

**POPLAR SPRINGS RESIDENTIAL SERVICES
APPLICATION COVER LETTER**

TO: POPLAR SPRINGS HOSPITAL
350 Poplar Drive
P.O. Box 3060
Petersburg, VA 23805
Attention: Quian Buford, Director of Patient Access
Phone: 804-733-6874
Fax: 804-862-6322

From: _____

Relationship to Applicant: _____

E-Mail Address: _____

Phone: _____ **Fax:** _____ **Total # Pages:** _____

Check all items that are included in this packet:

- | | |
|---|--|
| <input type="checkbox"/> Initial Residential Application | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Court Records |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> IEP/School Records/Transcript |
| <input type="checkbox"/> Current CAFAS | <input type="checkbox"/> Psychosexual Evaluation for
Daybreak Applications Only |
| <input type="checkbox"/> Copy of Insurance Card | |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Certification of Need |
| <input type="checkbox"/> Immunization History | <input type="checkbox"/> FAPT Service Plan |

I do hereby certify that I have the right to make application on behalf of this resident and that the information furnished is true and complete to the best of my knowledge.

Signature/Date _____

Confidentiality Notice

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**POPLAR SPRINGS HOSPITAL
INITIAL DAYBREAK APPLICATION**

Date: _____ Information provided by: _____ Phone # _____

Relationship to Child _____ Referral Source _____

Child's name: _____ Sex: _____ Race: _____ Age: _____

Address: _____ City _____ Zip _____

DOB: _____ SSN: _____ Payor/Insurance: _____

Legal Guardian: _____ Phone #'s _____

Where is child currently: _____ Phone # _____

Contact person: _____ Phone # _____

Type of placement: _____ How long _____ Urban _____ Rural _____ Sub _____

Explanation for Requesting Residential Treatment:

Potential Discharge plan:

Goals for Treatment:

Short term: _____

Long term: _____

Previous Treatment History:

Psychiatric Inpatient Treatment (begin with most recent to past)

Facility	Treatment Dates	Physician	Reason for Admission
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Name of Alternative Placements	Dates	Successful?

Outpatient (begin with most recent to past)

Physician/Therapist	Treatment Dates	Frequency	Last visit	Treatment Focus

Medical History

Are there any current or past medical issues that may influence treatment or placement? _____

Date of last physical exam? _____ Date of last dental exam? _____ Immunizations Current? _____
 (please provide copy of current immunization record)

Medication:	Dosage	How long?	Why Taken?	Compliant? Yes/No

Protection needs of resident:

Behavioral Support Needs of Resident: (What has or has not worked in past to assist with behaviors?)

Educational Performance:

School _____ Grade _____ Highest Grade Completed _____

Verbal IQ _____ Performance IQ _____ Full Scale IQ _____

[] Difficulties Reading/Writing [] Special Ed Classes _____ LD _____ ED [] Failed a Grade _____

Identify subjects/classes child find interests in _____

Identify subjects/classes child has difficulty in _____

History of Legal Problems

Behaviors Justifying Need for Daybreak Program:

Inappropriate Sexual Behaviors ____yes ____ no. Number of incidents: _____

Describe the sexual behavior(s) to include age of victim(s), where behavior occurred and relationship of victim to the child: _____

How was behavior discovered? _____

Describe the level / type of force used in committing each offense? _____

How has the family responded to the child's sexually inappropriate behavior? _____

By what agency was the sexual behavior investigated and what is the current status of the investigation?

Was a polygraph completed? ____yes ____ no Date: _____

Where/By whom _____ Outcome _____

Results Attached? ____yes ____ no

Was Psychosexual Completed? ____yes ____ no Date: _____

Attached ? ____yes ____ no

Who will need updates on progress of resident:

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax # _____ Release of Information Signed: YES NO

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax # _____ Release of Information Signed: YES NO

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax # _____ Release of Information Signed: YES NO

Name: _____ Agency: _____

Phone # _____ E-Mail _____

Fax # _____ Release of Information Signed: YES NO