Hallmark Youthcare
12800 West Creek Parkway Richmond VA 23238
Phone 804-784-6432 Fax 804-784-5261

Application for Residential Treatment

Medicaid Funded: ☐ **General Residential** ☐ **TSAY** **CSA Funded:** ☐ **Assessment & Diagnostic**

Please Include as much as possible of the following information along with the completed application:

- Most recent psychological evaluation, psychiatric evaluation; Discharge summaries from previous treating providers within last year; Social history-Family information-Foster care service plans/IFSP; Documents with Information describing behavior within past 2 months (treatment plans, nursing/progress notes, progress summary reports) indicating medical necessity for secure RTC treatment.
- IACCT Assessment/CANS/CON if already approved. If IACCT is still pending, date IACCT inquiry was completed:_____

Referring Agency/Case Manager:		
Address:		
Phone/Fax/Email:	**Phone:** **Fax:**	**Email:**
Legal Guardian Name:		**Address:**
Phone/Email	**Phone:**	**Email:**
Name of Resident		**Address Of Resident:**

Gender: **Age:** **Birth Date:** / / **Birthplace:** **Race:** **Religious Preference:**

Resident's Social Security Number		**Parents Right Terminated** ○ YES ○ NO

Reimbursement Source(s) (Please mark all that apply)	□ VA Medicaid/Number: _____ □ IV-E □ State Agency □ DC Medicaid/Number □ CSA □ School System _____ □ Parents private Insurance: _____ (Name and ID number)
Reason for Referral:	
Guardian's perception of applicant needs/preferences and goals for care/treatment:	
Applicant's perceptions of their needs/preferences and goals for care/treatment:	

Resident Admitted From: ○ **Home** ○ **Hospital** ○ **Detention Center** ○ **Other**

IF other than home, please list:

Name: _____

Address/Phone:_____

IEP: ☐ YES ☐ NO ☐ OHI ☐ LD ☐ ED

Grade:_____ School:_____ FSIQ:_____ Date: ____/____/____

Medical: Height_____ft _____in Weight_____ Primary Care Physician:_____

Current Medical Conditions/Treatment:

Allergies (Please check and list below): ☐Medication: ☐Food: ☐Environment

Current Diagnosis:

Current Medications:

Legal Charges **Supervised Probation:** ☐ YES ☐ NO **Name of Probation Officer: _____**

CHINS: ☐Supervision ☐Services Date: ____/____/____

Charge	Date	Disposition

List of treatment providers for the last 2 years:

(RTC, Group Homes, Intensive In home. Mentoring , CSB services, Out Patient Therapies)

Provider	Service	Start date- End date	Successful (Yes / No)	Reason for completion

HISTORY of SUBSTANCE USE

Date of SASSI: _____/_____/_____

Alcohol ☐	Barbiturates ☐	Stimulants ☐	Caffeine ☐
Hallucinations ☐	Inhalants ☐	K2spice ☐	Marijuana ☐
Methadone ☐	Cocaine ☐	Tobacco ☐	Opiates ☐
Over Counter Medication ☐	Pain Medication ☐	Tranquilizers ☐	Sedatives ☐

Does individual have a history of blackouts or memory impairments? Yes or No If yes, please describe:

Any reported symptoms of withdrawal or acute intoxication? If yes, please describe:

In utero exposure? If yes, please explain

Family history of Substance abuse: Yes or No -If yes, please explain:

Strength of Individual:	Skills demonstrated to self regulate as provided by the resident, parent/guardian, and review of history:

History of Pro-Social Behaviors/Interests/Hobbies:

Strength of family:	
Needs of family:	

History of family dynamics:

Custody Issues ☐	Financial ☐	Separation/Divorce ☐
Multiple Care Givers ☐	Homelessness ☐	Parental Incarceration ☐
Previously in Foster Care ☐	Multiple Moves ☐	Sibling Violence ☐
Foster Care Date:	Foster Care Date:	Domestic Violence ☐

Family History of Mental Illness: ◯ Yes or ◯ No – If yes, please explain: