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** (Check One) 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: (Check One) **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, Acute, Group Homes, Intensive In home. Mentoring , CSB services, Out Patient Therapies)

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

Protection of applicant: Personal safety risks to applicant, facility, residents or staff -History of substance use

Date of SASSI: _____/_____/_____

Alcohol ☐	Amphetamines (Adderall Ritalin Dexedrine) ☐	Barbiturates (Nembuta amytal phenobarbital) ☐	Caffeine ☐
Benzodiazepines (Ativan Xanax Valium Quaaludes) ☐	Hallucinogens (LSD Ecstasy PCP K2/Spice) ☐	Nicotine ☐	Inhalants(Glue Solvents Gas Nitrous Ether) ☐
Cocaine ☐	Methamphetamine ☐	Marijuana/Cannabis ☐	Over Counter Medication(cough syrup sleep aids) ☐
Opiates ☐	Pain Medication ☐	Tranquilizers ☐	Sedatives ☐

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

Any reported symptoms of withdrawal or acute intoxication? Yes ☐ No ☐ If yes, please describe:

Yes ☐ No ☐ In utero exposure?

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

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 ☐ No ☐ If yes, please explain: