ADMISSION CHECKLIST

The following admissions checklist is to be used as a guide when sending referral information to Liberty Point. Each packet received is reviewed by our Admissions Committee to determine appropriateness for the program. It is essential that we receive documentation that is current and presents an overall picture of the potential Applicant. This information is needed prior to the admission of an Applicant.

We appreciate your support and look forward to working with you. Should you have any questions, please do not hesitate to call Admissions at 540-213-0450 or 800-496-7941.

SOCIAL AND DEVELOPMENTAL SUMMARY

a) Social history describing family structure and relationships*
b) Current DSM-IV diagnosis (Axis I – V) *
c) Previous treatment/placement history (staffing reports, discharge summary, treatment plans, psychological/psychiatric evaluations, progress reports, etc.) *
d) Current behavioral functioning: strengths, talents and problems*
e) Documentation for need for care apart from the family setting
f) Custody Status (names, address, social security numbers and marital status of parent/guardian, custody papers)*
g) Names, ages and sex of siblings
h) Self-Help Skills Checklist*

PHYSICAL EXAMINATION

a) Immunization record*
b) Visual and auditory acuity
c) General physical condition*:
   - documentation of freedom from communicable disease including TB
   - allergies, chronic conditions and handicaps, if any
d) Nutritional requirements including special diets, if any
e) Restriction of physical activity, if any
f) Recommendations for further treatment, immunizations and other examinations indicated
g) Signature of licensed physician/designee or official of local health department
h) Date of last physical and dental exam*

MEDICAL HISTORY

a) Serious illness or chronic condition of individual's parents or siblings, if known
b) Past serious illnesses, infectious diseases, serious injuries and hospitalizations of the individual
c) Results of psychological, psychiatric and neurological evaluations/exams, if applicable (including intellectual and projective testing, EEG or EKG)*
d) Names, addresses and phone numbers of individual's former physician and dentist, if known.
e) MAR
f) Information Pertaining to Sources of Funding including copies of ID, Medicaid and/or Insurance Cards where applicable

EDUCATION (Statement concerning individual's academic performance)

a) Student's eligibility for Special Education placement*
b) Current grade placement, schedule of classes (if student is secondary placement), grades through date of withdrawal from previous school setting, cumulative transcripts*
c) Educational evaluation and test scores, if any*
d) Disciplinary file/actions, if any
e) **Must have a current Individualized Education Program (IEP), reflect change of placement and extended school year***

Information submitted on_____ DOB:_____
Applicant

Referral Source:_____ Date:_____
Parent/Agency Representative

Address:_____
Street/P.O. Box

_____
City **State** **Zip**

Email: _____

Telephone:_____

Fax: _____

***These items are deemed essential. A packet will not be reviewed until this documentation is received by Admissions.**

Part I – to be completed by referral source

Applicant's Full Name:

_____

Last **First** **Middle**

Applicant's Address: _____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone

Sex:____ Age:_____ Date of Birth:_____ Birthplace:_____

Race: _____ Religious Preference:_____

Applicant's Social Security Number:_____

Applicant being admitted from: Home_____ Hospital _____ Other: _____

If other than home, give name, address, telephone and fax number of facility:

_____
Name of Facility

_____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone **Fax**

Name and address of legal guardian, if not parent:

_____
Name

_____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone **Fax (If available)**

Reimbursement Source(s): ( ) VA Medicaid ( )CSA ( ) IV-E ( ) State Agency
(*check all that apply)* **( ) Private Insurance ( ) Parents ( ) School System**
( ) Other _____

Specific insurance information (company/agency name, ID#, claims address, etc. Include a copy of the card): _____

_____

Family Physician: _____
Name

_____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone **Fax (If available)**

How did you learn about Liberty Point?

