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 *The RTC Admission Office* at 804-733-6874 ext. 1114, fax 804-518-1350 or email to poplarspringsrtcadmissions@uhsinc.com.

DEMOGRAPHIC PROFILE

- Birth Certificate
- Social Security Card
- Copy of Insurance Cards, to include health, dental and eye insurance cards

SOCIAL AND DEVELOPMENTAL SUMMARY

- Social history describing family structure and relationship
- Current DSM-5 diagnosis
- Previous treatment/placement history (staffing reports, discharge summary, treatment plans, psychological/psychiatric evaluations, progress reports, etc.)
- Results of psychological, psychiatric and neurological evaluations

PHYSICAL EXAMINATION/ MEDICAL HISTORY

- Immunization Record
- Current Medication List (to include frequency and dosage)
- Negative COVID test results within 72 hours of admission
- History and Physical
- Past serious illnesses, infectious diseases, serious injuries (to include at the most recent labs up to 90 days)

EDUCATION

Poplar Springs Learning Center is licensed to educate students in the 6th -12th grades or ages 11-17, under the special education categories of OHI, LD, and ED .The Learning Center will provide the four core academic courses, Health/PE, and Careers Social Skills as an elective. ISAEP for students that are 16 years of age and lacking academic credit. Provisions for some online courses can be provided.

- Educational evaluation and test scores, if any
- Current Individualized Education Program (IEP), if identified as special education
- All paper work related to the ISAEP if enrolled

FUNDING

- Current CANS, Certificate of Need (dated within last 30days)
- FAPT Service Plan
- Level of Care Recommendation for completed IACCT

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:	
Primary Lanugage		Is Intrepreter Required?	

REFERRAL SOURCE

Agency Name			
Name			
Address			
Phone		Email	

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 Locality	CSA Contact Name	Address	
Email:		Phone Number:	

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:			
Name			
Address			
Phone		Email	

PLACEMENT NEED: Check the Box:

Child's current placement:	Home	Hospital	Other
Name of Placement:	Length of Time:	Date Placement Needed:	
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 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			

Treatment services 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. _____

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 (PLEASE ATTACH IEP)

Name and address of last school attended:	
Current grade level:	
IEP **(Yes/No)**, if Yes, Sped Category and date of IEP:	504 Plan: **Yes/No**

MENTAL HEALTH

Full scale I.Q., Verbal I.Q., Performance I.Q.
List all known DSM 5 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 (if applicable)?	
What are the tentative discharge plans for this child?	

PROGRAM REQUESTING REVIEW FOR (please check box)

Boys RTC	Girls RTC

Date Application Completed: _____

Who will need updates on the progress of resident

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax: _____

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax: _____

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax: _____

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax: _____

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax: _____

DISPOSITION OF APPLICATION:

Accepted _____ Denied _____

Rationale for Decision: _____

_____

_____

_____

Reviewed by:

_____

Jennifer Tunstall, Executive Director Date

_____

Ina Thompson, Interim Director of Clinical Services Date

_____

Shannon Booker, RN, Interim Director of Nursing Date

_____

Janell Price, Director of Education Date

_____

Jai'Da Brown, Manager of Operations Date

_____

Adrienne M. Turner, MSW, Admissions Coordinator Date