

Intercept Youth Services, Inc. Treatment Foster Care

11961 Ironbridge Road, Chester, VA 23831
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Intercept Youth Services, Inc. Referral Application & Required Components

Enclosed is an updated application package for your use in referring children to Intercept Youth Services, Inc., Treatment Foster Care Program. To *consider* a referral, we prefer to have the following items:

- Agency Application
- Psychological Testing report (completed within the last 2 years)
- Social History (written/updated within the past year), including: developmental and medical history (as known), family history including medical, significant family relationships, and other information relevant to working with the referred child.
- Educational Evaluation (including diagnostic label, if any)

PRIOR TO ADMISSION, we **must** have received the following information and documentation:

- Completed Application including:
 - Copy of Physical examination done within last 90 days, including TB And HIV test
 - Copy of Dental check-up done within last 12 months
 - Signed Original Release Forms
- Immunization and Allergy Record
- Original Birth Certificate
- Medicaid Card (or other health coverage)
- School Transcript
- Picture of Child (if available)
- Copy of Foster Care Service Plan (if possible)
- Copy of Entrustment Agreement (if applicable)
- Copy of Family and Child Services Agreement

MEDICAID REQUIREMENTS:

- Current CAFAS
- Current 5 Axis DSM IV Diagnosis
- FAPT Assessment
- CPMT approval for admission **OR** FAPT confirmation of medical necessity

If a child requires **SPECIAL EDUCATION**, then also include:

- I.E.P. for current school year with signature(s) of parent(s) or legal guardian
- Eligibility Minutes of Hearing (within last 3 years)
- Psychological Report Component of Eligibility Hearing
- School Social History Report Component of Eligibility Hearing
- School Medical Report Component of Eligibility Hearing

My signature below indicates that I understand and agree to provide the above listed requirements for admission of _____:

Guardian Signature

Date

Intercept Youth Services, Inc.
Treatment Foster Care

APPLICATION FOR ADMISSION
General Information

Application Date: _____

Client's Name: _____
Last First Middle

Date of Birth: ____/____/____

Race: _____ Sex: _____

Referred by: (your name and agency) _____

Mailing Address: _____

Phone: _____ Email Address: _____

Fax: _____ Emergency Phone: _____

Date Placement is Needed: _____

Reason for Referral and Services Needed (Long term care, short term care, supported adoption, etc.):

Current Permanency Goals and Anticipated Date: _____

Next Permanency Planning Hearing Date: _____

Is the child being referred to any other agency for placement? Yes / No

Placement History (beginning with current placement):

Placement	Relation to Client	Dates
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

FACE SHEET

Client's Name: _____

Date of Birth: ____/____/____ Place of Birth: _____

Social Security #: _____ Medicaid #: _____

Description of child or recent photo: _____

Custodial Party

(please note if the emergency contact is someone other than the Custodial Party):

_____	_____
Name	Relationship to the client

Address	
_____	_____
Business/Cell Phone	Home Phone
_____	_____
After-hours / Emergency Phone	Email Address

Client's Family

Mother: _____ Social Security # _____
Address: _____
Phone: _____ Education: _____ Marital Status: _____

Father: _____ Social Security # _____
Address: _____
Phone: _____ Education: _____ Marital Status: _____

Client's Siblings:

1. _____ Location _____ Phone _____
2. _____ Location _____ Phone _____
3. _____ Location _____ Phone _____
4. _____ Location _____ Phone _____

Other Close Relatives:

1. _____ Location _____ Phone _____
2. _____ Location _____ Phone _____
3. _____ Location _____ Phone _____

Client's Name: _____

Please describe the **client's strengths and interests**: _____

Behavioral Information

Presenting Behavior Problems (in order of severity)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Has the client ever had **legal charges**? Yes / No If yes, please describe: _____

Has the client ever exhibited **dangerous or destructive behaviors** to self or others? Yes / No

If yes, please describe: _____

Has the client ever exhibited **inappropriate sexual behavior**? Yes / No

If yes, please describe: _____

Has the client ever exhibited **emotional/psychological problems** and needs? Yes / No

If yes, please identify previous or current psychological services provided: _____

Family Information

Is family currently receiving services? Yes / No If yes, please identify provider:

Is it expected that the client will have regular contact with his/her family? Please describe anticipated involvement including types and frequency.

Mother Yes / No _____

Father Yes / No _____

Siblings Yes / No _____

Other Family Members _____

Client's Name: _____

School History

Current School Attending: _____ Grade level: _____

How does the client do in school? _____

Is the client currently receiving Special Education Services? Yes / No

If yes, current label: _____ Date of last eligibility meeting: _____

Is there a current IEP? Yes / No

Medical Information

Current Medications: _____

Please describe any current medical or health/nutritional problems (if any):

Date of most recent Physical Exam: _____

Date of most recent Dental Check-Up _____

Any drug or environmental Allergies? Yes / No Specify: _____

Is there a history of substance abuse? Yes / No If yes, please describe: _____

Has a psychological evaluation been conducted within the past 2 years? Yes / No

5 Axis DSM IV Diagnosis (if known)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

GAF current _____ past _____

WISC III Scores (if known): VIQ _____ PIQ _____ FSIQ _____

Guardian Signature

Date