Applicant's Name:_____

PART II – Social - Developmental Summary (completed by referral source)

Father's Information: _____
Name

_____
Street/P.O. Box

_____
City State Zip

_____
Telephone Fax (If available)

Father's Social Security Number:_____ Date of Birth:_____

Father's Employer: _____ Occupation:_____

Business Phone:_____

Mother's Information: _____
Name (with maiden name)

_____
Street/P.O. Box

_____
City State Zip

_____
Telephone Fax (If available)

Mother's Social Security Number:_____ Date of Birth:_____

Mother's Employer: _____Occupation:_____

Business Phone:_____

Marital Status:_____

Brothers/Sisters:_____ Age:_____

_____Age:_____

_____ Age:_____

Brief description of family relationships:_____

_____

_____

_____

Current behavioral functioning (strengths, talents and problems):

_____

_____

_____

Documentation of need for care apart from the family setting:_____

_____

_____

Legal involvement:_____

_____

Sexual history of applicant:_____

_____

Protection needs specific to this applicant: _____

Applicant's Name:_____

Alternative placements/services tried in the last year? If yes, please list.

Placement/Service (i.e. outpatient, in-home, mentoring, etc)	Dates	Successful
1.		Y N
2.		Y N
3.		Y N
4.		Y N
5.		Y N
6.		Y N
7.		Y N

If not successful, please explain reasons for failure?

1._____

2._____

3._____

4. _____

5._____

6._____

7._____

School Attending: _____
Name of School **Contact Person**

_____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone **Fax (If available)**

IEP Developed By (send current copy):_____
IEP Date:_____

Educational label: ED_____ LD _____ OHI_____
Full Scale IQ: _____
Grade Placement:_____
Educational needs specific to this applicant:_____

Referring Agency: _____
Name

_____
Street/P.O. Box

_____
City **State** **Zip**

_____
Telephone **Fax (If available)**

Signature:_____**Date:**_____

Applicant's Name:_____

Part III Specific Skills/Needs of Applicant

Self-Help Skills Checklist:

Personal Hygiene

Showering ____
Brushes teeth ____
Kleenex use ____
Toilets ____
Washes hands ____
Feeds self ____
Dresses self ____
Ties Shoes
Monitors self for cleanliness and odor ____
Care for hair ____

Housekeeping

Makes bed ____
Laundry ____
Puts away items ____
Cares for possessions ____

Social Skills

Personal space ____
Greet others ____
Voice tone ____
Volume ____
Respects others ____
Manages anger ____
Gets along with peers ____
Resolves conflict ____
Shares ____
Follows rules ____
Accepts No ____
Accepts redirection ____
Doesn't interrupt others ____
Give/receive compliments ____

Safety

Electricity ____
Appliances ____
Sharp Objects ____
Avoids Hazards ____
Spoiled Foods ____

Leisure

Selects activity ____
Hobbies ____
Group Activities ____
Takes turns ____
Good sport ____

Scale: I = Independent V = Verbal N = Skill needs taught

Comments:_____

_____

_____

Completed by:_____

LIBERTY POINT
1110 MONTGOMERY AVENUE
STAUNTON, VA 24401
540-213-0450
800-496-7941 (TOLL FREE)

MEDICAL HISTORY OF APPLICANT

1. **Applicant's Full Name** _____
   Last First Middle Initial

   Address: _____
   Street/P.O. Box

   _____
   City State Zip

   _____
   Telephone

2. **Date of Birth:**_____

3. **Place of Birth:** _____

4. **Sex** _____ **Height/ Weight:** _____**Feet**_____**Inches**_____**lbs**

5. **Mother's Name (include Maiden name):**_____

6. **Father's Full Name:**_____

7. **Describe any serious illnesses or chronic conditions of applicant's parents and siblings, if known: Check if applicable ( ) NONE ( ) UNKNOWN**

   _____

8. **About the applicant, describe the following:**

   a. **Past serious illnesses or infectious diseases (name of disease, duration, etc):**

      _____

      _____

   b. **Serious injuries:**_____

   c. **Hospitalizations:**_____

   d. **Impact of any of these on current health:**

      _____

   e. **Physical handicaps:**_____

   f. **Visual disorder:**_____

   g. **Hearing problems:**_____

Applicant's Name:_____

9. Examinations the applicant has had (copies may be attached, if available)

a. Psychological (dates, place, type of test or examination and results):

_____

b. Psychiatric (dates, place, type of test or examination and results):

_____

c. Neurological (dates, place, type of test or examination and results):

_____

d. Vision (dates, place, type of test or examination and results):

