Clear Form

DBHDS

Virginia Department of Behavioral Health and Developmental Services

Application for Services
Admission To Training Center

Type of Admission (please check):

- ☐ **MFP Admission**
- ☐ **Emergency Admission** (12 VAC 35-200-30)
- ☐ **Respite Care Admission** (12 VAC 200-20)

Please check one:

- ☐ Central Virginia Training Center
- ☐ Southeastern Virginia Training Center
- ☐ Southwestern Virginia Training Center

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.

Name:_____ DOB: _____ /_____ / _____

Age: _____ ☐ Male ☐ Female Race:_____

SSN: _____ - ____ - _____ Medicaid #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Residence: _____

Date(s) of Previous Admission(s) and Facility Name:

CSB: _____

Case Management/Support Coordinator Contact:

_____

Phone #: _____-_____-_____

E-mail:_____

Fax #: _____-_____-_____

Legal Status: ☐ Guardian ☐ Authorized Representative ☐ Self Representation

Name of Guardian/Authorized Representative:_____ Relationship to Individual:_____

Address: _____ Phone #: _____-_____-_____

Is willing to continue while individual is in training center? ☐ Yes ☐ No

Regional Support Team (RST) Referral Date: _____

RST Meeting Date: _____

RST Recommendations and Follow Up:

Critical & Complex Consultation Team (C3T) Date: _____

C3T Recommendations and Follow Up:

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 Intellectual 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:

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: _____ /_____ / _____

Facility Fax #: _____-_____-_____

Community Services Board (Name): _____

Support Coordinator (Print): _____

Support Coordinator 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