Fax- 828-286-4450

DirectCare Community Based Services, LLC
106 Orchard Street
Forest City, North Carolina 28043

Phone-828-305-4330

Level III Residential Treatment Admission Application

SECTION I

Applicant Identification

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____

County: _____ Zip: _____ Phone#: _____

SS#: _____ Sex: _____ Race: _____

Reason for Referral:

_____

_____

_____

Client's Case Manager: _____ Phone#: _____

Funding Source: _____

SECTION II

Family/Guardian Information

Parent/Guardian Name: _____ Relationship: _____

Address: _____
Street/Apt. # City State Zip

Phone#: _____ If guardian is not parent, parent's name: _____

Person to contact in case of emergency (In order):

Contact 1: Name: _____ Relationship: _____ Phone#: _____

Contact 2: Name: _____ Relationship: _____ Phone#: _____

Are there limitations on family visitation? Yes _____ No_____ If yes please explain:

_____

_____

SECTION III

Education History

Schools Attended:

(1)_____
Name Location

Dates of Enrollment: From _____/_____/_____ To _____/_____/____

(2)_____
Name Location

Dates of Enrollment: From _____/_____/____ To _____/_____/_____

(3)_____
Name Location

Dates of Enrollment: From _____/_____/____ To _____/_____/_____

Please list any significant school behavioral concerns:_____
_____
_____

SECTION IV

Out of Home placement History and Psychiatric Hospitalizations

(Begin with most recent. Use additional pages if necessary)

1) Name of Facility: _____ Dates: from_____to_____

Type of Facility: _____ Phone#:_____

2) Name of Facility: _____ Dates: from_____to_____

Type of Facility: _____ Phone#:_____

3) Name of Facility: _____ Dates: from_____to_____

Type of Facility: _____ Phone#:_____

4) Name of Facility: _____ Dates: from_____to_____

Type of Facility: _____ Phone#:_____

Section V

Medical History

(A separate medical clearance form needs to be filled out and signed by a medical physician or Pirmary Care Physician prior to admission to DirectCare)

Check one:
☐ Client has no current medical conditions
☐ Client's current medical condition of _____
is able to be appropriately cared for in a residential treatment facility with the following treatment and follow-up care: _____
_____

Any history of seizures: _____Yes _____ No
Type and frequency of seizures: _____
Neurologist: _____ Phone #: _____

Allergies and reactions:_____
_____

Immunizations up to date: _____YES _____NO
(A copy of the child's immunization record must be submitted prior to admission. All immunizations must be up to date.)

Previous Medical Hospitalizations:

1) Name of hospital: _____ Dates: _____

Reason for admission: _____

2) Name of hospital: _____ Dates: _____

Reason for admission:_____

Current Medical Medications:

Name	Reason	Dosage	Time(s) Taken	Prescribing Physician	Phone	Date Began

- **MD orders and prescriptions must be submitted to DirectCare prior to admission**

EXAM	LAST EXAM DATE	EXAMINER	PHONE
Physical			
Dental			
Eye			
Speech & Hearing			
Orthopedic / Physical Therapy			
Neurological			
Other			

PHYSICIAN'S NAME			PHONE
ADDRESS	CITY	STATE	ZIP
DENTISTS NAME			PHONE
ADDRESS	CITY	STATE	ZIP
PHARMACISTS NAME			PHONE
ADDRESS	CITY	STATE	ZIP
SPECIALISTS NAME	SPECIALTY		PHONE
ADDRESS	CITY	STATE	ZIP
SPECIALISTS NAME	SPECIALTY		PHONE
ADDRESS	CITY	STATE	ZIP

List all significant medical history and/or concerns: _____

_____

_____

_____

_____

SECTION VI

Mental Health Diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV:_____

Axis V: _____

Is applicant presently receiving psychological/psychiatric services? Yes_____ No_____

Therapist/counselor name: _____ Phone: _____
Length of time in treatment? _____ How often? _____

Current psychiatrist: _____ Phone: _____
Length of time in treatment? _____ How often? _____

Is there a family history of Developmental or Psychiatric Disabilities? Yes____ No____
Please Describe: _____

Current Psychotropic Medications:

Name	Reason	Dosage	Time(s) Taken	Prescribing Physician	Phone	Date Began

- **MD orders and prescriptions must be submitted to DirectCare prior to admission**

Client's current behavior can be appropriately treated and managed in a level 3 residential treatment facility: _____Yes _____No

Psychiatrist Signature _____ **Date** _____

APPLICANTS STRENGTHS / CAPABILITIES:
PREFERRED ACTIVITIES:
OTHER INTERESTS/HOBBIES:
NECESSARY SUPPORTS FOR APPLICANT:
DOES APPLICANT HAVE ANY SERIOUS BEHAVIOR PROBLEMS? _____YES _____NO
PLEASE CHECK BELOW ANY THAT APPLY TO APPLICANT:

Threatens physical harm to others	Damages property	Defied authority
Does physical harm to others	Has temper tantrums	Runs away
Threatens physical harm to self	Displays inappropriate sexual behavior	Is severely withdrawn
Does physical harm to self	Steals	Is hyperactive
Attempts or threatens suicide	Attempts or commits arson	Deliberately provokes others

Please describe checked items, and any other inappropriate behaviors exhibited by the applicant, giving details of how each has been a problem and what has been done to try to change these behaviors and what the results have been. (Attach copies of current and past Behavior Plans)
.

Client's current behavior can be appropriately treated and managed in a level 3 residential treatment facility: _____Yes _____No

Case Manger Signature _____**Date** _____

SECTION VII

Criminal History

Does applicant have a court record? _____Yes _____ No County? _____

Current and past offenses and dates, beginning with most recent: _____

_____

_____

Probation Officer/Court Counselor _____ Phone: _____

Is this client appropriate for residential care per DJJ? _____Yes _____No

Parole Officer Signature _____ Date_____

- **Please attach a copy of any court orders mandating services and/or conditions.**

Does client know this application is being submitted? _____Yes _____ No

Additional Comments: (applicant's attitude toward placement, applicant's personal goals, family's attitude toward placement, team's goals for this admission, etc.)

_____

_____

_____

Printed name of person submitting application: _____

Relationship to client: _____

Company and Title: (if applicable) _____

Signature of person completing application: _____

Date: _____ Phone: _____

DirectCare Management Only

Application received by _____ (Name and Title)

Application received on _____ (Date)

Status of applicant: _____Accepted _____Declined _____ Wait Listed

Person notified of status:_____ By:_____