North Central Ohio Rehabilitation Center

DISPOSITION INVESTIGATION REPORT

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ SSN: _____ AKA: _____

PHYSICAL MARKS: _____

_____

SEX: _____ HT: _____ GLASSES_____ HAIR_____ EYES: _____ RACE: _____

PARENT / GUARDIAN: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PARENT / GUARDIAN EMAIL: _____

COUNTY COURT: _____ COMMITTING JUDGE: _____

DATE PREPARED: _____ PREPARED BY: _____ TELEPHONE: _____

PERSON(S) INTERVIEWED:

_____

_____

CURRENT CASE #(S): _____ ORC #(S): _____ OFFENSE LEVEL(S): _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

COMMITTING OFFENSE INFORMATION:

DETAILED SUMMARY OF OFFENSE: (FROM COMPLAINT OR POLICE REPORT. ANY PERSON-TO-PERSON CRIME, INCLUDED POLICE REPORT)

_____

_____

_____

_____

YOUTH'S VERSION OF / ATTITUDE TOWARD OFFENSE:

_____

_____

_____

_____

IS THE YOUTH CURRENTLY DETAINED? YES NO DATE YOUTH WAS DETAINED? _____

WERE THE ORIGINAL CHARGES AMENDED OR DISMISSED? YES NO

LIST ORIGINAL CHARGES: _____

IS DNA TESTING REQUIRED? YES NO

LIST ORIGINAL CHARGE(S) THAT REQUIRE DNA TESTING: _____

DOES THE YOUTH ADMIT TO DRUG / ALCOHOL USE AT THE TIME OF THE OFFENSE? YES NO

WHAT TIME OF DAY DID THE OFFENSE OCCUR? _____ AM _____ PM CO-DEFEDANTS? YES NO

WEAPON DISPLAYED? YES NO TYPE: _____

WEAPONS USED? YES NO TYPE: _____

CRIMINAL ACTIVITY GANG RELATED? YES NO

EXPLAIN: _____

GANG AFFILIATION: _____

CO-DEFENDANTS' NAME(S): _____

_____

VICTIM INFORMATION (IS A VICTIME IMPACT STATEMENT ATTACHED? YES NO)

VICTIM ONE: AGE: UNDER AGE 5 OVER AGE 65 DIASBLED

VICTIM TWO: AGE: UNDER AGE 5 OVER AGE 65 DIASBLED

VICTIM THREE: AGE: UNDER AGE 5 OVER AGE 65 DIASBLED

ANY PERSONAL INJURY? YES NO PROPERTY DAMAGE OR LOSS? YES NO

WAS THERE A RELATIONSHIP WITH THE VICTIM? YES NO

EXPLAIN: _____

_____

BRIEF COURT HISTORY: (ATTACH THE COMPLETE LIST OF COURT CONTACTS)

PRIOR PROBATION: NO PRIOR SUCCESSFUL COMPLETION UNSUCCESSFUL COMPLETION

HAVE THE YOUTH AND FAMILY BEEN COOPERATIVE WITH COURT SERVICEDS IN THE PAST? YES NO

COMMENTS: _____

_____

_____

_____

_____

FAMILY MEMBERS:

FAMILY DATA: (INCLUDE PARENTS, STEP-PARENTS, AND SIGNIFICANT OTHERS)

RELATION	FIRST & LAST NAME	SSN	DOB	ADDRESS	MARITAL STATUS	EDUC LEVEL

SIBLINGS: (INCLUDE FULL, HALF, STEP)

FIRST & LAST NAME	DOB	LIVING WITH	COURT / PCSA / DHS INVOLVEMENT

FAMILY INFORMATION:

PARENTS' MARITAL STATUS: MARRIED: NEVER MARRIED: DIVORCED: SEPARATED:

IF DIVORCED, YEAR OF DIVORCE: _____ STATE: _____ COUNTY: _____

IF DIVORCED / NEVER MARRIED DOES YOUTH HAVE CONSISTENT CONTACT WITH PARENT NOT IN THE HOME? YES NO

WHAT IS THEIR RELATIONSHIP? _____

_____

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ATTEMPTED SUICIDE? YES NO

WHO? _____

HAS ANY FAMILY MEMBER COMPLETED SUICIDE? YES NO

WHO? _____

HAS EITHER PARENT RECEIVED MENTAL HEALTH SERVICES? YES NO

DESCRIBE SERVICES? _____

_____

HAS THERE BEEN A HISTORY OF DOMESTIC VIOLENCE? YES NO

PARENTAL SUPERVISION IS DESCRIBED AS: ADEQUATE SPORADIC / INCONSISTENT INEFFECTIVE

WHAT IS THE USUAL METHOD OF DISCIPLINE?

