

## **POPLAR SPRINGS RESIDENTIAL SERVICES APPLICATION COVER LETTER**

The following admissions checklist is to be used as a guide when sending referral information to Poplar Springs Residential Program. Each packet received is reviewed by our Admissions Committee to determine appropriateness for the program. It is essential that we receive documentation that is current and presents an overview picture of the potential resident. This information is needed prior to the admission of a resident.

We appreciate your support and look forward to working with you. Should you have any questions, please do not hesitate to call Quian Buford, Director of Residential Intake at 804-733-6874 ext 293, fax 804-862-6322 or email [Quian.Buford@psysolutions.com](mailto:Quian.Buford@psysolutions.com).

### **SOCIAL AND DEVELOPMENTAL SUMMARY**

- Social history describing family structure and relationship
- Current DSM-IV diagnosis (Axis I-V)
- Previous treatment/placement history (staffing reports, discharge summary, treatment plans, psychological/psychiatric evaluations, progress reports, etc.)
- Psychosexual Evaluation for RTC SAY (if applicable)
- Results of psychological, psychiatric and neurological evaluations

### **PHYSICAL EXAMINATION/ MEDICAL HISTORY**

- Immunization Record
- History and Physical
- Past serious illnesses, infectious diseases, serious injuries

### **EDUCATION**

- Educational evaluation and test scores, if any
- Individualized Education Program (IEP), if identified as special education

### **FUNDING**

- Current CANS
- Certificate of Need (dated within last 30days)
- Copy of Insurance Card
- FAPT Service Plan

#### **Confidentiality Notice**

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# POPLAR SPRINGS HOSPITAL

## Application for Admission

Child's Full Name:	
Name of party requesting placement:	
Relationship to the child of party requesting placement:	

### IDENTIFYING INFORMATION OF CHILD

Gender:	DOB:	Age:	SSN:
Hair Color:	Eye Color:	Height:	Weight:
Race/Ethnic Background:		Religious Preference:	

### GUARDIAN/EMERGENCY CONTACT

Child's legal guardian:			
Name			
Address			
Phone		Email	

### REIMBURSEMENT SOURCE(S):

VA Medicaid	Policy #
TRICARE	Sponsor SS#
Private Insurance	Insurance Provider & Policy #
CSA	Contact Person:

### COURT INVOLVEMENT:

	YES	NO	IF, YES, DESCRIBE
Has child been found guilty of criminal violations?			What and When:
Is child on probation? If YES, please provide copy of court order.			Terms of probation:

### Child's Probation Officer:

Child's Probation Officer:			
Name			
Address			
Phone		Email	

**PLACEMENT NEED:**

Child's current placement:	Home:	Hospital:	Other:	How Long:
Child's current address if different than legal guardian:				
Reason child needs placement NOW:				
What is the greatest concern about the child's behavior:				
Has the child's behavior disrupted the home environment:				
What behaviors have been displayed in the RECENT past: week/month/year with escalation:				

YES	NO	BEHAVIOR (YES or NO)	IF, YES, WHEN, WHERE, HOW OFTEN ETC.
		Fire Setting	
		Property destruction	
		Depression	
		Self harm (cutting, suicide attempts, etc.)	
		Drug use/abuse	
		Assaultive behavior	
		History of running away	
		Academic decline	
		School suspensions	
		Negative peer associations	
		Peer conflicts	
		Social withdrawal	
		Sexual activity	
		Engaged in inappropriate sexual behaviors	If yes, list the # of incidents and complete the next section:

**ADDITIONAL SCREENING OF SEXUAL BEHAVIORS**

Describe the sexual behavior(s) to include age of victim(s), where behavior occurred and relationship of victim to child:
How was behavior discovered:
Describe the level/type of force used in committing each offense:
How has the family responded to the child's sexually inappropriate behavior:
What agency investigated the sexual behavior and what is the current status of the investigation:

**Examinations the applicant has had (copies may be attached, if available)**

Type of Examination	Date	Place	Results/Recommendations
Psychological Evaluation			
Psychiatric Evaluation			
Neurological Evaluation			
Psychosexual Evaluation			
Polygraph (for RTC SAY)			

**Alternative placements/service tried in the past, please list**

(i.e. inpatient, outpatient, in-home, residential, etc)	Dates	Successful
1.		Yes No
2.		Yes No
3.		Yes No
4.		Yes No
5.		Yes No
6.		Yes No
7.		Yes No

If not successful, please explain reasons for failure?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

**Medications**

Medication	Dosage	Frequency	Start Date

**MEDICAL SCREENING**

YES	NO	Medical Condition	If YES, provide further detail
		Asthma	
		Diabetes	
		Seizures (history/current)	
		Cardiac Problems	
		Allergies (food, medicine etc)	
		Head Injury (history/current)	
		Visual Impairments	
		Hearing Impairments	
		Physical Handicaps	
		Infectious Diseases	

**EDUCATION**

What are the child's educational needs:	
Where did child most recently attend school:	
Current grade level:	IEP available (Yes/No), if Yes for what purpose:

**MENTAL HEALTH**

Full scale I.Q. , Verbal I.Q., Performance I.Q.
List all known DSM-IV diagnoses:
Mental health or diagnostic testing needed:
Specify any other mental health, emotional and psychological needs of the child:

**BEHAVIOR SUPPORT NEEDS OF THE CHILD:** please specify each problematic behavior of the child and provide information as indicated to assist him/her in self-managing.

Identify positive behavior(s):
Identify problem behavior(s):
Identify triggers for problem behavior(s):
Identify successful intervention strategies for problem behavior(s):
What techniques has the child used to self-manage anger and anxiety:

**GOALS OF PLACEMENT:**

Specify the goals you would like PSH to assist your child in accomplishing

1.	
2.	
3.	
4.	
5.	
What is the foster care goal for this child?	
What are the tentative discharge plans for this child?	

**PROGRAM REQUESTING REVIEW FOR (please check box)**

Boys RTC	RTC Say	Girls RTC
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Date Application Completed: \_\_\_\_\_