Alice C. Tyler Village of Childhelp East

Psychiatric Residential Treatment Facility

Admission Application

RESIDENT INFORMATION				
Child's Full Name:		**Male:** ☐ **Female:** ☐		**Today's Date:**
Ethnicity:	Language:	Religion:	DOB:	Age:
Current Placement/Address:				
Physical Description: Ht: Wt:		Discharge Plan (Return home, Foster Care):		

BIOLOGICAL Mother's Information		BIOLOGICAL Father's Information	
Name:		Name:	
Address:		Address:	
Phone:	Cell:	Phone:	Cell:
E-Mail:		E-Mail:	
Place of Employment:		Place of Employment:	
Is parent Legal Guardian: Yes: ☐ No: ☐ Parental Rights Terminated: Yes: ☐ No: ☐ Is child adopted: Yes: ☐ No: ☐ Is parent involved: Yes: ☐ No: ☐ Comments:		Is parent Legal Guardian: Yes: ☐ No: ☐ Parental Rights Terminated: Yes: ☐ No: ☐ Is child adopted: Yes: ☐ No: ☐ Is parent involved: Yes: ☐ No: ☐ Comments:	

LEGAL GUARDIAN INFORMATION – *If other than Parent*			
Name/Relationship:		Phone:	
Agency:		Cell:	
Address:		E-Mail:	
REFERRAL SOURCE INFORMATION			
Referral Source: ☐ School Parent: ☐ Agency/County: ☐ Other:			
County of Referral:			
Name/Agency of Referral Source:			
Name/Title (Case Manager, ICC Coordinator, etc.):			
Address:			
Phone:	Cell:	Fax:	E-Mail:

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FUNDING					
Childhelp will not be responsible for payment of medication costs, or any medical appointments/procedures that are not covered by Medicaid or private insurance.					
RESPONSIBLE PARTY for Co-Pays & unpaid Medical Bills:					
Medicaid: ☐	Title-IV-E: ☐	CSA: ☐	Adoption Subsidy: ☐	HMO: ☐	Private Insurance: ☐

Medicaid Insurance #:	**Social Security #:**
Private Insurance Company:	Private Insurance Member #:
Private Ins. Member's Name:	DOB: / Private Ins. Phone #:

FOR VIRGINIA REFERRALS

I agree to participate in the IACCT Process

Signature _____ **Date**_____

FUNDING/PLACING AGENCY		
Placing Agency/County that is **Funding** Placement:		
Address:	Phone:	Fax:
CSA Coordinator:	E-Mail:	

OTHER INVOLVEMENT *(Step-Parent, Foster Parent, GAL, CASA Worker, etc.)*	
Name/Relationship:	Phone:
Address:	Fax:
Name/Relationship:	Phone:
Address:	Fax:

MENTAL HEALTH INFORMATION				
Reason for Referral:				
Abuse History: Physical ☐	Sexual ☐	Emotional ☐	Neglect ☐	Trauma ☐
Clinical Assessments Requested:				

EDUCATIONAL INFORMATION			
Current Grade:	Local Ed. Agency (LEA):	IEP: Yes ☐	No ☐
Related Services (OT, Speech, etc.,):			
Current School:		Contact Person:	
Address:		Phone:	Fax:

CHILD and FAMILY INFORMATION		
Legal Involvement: Yes ☐ No: ☐	If "yes", explain:	
Parole Officer:	Address:	Phone:
Protective Order in Place: Yes ☐ No: ☐	If "yes", explain:	

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Is there Restrictive Contact: Yes ☐ No: ☐	If "yes", explain:	
Does family have reliable transportation to attend Therapy/Treatment/Meetings: Yes ☐ No: ☐		
HEALTH and NUTRITION INFORMATION		
Childhelp reserves the right to not admit a child who presents with a communicable disease at the time of admission, unless our Medical Director certifies that our facility is capable of providing care to the child, without jeopardizing residents and staff. Please advise the Admissions Department of any Communicable Disease - (i.e., Flu, Strep, MRSA, Lice, HIV, Hep A, B, or C, etc.) that your child may have prior to admission.		
Current Immunizations: Yes ☐ No: ☐	Orthodontic Braces: Yes ☐ No: ☐	Eye Glasses: Yes ☐ No: ☐
Diagnosed Allergies-including drug/food intolerance:		
Any noted Nutritional Problems:		
Doctor ordered Therapeutic Diet: Yes ☐ No: ☐		
CURRENT PHYSICIAN INFORMATION		
Doctor Name:	Phone:	Fax:
Address:	Last Appt:	
Dentist Name:	Phone:	Fax:
Address:	Last Appt:	
Other Specialist Name:	Phone:	Fax:
Address:	Last Appt:	
DEVELOPMENTAL HISTORY		
Please indicate if there were any concerns with the following:		
Child born at months	Child toilet trained at months	
Normal delivery: Yes ☐ No: ☐	If "no", explain:	
Complications at birth: Yes ☐ No: ☐	If "yes", explain:	
Concerns with Gross Motor Skills: Yes ☐ No: ☐	If "yes", explain:	
Concerns with Fine Motor Skills: Yes ☐ No: ☐	If "yes", explain:	
Concerns with Speech Development: Yes ☐ No: ☐	If "yes", explain:	
OTHER INFORMATION		
Likes:	Dislikes:	
Indicators of success at Home/Other placements:		
History of Unsubstantiated Claims: Yes ☐ No: ☐	If "yes", explain:	

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SIGNIFICANT BEHAVIOR INFORMATION						
Place an X next to behaviors that are occurring Indicate frequency with "Daily", 4-5 days/wk, 1-2 days/wk, etc.						
BEHAVIOR		**FREQUENCY**		**BEHAVIOR**		**FREQUENCY**
Sexually Inappropriate	☐			Poor Hygiene	☐	
Homicidal Ideation	☐			Fire Setting	☐	
Suicidal Ideation	☐			Self-Harming Behaviors	☐	
Temper Outbursts	☐			Animal Cruelty	☐	
Physical Aggression	☐			Lying	☐	
Verbal Aggression	☐			Property Destruction	☐	
Stealing	☐			Runs Away	☐	
Enuresis	☐			Wanders at Night	☐	
Encopresis	☐			Depressed/Anxious Symptoms	☐	
Nightmares	☐			Oppositional Defiant Behaviors	☐	

TREATMENT SERVICES and PLACEMENT HISTORY over PAST YEAR			
Name of Service/Placement	**Type of Service/Placement**	**Dates of Service (mm/dd/yy)**	**Reason for Removal**

MEDICATION RECONCILIATION FORM		
Current Medication Name	**Dosage**	**Schedule**

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MEDICATIONS TRIED in the PAST and their EFECTS		

Name of Person Providing Information:	**Date:**
Relationship:	**Phone:**