Jackson-Feild Behavioral Health Services, Inc.
546 Walnut Grove Drive
Jarratt, Virginia 23867-9989

APPLICATION FOR ADMISSION

(BLACK INK ONLY)

I hereby apply for admission of this individual to Jackson-Feild Behavioral Health Services, Inc.:

Applicant's Name: ____
Last First Middle
Race/Nationality: ______________________________ Is this a readmission? ____Yes ____No
Date of Birth: ______/_______/_______ Place of Birth: ____
Address: ____

Agency and/or Person Making Application on Behalf of Applicant:

Name: ___________________________________ Relationship to Applicant: _______________________

Address (Agency, if applicable):

____ Telephone: ____________________________
____ Emergency/After Hrs. No. ________________
____ E-mail Address: _________________________

Legal Guardian, if not the same as above:

Name: ____
Address: ____
Home Telephone: ______________________________ Work: _________________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

1. **Where (with whom) is the applicant currently residing?**
   ____
   ____

2. **Reasons for placement in present residence/placement:** ______________________________________
   ____
   ____

3. **Has applicant been in any residential intervention within the last two years?**
   Yes ______ No ________ (if "Yes", please list **chronologically** below)

Previous Placement	Type of Facility or Placement	Dates		Successful?	
		From	To	Yes	No

4. Check the current behaviors exhibited by the resident:

_____ Physical Aggression If Yes, date of most recent: ________________________
_____ Verbal Aggression If Yes, date of most recent: ________________________
_____ Gang Affiliation
_____ Manipulation
_____ Poor impulse control
_____ Lying
_____ Stealing
_____ Running away
_____ Promiscuity
_____ Homosexual activity
_____ Substance Abuse If Yes, describe: ____
_____ Homicidal acts If yes, date of most recent: ____________________
_____ Suicide attempts If yes, number of attempts: ___________________
If yes, date of last attempt: ___________________
_____ Prostitution
_____ Bed wetting
_____ Fire starting
_____ Other ____

Comments: ____
____

5. Treatment Needs and Referring Behaviors: What are the treatment needs and/or actual behaviors for which the individual is being referred and Jackson-Feild Behavioral Health Services that staff will need to address for discharge goals?

A. Mental Health, Emotional and Psychological Needs: ____
____
____

B. Educational Needs: ____
____
____

C. Physical Health Needs, Including Immunization Needs: _______________________________________
____
____

D. Religious Affiliation Needs: ____
____
____

E. **Are there any special protective measures that should be enforced while in placement?** ________
____
____

F. **Behavioral Support Needs:** ____
____
____

6. **What is the discharge plan for this individual?** ____
____
Target Date: _____/_______/_________

7. **What is the attitude of the parents & the resident towards placement?** __________________________
____

8. **Describe parental involvement:** ____
____

9. **History of Court Involvement:** ____
____

Please list all charges and the results/status of each, including status offenses below.

Charges	Date	Results/Current Status

Is applicant presently on probation? Yes ________ No _________ (If Yes, attach probation rules)
For what charge? ____
Name of Probation Officer: ____
Next Court Date: _____/______/_______ Time: _______ Location: _________________________
Is applicant court-ordered for treatment? Yes_______ No_______ (If Yes, attach court order)

10. **List names of all treatment interventions received within the past two years (i.e., out-patient, hospitalizations, mentoring, home-based):**

Name of Treatment Intervention	Date		Successful?	
	From	To	Yes	No

11. **Indicate any special needs concerning treatment, health and/or safety (Include any restraints or constraints that the facility may have to enforce, support, or provide etc.):** ________________________
____

12. **Strengths and areas of interest which may help motivate the resident (Names of people, hobbies, talents, areas of previous success, competencies or expressed interests):**
    1. ____________________
    2. ____________________
    3. ____________________
    4. ____________________
    5. ____________________
    6. ____________________

13. **What has worked best with this applicant in the past?** ____________________
    ____
    When has he/she been most successful? ____________________
    ____

The Resident

Present Age: ____ (Years) _____ (Months)   Social Security #: ______________________

