RESIDENTIAL TREATMENT REPORT FORM

Children & Adolescents Not Admitted to Licensed Residential Treatment Facilities

**Complete** **one form for each child for whom admission to a residential treatment facility was requested but not obtained FOR 30 days. DO NOT COMPLETE THIS FORM IF YOU OBTAINED ADMISSION IN LESS THAN 30 days. See “Instructions – Residential Treatment Report Form” for additional information.**

I. General Information *Complete all parts of Section I.*

**Date Request Initiated: / /**

**Agency Submitting Data:**

CPMT Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIPS Code: \_\_\_\_\_\_\_\_\_\_\_

CSB Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CSB Code: \_\_\_\_\_\_\_\_\_\_\_

**Contact Person:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Information:** DOB: / / Last 4 digits of child’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female

|  |  |  |
| --- | --- | --- |
| **II. Admission Information *Check all facilities licensed by DBHDS to which admission was requested but not obtained.\**** | | |
| Centra Health, Inc. Bridges Treatment Center  Childhelp USA  Cumberland Hospital, LLC  Fairwinds  Grafton Integrated Health Network  Hallmark Youthcare - Richmond  Hallmark Youthcare TSAY - Richmond  Hughes Center for Exceptional Children  Harbor Point Behavioral Health Center  Jackson Feild Homes  Kempsville Center for Behavioral Health  Liberty Point Behavioral Healthcare  Newport News Behavioral Health Center  Newport News Behavioral Health Center Project Valor | North Spring Behavioral Healthcare  Poplar Springs Hospital  Riverside Behavioral Health Center  Southstone Behavioral Healthcare Center  The James Barry Robinson Institute  Three Rivers Treatment Center  Timber Ridge School  United Methodist Family Services Leland House  United Methodist Family Services Richmond  Youth For Tomorrow    Other Residential Care Facility **(Specify below.)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |
| **III. Reason(s) Admission Was Not Obtained *Check all that apply.*** | | |
| No bed available for day(s) requested | | |
| Bed available, but child not placed - **Check AT LEAST ONE Child-Specific, Funding or Other Issue below.** | |
| **Child-Specific Issues** |  |
| Age of child | Physical limitations | | |
| Gender of child | Hearing impaired/deaf | | |
| Aggressive/Violent/Unable to Control | Vision impaired/blind | | |
| Fire-setting | Substance abuse | | |
| Running away  Sex offender/Sexually aggressive  Mental retardation or borderline intellectual functioning | Child formerly treated in same facility and facility choosing  not to approve subsequent admissions  Facility not accepting child as voluntary admission | | |
| Autism or other developmental disability | Type of service needed not available (Specify in **Comments** below.) | | |
| Learning disability | Facility not accepting child as voluntary admission | | |
| Funding Issues |  | | |
| No source of payment for residential educational services  Cost of services too high | | | |
| No guarantor for payment if Medicaid or appeal denied  No agreement reached regarding facility’s minimum  required length of stay | Child’s insurance not accepted by facility | | |

**Other Issues *Write in any other issues that have not been listed.***

Facility too far from child’s home community

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV. Comments

**Send form to: Pam Fisher, DBHDS, via encrypted email to pamela.fisher@dbhds.virginia.gov**