



Application for Admission Instruction Sheet

Thank you for your interest in Pure Faith House, Inc. and the program that we provide to youth throughout 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.

Documents that are required prior to admission/placement for consideration of Admission are listed below. These documents may be faxed, mailed, or emailed to the facility.

- Psychological Evaluation (within the past year) with a 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/Counseling information
- Copy of FAPT Treatment plan (if applicable)

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:**

- 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) **(PFH Form)**
- Physical exam w/dental and vision exam date (within the past 90 days) **(PFH Form preferred)**
- 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

Please use the above list as a checklist. If you have any questions please do not hesitate to contact the Admissions Coordinator at 757-232-2146. We look forward to working with you and again thank you for your interest in our program.

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: _____ <i>Last First Middle</i>
Address: _____
Social Security Number: _____ Date of Birth: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Marital Status: _____ Stepmother's Name: _____

Mother's Name: : _____ <i>Last First Middle</i>
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 date.



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: <input type="checkbox"/> above average <input type="checkbox"/> average <input type="checkbox"/> below average <input type="checkbox"/> 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)/Other: _____



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 behaviour 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

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

Placement Reasons (cont.)

Mental Health, Emotional, and Psychological Needs (identify type and frequency needed)



Individual Therapy _____
Family Therapy _____
Other Therapies _____

Describe Any Prior Therapy (Mental, Emotional, and Psychological)

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.]:

Describe Any Physical Health Needs to be noted [i.e. such as asthma, obesity, etc.]:

Describe Any Immunization Needs to be noted:

Describe The Suitability of the Resident Admission:

Please identify 3 short term objectives to be achieved during placement at Pure Faith House

1. _____
2. _____
3. _____

Please identify 3 long term objectives to be achieved during placement at Pure Faith House

1. _____
2. _____
3. _____

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: _____

Discharge Planning

Individuals who can assist in treatment and discharge planning (i.e. family, social worker, attorney, case 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"/> Education |
| <input type="checkbox"/> Medical/dental/nutritional services | <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: _____

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)

I am confirming that _____ has active health insurance. I understand that Pure Faith House Inc must have a copy of this card immediately. I will also provide any updated insurance information if insurance coverage changes.

Signature

Printed Name

Date

Required Attachments

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Person Submitting Application:

Signature

Printed Name

Date of Application

Work Phone: _____

Fax: _____

Email: _____