_____

e. Speech (dates, place, type of test or examination and results):

_____

f. Occupational therapy (dates, place, type of test or examination and results):

_____

g. Physical therapy (dates, place, type or test or examination and results):

_____

10. Medications used by the applicant, past and present. Please include all medications used during past year.

_____

_____

11. Describe general medical health and fitness:

_____

_____

12. Is applicant allergic to any medications? Yes □ No □ If yes, name medication and describe symptoms.

_____

_____

13. Does applicant have history of substance abuse? Yes □ No □ If yes, please give name of drug, and any facts surrounding use e.g., length of use, treatment etc.

_____

_____

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IMMUNIZATION INFORMATION

NAME OF APPLICANT:_____ DATE OF BIRTH:_____

A current immunization record should be included in the initial admission information. The legal guardian can fax this to the Admissions Office. In the state of Virginia, the following immunizations are required in school age children:

Hepatitis B #1_____ #2_____ #3_____
Date Date Date

DPT/DT #1_____ #2_____ #3_____
Date Date Date

Td (every 10 yrs) _____
Date

Oral Polio #1_____ #2_____ #3_____
Date Date Date

MMR #1_____ #2_____
Date Date

Varicella #1_____ #2_____
Date Date
(not needed if has documented history of chicken pox).

If immunization records are incomplete, the child can receive any of the immunizations listed above while at Liberty Point, with consent of the legal guardian. Immunizations are administered and maintained through the Nursing department.

As the legal guardian of _____ , I give consent for this child to receive the immunizations needed to complete the immunization record as required by the state of Virginia.

Signature:_____Date:_____
Parent/Legal Guardian

Signature:_____Date:_____
Witness

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REPORT OF APPLICANT'S PHYSICAL EXAMINATION
A licensed physician must complete (this form)

Applicant's Name:_____ Date of Examination:_____

Current Diagnosis:_____
ICD-9: DSMIV:

Skin Test (5TU PPD) Positive:_____ Negative:_____ Date of Test:_____
Chest X-Ray (if applicable) No evidence of TB:_____ TB to be ruled out:_____
Date of X-Ray:_____ Preventive Drug Recommended: YES__ NO__
This applicant appears to be free from Communicable Disease: YES___ NO____
Nutrition Requirements (including special diet, if any:_____
_____
Normal Evaluation? YES_____ NO_____ (If NO, describe any abnormal or chronic conditions or any allergies or handicaps the child has:_____
_____
_____
Neurological Exam Completed: YES_____ NO_____ (If YES, give results):_____
_____
Hearing: R_____ L_____ Height_____ Weight_____
Vision: W/O Glasses: R-20/_____ L-20/_____ W/Glasses: R-20/_____ L-20/_____
Color Discrimination:_____
Urinalysis:_____ Hemoglobin:_____ B/P:_____

Are there any recommendations as to future care, future tests or examinations, treatment(s) and immunizations? YES_____ NO_____ (if YES, describe):_____
_____
_____

Other Remarks/Recommendations:_____
_____
_____

Physician's Signature:_____

Physician's Address: _____
Street/P.O. Box

_____
City State Zip

_____
Telephone

LIBERTY POINT
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800-496-7941 (TOLL FREE)
DENTAL RECORD

Applicant:_____

Date Seen:_____

Evaluation Comments:_____

_____

_____

_____

Treatment Plan:_____

_____

_____

_____

Date(s) of Next Appointment:_____

_____

_____

Please PRINT Name, Address and Telephone Number of Dentist:

_____

_____

_____

_____

Signature of Dentist

As the legal guardian of _____ , I give consent for this child to receive routine dental care.

_____

Parent/Legal Guardian

Date_____

LIBERTY POINT
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540-213-0450
800-496-7941 (TOLL FREE)

PCP CHANGE AUTHORIZATION FORM

Patient Name: _____

Medicaid ID #: _____ D. O. B: _____

Patient Address: _____

_____

Patient Telephone Number: _____

Current PCP/Practice on Card: _____

PCP Requesting: _____

Practice Address: Augusta Pediatrics
22 N. Medical Park Drive
Fishersville, VA 22939

Telephone #: 540-932-5373

As the legal guardian of _____ , I give consent for the Primary Care Physician to be changed to Augusta Pediatrics while in the care of Liberty Point.

