Alice C. Tyler Village of Childhelp East
Psychiatric Residential Treatment Facility

Admission Application

Revised 06/21/2023

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: _____		

BIOLOGICAL PARENT'S INFORMATION ☐ NO KNOWN INFORMATION		BIOLOGICAL Father's Information	
BIOLOGICAL Mother'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:

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MENTAL HEALTH INFORMATION				
Reason for Referral: ☐ Long Term Placement ☐ Assessment Track				
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: ☐		

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CURRENT PHYSICIAN INFORMATION		
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:

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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	☐	

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		
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:**

Alice C. Tyler Village of Childhelp – East
Village Academy of Childhelp
23164 Dragoon Road Lignum, VA 22726
Psychiatric Residential Treatment Facility

Name:		**Today's Date:**
MRN:		**Admission#:**
DOB:	☐ **Male** ☐ **Female**	**Date of Admission:**

Insurance Acknowledgement

I, _____ , the parent/guardian of_____, certify that my child is covered by the following health insurance plan(s) (initial next to all that apply and complete Guarantor Information on back):

_____ Virginia Medicaid _____ West Virginia Medicaid _____ Maryland Medicaid
_____ Other Medicaid (list State): _____
_____ Tricare (list type- Prime, Select, etc…) _____
_____ Private Health Insurance (list Plan name): _____
_____ Prescription Coverage Plan (list Plan name): _____
_____ No Health Insurance

I understand that I must complete this form in its entirety and provide a copy of the front and back of my child's insurance card(s) at least 3 business days prior to my child's admission to the program. If my insurance information changes during my child's stay at Childhelp, I will notify the Childhelp Utilization Review Department at Ch-Lignum-Utilization-Review@childhelp.org within 3 business days of the change. If I fail to notify Childhelp of insurance changes, I may be responsible for full payment for all services rendered.

Assignment of Benefits

I, the undersigned, irrevocably assign to the provider, Childhelp Inc. ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical or behavioral health services provided by Provider, its employees and agents. I understand this document is a direct assignment of my rights and benefits under my Plan. I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me.

Release of Information

I authorize Childhelp Inc. to release and exchange my child's Protected Health Information with all healthcare insurance plans with whom I have coverage.

Financial Responsibility

I understand that some healthcare insurance plans require the insured to obtain services from certain providers, or to obtain a referral, authorization, precertification and/or approval to reimburse fees and costs. I acknowledge and agree that I have reviewed my healthcare insurance plan requirements and understand that if I fail to disclose or follow these requirements, I will be responsible for full payment of all services rendered.

Please note that optional medications or treatments which are not ordered by a physician and are not covered by the healthcare plan's formulary will be the sole financial responsibility of the parent or guardian. Additionally, Childhelp will not be responsible for the cost of replacing or repairing damaged eyeglasses except in the event that the damage was caused by another Childhelp resident or employee.

I further understand that I may be financially responsible for some or all of my services per the conditions of my healthcare plan. I agree to pay any co-pays, co-insurances and/or deductibles associated with my child's care. Unpaid accounts may be referred to collection agencies and may accrue interest at the current legal rate.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

continued on back

Child's Name:	**MRN:**

Guarantor Information

Primary Insurance:				
Insurance Company Name:	Phone:	Policy ID:	Group #:	
Subscriber's Legal Name (Last, First, Middle Initial):			Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security #:	
Employer Name:	Mailing Address:	City:	State:	Zip Code:

Secondary Insurance:				
Insurance Company Name:	Phone:	Policy ID:	Group #:	
Subscriber's Legal Name (Last, First, Middle Initial):			Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security #:	
Employer Name:	Mailing Address:	City:	State:	Zip Code:

Dental Insurance:				
Insurance Company Name:	Phone:	Policy ID:	Group #:	
Subscriber's Legal Name (Last, First, Middle Initial):			Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security #:	
Employer Name:	Mailing Address:	City:	State:	Zip Code:

Vision Insurance:				
Insurance Company Name:	Phone:	Policy ID:	Group #:	
Subscriber's Legal Name (Last, First, Middle Initial):			Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security #:	
Employer Name:	Mailing Address:	City:	State:	Zip Code:

Pharmacy/Drug Plan:				
Insurance Company Name:	Phone:	Policy ID:	Group #:	
Subscriber's Legal Name (Last, First, Middle Initial):			Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security #:	
Employer Name:	Mailing Address:	City:	State:	Zip Code: