

YOUTH FACE SHEET
Office of Juvenile Justice
Michigan Department of Human Services

IDENTIFYING INFORMATION		
Youth Name		
DHS Case Number	Recipient ID Number	Placement Date (mm/dd/yyyy)
Court File Number	Referral/Committing County	Acceptance Date (mm/dd/yyyy)
JJS Load #	JJS Name	
JJS Phone #	JJS Fax #	

YOUTH INFORMATION					
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (mm/dd/yyyy)	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Certificate Received or Date Applied For <input type="checkbox"/>	Title IV-E <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (If multiracial, enter all races separated by commas)				Present Religion or Preference	
Height	Weight	Hair Color	Eye Color	SSN (last four digits only) or Date Applied for (mm/dd/yyyy)	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
Distinctive Characteristics					
Does Family Have Private Medical Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes (Give Name & Group No.)				Date Medical Auth.(DHS-3762) Given	
Last School Attended:		Address of School:		School Phone #:	
Last Grade Completed:					

FATHER INFORMATION			MOTHER INFORMATION		
Check One <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Putative <input type="checkbox"/> Has Custody			Check One <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Has Custody		
Name		Home Phone	Name		Home Phone
Address			Address		
Birth Date (mm/dd/yyyy)	SSN (last four digits only)	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	SSN (last four digits only)	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No
Race (If multiracial, enter all races separated by commas)			Race (If multiracial, enter all races separated by commas)		
Marital Status		Education	Marital Status		Education
Occupation		Religion	Occupation		Religion
Work Phone		Language Spoken, Other than English	Work Phone		Language Spoken, Other than English
Is Currently Involved with Youth:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Currently Involved with Youth:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is an Approved Visitor:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is an Approved Visitor:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Parental Rights Terminated:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Parental Rights Terminated:		<input type="checkbox"/> Yes <input type="checkbox"/> No

GUARDIAN, IF OTHER THAN ABOVE:			
Name		Address	
Relationship	Birth Date	SSN (last four digits only)	
Home Phone	Work Phone	Is Currently Involved with: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is an Approved Visitor: <input type="checkbox"/> Yes <input type="checkbox"/> No

KINSHIP AND/OR SIGNIFICANT OTHERS (Siblings, etc.)

Name	Relationship	Address	Birth Date	Phone No.	Approved Visitor	
					Yes <input type="checkbox"/>	No <input type="checkbox"/>
					Yes <input type="checkbox"/>	No <input type="checkbox"/>
					Yes <input type="checkbox"/>	No <input type="checkbox"/>
					Yes <input type="checkbox"/>	No <input type="checkbox"/>
					Yes <input type="checkbox"/>	No <input type="checkbox"/>

OTHER APPROVED VISITORS:

Name	Relationship	Address	Birth Date	Phone No.

RESTRICTED VISITORS:

Name	Relationship	Address	Birth Date	Phone No.

OFFENSE HISTORY:

Offense Date	Arrest Date	Offense Description

PREPARATION FOR PLACEMENT:

(Who told the youth, face-to-face contact? How did the youth react, etc.) Explain.

PHYSICAL/PSYCHOLOGICAL INFORMATION

Family Physician's Name	Date of Last Physical	Copies of Latest Physical Available <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (Street Number and Name)	City	State	Zip Code

Immunizations Up-to-Date: See Attached

Current Medications and Dosage (Include Prescribing Physician's Name for each medication.)

Medication	Dosage	Prescribing Physician

Physical Considerations (Include Current Illnesses, Health Problems, Medications, including dosage, Allergies, etc.)

Psychologist/Psychiatrist Name	Date of Last Psychological	Copies of Latest Psychological Available <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (Street Number and Name)	City	State	Zip Code

Emotional/Behavioral Considerations

IMMEDIATE AND SIGNIFICANT NEEDS AND SERVICES TO BE PROVIDED

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JJS Signature	Date
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