



MAAC Application

Date of application: _____

Revision Date: _____

1. Youth's Name: _____

2. SS# _____ 3. Date of Birth: _____ / Age: _____ 4. Medicaid#: _____

AGENCY INVOLVEMENT

5. Referring Agency type: DFCS DJJ MHM RSA Other _____

6. Referring Agency Name: _____

Case Worker Name: _____

Address: _____

City/Zip: _____

Phone: _____

Cell: _____

Email: _____

Fax: _____

New Worker: _____

Phone: _____

Cell: _____

Email: _____

Fax: _____

Supervisor Name: _____

Phone: _____

Cell: _____

Email: _____

Fax: _____

New Supervisor: _____

Phone: _____

Cell: _____

Email: _____

7) What date (month, day, and year) youth came into care? _____ ← MANDATORY

8. Agency (ies) currently serving youth (mark all that apply)

- DFCS DJJ Community Mental Health Mental Retardation Substance Abuse Independent Juvenile Court
- Private mental health providers Other _____

9. Gender: Female Male 10. Ethnicity: White Black/African American American Indian/Alaskan Asian or Pacific Islander Hispanic Multi-racial Unable to determine

11. Sexual Orientation: Lesbian Bisexual Gay Transgendered Questioning Heterosexual Unknown

12. Religion: Protestant Catholic Jewish Muslim No Affiliation Other: _____

13. Legal Custodian (relationship to child) Mark only one:

Biological parent(s): Name/Address/Phone # _____

Adoptive parent(s): Name/Address/Phone # _____

Other: Name/Address/Phone # _____

DFCS

14. Is youth in joint custody of DFCS/DJJ? Yes No Date of Commitment: _____ ← MANDATORY

15. Payor/Funding: _____

Address/ Phone number: _____

16. Current placement:

- Jail Foster Family Treatment Residential Treatment Center
- State Mental Hospital Home Emergency Shelter Group Emergency Shelter
- County Detention Center Specialized Foster Care Residential Job Corps Center
- Youth Correctional Center Regular Foster Care Group Home
- Intensive Treatment Unit Supervised Independent Living Independent living with Friend
- Drug/Alcohol Rehab Center Home of Family Friend Independent living with self
- Medical Hospital (Inpatient) Adoptive Home School Dormitory
- Wilderness Camp (24hr) Home of Relative Natural Parent (child)
- Natural Parent (age 18)

16a. Current Placement

Name: _____
 Address/ Phone #: _____
 Contact Person: _____ Length of time at current placement? _____
 Prior history? _____
 Reason for seeking new placement? _____

PLACEMENT HISTORY MUST BE COMPLETELY FILLED OUT, THIS IS MANDATORY!!!

17. Placement / Treatment History

- 01 Jail / 02 State Mental Hospital / 03 County Detention / 04 Youth Correction Center
- 05 Intensive Treatment Unit / 06 Drug/Alcohol Rehab Center / 07 Medical Hospital Inpatient)
- 08 Wilderness Camp / 09 Residential Treatment Center / 10 Group Emergency Shelter
- 11 Residential Job Corps Center / 12 Group Home / 13 Foster Family Treatment
- 14 Home Emergency Shelter / 15 Specialized Foster Care / 16 Regular Foster Care
- 17 Supervised Independent Living / 18 Home of Family Friend / 19 Adoptive Home
- 20 Home of Relative / 21 School Dormitory / 22 Natural Parent (child) / 23 Natural Parent (age 18+)
- 24 Independent Living/Friend / 25 Independent Living/Self / 26 Other

Begin with the FIRST placement

List each out-of-home placement; Include medical and psychiatric hospitalizations

Attach Historical Placement Summary/Attach additional sheet if needed

Code	Placement Name	Beginning Date	Ending Date	Why did Youth leave	Youth's Next Placement

18. Has the youth had the following services?(Check all that apply) In-Patient Hospital? _____ If so, date and where: _____
 Crisis Placement? _____ If so, date and where: _____ ER Involvements? _____ If so, date and where: _____
 SA detox attempts? _____ If so, date and where: _____

19. Is there a relative, foster family, or other visiting resource? Yes **Who?** _____ No

20. Mother's rights terminated or visiting resource? Yes No **19. Father's rights terminated or relinquished:** Yes No

21. Any Birth Family contact? Yes No If yes, Phone Visits /Who **and How many times within a month?** _____

22. Any Surrgoate family contact? Yes No If yes, Mentor, Respite, or foster family/Phone Visits **Who and How many times within a month?** _____

