**804.612.3344**

Admission Application

Referral Fax: 804.264-2541

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

Youth’s Name Youth’s Date of Birth Youth’s Social Security Number

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

Referring Agency Referring Worker’s Name Referring Worker’s Phone Number

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

Referring Agency’s Address Referring Agency Fax Number Referring Agency After Hours Number

Youth’s Current Foster Care Permanency Goal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Achievement Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Youth’s Current Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Admitted to Current Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information for Current Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Placement is Needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Funding Source for Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next FAPT Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Funding Approved: [ ]  Yes [ ]  No

Reason for Placement Needed at YouthQuest: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all services that your youth will need at YouthQuest:**

 [ ]  Daily Living [ ]  Education [ ]  Employment [ ]  Money Management [ ]  Self-Care

 [ ]  Social Relationships [ ]  Parenting Support [ ]  Outpatient Counseling [ ]  Medication Management [ ]  Permanency

**Please check all that apply to your youth:**

[ ]  Substance Abuse History [ ]  Sex Offender History [ ]  Current/Pending Criminal History

**Please check your youth’s current educational status:**

[ ]  Enrolled in High School [ ]  Enrolled in Community College [ ]  Enrolled in Trade/Vocational School [ ]  None

Contact Information for Current School Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check your youth’s current employment status:**

[ ]  Employed Full-Time [ ]  Employed Part-Time [ ]  Seeking Employment [ ]  Not Eligible for Employment

**Youth’s Full Scale IQ:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of last IQ Screening:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DSM-V Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage of Medication | Frequency Medication is Taken | Reason for Medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medication Allergies:** [ ]  Yes [ ]  No If yes, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environmental Allergies:** [ ]  Yes [ ]  No If yes, list allergens: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Medical Conditions:** [ ]  Yes [ ]  No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Virginia Medicaid Recipient**: [ ]  Yes [ ]  No If yes, list Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Virginia Medicaid MCO**: [ ]  Yes [ ]  No If yes, list MCO Name & ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other Insurance:** [ ]  Yes [ ]  No If yes, list other insurance provider & ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other Medical appointment scheduled from date of last physical through placement date?** [ ]  Yes [ ]  No

If yes, please provide date of upcoming appointment, name of provider and documentation.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Required Supporting Documentation to be attached to the Application:**

[ ]  Copy of Birth Certificate [ ]  Copy of Social Security Card [ ]  Copy of Insurance Cards

[ ]  Immunization Record [ ]  Physical Examination (within 12 months) [ ]  PPD Screening (within 12 months)

[ ]  Dental Examination (within 6 months) [ ]  Hearing Screening (within 12 months) [ ]  Vision Screening(within 12months)

[ ]  Foster Care Service Plan [ ]  Casey Life Skills Assessment (within 3 months) [ ]  Most Recent FAPT Report

[ ]  Most Recent Social History [ ]  Most Recent Psychological Evaluation [ ]  Recent Provider Reports

[ ]  Most Recent School Transcript [ ]  Copy of High School Diploma (if applicable) [ ]  Copy of I.E.P. (if applicable)

[ ]  Letter of Recommendation for Independent Living (from referring worker, therapist, probation officer, etc.)

[ ]  Recent medical reports (dated between last physical and pending placement date)

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

Printed Name of Person Completing Application Phone Number of Person Completing Application

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

Email Address of Person Completing Application Fax Number of Person Completing Application

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

Signature of Person Completing Application Date of Application

YouthQuest Independent Living

Authorization for Disclosing and/or Requesting Information

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intercept Youth Services, Inc. / YouthQuest Independent Living is hereby authorized to:

[ ]  Disclose/send information to the following person(s)/agency(s):

[ ]  Request/receive information from the following person(s)/agency(s):

Person/Agency Name(s), Address(es), & Phone Number(s):

(1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Exchange includes:

[ ]  Case Closing Summary [ ]  General Health/Physical Information [ ]  Medication(s) Prescribed

[ ]  Diagnosis [ ]  Services Received Summary [ ]  Individual Service Plan

[ ]  Participation and Attendance [ ]  Social History [ ]  Evaluations/Assessments

[ ]  Progress Notes [ ]  Legal Information [ ]  Intake/Referral Information

[ ]  Psychological Evaluation [ ]  Educational Records [ ]  Medical/Dental Information

This authorization is effective beginning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will terminate in: [ ]  90 Days [ ]  365 Days (one year) [ ]  Upon the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above client is being referred for a service through Intercept Youth Services, Inc.. As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. This authorization is automatically revoked upon termination of service. The person who receives the records to which this authorization pertains may not re-disclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is NOT sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or Federal law protect the disclosed confidential information. Federal Regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Parent/Guardian or Authorized Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INTERCEPT HEALTH**

5511 Staples Mill Road, Suite 102
Richmond, VA 23228