



Application for Admission Instruction Sheet

Thank you for your interest in Elk Hill and the programs we provide young people throughout central Virginia.

To make a referral, please complete the Application for Admissions. The more thoroughly the application is completed, the more helpful it will be in making an appropriate Admissions decision.

Also required for consideration of Admission are the following informational documents:

- Psychological Evaluation (within the past year) with a Full Scale IQ and all 5 DSM-IV Axis's completed
- Social History (within the past year)
- Current IEP and most recent school transcript
- Educational evaluations and test scores
- Copy of FAPT/Treatment plan
- Proof of Active Health Insurance
- Immunization Records
- Copies of youth's Birth Certificate and Social Security Card
- Letter of Program Completion and Letter of Therapist Recommendation if stepping down from a higher level of care

Once these items have been reviewed and appropriateness of the youth has been considered, an interview as well as an admissions/pre-placement visit date will likely be set. **At the time of admissions/pre-placement visit, we will also need the following:**

- Certificate of Need (signed within 30 days of Admission Date)
- CANS Assessment (completed within 30 days of Admission Date)
- Current physical exam (within the past 90 days)
- TB skin test 30 days prior to admission
- Standing Medication Order from a medical doctor to receive over the counter medications
- Missed Medication Protocol form must be completed by the prescribing doctor for any prescription medication(s) the youth is taking
- Date of last Dental Exam and contact information for current dentist
- Statement of any special needs
- A 4-6 week supply of current medications

Please use the above list as a checklist. If you have any questions please do not hesitate to contact the Elk Hill Admissions Coordinator at 804-457-4866 ext. 339. We look forward to working with you and again thank you for your interest in our program.



Elk Hill _____ Application for Admission

Name of Youth: _____ Nickname: _____
Last *First* *Middle*

Date of Birth: _____ Place of Birth: _____

Youth's Social Security Number: _____ Race: _____

Sex: Male Female Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Marks, Scars, Tattoos: _____

Allergies: _____ Medication Allergies: _____ Other: _____

Last Known Address: _____

Religious Preference: _____

Legal Guardian: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Address: _____

Social Security Number: _____ Date of Birth: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Stepmother's Name: _____

Mother's Name: _____
Last *First* *Middle*

Address: _____

Social Security Number: _____ Date of Birth: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Stepfather's Name: _____

Please list brothers or sisters of youth. Identify step and/or half siblings and specify birth dates.

	Name	Relationship	Birthdate	Address
1.				
2.				
3.				
4.				



Emergency Contact Information

Contact Person: _____ Phone Number: _____
Address: _____

Agency Information

Local Educational Agency: _____
Address: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____
Youth's Grade: _____ Is Youth Special Education Yes No Special Education Designation: _____
FSIQ: _____ Current School Status: Attending Truant Home School Expelled/Suspended
Estimated Intellectual/Functional Capacity: above average average below average diagnosed MR
Educational Needs: _____

Base School: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____

Social Services Agency (if applicable): _____
Address: _____
Contact Person: _____ Phone Number: _____
Supervisor: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____

Juvenile Court Services Agency (if applicable): _____
Address: _____
Contact Person: _____ Phone Number: _____
Fax Number: _____ email: _____ Cell Phone: _____
Please list legal charges, dates obtained, and disposition of charges: _____

Placement Reasons

Reason for Placement (description of problem behaviors in the past 30 days): _____

Please list last two placements and reasons why discharged _____

Please identify feelings this youth struggles with managing effectively: _____

Please identify stressors that provoke this youth: _____

Please identify interventions that work well in deescalating this youth: _____

Identifying Problems *(Please check all that apply)*

- | | | | |
|------------------------------|--------------------------|-------------------------------|--------------------------|
| Verbal aggression/disrespect | <input type="checkbox"/> | Irritability/Mood Swings | <input type="checkbox"/> |
| Physical Aggression | <input type="checkbox"/> | Psychological/Psychiatric | <input type="checkbox"/> |
| Stealing/Shoplifting | <input type="checkbox"/> | Poor/Low Academic Performance | <input type="checkbox"/> |
| Absconding/Runaway | <input type="checkbox"/> | Self-destructive behaviors | <input type="checkbox"/> |
| Lying | <input type="checkbox"/> | Low Motivation | <input type="checkbox"/> |
| Substance Abuse | <input type="checkbox"/> | Peer Relationships | <input type="checkbox"/> |
| Family Relationships | <input type="checkbox"/> | | |

Current Medications:

Name	Dose	Schedule	Length of Time Taken

Recent Medication Changes Y N (if yes explain) _____

Has the youth complied with recommended medication and treatment plans? Y N (if yes explain) _____

DSM-IV Diagnosis

- Axis I _____
- Axis II _____
- Axis III _____
- Axis IV _____
- Axis V _____



Placement Reasons (cont.)

Mental Health Needs (identify type and frequency needed)

Individual Therapy _____
 Family Therapy _____
 Other Therapies _____

Any Protection Needs to be Addressed [i.e. such as history of victimization, bullying, assaults, etc.]: _____

Describe Any Significant Risks to self and others [i.e. such as history of self-harm, substance abuse, awol, etc.]: _____

Any Physical Health and/or Immunization Needs to be noted [i.e. such as asthma, obesity, etc.]: _____

Please identify 3 short term objectives to be achieved during placement at Elk Hill

1. _____
2. _____
3. _____

Please identify 3 long term objectives to be achieved during placement at Elk Hill

1. _____
2. _____
3. _____

Discharge Planning

Individuals who can assist in treatment and discharge planning (i.e. family, social worker, attorney, CASA worker, therapist, etc.)

Name	Phone Number	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____

Services to be considered in planning discharge

- | | | |
|---|---|--|
| <input type="checkbox"/> Medication management | <input type="checkbox"/> Substance abuse services | <input type="checkbox"/> Housing assistance |
| <input type="checkbox"/> Case management | <input type="checkbox"/> Individual counseling | <input type="checkbox"/> Medical/dental/nutritional services |
| <input type="checkbox"/> Education | <input type="checkbox"/> Family counseling | <input type="checkbox"/> Legal assistance/advocacy |
| <input type="checkbox"/> Independent living skills/training | <input type="checkbox"/> Transportation/drivers education | <input type="checkbox"/> Vocational training |
| <input type="checkbox"/> Other | | |



Insurance Information

Primary Insurance

Insurance Company: _____

Policy#: _____ Group#: _____

Insurance Company's Telephone Number: _____

Employer's Name and Address: _____

Does this policy include:

Dental coverage? Yes No

Prescription Yes No

Vision Yes No

(You must provide a copy of insurance cards)

Secondary Insurance (if applicable)

Insurance Company: _____

Policy#: _____ Group#: _____

Insurance Company's Telephone Number: _____

Does this policy include:

Dental coverage? Yes No

Prescription Yes No

Vision Yes No

(You must provide a copy of insurance cards)

I am confirming that _____ has active health insurance. I understand that Elk Hill must have a copy of this card immediately. I will also provide any updated insurance information if insurance coverage changes. An Elk Hill sanctioned physician has my permission to treat patient and file claim to my insurance carrier. I understand that if services rendered are not covered, I am responsible for payment of those services.

Signature

Printed Name

Date

Required Attachments

Copy of FAPT service/treatment plan

No Record Available

Comment: _____

Copy birth certificate

No Record Available

Comment: _____

Social History

No Record Available

Comment: _____

Copy social security card

No Record Available

Comment: _____

Psychological evaluation

No Record Available

Comment: _____

Most recent school transcript

No Record Available

Comment: _____

Copy of Medicaid card or other

No Record Available

Comment: _____

Current IEP

No Record Available

Comment: _____

Immunization Record

No Record Available

Comment: _____

Educational evaluation and test scores

No Record Available

Comment: _____

Therapist recommendation if stepping down from higher level of care

Letter of program completion, or
Psychosexual, or Risk Assessment (Sex Offenders)

Certificate of Need/Independent Team Certificate

No Record Available

CAFAS/CANS (current within 30 days of placement)

No Record Available

Dental Exam Date: _____

Physical Exam Date: _____

Person Submitting Application:

Signature

Printed Name

Date of Application

Work Phone _____ Fax _____

Email _____