23. Agency (ies) currently serving youth (mark all that apply)
DFCS DJJ Community Mental Health Mental Retardation Substance Abuse Independent Juvenile Court Private mental health providers Other _____

JUVENILE JUSTICE INVOLVEMENT

24. History of involvement with Juvenile Justice: Yes No **Current involvement:** Yes No

25. Current Juvenile Justice Disposition (mark all that apply):
 Commitment to DJJ Probation Sentenced to Boot Camp Informal Adjustment Pending

26. Any Arrests in the past 30 days? _____ **If yes, For?** _____

SUBSTANCE ABUSE

27. Does the youth experiment with or use alcohol and/or drugs? Yes No Unknown
28. Has the youth received treatment for alcohol or drugs? Yes No Unknown

HISTORY OF MALTREATMENT

- 29. History of Maltreatment (mark all that apply):** Neglect Emotional abuse Physical abuse Sexual abuse Suspected or alleged abuse/neglect
- 30. Parental/Caregiver Issues:** Criminality Current incarceration Mental illness/Mental retardation Family Violence Suicide attempts Death resulted from suicide or homicide

PHYSICAL HEALTH

- 31. Diagnosed Physical Conditions (mark all that apply):** Anemia Sickle Cell Anemia Sever Allergies Rheumatic Fever Heart Disease Heart Murmur Epilepsy (seizure disorder) Tuberculosis Diabetes Cancer Asthma Eczema AIDS HIV Herpes Hepatitis Other: _____

EDUCATIONAL INFORMATION

32. Status of Current School Placement:

- Public school Private School Regular classes Alternative school Special education classes (mark all that apply): Psycho educational placement Self contained classroom Resource or other special educational placement Gifted Learning disability Emotional behavioral disorder/Severe emotional disturbance Mild intellectual disability Moderate intellectual disability Severe intellectual disability Profound intellectual Disability Orthopedic impairment Other health impairment Speech-language impairment Deaf Blind Hearing impairment Significant development delay Visual impairment Traumatic brain injury Autism Not currently in school/ Why? _____

33. Speech and Language: Problem identified Yes No / Evaluation completed Yes No

34. Grade Level _____ **Most recent school placement:** _____
Last grade completed _____ **How many days of school missed in the past 30 days?** _____

35. Employment: Is the child available for work? _____ **If no, why?** _____

36. Adaptive Behavior Scale

- (1) Vineland
 (2) American Association of Mental Retardation
 (3) Other: _____
 Test#: _____
 Date completed: _____

37. IQ Score

- (1) Stanford Binet
 (2) Kaufmann Brief Intelligence Test (K-Bit)
 (3) Weschler Intelligence Scale for Children (WISC)
 (4) Weschler Adult Intelligence Scale (WAIS)
 (5) Other: _____
 Date of Test: _____
 Full Scale Score: _____
 Verbal Score: _____
 Performance Score: _____

38. Most current diagnoses: (use “other diagnosis” or “rule out diagnosis” as needed)

Disorder of Infancy, childhood and Adolescence:

- Asperger’s Disorder
 Pervasive Developmental Disorder NOS (299.80)
 Attention Deficit/Hyperactivity Disorder
 Conduct Disorder (312.8)
 Oppositional Defiant Disorder (313.81)
 Tourette’s Disorder (307.23)
 Enuresis (not due to medical condition) 307.6
 Encopresis – With Constipation (786.7)
 Encopresis – Without Constipation
 Separation Anxiety Disorder (309.21)
 Reactive Attachment Disorder (313.89)
 Disruptive Behavior Disorder (312.9)
 Mild mental Retardation (317)
 Moderate Mental Retardation (318.0)
 Severe mental Retardation (318.1)

Cognitive Disorders;

- Cognitive Disorder (NOS) (294.9)

Substance Use Disorders;

- Alcohol Abuse (305.0)
 Other or Unknown Substance Abuse (305.90)

Schizophrenia & Other Psychotic Disorders:

- Schizophrenia, Paranoid type (295.30)
 Schizophrenia, Undifferentiated Type (295.30)
 Schizoaffective Disorder (295.70)
 Psychotic Disorder NOS (298.9)

Mood Disorders:

- Bipolar disorder NOS (296.8)
 Depressive Disorder NOS (311)
 Major Depressive Disorder, Single Episode (296.2)
 Major Depressive Disorder, Recurrent Episode (296.3)
 Dysthymic Disorder (300.4)
 Mood Disorder NOS (296.9)

Anxiety Disorders:

- Posttraumatic Stress Disorder (309.81)
 Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood) (300.02)
 Anxiety Disorder NOS (300.00)

39. Achievement Test Score

- (1) Woodcock Johnson (WJR)
 (2) Weschsler (WIAT)
 (3) Peabody (PIAT) (4) Wide Range
 Achievement Test (WRAT)
 (5) Kaufman Test of Educational
 Achievement Test (KTEA)
 (5) Other: _____
 Test#: _____
 Test#: _____
 Reading: _____
 Grade Level: _____
 Standard Score: _____
 Math: _____
 Grade Level: _____
 Date Completed: _____

Sexual and Gender Identify Disorders:

- Paraphilia NOS (302.9)
 Gender Identify Disorder NOS (302.6)
 Sexual Disorder (302.9)

Eating Disorders

- Eating Disorder NOS (307.50)
 Anorexia Nervosa (307.1)
 Bulimia Nervosa (307.51)

Impulse Control Disorders:

- Intermittent Explosive Disorder (312.34)
 Impulse Control disorder NOS (312.20)

Adjustment Disorders:

- Adjustment Disorder with Depressed Mood (309.0)
 Adjustment Disorder with Anxiety (309.24)
 Adjustment Disorder with Disturbance of Conduct (309.3)
 Adjustment Disorder with Mixed Disturbance of Emotions and conduct (309.4)

Personality Disorders: * can not be assigned to youth under 18

- Personality Change due to Medical Condition (310.1)
 Antisocial Personality Disorder (301.7)
 Borderline Personality Disorder (301.83)
 Histrionic Personality Disorder (301.50)
 Narcissistic Personality Disorder (301.81)
 Date of _____
 Diagnosis: _____
 Other diagnosis: _____
 Other Current _____
 diagnosis: _____
 Other _____
 diagnosis: _____

VCodes:

- Physical Abuse of Child focus on victim
 Sexual Abuse of Child
 Neglect of a Child

Child Strengths (Interests or Abilities):

- | | | |
|--|---|--|
| <input type="checkbox"/> Artistic | <input type="checkbox"/> Communication | <input type="checkbox"/> "Street Smart" |
| <input type="checkbox"/> Personable | <input type="checkbox"/> Humor | <input type="checkbox"/> Athletics |
| <input type="checkbox"/> Family support | <input type="checkbox"/> Can form emotional connections | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Motivation | <input type="checkbox"/> Academics | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> External/internal support | | <input type="checkbox"/> Music/ Instrument |

Other strengths: _____

Describe situations when child has been most successful: _____

Identified Family Participating in Treatment (include relatives, mentor, coach, former foster family, adoptive family, birth family and any others participating in treatment): _____

Who does child identify as family of choice (please include contact info)?
IF APPLICABLE, What is the birth family's income? _____

Describe any cultural or religious considerations/affiliations in treatment: _____

Services (within last 6 months):

- | | | |
|---|--|---|
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Behavior Aide | <input type="checkbox"/> Specialized Adaptive Devices |
| <input type="checkbox"/> Community Support | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Specialized Medical/ Dental Care |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Additional Case Mgmt. | <input type="checkbox"/> Medication Monitoring |
| <input type="checkbox"/> Special Ed Services | <input type="checkbox"/> Family Intervention/ Family Therapy | <input type="checkbox"/> Birth Family Contact/ Transportation |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Specialized Assessment | Other _____ |
| <input type="checkbox"/> Physical Ailment | <input type="checkbox"/> Specialized Treatment Services | |
| <input type="checkbox"/> Respite Services | | |
| <input type="checkbox"/> Family Education | | |
| <input type="checkbox"/> Mentoring/ Tutoring | | |
| <input type="checkbox"/> Crisis Stabilization | | |

- Successful Interventions:**
- | | | |
|---|---|---|
| <input type="checkbox"/> Redirection | <input type="checkbox"/> Therapeutic Hold | <input type="checkbox"/> Reward/ Incentives |
| <input type="checkbox"/> Time out | <input type="checkbox"/> Humor/ Distraction | |
| <input type="checkbox"/> Loss of Privileges | <input type="checkbox"/> Behavior Plan | |

Describe Other Successful Interventions: _____

Child/Families feeling about transition/treatment: _____

Does your child require assistance with personal care chores? _____
 Toileting Bathing Grooming Dressing

Describe other Assistance Needed: _____

Mild: The behavior has Slight effect and the behavior occurs only occasionally.

Moderate: The behavior has a Serious effect and the behavior occurs on a frequent basis.

