Application for Admission
Instruction Sheet

Thank you for your interest in Elk Hill and the programs we provide young people throughout central 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.

Also required for consideration of Admission are the following informational documents:

- Psychological Evaluation (within the past two years) with a Full Scale IQ and DSM-V completed, which is preferred; or a recent diagnosis from a licensed LMHP or Physician
- Social History (within the past two years)
- Current IEP and most recent school transcript
- Educational evaluations and test scores
- Copy of FAPT/Treatment plan
- Proof of Active Health Insurance
- Immunization Records
- Copies of youth’s Birth Certificate and Social Security Card
- Letter of Program Completion and/or Letter of Therapist Recommendation if stepping down from a higher level of care

Once these items have been reviewed and appropriateness of the youth has been considered, an interview will be determined. Based on the interview and feedback from the team, an admissions date will be determined. At the time of admissions, we will also need the following:

- Certificate of Need (signed within 30 days of Admission Date)
- CANS Assessment (completed within 30 days of Admission Date)
- Current physical exam (within the past 90 days)
- TB skin test 30 days prior to admission
- Standing Medication Order from a medical doctor to receive over the counter medications
- Missed Medication Protocol form must be completed by the prescribing doctor for any prescription medication(s) the youth is taking
- Date of last Dental Exam and contact information for current dentist
- Statement of any special needs
- A 4-6 week supply of current medications

Please use the above list as a checklist. If you have any questions please do not hesitate to contact the Elk Hill Admissions Coordinator at 804-457-4866 ext. 339. We look forward to working with you and again thank you for your interest in our program.
Elk Hill 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: ____________________________ Last       First       Middle

Address: ______________________________________________________________________

Social Security Number: __________________________ Email: __________________________

Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

Marital Status: ____________________________ Stepmother’s Name: __________________________

Mother’s Name: ____________________________ Last       First       Middle

Address: ______________________________________________________________________

Social Security Number: __________________________ Date of Birth: __________________________ Email: __________________________

Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

Marital Status: ____________________________ Stepfather’s Name: __________________________

Emergency Contact Information

Contact Person: ___________________________ Phone Number: __________________________

Address: ______________________________________________________________________

Form revised 4/17/17
**Family History, Relationships, Social and Development History**

Please list brothers or sisters of youth. Identify step and/or half siblings and specify birth dates.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Birthdate</th>
<th>Address</th>
</tr>
</thead>
<tbody>
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<td>4.</td>
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</tbody>
</table>

Please describe family history and youth’s relationship with parents, siblings, or extended family. Please include any recent foster family relationships as well:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please describe youth’s social and developmental history:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**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: ☐ above average ☐ average ☐ below average ☐ diagnosed MR

Educational Needs: __________________________________________

Base School: __________________________________________

Contact Person: ___________________________ Phone Number: ___________________________

Fax Number: ___________________________ Email: ___________________________
### Placement Reasons

**Reason for Placement** (description of problem behaviors 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
- Physical Aggression
- Stealing/Shoplifting
- Absconding/Runaway
- Lying
- Substance Abuse
- Family Relationships
- Irritability/Mood Swings
- Psychological/Psychiatric
- Poor/Low Academic Performance
- Self-destructive behaviors
- Low Motivation
- Peer Relationships

Form revised 4/17/17
Placement Reasons (cont.)

Please list youth’s current behavioral functioning:

________________________________________________________________________

________________________________________________________________________

Please list youth’s current social competence:

________________________________________________________________________

Current Medications:

<table>
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<tr>
<th>Name</th>
<th>Dose</th>
<th>Schedule</th>
<th>Length of Time Taken</th>
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Recent Medication Changes Y N (if yes explain) ________________________________

Has the youth complied with recommended medication and treatment plans? Y N (if yes explain) ________________________________

DSM-V Diagnosis

Primary ____________________________________________
Secondary __________________________________________
Tertiary ____________________________________________
Diagnosis __________________________________________
Diagnosis __________________________________________

Mental Health Needs (identify type and frequency needed)

Individual Therapy ____________________________________________
Family Therapy ________________________________________________
Other Therapies ________________________________________________

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.]: _________________

________________________________________________________________________
Placement Reasons (cont.)

Any Physical Health and/or Immunization Needs to be noted [i.e. such as asthma, obesity, etc.]:


Please identify 3 short term objectives to be achieved during placement at Elk Hill

1.

2.

3.

Please identify 3 long term objectives to be achieved during placement at Elk Hill

1.

2.

3.

Discharge Planning

Individuals who can assist in treatment and discharge planning (i.e. family, social worker, attorney, CASA worker, therapist, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Relationship to Client</th>
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Services to be considered in planning discharge

- Medication management
- Case management
- Education
- Independent living skills/training
- Other

- Substance abuse services
- Individual counseling
- Family counseling
- Transportation/drivers education
- Housing assistance
- Medical/dental/nutritional services
- Legal assistance/advocacy
- Vocational training
## 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: ________________________________

### Does this policy include:

- Dental coverage? □ Yes □ No
- Prescription □ Yes □ No
- Vision□ Yes □ No

*(You must provide a copy of insurance cards)*

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**I am confirming that ________________________________ has active health insurance. I understand that Elk Hill must have a copy of this card immediately. I will also provide any updated insurance information if insurance coverage changes. An Elk Hill sanctioned physician has my permission to treat patient and file claim to my insurance carrier. I understand that if services rendered are not covered, I am responsible for payment of those services.**

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**Signature**  
**Printed Name**  
**Date**

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Form revised 4/17/17  
7 of 8
Required Attachments

Copy of FAPT service/treatment plan
- No Record Available
  Comment: ____________________________

Social History
- No Record Available
  Comment: ____________________________

Psychological evaluation or Diagnosis by Licensed Therapist/Physician
- No Record Available
  Comment: ____________________________

Copy of Medicaid card or other
- No Record Available
  Comment: ____________________________

Immunization Record
- No Record Available
  Comment: ____________________________

Therapist recommendation if stepping down from higher level of care

Certificate of Need/Independent Team Certificate
- No Record Available

Café/CANS (current within 30 days of placement)
- No Record Available

Dental Exam Date: ________________

Physical Exam Date: ________________

Person Submitting Application:

Signature __________________________________________

Date of Application __________________________

Printed Name __________________________________________

Work Phone ___________ Fax ___________

Email ________________