INTAKE ASSESSMENT

Initial Youth Strengths, Needs, and Risk Review

Operating Entity	PLOMC Community Service
Program	Youth Residential Program
Effective Date	DRAFT – Pending Licensing/Administrative Approval
Review Cycle	At least annually and when law, regulation, contract, or program practice changes

People Today. Stronger Tomorrows.

Identification and Placement

Youth Name	**DOB/Age**
Admission Date	**County/Agency**
Caseworker	**Legal Custody/Placement Authority**
Current School	**Primary Language**
Race/Ethnicity (self-identified/recorded as required)	**Gender Identity/Pronouns**
Religion/Cultural Considerations	**Emergency Contacts**

Placement History and Current Need

Reason for Placement	**Previous Placements**
Recent Disruptions	**Youth's View of Placement**
Strengths/Interests	**Important Relationships**
Permanency Goal	**Anticipated Length of Stay**

Safety and Behavioral Risk

Elopement/AWOL History	**Aggression/Violence**
Self-Harm/Suicidal Ideation/Attempts	**Sexual Safety/Problematic Sexual Behavior**
Victimization/Exploitation/Trafficking Concerns	**Fire-Setting**
Weapons Access/History	**Substance Use**
Criminal/Juvenile Justice Involvement	**Known Triggers**
Effective Calming Strategies	**Current Safety Plan**

Health and Medication

Primary Care Provider	**Insurance**
Allergies	**Medical Conditions**
Dietary Needs	**Current Medications**
Medication Allergies/Adverse Reactions	**Recent Hospitalization**
Dental/Vision Needs	**Sleep Concerns**
Pregnancy/Parenting Needs if applicable	

Behavioral Health and Development

Diagnoses	**Therapist/Psychiatrist**
Current Treatment	**Trauma/Loss History (minimum necessary)**
Developmental/IDD/Autism/ADHD Needs	**Communication Needs**
Sensory Needs	**Substance-Use Treatment**
Crisis Plan	

Education / Employment

School/District	**Grade/Credits**
IEP/504	**Attendance**
Academic Strengths	**Academic Concerns**
Vocational Interests	**Employment Status**

Transportation to School/Work	

Family / Contacts

Parents/Guardians	**Siblings/Significant Persons**
Approved Contacts	**Restricted Contacts**
Visitation Plan	**Family Strengths**
Family Conflict/Safety Issues	**Attorney/GAL/Advocate**

Independent Living Skills

Hygiene	**Laundry**
Cooking	**Cleaning**
Budgeting	**Banking/Credit**
Shopping/Nutrition	**Public Transportation**
Time Management	**Communication**
Conflict Resolution	**Community Resources**

Initial Recommendations

Recommended Supervision Level	**Room/Peer Compatibility**
Immediate Medical Follow-Up	**Immediate Behavioral-Health Follow-Up**
Education Actions	**Family/Contact Actions**
Life-Skills Priorities	**Restrictions/Safety Precautions**
First 30-Day Goals	

Assessment Summary

Youth	Signature/Date: _____
Assessor	Signature/Date: _____
Program Director/Designee	Signature/Date: _____
Placing Agency (if required)	Signature/Date: _____