Pure Faith House Inc

A MH Therapeutic Group Home for Children & Adolescents

Empowering Dreams • Embracing Possibilities

Main Office: 1 Blackwater Ln, Hampton, VA 23669

Phone: 757-232-2146 | Fax: 757-527-2771

Referral to Admission Application — Instruction Sheet

Thank you for your referral to Pure Faith House Inc. To ensure a smooth and timely admission process, please review the following requirements. All documents must be submitted prior to or at the time of placement. For questions regarding the referral and admission process, please contact the Admissions Coordinator.

DOCUMENTS REQUIRED PRIOR TO ADMISSION

- Psychological Evaluation (within the past year) with Full Scale IQ and all 5 DSM-V Axis's
- Social History (within the past year)
- Current IEP (if applicable) and most recent school transcript
- Educational evaluations and test scores
- Previous Treatment/Counselling information
- Copy of FAPT Treatment plan (if applicable)

DOCUMENTS NEEDED AT ADMISSIONS/PRE-PLACEMENT VISIT

- Assessment Information to Admission Application (PFH Form)
- Placement Agreement (PFH Form)
- Resident Emergency and Health Care Information (PFH Form)
- Medical Treatment Authorization (PFH Form)
- TB Screening (30 days prior to admission)
- Legal Custody Agreement
- Physical exam w/dental and vision exam date (within the past 90 days)
- Standing Medication Orders to receive PRN medications (if applicable)
- Medication Orders
- Prescription Orders
- Immunization Records
- Copy of Birth Certificate
- Copy of Security Card
- Copy of Insurance Card
- 3–5 weeks supply of current medications
- Certificate of Need (CON)
- Child and Adolescent Needs and Strength Assessment (CANS)
- Initial Plan of Care (IPOC)
- Purchase of Service
- Financial Agreement/Letter of Intent

Contact: If you have any questions please contact the Admissions Coordinator at **757-232-2146** | Fax: **757-527-2771**

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Referral to Admission Application

REFERRAL INFORMATION

Referral Source Name		**Title**	
Agency		**Phone**	
Fax		**Email**	
Relationship to Youth		**Funding Source**	
Date of Referral			

YOUTH INFORMATION

Name of Youth (Last, First, Middle)				**Nickname**			
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 Allergies							
Last Known Address							
Religious							

Preference	

LEGAL GUARDIAN

Legal Guardian			
Relationship		**Address**	
Home Phone		**Work Phone**	
Cell Phone			

FATHER'S INFORMATION

Father's Name (Last, First, Middle)			
Address		**SSN**	
DOB		**Email**	
Home Phone		**Work Phone**	
Cell Phone		**Marital Status**	
Stepmother's Name			

MOTHER'S INFORMATION

Mother's Name (Last, First, Middle)			
Address		**SSN**	
DOB		**Email**	
Home Phone		**Work Phone**	

Cell Phone		**Marital Status**	

Stepfather's Name	

SIBLINGS

Name	Relationship	Birthdate	Address

EMERGENCY CONTACT INFORMATION

Contact Person	

Phone Number		**Address**	

AGENCY INFORMATION

Local Educational Agency

Agency Name		**Address**	
Contact Person		**Phone**	
Fax		**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 Capacity: □ Above Average □ Average □ Below Average □ Diagnosed MR

Educational Needs	

Current IEP on file: □ Yes □ No		**IEP Date**	

IEP Disability Classification:	

Current Grade Level:	

Base School		**Contact Person**	
Phone		**Fax**	
Email		**Cell Phone**	

Social Services Agency

Agency Name		**Address**	
Contact Person		**Phone**	
Supervisor		**Phone**	
Fax		**Email**	
Cell Phone			

Juvenile Court Services Agency

Agency Name			
Address		**Contact Person**	

Phone		**Fax**	
Email		**Cell Phone**	
Legal Charges			

Probation/Parole Information (if applicable)