_____

IS THIS METHOD EFFECTIVE? YES NO

WHAT ISSUES CAUSE CONFLICTS IN THE HOME?

_____

_____

HOW ARE CONFLICTES RESOLVED?

_____

HAS EITHER PARENT RECEIVED MR/DD CASE MANAGEMENT SERVICES? YES NO

DESCRIBE SERVICES? _____

_____

HAS ANY FAMILY MEMBER HAD INVOLVEMENT WITH THE COURT SYSTEM? YES NO

NAME / RELATIONSHIP	DATE / AGE	OFFENSE	DISPOSITION / STATUS

IS ANY FAMILY MEMBER GANG INVOLVED? YES NO

WHO: _____ WHICH GANG? _____

YOUTH INFORMATION:

YOUTH PLACE OF BIRTH: CITY: _____ STATE: _____ COUNTY: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ TELEPHONE: _____

ADDRESS: _____

LEGAL CUSTODIAN IF NOT PARENT: _____

YOUTH ADOPTED? YES NO AGE AT ADOPTION _____

HAS A REFERRAL EVER BEEN MADE TO A PUBLIC CHILDREN SERVICES AGENCY? YES NO

DATE OF REFERRAL(S)? _____

_____

IF YES, REFERRAL MADE FOR: ABUSE NEGLECT DEPENDENCY OTHER

IS YOUTH IN CUSTODY OF A PUBLIC CHILDREN SERVICES AGENCY? YES NO

CASE WORKER: _____

CUSTODY STATUS: PERMANENT TEMPORARY

HAS THE YOUTH EXPERIENCED A RECENT SIGNIFICANT LOSS OR FAMILY CHANGE? YES ✘ NO

WHAT? _____

_____

_____

IF THE YOUTH HAS A PROBLEM, TO WHOM DOES HE/SHE TURN?

LIST HISTORY OF OUT-OF-HOME PLACEMENTS e.g., FOSTER HOMES, RELATIVE PLACEMENTS, AND RESIDENTIAL FACILITIES)

WITH WHOM / WHERE	DATE / LENGTH OF STAY	WHY	SECURE / NONSECURE	ADJUSTMENT / AWOL

HAS THE YOUTH HAD A HISTORY OF RUNNING AWAY FROM HOME OR PLACEMENTS INCLUDING SECURE FACILITY? YES NO

EXPLAIN? _____

_____

DOES THE YOUTH HAVE ANY CHILDREN? YES NO IF YES, LIST:

NAME	DOB	ADDRESS	FATHER OF CHILD	CUSTODY

DESCRIBE YOUTH'S BEHAVIOR WHEN ANGRY? _____

_____

DESCRIBE YOUTH'S RELATIONSHIP WITH SIBLINGS: (NOT APPLICABLE)

HAS POSITIVE RELATIONSHIP: YES NO VERBALLY / PHYSICALLY ABUSIVE: YES NO

SEXUALLY ABUSIVE / ABUSED: YES NO ENGAGES WITH YOUTH IN ANTISOCIAL BEHAVIOR: YES NO

RELIGION

WHAT IS THE YOUTH'S RELIGIOUS AFFILIATION? _____

DOES THE YOUTH PARTICIPATE? YES NO

YOUTH'S SCHOOL HISTORY

TRANSCRIPT ATTACHED? YES NO IMMUNIZATION RECORD ATTACHED? YES NO

ENROLLED IN SCHOOL? YES NO

CURRENT GRADE _____ IF NOT, LAST DATE ATTENDED / GRADE? _____

LAST SCHOOL ATTENDED: _____

ADDRESS: _____ TELEPHONE: _____

HAS YOUTH OFFICIALLY DROPPED OUT? YES NO DATE: _____

GRADUATED? YES NO DATE? _____

IS THE YOUTH ATTEMPTING TO OBTAIN HIS GED? YES NO WHERE? _____

SCHOOL DISTRICT AND SCHOOL OF PARENT /GUARDIAN RESIDENCE? _____

SPECIAL EDUCATION PROGRAMMING? YES NO DH SED SLD OTHER: _____

IEP ATTACHED? YES NO LIST THE EFFECTIVE DATE OF THE MOST RECENT IEP? _____

WAS YOUTH IN SPECIAL PROGRAMMING (e.g. VOCATIONAL, TITLE ONE)? YES NO

SPECIFY: _____

DISCIPLINE: (PAST 2 SEMESTERS)

