

INTERAGENCY APPLICATION FOR PLACEMENT (IAP)

Form 2087
April 2004

LEVEL OF CARE ASSESSMENT A. Screening Profile

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Child's Name		Date of Birth		Age	Social Security No.
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity		Primary Language	Place of Birth (city, state, country)	
Child's Agency ID No.	Height		Weight	Religious Preference	Child's Current Location or Placement
Country of Citizenship					

1. Briefly describe your impressions of the child including present problems:

Briefly describe the child's strengths:

2. Special Needs, Problems and Behaviors

Is child considered a danger to self? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is child considered a danger to others? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number runaways from home: →	Number runaways from placement: →
Any history of setting fires? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Program Needs? Specify: <input type="checkbox"/> Maternity <input type="checkbox"/> Preparation for Adult Living <input type="checkbox"/> Other: →		
Other Significant Problems or Behaviors			

3. Juvenile Justice History

Does the child have a history of involvement with the juvenile justice system? Yes No Unknown

If Yes: Number of referrals to juvenile authorities: →	Number of adjudications for delinquent acts: →	Number of adjudications for CINS offenses: →	Current Offense
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4. Placement History

Has the child been placed away from home before? Do not include stopover placements such as emergency shelters, detention, TYC Reception Center, informal placements with relatives, or return(s) to home Yes No Unknown

If yes: Number of previous out-of-home placements: →	Number of failed adoption placements: →	LOC of current/most recent out-of-home placement: →
Date of discharge from most recent out-of-home placement: →		

Reason for Discharge:

5. Substance Abuse History

Does the child have a history of substance abuse? Yes No Unknown

If yes, indicate degree of substance abuse:

Alcohol <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Inhalants <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Marijuana <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Cocaine/Crack <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Other Drugs (Specify) → <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Is specialized program required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown → If yes, specify: →	

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6. History of Abuse and Neglect

Does the child have a history of abuse or neglect? Yes No Unknown

If yes, indicate degree:

Physical <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Sexual <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Emotional <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Neglect <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Abandonment? Yes No Unknown

7.-8. Family/Parental Involvement

Managing Conservator <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> FPS <input type="checkbox"/> Other	Mother's Parental Rights Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Parental Rights Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No
Will family/others participate in treatment or cooperate with others? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can child return home? <input type="checkbox"/> Yes-Permanently <input type="checkbox"/> No-Not At All <input type="checkbox"/> For Visits Only <input type="checkbox"/> Unknown	

9. Education

Highest Grade Completed	Currently Enrolled in School? <input type="checkbox"/> Yes <input type="checkbox"/> No	Educational Needs <input type="checkbox"/> Regular Classes <input type="checkbox"/> Vocational <input type="checkbox"/> Resource <input type="checkbox"/> Special Education	
History of Truancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> On Campus <input type="checkbox"/> Other (specify):	
IQ Scores: Full Scale	Verbal	Performance	Date of Most Recent IQ Test
Scale	<input type="checkbox"/> Unknown	Name of Test ➔	

10. Physical Health/Disabilities

Does the child have a diagnosed or suspected health condition or disability? Yes No Unknown

If yes, describe the condition and treatment required, if any:

Condition <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown	Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown	Requires Specialized Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
List Current Medications		List Allergies

11. Mental Health

Does the child have mental health needs requiring treatment? Yes No Unknown

Date of most recent psychological or psychiatric evaluation:

DSM III Diagnosis:

Condition <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown	Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown	Requires Specialized Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Psychotropic medications prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		➔ If yes, specify:
Referring Agency/Organization	Agency Contact Person	Telephone No. (Inc. A/C)
Agency Address		
Name of Person Completing Form	Title	Date Completed
Where Placed--Facility Name and Location		

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A. Recommended level of care

List the key elements, in order of importance, that led you to the recommended Level of Care:

1. Most important:

2. Next most important:

3. Third most important:

Other considerations or comments, if any:

B. Billing Level of Care

If the billing level of care is different from the recommended level of care, explain:

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C. Referral/Admissions Packet

C O N T E N T S		
SECTION 1--Social and Developmental Assessment	SECTION 5--Substance Abuse History	SECTION 9--Education
SECTION 2--Special Needs, Problems, and Behaviors	SECTION 6--History of Abuse/Neglect	SECTION 10--Physical Health/Disabilities
SECTION 3--Juvenile Justice History	SECTION 7--Family History	SECTION 11--Mental Health
SECTION 4--Placement History	SECTION 8--Financial Information	SECTION 12--Other Attachments

SECTION 1--Social and Developmental Assessment

Describe the child's general social and developmental history. Feel free to expand the description of your impressions of the child. Be sure to include all of the following:

- A. A description of the circumstances that led to the child's referral.

- B. The immediate and long-range goals of placement.

- C. A description of the child's relationship with other significant adults and children.

- D. A description of the child's behavior, including both appropriate and inappropriate behavior:

- E. The child's developmental history and current level of functioning.

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SECTION 2--Special Needs, Problems and Behaviors

Describe in detail the special needs, problems, or behaviors identified in Section 2 of the Screening Profile.

- A. Suicide history. Describe in detail suicide attempts and suicidal gestures. Include the number of suicide attempts, and the date of the last known suicide attempt.**

- B. History of assaultive behavior.**

- C. Runaway history.**

- D. Other significant needs, problems and behaviors (including setting fires, maternity, etc.).**

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SECTION 3 -- Juvenile Justice History

REFERRALS (list only one referral per date)				DISPOSITIONS				
Date	Offense	Level*	Penal Code	Type**	Date	Offense	Level* (list only if different from referral)	Penal Code

*LEVEL OF OFFENSE CODES.....**TYPE OF DISPOSITION CODES:

<p>Total Number of Referrals: (Count only one per date) {</p> <hr/> <p>Total Number of Adjudications/ Certifications (AP,AT,PT, or CA): (Count only one per date) {</p>	<p>FL=Felony MI=Misdemeanor FC=Family Code</p>	<p>CR=Counseled and Released IA=Informal Adjustment AP=Adjudicated to Probation PT=Proven by TYC Hearing</p>	<p>RD=Refused/Dismissed AT=Adjudicated to TYC CA=Certified as Adult</p>
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Briefly describe the child's history of delinquency. Include a description of contributing factors, and any patterns delinquency you detect. Indicate whether the child is a follower or a leader.

Describe the child's most recent criminal episode, contributing factors, the child's actions or role in the episode, and how this episode fits into the child's history of delinquency.

Does the child have gang affiliation? Yes No If yes, gang name: _____

Does the child admit to a gang affiliation? Yes No If yes, gang name: _____

Do any family members or relatives have gang affiliation?
 Yes No Unknown If yes, gang name(s): _____

TYC COMMITMENT Yes No

County	Commitment Date	Judge's Last Name	Court Name
Cause No.	Prosecuting Attorney's Name		Probation I.D. No.

TYPE OF COMMITMENT: Direct Commitment Revocation of Probation

Probation Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe most serious offense for which on probation: →	Offense Code →
Reason for Failure		
Description of Current Offense		Offense Code →
Time in Detention in Connection with this Offense (Number of Days)		
Weapon Used <input type="checkbox"/> Firearm <input type="checkbox"/> Cutting Instrument <input type="checkbox"/> Blunt Object <input type="checkbox"/> Hands, Feet, etc. <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown		Determinate Sentence <input type="checkbox"/> Yes <input type="checkbox"/> No
OFFENSE LEVEL →	Felony <input type="checkbox"/> Capital <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> State Jail	Misdemeanor <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C Other <input type="checkbox"/> Specify:
Gang Related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of Prior TYC Commitment	Description of Offense →
		Offense Code →

ATTACH ALL COURT ORDERS INVOLVING THE JUVENILE JUSTICE SYSTEM

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Section 4--Placement History

Start with the child's first out-of-home placement:

Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date Placed	Name of Facility or Living Arrangement	License Type		
Address		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Contact Person</td> <td style="width: 50%;">Telephone No.</td> </tr> </table>	Contact Person	Telephone No.
Contact Person	Telephone No.			
Date Placement Ended	Reason Placement Ended			
LOC and Dates Assigned	Continued Contact of Child with Placement Recommended <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

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SECTION 5--Substance Abuse History

- A. Describe the child's history of substance use, abuse, manufacture, possession, and/or delivery.

- B. Describe the child's family history of substance use, abuse, manufacture, possession, and/or delivery. Include not only parents and siblings, but also extended-family members (such as grandparents, aunts, uncles) even if they do not live in the same household as the child.

- C. Describe any treatment the child has received for substance abuse and the success or failure of this treatment. Include the lengths and dates of treatment, whether the program was residential or outpatient, whether the child completed the program, whether the family was included in the treatment and so on.

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SECTION 6--History of Abuse and Neglect

A. Type of Abuse and Neglect (check all that apply):

<p>Abandonment</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated	<p>Neglectful Supervision</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated
<p>Medical Neglect</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated	<p>Physical Neglect</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated
<p>Emotional Abuse</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated	<p>Physical Abuse</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated
<p>Sexual Abuse</p> <input type="checkbox"/> Reason to Believe <input type="checkbox"/> Legally Confirmed/Adjudicated	

B. What did the parent/perpetrator do? Summarize the role of each parent/perpetrator.

C. What happened to the child? Summarize the extent of harm (or the substantial risk of harm) to the child.

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SECTION 7--Family History

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Home Address (Street, City, State, Country, ZIP)	Telephone No. (inc. A/C)
Marital Status of Birth Parents <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Marital Status of Adoptive Parents (if applicable) <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Deaths in immediate family (list names, relationships, and age of referred child age at the time of each death):	
If adopted, what does the child know about his or her birth parents?	

Persons in Home

Father	Date of Birth*	Type of Parent <input type="checkbox"/> Birth <input type="checkbox"/> Adoptive <input type="checkbox"/> Step	Social Security No.
Mother	Date of Birth*	Type of Parent <input type="checkbox"/> Birth <input type="checkbox"/> Adoptive <input type="checkbox"/> Step	Social Security No.

BLOOD SIBLINGS	DATE OF BIRTH*	BLOOD SIBLINGS	DATE OF BIRTH*
OTHER CHILDREN	DATE OF BIRTH*	RELATIONSHIP / ROLE	
OTHERS	DATE OF BIRTH*	RELATIONSHIP / ROLE	

*Give approximate age if date of birth is unknown.

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Significant Persons Out of Home

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Father	Date of Birth*	Type of Parent <input type="checkbox"/> Birth <input type="checkbox"/> Adoptive <input type="checkbox"/> Step	Social Security No.
Address (Street, City, State, Country, ZIP)		Telephone No. (Inc. A/C)	Currently Involved with Child <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother	Date of Birth*	Type of Parent <input type="checkbox"/> Birth <input type="checkbox"/> Adoptive <input type="checkbox"/> Step	Social Security No.
Address (Street, City, State, Country, ZIP)		Telephone No. (Inc. A/C)	Currently Involved with Child <input type="checkbox"/> Yes <input type="checkbox"/> No
OTHERS	DATE OF BIRTH*	RELATIONSHIP / ROLE	

*Give approximate age if date of birth is unknown.

CHARACTERISTICS OF INDIVIDUAL FAMILY MEMBERS WITH WHOM CHILD HAS LIVED:	NO	YES	FAMILY MEMBER(S)
1. Violent Toward Family Members	<input type="checkbox"/>	<input type="checkbox"/>	
2. Suicide	<input type="checkbox"/>	<input type="checkbox"/>	
3. Substance Abuse Problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
5. Involving a Child in Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
6. Mental Retardation or Limited Intellectual Ability	<input type="checkbox"/>	<input type="checkbox"/>	
7. Mental Illness or Disability	<input type="checkbox"/>	<input type="checkbox"/>	
8. Physical Illness or Disability	<input type="checkbox"/>	<input type="checkbox"/>	
9. Sexual Deviance	<input type="checkbox"/>	<input type="checkbox"/>	

