



APPLICATION FOR ADMISSION Owasso Maternity Services

Baptist Children's Home
12700 E. 76th St. North
Owasso, OK 74055
Phone: 918-272-2233
FAX: 918-272-3206

Applicant's Name		Social Security Number	
Present Address		Phone Number:	
DHS Number		County	
Date of Birth		Place of Birth	
Sex	Nationality	Race	Grade
Height	Weight	Color of Eyes	Hair
Is Applicant Pregnant? Yes___ No___ If so, how many weeks?_____ Due Date_____		Does Applicant have a child? Yes___ No___ If so, how old? ___ Baby's Name_____	
Applicant's Father's Name		Social Security Number	
Present Address Street/City/State/Zip			
Place of Employment			
Home Phone		Work Phone	
Date of Birth		County	
Birthplace City/State		Nationality	Race
If Deceased: Date of Death		Place Of Death	Cause Of Death
Applicant's Mother's Name		Social Security Number	
Present Address Street/City/State/Zip			
Place of Employment			
Home Phone		Work Phone	
Date of Birth		County	
Birthplace		Nationality	Race
If Deceased: Date of Death		Place Of Death	Cause Of Death
Who has Legal Custody of this Applicant?			
Name		Relationship	
Address			
Place of Employment			
Home Phone		Work Phone	
If by Court Action, Give Type: <input type="checkbox"/> Divorce <input type="checkbox"/> Guardianship <input type="checkbox"/> Temporary <input type="checkbox"/> Adoption			
Court of Jurisdiction		Case Number	
Date of Most Recent Court Action (Please attach copy of most recent legal document)			



Where is applicant currently living?	
Relationship:	Address:
Phone Number	City & State:

Age and relationship of others living in the home:

Name	DOB	Relationship	Name	DOB	Relationship

MEDICAL INFORMATION

INSURANCE:

Person Named on Policy:		Insurance Company:	
Policy Number:	Group Number:	Effective date:	Co-Pay:
Applicant's Medicaid #:		Renewal date:	
Baby's Medicaid #:		Renewal date:	

PREGNANCY:

Has pregnancy been confirmed?	If yes, by whom?
Date Prenatal Care Began:	Date of Ultrasound:
Physician:	Hospital:
Number of Previous Pregnancies:	
Date of Previous Pregnancies:	Results: (birth, abortion, miscarriage)
List any medical problems/illness/treatments during previous pregnancies:	

APPLICANT'S EDUCATIONAL INFORMATION

Name of Last School Attended:	
Address:	Phone:
Principal:	Counselor:
Present Grade:	What kind of grades?
Relationship with teachers:	Relationship with peers:
Suspensions? (Give Reasons)	
Special Classes: <input type="checkbox"/> LD <input type="checkbox"/> EMH <input type="checkbox"/> ED <input type="checkbox"/> SED <input type="checkbox"/> Other	

Mark items below, in order of their importance, which indicate problem areas.

- | | | |
|---|---|--|
| <input type="checkbox"/> Over active | <input type="checkbox"/> Fighting | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Under active | <input type="checkbox"/> Violent | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Physical limitation | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Soiling (lack of bowel control) |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Striking others (who?) | <input type="checkbox"/> Sexually preoccupied |
| <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Use of weapons | <input type="checkbox"/> Fondling |
| <input type="checkbox"/> Bites nails | <input type="checkbox"/> Property destruction | <input type="checkbox"/> Molestation |
| <input type="checkbox"/> Chews objects | <input type="checkbox"/> Stealing | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Lying (Excessive) | <input type="checkbox"/> Homosexual behavior |
| <input type="checkbox"/> Whines | <input type="checkbox"/> Sneaking out/ curfew violation | <input type="checkbox"/> Bizarre behavior |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Runaway | <input type="checkbox"/> Harmful to animals |
| <input type="checkbox"/> Moody | <input type="checkbox"/> School truancy | <input type="checkbox"/> Firestarting |
| <input type="checkbox"/> Temper problems | <input type="checkbox"/> School behavior | <input type="checkbox"/> Rap / hard rock music |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> School performance | <input type="checkbox"/> Violent movies / video games |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tobacco use (what?) | <input type="checkbox"/> Gang/subculture groups |
| <input type="checkbox"/> Harmful to self | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Occult, cults, satanism |
| <input type="checkbox"/> Suicide attempt/threat | <input type="checkbox"/> Drug use (what?) | <input type="checkbox"/> Other (explain) |

Please explain why you think this child needs an out of home placement:

Describe previous attempts to resolve family conflict and negative behaviors: _____

List every family setting in which this child has lived (from birth to present age). Specify the relationship of the person caring for the child (natural parents, step-parents, grandparents, foster homes, other children's homes, etc.)

AGE of Child	LOCATION	WITH WHOM	AGE of Child	LOCATION	WITH WHOM



GENERAL INFORMATION

Is there any history of alcohol or drug dependency by either the child or any other family member? Yes No

Describe this involvement: _____

Has the applicant been involved in cults, and/or gangs? Yes No

Describe: _____

Has the applicant been involved with unlawful activity? (Shoplifting, robbery, vandalism) Yes No

Describe: _____

Has Applicant ever experienced or witnessed any type of abuse, violence or neglect?			
Type	Witnessed	Experienced	Explain
Physical			
Emotional			
Sexual			

Has psychological testing been done?	By whom?
Name:	Phone:
Address:	City/State/Zip:
Date of testing	

Other agencies involved: (For example, Child Welfare, Juvenile Court, Mental Health Clinic, Psychologist, Previous Placements, etc.)

Agency:
Worker's Name:
Address:
Phone:

Agency:
Worker's Name:
Address:
Phone:

Agency:
Worker's Name:
Address:
Phone:

Agency:
Worker's Name:
Address:
Phone:

CONTACT RESTRICTIONS:

List any individuals who may **NOT** have contact with the child if admitted into our care.

APPLICANT'S PAGE

APPLICANT NEEDS TO COMPLETE:

Your parents or guardians are in the process of making application for you to be admitted to our program. It is important that you have a say in this process. If you would answer the following questions, it would help us know you and your feelings about coming to the Maternity Services Program of Owasso Baptist Homes for Children.

Do you understand that you have come to a place where it may be helpful for you (and your child) to live outside your home? _____

Explain:

Do you understand that this program is designed to help you prepare for independence by teaching life skills, including but not limited to: clothes care, meal preparation, menu planning, money management, parenting, and organizational skills? _____

What do feel will be most helpful for you and your child?

PLEASE COMPLETE THE FOLLOWING SENTENCES:

1. The thing I like most is _____

2. My interests and hobbies are _____

3. I make friends easily not very easily

4. Friends describe my personality as _____

5. The thing I hate most is _____

6. My favorite food is _____

7. My goals are _____

8. Are people cooperative with you? Yes No Explain:

9. What benefits do you expect to receive from coming here?

BABY'S PAGE

Baby's Name:		Date of Birth:	
Place of Birth:	Sex:	Current Weight:	Current Height:
DHS Number	County	Premature birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how early? _____	
Birth Weight:	Birth Length:	Race:	
Any Complications during birth?			

Who has legal Custody:		
Address:		Phone:
If by court action, give type: <input type="checkbox"/> Divorce <input type="checkbox"/> Guardianship <input type="checkbox"/> Temporary <input type="checkbox"/> Voluntary		Court of Jurisdiction: Case Number:
With whom is infant currently living?		
Name:		Address:

Name of Baby's Father		Social Security Number	
Present Address			
Place of Employment			
Home Phone		Work Phone	
Date of Birth		County	
Birthplace		Nationality	Race
Is he involved in baby's life: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how? _____ _____		Does he contribute to child? If so, how? _____ _____	