Psychosocial Rehabilitation Services Questionnaire

**ADULTS ( ages 21 and over) Please circle Yes or No**

Have you ever been hospitalized for a Mental Health Issue or admitted to a Crisis Center

 for Mental Health Issues? **Yes No**

**If Yes, Name of Facility /date of hospitalization** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If answer is yes, consumer must answer yes to one of the below criteria to receive Rehabilitation Services at Edwin Fair)

Are you receiving SSI or SSDI due to a Mental Health disability? **Yes No**

Are you currently residing in a Residential Care Facility? **Yes No**

**If Yes, name of facility**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a currently in a Mental Health Court or Drug Court Program? **Yes No**

**If Yes, name of program**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDREN ( ages 6 through 20)**

Haschild ever been hospitalized for a Mental Health Issue or admitted to a Crisis Center

 for Mental Health Issues? **Yes No**

**If Yes, Name of Facility /date of hospitalization**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child receiving SSI or SSDI due to a Mental Health disability? **Yes No**

Is child currently in a Mental Health Court or Drug Court Program? **Yes No**

Does child have a current Individual Education Plan for Emotional Disturbance? **Yes No**

**If Yes, name of school**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does child have a current 504 Plan for Emotional Disturbance? **Yes No**

**If Yes, name of school**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child been referred for services by school psychologist, fully licensed psychologist or a psychiatrist due to mental illness and/ or severe behavioral problems in class room? **Yes No**

**If yes, name of professional who referred** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child transitioning out of a Therapeutic Foster Care or OKDHS Level E Group home? **Yes No**

**If Yes, name of home** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Consumer Signature (Parent or Legal guardian signature if consumer is 17 or younger) Date