



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



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

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 the client currently on probation/parole? Yes No

Does the 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:



SEXUAL ABUSE ISSUES:

Does the 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 to 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: _____



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)



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 ___/___/___
TYPE _____	DATE ___/___/___	TYPE _____	DATE ___/___/___



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 _____ / _____ / _____
 Printed Name of Agency Representative Signature of Agency Representative Date

Please either mail, fax or email completed application to:
MAILING ADDRESS:
 Divinely Directed Services
 3401 Cedar Lane, Suffolk, VA 23703
FAX #: 757-558-6915
EMAIL ADDRESS: rhawthorne@ddsbuildinghope.com