Alice C. Tyler Village of Childhelp East

Psychiatric Residential Treatment Facility

Admission Application

Revised 9/24/2020

RESIDENT INFORMATION				
Child's Full Name:		**Male:** ☐ **Female:** ☐		**Today's Date:**
Ethnicity:	Language:	Religion:	DOB:	Age:
Current Placement: ☐ Home ☐ Acute Facility ☐ Foster Care ☐ Other: _____ Address:				
Physical Description: Ht: Wt:		Discharge Plan: ☐ Return home ☐ Foster Care ☐ Adoption ☐ Other: _____		

BIOLOIGCAL PARENT'S INFORMATION ☐ NO KNOWN INFORMATION	
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 bio-parent Legal Guardian: Yes: ☐ No: ☐	Is bio-parent Legal Guardian: Yes: ☐ No: ☐
Parental Rights Terminated: Yes: ☐ No: ☐	Parental Rights Terminated: Yes: ☐ No: ☐
Is parent involved: Yes: ☐ No: ☐	Is parent involved: Yes: ☐ No: ☐
Comments:	Comments:

LEGAL GUARDIAN INFORMATION – *If NOT Biological Parent*	
Name:	Phone:
Relationship: ☐ DSS Guardian ☐ Adoptive Parent ☐ Family member Legal Guardian ☐ Other: _____	
Agency:	Cell:
Address:	E-Mail:
When did the child come into your care?	
Is the child adopted? Yes: ☐ No: ☐	
If adopted, When was the child's adoption finalized?	

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REFERRAL SOURCE INFORMATION			
Referral Source: ☐ School ☐ Parent/Legal Guardian ☐ Agency/County ☐ Other: _____			
County of Referral:			
Agency of Referral Source:			
Name and Title (Case Manager, ICC Coordinator, etc.):			
Address:			
Phone:	Cell:	Fax:	E-Mail:

INSURANCE & 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.						
IDENTIFY RESPONSIBLE PARTY for Co-Pays & unpaid Medical Bills:						
Medicaid: ☐	Title-IV-E: ☐	CSA: ☐	Adoption Subsidy: ☐	HMO: ☐	Private Insurance: ☐	Tricare: ☐
Medicaid Insurance #:			Social Security #:			
Tricare Insurance ID:			Tricare Phone #:			
Private Insurance Company:			Private Insurance Member #:			
Private Insurance Member's Name:			DOB:	Private Ins. Phone #:		

FOR VIRGINIA REFERRALS		
I agree to participate in the IACCT Process		
Signature _____ Date_____		
IACCT assessment: ☐ Started ☐ Completed recommending RTF		
Placing Agency/County that is **Funding** Placement/Education:		
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

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Reason for Referral: ☐ Long Term Placement ☐ Assessment and Diagnostic				
Abuse History: Physical ☐	Sexual ☐	Emotional ☐	Neglect ☐	Trauma ☐
Comments regarding abuse history:				
Current Mental Health Diagnosis:				
Clinical Assessments Requested:				

EDUCATIONAL INFORMATION			
Current Grade:	Local Ed. Agency (LEA):	IEP: Yes ☐	No ☐
FSIQ: (☐ Never Tested)	Child is (☐ on ☐ below ☐ above) grade level		
Related Services (OT, Speech, etc.,):			
Current School:	Contact Person:		
Address:	Phone:	Fax:	

CHILD and FAMILY INFORMATION		
Legal Involvement: Yes ☐ No: ☐	Child ☐ Parent ☐ If "yes", explain:	
Probation/Parole Officer:	Address:	Phone:
Protective Order in Place: Yes ☐ No: ☐	If "yes", explain:	
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:		
Diagnosed Medical issues:		
Any noted Nutritional Problems:		
Doctor ordered Therapeutic Diet: Yes ☐ No: ☐		

CURRENT PHYSICIAN INFORMATION

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Primary Care Physician Name:	Phone:	Fax:
Address:	Last Appt:	
Psychiatrist Name:	Phone:	Fax:
Address:	Last Appt:	
Dentist Name:	Phone:	Fax:
Address:	Last Appt:	
Other Specialist Name:	Phone:	Fax:
Address:	Last Appt:	

DEVELOPMENTAL HISTORY ☐ NO KNOWN INFORMATION	
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:
Strengths:	
Indicators of success at Home/Other placements:	
History of Unsubstantiated Claims: Yes ☐ No: ☐	If "yes", explain:
History of Substance use: Yes ☐ No: ☐	Child ☐ Parent ☐ If "yes", explain:

SIGNIFICANT BEHAVIOR INFORMATION

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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	☐	

PAST PLACEMENTS (Provide for up to the last year)			
Name of Placement	**Type of Service/Placement** (i.e. Acute Hospital, Foster care, Residential, etc.)	**Dates of Service** (mm/dd/yy – mm/dd/yy)	**Reason for Removal/Discharge**

PAST SERVICES (Provide for up to the last year)			
Name of Agency	**Type of Service** (i.e. Psychiatric, Outpatient, Family Therapy, Play Therapy, etc.)	**Dates of Service** (mm/dd/yy – mm/dd/yy)	**Reason for Discharge**

MEDICATION RECONCILIATION FORM

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Current Medication Name	Dosage	Schedule
MEDICATIONS TRIED in the PAST and their EFECTS		
Medication Name	**Effects**	

For referrals to be considered by the admissions team the following documentation will need to be reviewed:		
Most recent Medical Physical	☐ Attached	☐ Never had one
Most recent Grades	☐ Attached	☐ Never attended school
Most recent behavior reports (school)	☐ Attached	☐ Never attended school
Psychiatric evaluation	☐ Attached	☐ Never had one
Psychological evaluation	☐ Attached	☐ Never had one
Assessments and Daily progress notes from previous placements	☐ Attached	☐ Never had one

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