorced? Yes No

If divorced, is she remarried? Yes No

Does the Mother have any mental or physical handicaps? Yes No

If yes, please explain: _____

If deceased, what is the date/cause of death: _____



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Injuries (Please check all that apply. Indicate date of last injury and explain below.)

Injury	Date
<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> Back Injury	_____
<input type="checkbox"/> Broken Bones	_____
<input type="checkbox"/> Recurrent Ankle Injury	_____
<input type="checkbox"/> Recurrent Knee Injury	_____
<input type="checkbox"/> Other: _____	_____

Please explain any of the above or list any special physical limitations: _____

Does the Child have any allergies, including reactions to foods, antibiotics or any other medications, nature (trees, grass, etc.), or other environmental reactions? Yes No

If yes, please explain: _____

Does the Child have any special dietary needs? Yes No

If yes, please explain: _____

Has the Child ever undergone surgery for any reason? Yes No

If yes, please explain: _____

Does the Child have any dental problems? Yes No

If yes, please explain: _____

Has the Child ever taken any prescription medications for any reason? Yes No

Has the Child taken any medications in the past two weeks? Yes No

Please list medication and reason taken: _____

Was the Child compliant with taking medications in the past? Yes No

Please list all Prescription medications currently taken by the Child. (Use back if necessary.)

Medication Name: _____

Dosage: _____

Instructions for taking: _____

Reason prescribed: _____

How long will Child need to take this medicine? _____

Condition being treated: _____



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Medication Name: _____

Dosage: _____

Instructions for taking: _____

Reason prescribed: _____

How long will Child need to take this medicine? _____

Condition being treated: _____

SPIRITUAL CONSIDERATIONS

What is the Child's primary religious affiliation? _____

Has the Child ever asked Jesus into his/her heart? Yes No

Does the Child attend church regularly? Yes No

Do you, as the parent/guardian, attend church regularly? Yes No

What is the name and address of a pastor who knows this Child?

I do hereby attest and affirm that all of the above information I have provided is truthful and accurate to the best of my ability. I fully realize that providing false information is against the law and against the best interests of my Child. Any perjury on my part is punishable to the fullest extent of the law.

 Name of Parent/Guardian (Print)

 Signature of Parent/Guardian

 Date

 Name of Parent/Guardian (Print)

 Signature of Parent/Guardian

 Date

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: TENNESSEE		FROM:	
SECTION I – IDENTIFYING DATA			
Notice is given of intent to place - Name of Child:		Race/Ethnicity:	Hispanic Origin:
Social Security Number:		<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Yes <input type="checkbox"/> No
ICWA Eligible:		<input type="checkbox"/> White	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> American Indian or Alaskan Native	
Sex:	Date of Birth:	Title IV-E eligibility:	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	<input type="checkbox"/> Unable to determine/ unknown
Name of Mother:		Name of Father:	
Name of Agency or Person Responsible for Planning for Child:			Phone:
Address:			
Name of Agency or Person Financially Responsible for Child:			Phone:
SAME AS ABOVE			
Address:			
SECTION II – PLACEMENT INFORMATION			
Name of Person(s) or Facility Child is to be placed with:		Soc Sec #:	
GOOD SHEPHERD CHILDREN'S HOME		Soc Sec #:	
Address:		Phone:	
P.O. BOX 519 203 WOOD CRAFT, MURFREESBORO, TN 37133-0516		615-896-1459	
Type of Care Requested:		<input type="checkbox"/> Parent	<input type="checkbox"/> ADOPTION
<input type="checkbox"/> Foster Family Home		<input type="checkbox"/> Relative (Not Parent)	<input type="checkbox"/> IV-E Subsidy
<input type="checkbox"/> Group Home Care		Relationship: _____	<input type="checkbox"/> Non IV-E Subsidy
<input checked="" type="checkbox"/> Child Caring Institution		<input type="checkbox"/> Other: _____	To Be Finalized In:
<input type="checkbox"/> Residential Treatment Center			<input type="checkbox"/> Sending State
<input type="checkbox"/> Institutional Care-Article VI, Adjudicated Delinquent			<input type="checkbox"/> Receiving State
Current Legal Status of Child:		<input type="checkbox"/> Protective Supervision	
<input type="checkbox"/> Sending Agency Custody/Guardianship		<input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption	
<input checked="" type="checkbox"/> Parent Relative Custody/Guardianship		<input type="checkbox"/> Unaccompanied Refugee Minor	
<input type="checkbox"/> Court Jurisdiction Only		<input type="checkbox"/> Other: _____	
SECTION III - SERVICES REQUESTED			
Initial Report Requested (if applicable):		Supervisory Services Requested:	
<input type="checkbox"/> Parent Home Study		<input type="checkbox"/> Request Receiving State to Arrange Supervision	Supervisory Reports Requested:
<input type="checkbox"/> Relative Home Study		<input checked="" type="checkbox"/> Another Agency Agreed to Supervise	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Adoptive Home Study		<input type="checkbox"/> Sending Agency to Supervise	<input type="checkbox"/> Semi-Annually
<input type="checkbox"/> Foster Home Study			<input type="checkbox"/> Upon Request
			<input checked="" type="checkbox"/> Other: AS ARRANGED
Name and Address of Supervising Agency in Receiving State: GOOD SHEPHERD CHILDREN'S HOME ADDRESS ABOVE			
Enclosed: <input type="checkbox"/> Functional Assessment/Child's Social History <input type="checkbox"/> Court Order <input type="checkbox"/> Financial/Medical Plan <input checked="" type="checkbox"/> Other Enclosures			
<input type="checkbox"/> Home Study of Placement Resource <input type="checkbox"/> ICWA Enclosure <input type="checkbox"/> IV-E Eligibility Documentation			
Signature of Sending Agency or Person:			Date:
Signature of Sending State Compact Administrator, Deputy or Alternate:			Date:
SECTION IV – ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC			
<input type="checkbox"/> Placement may be made		<input type="checkbox"/> Placement shall not be made	
REMARKS:			
Signature of Receiving State Compact Administrator, Deputy or Alternate:			Date:

DISTRIBUTION (Complete six (6) copies): Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to: Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to: Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Section IV) and forwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days. Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the completed original to the sending agency.