Divinely Directed Services
3401 Cedar Lane * Portsmouth, VA 23703
757-558-6914 Office * 757-558-6915 Fax
www.ddsbuildinghope.com

Required Documentation for Referral Consideration

- ☐ Completed Pre-Application
  - ☐ General Info
  - ☐ Health History Form

- ☐ Current IEP=Pertinent School Information

- ☐ Current Evaluations
  - ☐ Psychiatric
  - ☐ Psychological
  - ☐ Psychosexual (if applicable)

- ☐ Current Placement Clinical Treatment Reports/ISP's – (Last 90 days)
- ☐ Discharge Assessments
- ☐ Court Involvement Information
- ☐ Social History
- ☐ Placement History
- ☐ Current CANS
- ☐ Current FAPT Report

If accepted: Additional Required Documentation for Admittance

- ☐ CON (Certificate of Need)
- ☐ Birth Certificate (Original)
- ☐ Social Security Card (Original)
- ☐ Medicaid Card
- ☐ Immunization Record
- ☐ Current School Records
- ☐ Scheduled Date for BID (Best Interest Determination) Meeting
- ☐ Completion of Remaining Admissions Process
- ☐ Legal Custody Order

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Pre-Admissions Application

GENERAL INFORMATION

Application Date: _____

Client Full Name: _____

Current Age:_____ Date of Birth: _____

Legal Status: _____

Highest level of education completed:_____

Current resident address:_____

City:_____ State:_____ Zip Code: _____

Ethnicity:

☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic
☐ Native American ☐ Biracial ☐ Other: _____

Religious preference: _____

Anticipated date of admission: _____

Anticipated length of stay: _____

Current place of residency: _____

Date of assessment interview: _____

PLACEMENT HISTORY

Current placement: _____ Number of placements: _____

List previous placements:

Facility	Type of Facility	Date of Admission	Date of Discharge

Reason for discharge from last placement:_____

_____

Explain reasons for removal:_____

_____

_____

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LEGAL INVOLVEMENT

Is client currently on probation / parole? ☐ Yes ☐ No

Does client have previous or current legal charges? ☐ Yes ☐ No. If yes, please explain in detail. _____
_____
_____

BEHAVIORAL MANAGEMENT

History of AWOL(s):

Current behavioral problems:

History of substance abuse:

Treatment of substance abuse:

Current therapy (counselor and frequency):

Current level of functioning:

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SEXUAL ABUSE ISSUES:

Does applicant have any sexual perpetration issues? ☐ Yes ☐ No

If yes, against whom did the applicant perpetrate against? _____
_____

Was a psychosexual assessment completed? ☐ Yes ☐ No

If so, list the date and results of the assessment: _____
_____

Was a polygraph assessment completed? ☐ Yes ☐ No

If so, list the date and results of the assessment: _____
_____

What is the applicant's risk level of re-offending? ☐ Low ☐ Moderate ☐ High

Was a sex offender treatment program completed? ☐ Yes ☐ No

Was the applicant a victim of sexual abuse? ☐ Yes ☐ No

If so, who was the perpetrator? _____
_____

What type of treatment was administered as a victim? _____
_____

Describe the applicant's sexual health and reproductive history. _____
_____

PSYCHOLOGICAL NEEDS AND/OR ASSESSMENTS

List applicant's psychological needs and/or assessments: _____
_____
_____

GENERAL NEEDS

List applicant's general needs: _____
_____
_____

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GENERAL MEDICATIONS WITHIN LAST 6 MONTHS

Name of Medication	Dosage	Frequency	Purpose	Date of last medication review

Medication Management (Doctor's name and frequency) _____

_____

PSYCHOTROPIC MEDICATIONS WITHIN LAST 6 MONTHS

Name of Medication	Dosage	Frequency	Purpose	Date of last medication review

Medication Management (Doctor's name and frequency): _____

_____

List drug allergies and adverse reactions: _____

_____

List ineffective medications:_____

_____

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MEDICAL RISK ASSESSMENT FORM

DDS prides itself on providing a safe, nurturing environment where we can better develop our at-risk youth. In providing this quality service for our clients, it is in our best interest to ensure that this environment provides safety for its residents as well as its staff.

Any child processed for admittance into DDS shall be free from any and all communicable diseases (i.e., measles, mumps, chicken pox, hepatitis and/or HIV / AIDS) Any child who has or is suspected of any of these ailments may place another resident and/or staff member at risk of contracting such a virus, therefore it is at the agency's discretion to accept or reject any client who may be a known carrier.

To the best of my knowledge, I _____
(Case Worker and Agency Name)

certify that _____ is free from all communicable diseases.
(Client Full Name)

_____ last physical examination was completed on
(Client Full Name)

_____/_____/_____ and was performed by _____.
(MM/DD/YY) (Name of Facility Rendering Services)

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HEALTH HISTORY

Known allergies: _____
_____

Nutritional requirements / special diet: _____
_____

Recent physical complaints, medical conditions, and/or restrictions: _____
_____

Physical limitations: _____
_____

Chronic medical conditions: _____
_____

Communicable diseases (including TB): _____
_____

Past serious illnesses, injuries and hospitalizations: _____
_____

Family medical / mental health history: _____
_____

Current and past substance abuse history: _____
_____

Communication barriers: _____
_____

IMMUNIZATION HISTORY

TYPE_____ DATE ___/___/___	TYPE_____ DATE ___/___/___
TYPE_____ DATE ___/___/___	TYPE_____ DATE ___/___/___
TYPE_____ DATE ___/___/___	TYPE_____ DATE ___/___/___
TYPE_____ DATE ___/___/___	TYPE_____ DATE ___/___/___
TYPE_____ DATE ___/___/___	TYPE_____ DATE ___/___/___
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EDUCATION

Current grade level: ☐ Special Education ☐ I.E.P Report ☐ Mainstream

Last school attended: _____
Recurring behavioral problems: _____
_____
Educational needs: _____
_____

DIAGNOSIS

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
PREVIOUS GAF: _____
CURRENT GAF: _____

FAMILY / CAREGIVERS INVOLVEMENT

Mother: _____ Father: _____
Stepmother: _____ Stepfather: _____
Foster Parent(s): _____
Siblings: _____
Extended family (ex. aunt, uncle, grandparents): _____
_____
Legal guardian: _____
Describe family history involvement: _____
_____
_____
_____

DISCHARGE PLAN

State discharge plan: _____
_____
_____
_____
_____

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CONTACT INFORMATION

Person / Agency having legal custody of applicant:

☐ Biological parent ☐ Adoptive parent ☐ Relative

☐ Local Educational Agency ☐ Community Services Board ☐ Social Services

☐ Juvenile Justice ☐ Other _____

Legal Custodian's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone #: ( ) _____ Mobile #: ( ) _____
Work / Office #: ( ) _____ Fax #: ( ) _____
Email Address: _____

INSURANCE INFORMATION

Insurance company: _____ ID / Policy Number: _____
Who will be responsible for medical bills not covered by insurance? _____
Responsible party's name: _____ Employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone #: ( ) _____ Mobile #: ( ) _____
Work / Office #: ( ) _____ Fax #: ( ) _____

REFERRAL INFORMATION

Referring Agency:_____
Address: _____ City: _____ State: _____ Zip: _____
Office #: ( ) _____ Fax #: ( ) _____
Email Address: _____

x_____ x_____ _____ / ____ / ____
Printed Name of Agency Representative — Signature of Agency Representative — Date

Please either mail, fax or email completed application to:

MAILING ADDRESS:
Divinely Directed Services
3268 S. Military Hwy. Chesapeake, VA 23323

FAX #: 757-558-6915

EMAIL ADDRESS: rhawthorne@ddsbuildinghope.com