_____ _____
Member/Guardian Permission to change PCP Date

_____ _____
Witness Signature Date

Please fax completed form to: Liberty Point @ 1-540-213-0456

Applicant's Name:_____

LIBERTY POINT
Paperwork Needed Prior to Admission for *All* Applicants

Date Received

- ❑ 1. Application _____
- ❑ 2. Signed Placement/Financial agreement _____
- ❑ 3. Dental (within 1 year prior to admission) _____
- ❑ 4. Immunization record _____
- ❑ 5. History and Physical (within 30 days prior to admission) _____
- ❑ 6. Current IEP specifying Applicant Needs (or request addendum) _____
- ❑ 7. Copies of ALL insurance cards _____

*****If VA MEDICAID, Then We Also Need:**

CSA FUNDED APPLICANTS

- ❑ Certificate of Need (dated within 30 days prior to admission) _____
- ❑ Medicaid Reimbursement Rate Certification _____
- ❑ CANs(dated within 90 days prior to admission) _____

NON-CSA FUNDED APPLICANTS

- ❑ Uniform Pre-Admission Screening Form _____

For Applicants in DSS Custody

- ❑ Clothing allowance information sheet _____

*****PLEASE be sure to bring a list of all current medications and doses on the day of admission*****

ITEMS THAT ARE CONSIDERED CONTRABAND IF IN A RESIDENT'S POSSESSION*:

- ☒ GLASS (INCLUDING PICTURE FRAMES, MIRRORS, PORCELAIN FIGURINES, BOTTLES, ETC.)
- ☒ METAL OBJECTS (SPIRAL NOTEBOOKS, TWEEZERS, NAIL CLIPPERS, ETC.)
- ☒ FOOD
- ☒ MEDICATIONS OF ANY KIND
- ☒ CAMERAS

ITEMS TO BRING*:

- ❖ 10 DAYS WORTH OF CLOTHING (STORAGE IS LIMITED)
- ❖ ATHLETIC SHOES
- ❖ OUTDOOR SHOES
- ❖ OUTERWEAR (FOR FALL/WINTER MONTHS)
- ❖ SWIMMING TRUNKS (FOR SUMMER)
- ❖ FAVORITE PILLOW OR BLANKET (THEY ARE PROVIDED BUT YOU ARE WELCOME TO BRING YOUR OWN)
- ❖ POSTERS FOR YOUR ROOM (NO VIOLENT OR VULGAR SUBJECT MATTER)

***This list is not meant to be all-inclusive and is subject to change. All items that come into the facility are inspected and appropriateness is determined at that time.**

LIBERTY POINT

RESIDENT CLOTHING ALLOWANCE INFORMATION

(FOR CHILDREN IN THE CUSTODY OF THE DEPARTMENT OF SOCIAL SERVICES)

RESIDENT NAME:_____

CUSTODIAL AGENCY:_____

1. DOES THE RESIDENT HAVE CLOTHING ALLOWANCE MONEY REMAINING FOR THE PRESENT FISCAL YEAR? **YES** / **NO**

IF YES, HOW MUCH REMAINS? _____

2. DOES YOUR AGENCY HAVE RESTRICTIONS REGARDING WHAT MAY OR MAY NOT BE PURCHASED WITH THESE FUNDS? **YES** / **NO**

IF YES, PLEASE EXPLAIN: _____

_____

3. DOES YOUR AGENCY REIMBURSE FOR SALES TAX? **YES** / **NO**

4. WHAT IS YOUR AGENCY'S PROCEDURE FOR DISBURSEMENT OF FUNDS? (i.e. A specific amount is automatically sent monthly, reimbursement will be provided to Liberty Point for items purchased for the resident, etc.) *If Liberty Point will be purchasing items for reimbursement, all items will be purchased from Wal-Mart.*

_____

_____

_____

COMMENTS:

_____

_____

_____

CONTACT NAME/TITLE:_____

TELEPHONE NUMBER:_____

SIGNATURE:_____