

# NORTH SPRING BEHAVIORAL HEALTHCARE

## Application and Checklist

The following admissions checklist is to be used as a guide when sending referral information to North Spring Behavioral Healthcare, Inc. Each packet received is reviewed by our Admissions Committee to determine appropriateness for the program. It is essential that we receive documentation that is current and presents an overall picture of the potential resident. This information is needed prior to the admission of a resident.

We appreciate your support and look forward to working with you. Should you have any questions, please do not hesitate to call Admissions at 703-777-0800 or 800-777-8855. Please make sure that your packet contains as much of the following information as possible:

### SOCIAL and PSYCHIATRIC SUMMARY

- a) Social History\*
- b) Psychological and/or Psychiatric Evaluations (Current DSM-IV diagnosis (Axis I – V)\*)
- c) Previous treatment/placement history (staffing reports, discharge summary, treatment plans, progress reports, etc.)\*
- d) Current behavioral functioning: strengths, talents and problems
- e) Custody Status

### PHYSICAL EXAMINATION

- a) Immunization record
- b) TB Test
- c) Last Dates of Dental, Vision, or Gynecological Visits
- d) Health Physical
- e) General physical condition; nutritional requirements; or allergies.

### EDUCATION

- a) Current Grade and Report Card, school transcripts
- b) Student's eligibility for Special Education placement\*
- c) Educational evaluation and test scores, if any
- d) Individualized Education Program (IEP), if identified as special education\*

\*These items are deemed essential. A packet will not be reviewed until this documentation is received by Admissions.

Information submitted on \_\_\_\_\_ DOB: \_\_\_\_\_  
Applicant

Referral Source: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Agency Representative

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

CSA Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_



**PART II – Social - Developmental Summary (completed by referral source)**

**Resident's Name:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Father's Home Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

\_\_\_\_\_  
**Father's Employer:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Father's Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Mother's Name with Maiden Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Mother's Home Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

\_\_\_\_\_  
**Mother's Employer:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Mother's Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Brothers/Sisters:** \_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

**Brief description of family relationships:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current behavioral functioning (strengths, talents and problems):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Documentation of need for care apart from the family setting:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Legal involvement:** \_\_\_\_\_

\_\_\_\_\_

**Protection needs specific to this applicant:** \_\_\_\_\_

**Axis Diagnosis (If known)**

I.	_____	_____
	_____	_____
II.	_____	_____
III.	_____	_____
IV.	_____	
	_____	
V.	_____	

**Expectations / Treatment Goal Ideas for Resident while at North Spring:**

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**Referrals for the Sexually Acting Out or Sexually Reactive Program**

Is reunification therapy desired with the resident's family? \_\_\_\_ Yes \_\_\_\_ No  
*Reunification therapy can only be conducted at North Spring if the victim is receiving therapeutic services and both the victim and their therapist are willing to be involved in reunification therapy with the resident and their North Spring therapist.*

If yes, Victim Initials and Relationship with resident:

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Victim's Therapist and Contact Information:

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**Alternative placements/services tried in the past, please list most current first.**

(i.e. outpatient, in-home, mentoring, residential, etc)	Dates	Successful
1.		Y N
2.		Y N
3.		Y N
4.		Y N
5.		Y N
6.		Y N
7.		Y N

**If not successful, please explain reasons for failure?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

**School Attending:** \_\_\_\_\_

**School Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**IEP Developed By (send current copy):** \_\_\_\_\_ **IEP Date:** \_\_\_\_\_

**Educational label:** ED \_\_\_\_ LD \_\_\_\_ OHI \_\_\_\_ **Grade Placement:** \_\_\_\_\_

**Educational needs specific to this applicant:** \_\_\_\_\_

\_\_\_\_\_

**Full Scale IQ Score** \_\_\_\_\_ **Test Administered:** \_\_\_\_\_ **Date of Testing:** \_\_\_\_\_

**Referring Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone No:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



Applicant name \_\_\_\_\_

**9. Examinations the applicant has had (copies may be attached, if available)**

a. **Psychological (dates, place, type of test or examination and results):**

\_\_\_\_\_

b. **Psychiatric (dates, place, type of test or examination and results):**

\_\_\_\_\_

c. **Neurological (dates, place, type of test or examination and results):**

\_\_\_\_\_

d. **(For female residents) Gynecological Exam:**

\_\_\_\_\_

e. **Vision (dates, place, type of test or examination and results):**

\_\_\_\_\_

f. **Speech (dates, place, type of test or examination and results):**

\_\_\_\_\_

g. **Occupational therapy (dates, place, type of test or examination and results):**

\_\_\_\_\_

h. **Physical therapy (dates, place, type or test or examination and results):**

\_\_\_\_\_

**10. Medications used by the applicant, past and present. Please include all medications used during past year.** \_\_\_\_\_

\_\_\_\_\_

**11. Wetting:** Day 🍏 Night 🍏 **Soiling:** Day 🍏 Night 🍏

**12. Describe general medical health and fitness:** \_\_\_\_\_

\_\_\_\_\_

**13. Is applicant allergic to any medications or foods? Yes 🍏 No 🍏 If yes, name medication and describe symptoms.**

\_\_\_\_\_

\_\_\_\_\_

**14. Does applicant have history of substance abuse? Yes 🍏 No 🍏 If yes, please give name of drug, and any facts surrounding use e.g., length of use , treatment etc.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NORTH SPRING BEHAVIORAL HEALTHCARE**

**42009 Victory Lane  
Leesburg, Va. 20176  
703-777-0800  
800-777-8855 (TOLL FREE)**

**DENTAL RECORD**

**Applicant:** \_\_\_\_\_

**Date Seen:** \_\_\_\_\_

**Evaluation Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Treatment Plan:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date(s) of Next Appointment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please PRINT Name, Address and Telephone Number of Dentist:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Parent/Legal Guardian**

**Date** \_\_\_\_\_

**Once a child has been accepted into the program we will need the following information in addition to other information sent.**

**Paperwork Needed Prior to Admission for All Residents**

	Date Received
<input type="checkbox"/> 1. Application	_____
<input type="checkbox"/> 2. Signed Placement/Financial agreement	_____
<input type="checkbox"/> 3. Copies of ALL insurance cards	_____
<input type="checkbox"/> 4. Copy of Birth Certificates	_____
<input type="checkbox"/> 5. Court Order for Custody	_____
<input type="checkbox"/> 6. Behaviors a week prior to admission warranting residential care	_____

**\*\*\*If VA MEDICAID, Then We Also Need:**

**CSA FUNDED RESIDENTS**

<input type="checkbox"/> Certificate of Need (dated within 30 days prior to admission)	_____
<input type="checkbox"/> Medicaid Reimbursement Rate Certification	_____
<input type="checkbox"/> CANS (dated within 90 days prior to admission)	_____

**NON-CSA FUNDED RESIDENTS**

<input type="checkbox"/> Uniform Pre-Admission Screening Form	_____
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**\*\*\*If WV Medicaid, Then We Also Need**

- MCM1 with all attachments
- W.Virginia Medicaid Pre-Authorization
- Interstate Compact Agreement
- Court Order for Admission and Education
- Letter of Intent & Educational Funding (If no court order)
- Signed Funding Agreement

**\*\*\* DC Medicaid, Then We Also Need**

- Level Of Care
- Interstate Compact Agreement
- Court Order for Admission and Education
- Letter of Intent & Educational Funding (If no court order)
- Signed Funding Agreement

**\*\*\*DCPS , Then We Also Need**

- Court Order (Identifying DCPS will fund room, board and education of prospect)
- Signed Funding Agreement
- Interstate Compact Agreement

**\*\*\* MD Medicaid, Then We Also Need**

- Certificate Of Need (dated within 30 days of admission)
- Signed Funding Agreement
- Interstate Compact Agreement

\*\*\*\*\*PLEASE be sure to bring all **medications** on the day of admission\*\*\*\*\*