Severe: The behavior has a Very Serious effect and the behavior occurs on a frequent

Behaviors	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity.			Except where behavior is not applicable, give description of behavior
			Mild	Moderate	Severe	
1. Difficulty concentrating, easily distracted			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Can't sit still, is restless.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Impulsive, acts before thinking.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Underactive, lack energy.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Act disobediently at home.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Acts disobediently at school.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Demands attention.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Associates with children who get into trouble.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Doesn't get along well with other children			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
other children.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is bullying or mean.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Gets into fights.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Lies and/or cheats.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feels no guilt after misbehaving			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
misbehaving			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Runs away.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Has volatile temper tantrums.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Screams			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Child will indiscriminately go with or to unfamiliar adults			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Child exhibits multiple fears, obsessions and worries.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Child appears to be comfortable in his/her isolation and aloneness. A sense of distance marks their relationships.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Child exhibits insatiable neediness (i.e. clinging behavior).			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Child appears to be cooperative and submissive but usually does not follow through on actions or requests.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Parentified child. Child acts older than his/her chronological age. Attempts to parent other children.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood and Anxiety Behaviors			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Appears sad, unhappy.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Has trouble sleeping.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Is fearful or anxious.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Stares blankly			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Behaviors	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity.			Except where behavior is not applicable, give description of behavior
			Mild	Moderate	Severe	
27. Expresses feeling worthless or inferior.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Withdraws, does not get involved with others.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. Worries excessively, preoccupied with minor annoyances.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Complaints of psychosomatic ailments.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Sudden mood changes.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Has stopped speaking.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Elimination Behaviors						
33. We4s on self during day.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Wets pm be at night.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35. Has bowel movements other than in toilet.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Smears or plays with bowel movements or urine.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Hallucinates.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Disorganized or incoherent.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. Has delusions.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. Bizarre/Grossly Disorganized or incoherent.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behaviors eating Disorders						
41. Compulsive Overeating.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
42. Anorexia-child refuses to maintain a minimally normal body weight.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43. Bulimia-child maintains normal body weight through bingeing and purging (through vomiting, laxatives, diuretics or enemas).			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Behavior Problems						
44. Sexually Promiscuous			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Prostitutes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
46. Sexually provocative			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48. Exhibits self in public			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49. Sexually peeks at others			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50. Masturbates in public			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51. Sexual play with peers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52. Other sexual problems (such as touching other s inappropriately.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Offending Behaviors						
53. Coerces other children into sexual acts.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54. Sexually molests other children			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55. Has exhibited sexual aggressiveness.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Danger to others						
56. Verbal or physical suicidal threats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Behaviors	N/A	Mark if by History	Has behavior occurred within past year? If yes, mark severity.			Except where behavior is not applicable, give description of behavior
			Mild	Moderate	Severe	
57. Suicidal gestures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58. Talks about suicide			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
59. Serious self abusive behavior			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
60. Places self in dangerous situations			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
61. Exhibits life threatening aggression			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
62. Physically aggressive behavior toward a child that results in any injury, potential injury, or intent to injure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
63. Physically aggressive behavior toward an adult that results in any injury, potential injury, or intent to injure.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
64. Verbally threatens others			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
65. Damages or destroys property			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
66. Steals at home			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
67. Steals outside home			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
68. Vandalizes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69. Is cruel to animals			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
70. Carries Weapons			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
71. Sets fires			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
72. Ritualism			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
73. Gang involvement			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Substance Abuse/Dependence/Use? _____ Type(s): Alcohol Drugs Both

Name of Substance Used	Route of Administration	Frequency of Use	Age at First Use

How many previous treatment episodes has the client received in any drug or alcohol program? _____

Medication	Dosage	Reason

Allergies/Physical/Medical Conditions: _____

General Health: Good Poor Why? _____

Discharge/Transition Expectations? Dates? Care needed after? What step-down?

If you are looking for Specialized Foster Care, please complete the below questions:

Please check all that apply:

Cross-Cultural placement is appropriate _____ OR Race-specific placement is required _____
Can reside with single parent _____ **OR Two-parent** home is required _____
Can reside with other children _____ **OR Needs** home with no other children _____
Can reside with younger children _____
Can reside with older children _____

Any other special requirements regarding type of home: _____

In your opinion, what would be the “ideal” family that would most appropriately meet this child’s needs?

How does the child feel about going into a Specialized Foster Care Family? (please specify) _____

What is the plan for visitation and/or reunification once the child is placed? _____

Would it be necessary for the child to be placed in close proximity to his/her family? _____ If so, where?