Probation/Parole Officer		**Phone**	
Agency		**Address**	
Fax		**Email**	
Probation/Parole Conditions:			
Start Date		**End Date**	

PLACEMENT REASONS

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

Last two placements and reasons discharged:

Feelings youth struggles with managing:

Stressors that provoke this youth:

Interventions that work well in de-escalating:

IDENTIFYING PROBLEMS (Check All That Apply)

□ Verbal Aggression/Disrespect	□ Irritability/Mood Swings	□ Impulsive

□ Physical Aggression	□ Psychological/Psychiatric	□ Abandonment Issues
□ Stealing/Shoplifting	□ Poor/Low Academic Performance	□ Difficulty w/Authoritative Figures
□ Absconding/Runaway	□ Self-Destructive Behavior	□ Antisocial Behaviour
□ Lying	□ Low Motivation	□ Sexually Inappropriate Behavior
□ Substance Abuse	□ Peer Relationships	□ Sibling Related Difficulty
□ Family Relationships	□ Fire Starter	□ Suicidal

DSM-V DIAGNOSTIC INFORMATION

Axis I — Clinical Disorders:	
Axis II — Personality Disorders / Intellectual Disability:	
Axis III — General Medical Conditions:	
Axis IV — Psychosocial and Environmental Problems:	
Axis V — GAF Score:	

MENTAL HEALTH, EMOTIONAL, AND PSYCHOLOGICAL NEEDS

Identify type and frequency of mental health, emotional, and psychological needs:

SUBSTANCE ABUSE, DRUG, OR ALCOHOL

History of substance abuse: □ Yes □ No	**If yes:**	
Current substance abuse: □ Yes □ No	**If yes:**	

Substance abuse treatment history, dates, and providers:

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BEHAVIOR HISTORY

Suicide attempts: □ Yes □ No	**If yes:**
Self-injurious behaviors: □ Yes □ No	**If yes:**
Sexually abusive/aggressive toward others: □ Yes □ No	**If yes:**
Sexual abuse history: □ Yes □ No	**If yes:**
History of setting fires: □ Yes □ No	**If yes:**
History of running away: □ Yes □ No	**If yes:**
History of physical aggression: □ Yes □ No	**If yes:**
Weapons use: □ Yes □ No	**If yes:**

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MEDICAL HISTORY

Current physical health conditions:

Current Medications:

Medication Name	Dosage	Prescriber

Known allergies (food, drug, environmental):

Immunization status — Up to date? □ Yes □ No	**If yes:**	

Most recent physical exam date		**Most recent dental exam date**	

Most recent vision exam date	

PREVIOUS PLACEMENTS/SERVICES

Facility/Provider Name	Type of Service	Dates	Reason for Discharge

MENTAL HEALTH SERVICE PROVIDERS

Current Therapist/Counselor

Name		**Phone**	

Address	

Current Psychiatrist

Name		**Phone**	

Address	

Previous mental health providers:

INSURANCE INFORMATION

Primary Insurance Carrier:		**Policy/Member ID:**	
Group Number:		**Policyholder Name:**	
Policyholder DOB:		**Relationship to Youth:**	
Insurance Company Phone:			

Secondary Insurance (if applicable)

Secondary Insurance Carrier:		**Policy/Member ID:**	
Group Number:		**Policyholder Name:**	

Medicaid Information

Medicaid Eligible? □ Yes □ No	**Medicaid ID:**
Medicaid MCO (Managed Care Organization):	

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AUTHORIZATION

By signing below, I certify that the information provided in this application is true and complete to the best of my knowledge. I authorize Pure Faith House Inc to obtain and verify any information needed to evaluate this application.

Referring Agency Representative Signature	**Date:**	
Legal Guardian Signature	**Date:**	
Pure Faith House Inc Admissions Coordinator Signature	**Date:**	

ADMISSION DECISION

☐ **ACCEPTED**	☐ **NOT ACCEPTED**

Reason (if not accepted):	

Decision Made By		**Title**	
Authorized Signature		**Date:**	
Date of Decision			