With whom was resident living with prior to placement?
Name: ______________________
Relationship: ______________________
Address: ______________________

Are there any persons with whom this child cannot have contact?   Yes ________   No _________
____

Religious Preference: ______________________

Does resident have health insurance coverage?   Yes _________   No __________
Company Name: ______________________   Policy #: ______________________

Past serious illness or infectious diseases: ______________________
____

Allergies: ______________________
____

Medical problems: ______________________
____

Current medication(s): ______________________
____

Date of last physical (please attach): ____________________   Condition: ______________________
____

Height: __________ Weight: __________

Date of Last dental exam (please attach): _______________ Follow-up needed: _________________

Date of last psychological (please attach): _______________ Condition: ______________________________
____

Date of last neurological (if applicable, please attach): _______________ Condition: _________________
____

IQ Scores
Verbal __________ Performance ___________ Full Scale __________ Date _______________

Resident's physician: ____ Telephone: ________________
Address: ____
Resident's dentist: ____ Telephone: ________________
Address: ____

Family Information

MOTHER:
Full name: ____
(First) (Middle) (Last) (Maiden)
Present address: ____
Home telephone: __________________________ Work telephone: ____________________________
Date of birth: ______/_______/_______ Place of birth: ____
Marital status: ___________________________ Social Security #: _______________________________
Religious preferences: ____
Occupation (type of work & company): ____
Monthly Salary: ________________ Serious illness: ____
If deceased: Date: _____/_______/_______ Place: ________________ Cause: ____________________

FATHER:
Full name: ____
(First) (Middle) (Last)
Present address: ____
Home telephone: __________________________ Work telephone: ____________________________
Date of birth: ______/_______/_______ Place of birth: ____
Marital status: ___________________________ Social Security #: _______________________________
Religious preferences: ____
Occupation (type of work & company): ____
Monthly Salary: ________________ Serious illness: ____
If deceased: Date: _____/_______/_______ Place: ________________ Cause: ____________________

Siblings:

Name	Sex	Date of Birth	Address	Serious Illness

List other significant family members: ____
____

Other relevant information concerning family involvement in treatment: _________________________________
____

Educational Program

Name of Resident: ____
Last Public School Attended: ____
Address: ____
Phone Number: _________________________ Contact Person: _________________________________
Last Date of Attendance: _____________________ Grade Level: ____________________________________
Has resident attended any other specialized school? Yes __________ No _________
School Attended: ____
Address: ____
Phone Number: ________________________ Last Date of Attendance: _________________________

Scholastic performance (academic strengths, weaknesses, school behavior & goals): _______________________
____
____
____
____

Attendance:

Attends regularly ________
Often misses school _______
Occasionally misses school _______
Has not been attending school ______

Is this resident identified as a special education resident? Yes _______ No _________

If this resident has an IEP, please have the form on the next page signed by the parent or legal guardian. This will give us time to arrange the appropriate changes in their IEP.

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CONSENT FORM FOR TRANSFER STUDENT

Educational Services

As part of ____________________________________’s placement at Jackson-Feild Behavioral Health Services, we would like to provide the most effective educational program we possibly can. In our goal to continue and/or develop an educational program which will best facilitate this student’s General or Special Education success, we would like your consent for the following:

A. To use his/her current IEP until we can meet to make the appropriate changes consistent with his/her present placement (a meeting will be scheduled within the first five (5) days of placement).

B. To consider the option of obtaining a General Education Diploma.

C. To administer educational assessments in order to determine academic functioning and progress.

I give my consent for the aforementioned actions of Gwaltney School.

____ ___________________
Parent/Guardian Date

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Along with this completed application please be sure to include the items spelled out on the “documentation required” form. Please do not omit any questions on this application. If you do not know the answer please state that accordingly, or put “n/a” where applicable. Please take the time to include dates where applicable as well.

Thank you so much for entrusting Jackson-Feild Behavioral Health Services in meeting this child’s psychiatric needs.

Person/Agency Authorized to Place Applicant: ____
If agency, name and title of authorized agent: ____
Application Submitted by: ____ Date: _______________

____ _____________________
Signature Date