Application for Admission

Part I. Personal Information

Applicant's Full Name:

____
Last First Middle

Current Address: ____
Street

____
City State Zip Phone

Sex: _______ **Age:** _________ **DOB:** _______________ **Place of Birth:** ____________________

Race: _________________ **Religious Preference:** ______________________________

Weight: _______________ **Height:** _________ **Eye Color:**____________ **Hair Color:**____________

Markings (scars, moles, etc.) & where:____

Social Security Number: ____

Applicant is being admitted from: Home ____ **Hospital** ____ **Other:** ____________________________

If other than home, please provide: ____
Name of Facility

____
Street

____
City State Zip Phone

Legal Guardian's Name: ____

Address:____
Street

____
City State Zip Phone

Reimbursement Source(s): ***Check all that apply.***

- ☐ **Medicaid** ***(Please attach copy of current card)***
- ☐ **CSA**
- ☐ **IVE**
- ☐ **State Agency (list):** ____________________
- ☐ **Private Insurance**
- ☐ **Self Pay**
- ☐ **School System**
- ☐ **Other:** ____________________

Insurance Information: (company/agency name, ID# and claims address). Please attach a copy, front and back, of the card:

____

____

____

Family Physician: ______________________________
Name

____
Street **City** **State** **Zip** **Phone**

Part II. Social & Developmental Summary

Father's Name: ______________________________
Last **First** **Middle**

____
Street **City** **State** **Zip** **Phone**

Social Security Number: ____________________ **DOB:** ____________

Father's Marital Status: ____________________

Father's Employer: ____________________

Occupation: ____________________

Business Number: ____________________

Mother's Name (w/ Maiden Name): ______________________________
Last **First** **Middle** **(Maiden)**

____
Street **City** **State** **Zip** **Phone**

Social Security Number: ____________________ **DOB:** ____________

Mother's Marital Status: ______________________________

Mother's Employer: ______________________________

Occupation: ______________________________

Business Number: ______________________________

Siblings:

Name	Age

Brief description of family relationships: ______________________________

Mental Health, emotional and psychological needs of the child: ______________________________

Current behavioral functioning of the applicant, including strengths and problems: ______________________________

Behavioral Supports needed for the applicant: ______________________________

Documentation of need for care apart from the family setting: ______________________

____

____

____

Legal Involvement: ______________________

____

____

____

Prior Placements and Services:

Placement / Service	Dates	Successful
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N

If not successful, please explain reasons for failure:

____

____

____

____

____

____

____

____

____

Part III. Education

Where is this applicant currently enrolled in school?

____

____

Street City State Zip

School Contact Person: ____

Phone: ______________________________________

Date of most current IEP: ___________________________ *(Please attach.)*

Special Education Classification: ASD ______ ED ______ ID ______ SLD ______ OHI ______

Grade Placement: ___________________________

Specific educational needs: _______________________________________

____

____

____

____

____

____

Part IV. Medical History

Describe any serious illnesses or chronic conditions of the applicant's biological parents and siblings, if any. Please indicate if there are none or if the history is unknown.

____

____

____

Regarding the applicant, describe the following:

Past serious illnesses or infectious diseases (name of disease, date of occurrence, and duration):

____

____

____

Serious Injuries: ____

____

____

Hospitalizations: ____

____

____

Impact of these on current health: ______________________________________

____

____

Physical Handicaps: ____

____

____

Visual Disorders: ____

____

Hearing Challenges: ____

____

Examination History: ***please attach copies, if applicable***

- ☐ **Psychological (dates, place, types of tests or examinations and results):**

  ____

- ☐ **Psychiatric (dates, place, types of tests or examinations and results):**

  ____

- ☐ **Neurological (dates, place, types of tests or examinations and results):**

  ____

- ☐ **(For female applicants) Gynecological Exam:**

  ____

- ☐ **Vision (dates, place, types of tests or examinations and results):**

  ____

- ☐ **Speech (dates, place, types of tests or examinations and results):**

  ____

- ☐ **Occupational therapy (dates, place, types of tests or examinations and results):**

  ____

- ☐ **Physical therapy (dates, place, types of tests or examinations and results):**

  ____

Please list all medications (prescription, non-prescription and illicit drugs) used by the applicant in the past and present, including all medications currently prescribed. Also, please indicate if any medications have been ineffective:

____

____

____

____

____

____

____

Enuresis (wetting):

- ☐ No
- ☐ Day
- ☐ Night

Encopresis (soiling):

- ☐ No
- ☐ Day
- ☐ Night

Describe the applicant's overall (general) health and fitness: ______________________________

____

____

____

____

____

Does the applicant have any drug allergies (unusual and other adverse drug reactions)?
(Y / N) If yes, please name the medications and describe the symptoms.

____

____

____

____

Does this child have a history of substance abuse? (Y / N) If yes, please give the names of the drugs, including alcohol, and any facts surrounding the use: (e.g. length of use, treatment, etc.)

____

____

____

____

____

Immunization Record

Applicant's Name: ______________________________ **DOB:** ____________________

In the Commonwealth of Virginia, the following immunizations are required for all school-age youth. If a copy of the child's immunization record was included with the referral packet, this should be sufficient. Otherwise, the parent or guardian may fax the record(s) to the Admissions Office. Please do not feel the need to complete this form, if a copy of the immunization record was received by the Admissions Office.

Hepatitis B	**#1** ____________ Date	**#2** ____________ Date	**#3** ____________ Date
DPT / DT	**#1** ____________ Date	**#2** ____________ Date	**#3** ____________ Date
Td **(every 10 years)**	**#1** ____________ Date		
Oral Polio	**#1** ____________ Date	**#2** ____________ Date	**#3** ____________ Date
MMR	**#1** ____________ Date	**#2** ____________ Date	
Varicella	**#1** ____________ Date	**#2** ____________ Date	

(not needed if applicant has a documented history of chicken pox)

If the immunization record is incomplete, the applicant may receive any of the immunizations listed above while at The Hughes Center with consent from the legal guardian. Immunizations are administered and maintained through the Nursing Department.

As the legal guardian of ________________________________, I give permission for my child (or client) to receive the immunizations needed to complete his/her immunization record as required by the Commonwealth of Virginia.

______________________________ ____________
Signature of Parent / Legal Guardian **Date**

______________________________ ____________
Signature of Witness **Date**

Dental Treatment Record

Applicant's Name: ______________________________

Date of Appointment: ______________________________

Evaluator's Comments: ______________________________

____

____

____

Treatment Plan: ______________________________

____

____

____

Date(s) of Next Appointment(s): ______________________________

Current Dentist: ______________________________
Name

____
Street City State Zip Phone

______________________________ ______________________________
Parent / Legal Guardian's Signature Date

Report of Physical Examination

The following information must be completed by a licensed physician prior to admission, unless a physical examination has been recently completed (within the last 30 days) and a copy of the results is included in the referral information received.

Applicant's Name: ____

Last First Middle

Date of Examination: ____

Current Diagnosis: ____

ICD-9: ______________________ **DSM-V:** ______________________

Skin Test (STU PPD): (Positive / Negative) **Date of Test:** ______________________

Chest X-Ray, if applicable: (No evidence of TB / TB to be ruled out)

Date of X-Ray: ______________________

Preventive Drug Recommended: ____

This applicant appears to be free from communicable disease: (Y / N)

Nutrition Requirements, including special diet, if any:

____

____

Normal Evaluations: (Y / N) If no, describe any abnormal or chronic conditions or any allergies or handicaps the child has:

____

____

Neurological Exam Completed: (Y / N) If yes, give results: ______________________

____

____

Hearing: R __________ **L** __________ **Height:** __________ **Weight:** __________

Vision w/o Glasses: R-20/ __________ **L-20** __________ **With Glasses: R-20/** __________ **L-20** __________

Color Discrimination: ____

Urinalysis: ______________________ **Hemoglobin:** __________ **B/P:** __________

Are there any recommendations as to future care, examinations, treatments and immunizations? (Y / N)
If yes, please describe: ____

____

____

____ ______________________
Physician's Signature **Date**

____ ______________________
Address **Phone**

Behavior Inventory

Applicant's Name: ____

Please check all applicable behaviors exhibited by the applicant during the past 30 days that warrant residential level of care. Also, please indicate the behaviors (only) that were exhibited within the <u>last seven days</u> prior to admission. This document must be completed in its entirety and submitted to the Admissions Office no later than the day of admission.

Behavior Prior to Admission	**Frequency**	**Intensity**	**Describe Behaviors (Last 7 days)**
☐ Suicidal ideation/attempts	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Homicidal ideation	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Self-injurious behaviors	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Fire-setting	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Cruelty to animals	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Stealing	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Gang involvement	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Defiant/oppositional	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Explosive	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Low frustration tolerance	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Impulsive	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Substance abuse/use	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Runaway (actual or threatened)	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Sexual acting out	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Academic issues	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Destructive	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Aggressive/injuries toward others	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Self-esteem issues	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Blames self/others	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Poor hygiene	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Social withdrawal/isolation	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Anxiety	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	

☐ Fearfulness/phobias	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Obsessive/compulsive/intrusive thoughts	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Sadness	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Sleep disturbances	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Bizarre thoughts	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Hallucinations or Delusions	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Paranoia	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Other: ______________________	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Other: ______________________	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	
☐ Other: ______________________	☐ daily ☐monthly ☐ weekly ☐ not often	☐minor ☐moderate ☐severe	

Please feel free to list any other behaviors (indicating dates, frequency, and severity):

____

____

____

____

____

____

____

____

____

____

____

____

Completed by: ____ Date: __________________________