TYPE	NO	YES	TOTAL DAYS	REASON
SUSPENSIONS				
EXPULSION				
OTHER				

SCHOOL VIEW OF YOUTH'S BEHAVIOR: NO PROBLEM SOME PROBLEMS MAJOR PROBLEM

HAS YOUTH TAKEN PROFICIENCY TESTS? YES NO SPECIFY DATES AND RESULTS: _____

_____

INDICATE ANY RESULTS OF APTITUDE OR ACHIEVEMENT TESTS: _____

_____

LIST GRADE AVERAGES FOR LAST SEMESTER ATTENDED: _____

_____

SPECIAL TALENTS OR EXTRACURRICULAR ACTIVITIES: _____

_____

YOUTH PERSONAL EDUCATIONAL GOALS: _____

_____

READING LEVEL: _____ MATH LEVEL: _____

TOTAL NUMBER OF DAYS	CURRENT SEMESTER	LAST SEMESTER	PREVIOUS SCHOOL YEAR
ABSENT			
TRUANT			

YOUTH'S EMPLOYMENT: (NOT APPLICABLE)

EMPLOYED? YES NO FULL PART TYPE OF WORK? _____

EMPLOYER NAME: _____ SUPERVISOR: _____

EMPLOYER ADDRESS: _____

PHONE NUMBER:_____ HOURS WORK: _____ WAGE: _____

PAST EMPLOYERS: _____

IS THE YOUTH RECEIVING SERVICES FROM THE BUREAU OF VOCATIONAL REHABILITATION? YES NO

MR/DD ISSUES: (NOT APPLICABLE)

IQ SCORE: _____ TEST ADMINISTERED: _____ DATE: _____

COEDI / OEDI ADMINISTERED? YES NO DATE OF TEST: _____

DESCRIBE RESULTS: _____

IS YOUTH RECEIVING MR/DD SERVICES? YES NO

WHO IS THE MR/DD CASE MANAGER? _____

DESCRIBE SERVICES: _____

MENTAL HEALTH ISSUES:

HAS THE YOUTH EVER TRIED TO COMMIT SUICIDE? YES NO DATE? _____

NATURE OF ATTEMPT: _____

DOES THE YOUTH HAVE A HISTORY OF SELF-MUTILATING BEHAVIOR? YES NO

NATURE OF BEHAVIOR: _____

DOES THE YOUHAVE A HISTORY OF SUICIDAL IDEATION? YES NO

EXPLAIN: _____

DOES THE YOUTH HAVE A HISTORY OF ABUSE TO ANIMALS? YES NO

EXPLAIN: _____

DOES THE YOUTH HAVE A HISTORY OF FIRESETTING BEHAVIOR? YES NO

EXPLAIN: _____

HAS THE YOUTH EVER BEEN TO COUNSELING? YES NO

IF YES, TYPE OF COUNSELING: OUTPATIENT RESIDENTIAL INPATIENT HOSPITALIZATION

IF IN A PSYCHIATRIC HOSPITAL, WHAT EVENTS LED UP TO THE HOSPITALIZATION?

_____

_____

WAS A PYSCHIATRIC EVALUATION CONDUCTED? YES NO DATE: _____

DIAGNOSIS / EVALUATION (ATTACH IF AVAILABLE)

_____

_____

LIST AGENCY / INSTITUTIONAL EXPERIENCES: (NOT APPLICABLE)

AGENCY / INSTITUTION	SERVICES	COUNSELOR	DATE

WAS A PSYCHOLOGICAL EVALUATION CONDUCTED? YES NO DATE: _____

DIAGNOSIS / EVALUATION (ATTACH IF AVAILABLE)

_____

_____

YOUTH'S MEDICAL INFORMATION: **(ATTACH COPY OF INSURANCE CARD AND IMMUNIZATION RECORDS)**

FAMILY PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

MEDICAL INSURANCE? YES NO

COMPANY NAME: _____ PHONE: _____

POLICY HOLDER: _____ POLICY #: _____ GROUP #: _____

OTHER SOURCES OF INCOME: SSI PENSION CHILD SUPPORT TITLE IV-E SOCIAL SECURITY

OTHER: _____

DOES THE YOUTH HAVE ANY CURRENT OR PAST MEDICAL PROBLEMS? (INCLUDING ANEMIA, ASTHMA, BROKEN BONES, DIABETES, HEART CONDITION, HERNIA, KIDNEY INFECTION OR DISEASE, LIVER DISEASE, SEIZURES, THYROID DISORDER, ULCER) YES NO

EXPLAIN: _____

_____

_____

DOES THE YOUTH HAVE ANY ALLERGIES TO MEDICATION? YES NO

EXPLAIN: _____

_____

DOES THE YOUTH HAVE ANY ALLERGIES TO FOOD, INSECT BITES, ANIMALS, OR ENVIRONMENTAL ALLERGIES? YES NO

EXPLAIN: _____

_____

HAS THERE BEEN ANY MAJOR TRAUMA OR HEAD INJURIES? YES NO

DESCRIBE: _____

_____

HAS THE YOUTH EVER BEEN TESTED FOR SICKLE CELL ANEMIA? YES NO RESULTS: _____

HAS THE YOUTH EVER BEEN TESTED FOR HEPATITIS? YES NO RESULTS: _____

HAS THE YOUTH EVER HAD A POSITIVE TUBERCULOSIS SKIN TESET, OR BEEN TREATED FOR TUBERCULOSIS OR TUBERCULOSIS INFECTION? YES NO

IF YES, DESCRIBE SKIN TEST REACTION AND TREATMENT GIVEN: _____

_____

IS THE YOUTH TAKING ANY MEDICATIONS? YES NO

IF YES, LIST TYPE, DOSAGE, AND START DATE: _____

_____

FOR WHAT CONDITION: _____

PAST SURGICAL HISTORY: YES NO

DESCRIBE AND INCLUDE DATES:_____

_____

_____

PAST HOSPITALIZATION HISTORY: YES NO

DESCRIBE AND INCLUDE DATES:_____

_____

_____

IS THE YOUTH UP TO DATE WITH IMMUNIZATIONS? YES NO (ATTACH RECORDS) LAST Td (TETANUS, DIPTHERIA, TOXOIDS) DATE: _____ MMR2 (MEASLES, MUMPS, & RUBELLA) DATE: _____

HEPATITIS B VACCINATION DATE: 1ST SHOT _____ 2ND SHOT _____ 3RD SHOT _____

IS THE YOUTH SEXUALLY ACTIVE? YES NO

HAS THE YOUTH BEEN TREATED FOR A SEXUALLY TRANSMITTED DISEASE? YES NO

TYPE AND TREATMENT:_____

HAS THE YOUTH BEEN SEXUALLY ABUSED? YES NO

IF SO, BY WHOM:_____

ABUSE HAS BEEN SUBSTANTIATED? YES NO

ACTION TAKEN:_____

ALCOHOL & DRUG HISTORY

DOES THE YOUTH USE ALCOHOL? YES NO

ALCOHOL TYPE	AGE FIRST USED	FREQUENCY & QUANTITY OF USE	MOST RECENT USE

HAS THE YOUTH EVER PASSED OUT? YES NO EVER BLACKED OUT? YES NO

QUANTITY CONSUMED BEFORE CONSIDERED DRUNK: _____

NUMBER OF ARRESTS ASSOCIATED WITH ALCOHOL USE: NONE ONE 2 OR MORE

DOES THE YOUTH USE SUBSTANCES OR INHALANTS? YES NO

TYPE	AGE FIRST USED	FREQUENCY & QUANTITY OF USE	MOST RECENT USE

HAS THE YOUTH PURCHASED DRUGS? YES NO HAS THE YOUTH EVER SOLD DRUGS? YES NO

HAS THE YOUTH OVERDOSED? YES NO EXPLAIN: _____

_____

NUMBER OF ARRESTS ASSOCIATED WITH DRUG USE: NONE ONE 2 OR MORE

YOUTH GETS HIGH WITH: SELF FRIENDS PARENTS OTHER

PARENTAL VIEW OF USE: NO PROBLEM SOME PROBLEM MAJOR PROBLEM

HAS THE YOUTH RECEIVED ALCOHOL AND/OR SUBSTANCE ABUSE TREATMENT? YES NO

AGENCY / INSTITUTION	SERVICES	COUNSELOR	DATE

YOUTH PERSONAL / /SOCIAL DATA

HOBBIES AND ACTIVITIES THE YOUTH DOES IN SPARE TIME: _____

_____

FAMILY ACTIVITIES: _____

DOES THE YOUTH HAVE ANY CLOSE FRIENDS? YES NO

WHAT LEISRUE ACTIVITIES DOES THE YOUTH DO WITH HIS FRIENDS? _____

_____

DOES THE YOUTH ASSOCIATE WITH OTHER YOUTH: SAME AGE YOUNGER OLDER

IS THE YOUTH CONSIDERED TO BE A: LEADER FOLLOWER NEITHER

DOES THE YOUTH HAVE ANY FRIENDS WHO HAVE HAD CONTACT WITH THE COURT? YES NO

IS THE YOUTH ASSOCIATING WITH A NEW PEER GROUP? YES NO

IF YES EXPLPAIN: _____

YOUTH'S SELF-ASSESSMENT OF STRENGTHS AND WEAKNESSES

_____

_____

_____

_____

YOUTH'S ASSESSMENT OF FAMILY STRENGTHS AND WEAKNESSES

_____

_____

_____

_____

SUMMARY OF IMPRESSIONS

_____

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

PROBATION OFFICER: _____ DATE COMPLETED: _____

ATTACHMENT 1

YOUTH'S NAME: _____

<u>PRIOR COURT REFERRALS:</u> (FIRST AND MOST RECENT CONTACT MUST BE INCLUDED – BOTH OFFICIAL AND UNOFFICIAL) ATTACH ADDITIONAL PAPERWORK IF NECESSARY

DATE OF ADJUDICATION / AGE	OFFENSE / LEVEL	DISPOSITION

PLEASE LIST ALL INDIVIDUALS THE YOUTH IS COURT ORDERED TO HAVE NO CONTACT WITH

NAME	ADDRESS (IF KNOWN)	REASON

ATTACHMENT 2

COURT APPROVED RESIDENT VISITATION LIST

Youth: ____ Date: ______________________

Please list approved parents / guardians / grandparents / siblings / clergy (or professionals) -**ONLY**

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

Visitor's name: ________________________ Relationship: ________________
Address: ________________________ Phone: ________________
SS#: ________________________

ATTACHMENT 3

YOUTH NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

Authorization for medical/dental Treatment

I hereby give permission for such medical / dental treatment and procedures as are necessary in the diagnosis and treatment for this youth. As the parent or legal guardian, I agree to allow the North Central Ohio Rehabilitation Center to provide medical / dental care or treatment when necessary.

Parent or Guardian signature: _____ Date: _____

Relationship: _____

Authorization to release information

Permission is granted to any clinic, dental clinic, hospital, physician, dentist, or health agency to release information to the North Central Ohio Rehabilitation Center pertaining to the health, dental or previous medical / dental care of this youth.

Parent or Guardian signature: _____ Date: _____

Relationship: _____

JOURNAL ENTRY MUST INCLUDE

A Journal Entry committing a youth to the North Central Ohio Rehabilitation Center must include certain information to comply with the Ohio Department of Youth Services Standards.

- Felony offense
- Felony offense level (i.e.: F5, F4, F3, F2, F1)
- Offense ORC code
- Youths date of birth
- Date youth will arrive at NCORC
- School district ordered to pay for educational cost
- Youth's home school ordered to provide NCORC with copies of school records
- Suspended commitment to ODYS and committed to NCORC for successful completion of the program (DO NOT place the youth in the custody or temporary custody of NCORC, legally we cannot take custody of a youth)
- Parents (custodians) shall comply with all reasonable requests from the North Central Ohio rehabilitation Center.

DOCUMENTS CHECKLIST

- Copies of:
    1. insurance information
    2. child support,
    3. immunization records
    4. birth certificate.

- (2) documents with social security number and Date of Birth