CHARACTERISTICS OF INDIVIDUAL FAMILY MEMBERS WITH WHOM CHILD HAS LIVED:	NOT AT ALL LIKE FAMILY	SOMEWHAT/SOMETIMES LIKE FAMILY	VERY MUCH OR OFTEN LIKE FAMILY
1. Chronic Poverty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Chaotic Home Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rigid, Inflexible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Smothering; Individualization of Members is Discouraged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Enmeshed; Few Outside Involvements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Discipline Skills Lacking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Difficult or Unacceptable to Express Emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Frequent family Moves or School Moves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Child Moved from One Parent or Family Member to Another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Concern with Psychosomatic Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Social Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Illiteracy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Briefly describe the child's relationships with family members and significant others, both in and out of the home. Address both strengths and weaknesses.

Briefly describe the overall family situation, highlighting the positive and negative aspects of the child's family environment including all the "Family Characteristics" checked on page 12.

Other significant information:

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SECTION 8--Financial Information

Attach: A copy of client's Medicaid card, if any.

Name of Responsible Male	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation
Employer	Salary _____ per _____	
Employer's Address		
Other Income Source (1)	Amount →	Other Income Source (2)
		Amount →

Name of Responsible Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation
Employer	Salary _____ per _____	
Employer's Address		
Other Income Source (1)	Amount →	Other Income Source (2)
		Amount →

Is the family eligible for Medicaid?..... Yes No Unknown

Is the family currently receiving Medicaid?..... Yes No Unknown

Funds Applicable to Child:

VA -- Amount	VA No.	Received By		
Social Security -- Amount	Social Security No.	Received By		
CHAMPUS -- Amount	CHAMPUS I.D. No.	Received By		
AFDC/SPFC -- Amount	County Paid FC -- Amount	Child Support -- Amount	Paid By	County

Insurance Applicable to Child:

Insurance Company Name (1)	Policy Holder	Policy No.
Insurance Company Name (2)	Policy Holder	Policy No.
Insurance Company Name (3)	Policy Holder	Policy No.
Type of Insurance <input type="checkbox"/> Basic Medical <input type="checkbox"/> Hospitalization <input type="checkbox"/> Basic Dental <input type="checkbox"/> Orthodontic <input type="checkbox"/> Mental Health		

Other Resources Applicable to Child:

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SECTION 9--Education

- Attach:
- A. Current IEP (Individualized Education Plan)
 - B. Most Recent ARD Committee report (if any)
 - C. Transcript
 - D. Adaptive Behavior Level Information (if any)

Name of Most Recent School Attended	School District
Address (fill in city and state at least, and street address if known)	

Describe any educational problems, needs, or behaviors not otherwise documented. Add any additional information you feel is important.

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SECTION 10--Physical Health/Disabilities

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- Attach: A. Medical Records
 (1) Physical Examination
 (2) Immunization Records
 B. Dental Records

Describe any physical health problems or disability not otherwise documented. Add any additional information you feel is important.

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SECTION 11--Mental Health

Attach (as appropriate):

- A. Psychological Report(s)
- B. Psychiatric Report(s)

Describe any mental health problems not otherwise documented. Add any additional information you feel is important.

SECTION 12--Other Attachments

- Attach:
- A. Birth Certificate or Other Birth Verification
 - B. Legal Records (if any)
 - C. Authorization Forms

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ATTACHMENT CHECKLIST

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Child's Name	Date Completed
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DOCUMENT	ATTACHED	FORTH-COMING	NOT RELEVANT	NOT AVAILABLE BECAUSE
Birth Verification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Certificate.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legal Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Commitment Order.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Court Orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Police Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Divorce Decree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Custody Order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Individual Education Plan (IEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Admission, Review, Dismissal (ARD) Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transcript	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adaptive Behavior Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Health/Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunization Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological Report(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Report(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid Approval/Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Security Card.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	