



Application for Services

Admission to Southeastern Virginia Training Center

Type of Admission (please check):

Emergency Admission (12 VAC 35-200-30)

Respite Care Admission (12 VAC 200-20)

This form is to be completed by a staff member of the Community Services Board responsible for pre-screening. It is to include medical, social, psychological and educational/vocational reports for the admission of any person to a state training facility in accordance with section 37.2-807 of the Code of Virginia.

CSB: _____ CSB Support Coordinator: _____

Contact Information: Phone: Office _____ Alt: _____ Fax: _____

CSB Support Coordinator Email Address: _____

Individual's Name: _____ DOB: ____/____/____ Male Female

SSN: ____ - ____ - ____ Medicaid #: _____ Date(s) of previous admissions and facility name: _____

Marital Status: Single Married Divorced Widowed

Current Residence: _____

Contact Information: _____

Legal Status: Guardian Authorized Representative Self Representation

Name of Guardian/Substitute Decision Maker (SDM) : _____

Relationship to Individual: _____

Address: _____ Phone #: ____ - ____ - ____

Is the SDM willing to continue to fulfill this responsibility while the individual is in a training center? Yes No

Reason for Admission Request:

Cultural Preferences

Food: _____
Dress: _____
Medical Treatment: _____
Religion: _____
Other: _____

Linguistic Preferences

Language Spoken: _____
Language Understood: _____
Preferred Language: _____
Comments: _____

Individual Requires: Acute Psychiatric Treatment Medical Treatment
 Behavioral Treatment Medication/Pharmacological Review

Diagnoses:

Level of Developmental Disability: _____ Determined by (type of testing, etc.): _____

Date of Testing: ____ / ____ / ____

Psychiatric:

Axis I: _____

Axis II: _____

Medical: _____

Attending Physician: _____ Phone #: ____ - ____ - ____

Community Psychiatrist: _____ Phone #: ____ - ____ - ____

Current Pharmacy: _____ Phone #: ____ - ____ - ____

Comments: _____

Hospitalizations during the last two years (attach information if available):

Hospitalization _____

Psychiatric Hospitalization _____

Surgery _____

Comments: _____

Immunizations: DT: ____ / ____ / ____ Last PPD: ____ / ____ / ____ PPD Result: _____

 Flu: ____ / ____ / ____ Pneumonia: ____ / ____ / ____ H1N1: ____ / ____ / ____

Hepatitis B: 1st ____ / ____ / ____ 2nd ____ / ____ / ____ 3rd ____ / ____ / ____ Other:

Dietary Needs/Special Requirements (Diet Order):

Food Allergies: _____

Current Medications	Reason (Attach MAR)

Current Medications	Reason (Attach MAR)

Medication Allergies:

Psychiatric Medication History (For the last two years if Available):

Sexual History:

Last Menstrual Cycle: ____ / ____ / ____

Are there any criminal charges pending? Yes No If yes, explain.

Based upon your knowledge of the individual, is he/she capable of requesting his/her own admission to the facility? Yes No

Presenting Issues (behaviors, goals, abusive problems, substance use, etc.):

Community Residential Providers/Placements during the last two years (include date resided with provider):

_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____

Alternative Community Options Explored:

Has this individual been referred to the Regional Support Team? Yes No

Date of the meeting ____/____/____

RST Recommendations and outcomes:

Education (if under age 22): _____

Activities of Daily Living (ADL) Skill Level/Supports Needed With Personal Care:

Adaptive Devices Used: Wheelchair Helmet Eating Utensils Other: _____

Comments:

Individual's Likes (or attach current Person-Centered Plan)

Individual's Dislikes (or attach current Person-Centered Plan)

Outline Preliminary Discharge Plans and Post-Discharge Follow-Up, (may be required by the individual upon return to the community):

Date Completed: ____ / ____ / ____ Community Services Board (Name): _____

Facility Fax #: ____ - ____ - ____ Case Manager (Print): _____

Case Manager Signature: _____

Required Attachments:

Free of Communicable Disease Statement

Current Psychological - 12VAC 35-200-20 (4)

Social History - 12 VAC 35-200-20 (3)

IEP for School Aged Children - 12 VAC 35-200-20 (5) |

ISP

SIS (if currently in Waiver or ICF/DD Services)

Vocational Assessment - 12 VAC 35-200-20 (6)

Statement from CSB that respite care is not available in the community - 12 VAC 35-200-20 (7)

Statement from CSB regarding arrangements to return to community pursuant to 12 VAC 35-200-20 (8)

Statement from the individual, a family member, or AR specifically requesting services in the training center - 12 VAC 35-200-20

(9) Copy of court order for guardianship if individual has a legal guardian