Client Name_____

FLORIDA PALMS ACADEMY
SIPP APPLICATION FORM

(Completed by parent or legal guardian)

Request Date:	

DEMOGRAPHICS – CLIENT INFORMATION							
Medicaid #		**SSN**		**DOB**		**AGE**	
Last Name:		**First Name:**		**Middle:**			
☐**Male** ☐**Female**	**Living Arrangement:**						
Street Address 1:							
Street Address 2:				**Phone**			
City		**State**	Florida	**Zip**		**County**	

RESPONSIBLE PARTY/LEGAL GUARDIAN							
Last Name:		**First Name:**		**Middle:**			
Organization				**Relationship**			
Street Address 1:							
Street Address 2:				**Phone**		**Ext.**	
City		**State**	Florida	**Zip**		**County**	

PROBLEM IDENTIFICATION

Check	Text	Specify
☐	**Problems with family/support group**	
☐	**Problems related to peers/ social environment**	
☐	**Educational/School problems**	
☐	**Problems with personal responsibility**	
☐	**Home/placement problems**	
☐	**Problems related to limited family finances**	
☐	**Problems related to the legal/guardian system**	
☐	**Problems related to DJJ system**	
☐	**Other psychosocial and environmental problems**	

MEDICATIONS (Psychiatric/Behavioral Only)

Medications	**Dosage/Route**	**Frequency**	**Date(s)**

Client Name_____

Allergies:	☐ NKA	*List All Known & Reactions:*

HISTORY	
Is there a family History of Mental Illness?	☐ Yes ☐ No
Is there a family History of Substance Use/Abuse?	☐ Yes ☐ No
Has there been a recent Loss of Significant Other?	☐ Yes ☐ No

Other Significant Events/History:	

TREATMENT HISTORY

List prior psychiatric/chemical dependency treatment. Be as complete as possible. If none listed below, please check:

☐ **No Prior Treatment**

Service	Type	Dates of Service	Facility	Reason for Treatment
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			
Psych/SA	☐ Inpatient ☐ Outpatient			

History of Compliance and/or Non-Compliance With Past Treatment:	

Client Name_____

CLINICAL DATA					
Describe current behavior(s) and include any Diagnoses Given:					
Substance Abuse History	**Name Drug/Chemical**	**Date 1st Use**	**Amount/Route Use**	**Date Last Use**	**Length Time This Level**
☐ Yes ☐ No					
Educational Services Needed:					
Medical Services Needed:					