

# Application for Services Admission To Training Center

Type of Admission (please check):

- Emergency Admission** (12 VAC 35-200-30)  
 **Respite Care Admission** (12 VAC 200-20)

This form is to be completed by a staff member of the Community Services Board responsible for pre-screening. It is to include medical, social, psychological and educational/vocational reports for the admission of any person to a state training facility in accordance with section 37.2-807 of the Code of Virginia.

Please check one:

- Central Virginia Training Center  
 Northern Virginia Training Center  
 Southeastern Virginia Training Center  
 Southside Virginia Training Center  
 Southwestern Virginia Training Center

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age: \_\_\_\_  Male  Female Race: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medicaid #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Current Residence: \_\_\_\_\_

Date(s) of Previous Admission(s) and Facility Name: \_\_\_\_\_

CSB: \_\_\_\_\_

Case Management/Support Coordinator Contact: \_\_\_\_\_

Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

E-mail: \_\_\_\_\_

Fax #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Legal Status:  Guardian  Authorized Representative

Name of Guardian/Authorized Representative: \_\_\_\_\_ Relationship to Individual: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Is willing to continue while individual is in training center?  Yes  No

Reason for Admission Request: \_\_\_\_\_

## Cultural Preferences

Food: \_\_\_\_\_

Dress: \_\_\_\_\_

Medical Treatment: \_\_\_\_\_

Religion: \_\_\_\_\_

Other: \_\_\_\_\_

## Linguistic Preferences

Language Spoken: \_\_\_\_\_

Language Understood: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Comments: \_\_\_\_\_

Individual Requires:  Acute Psychiatric Treatment  Medical Treatment  
 Behavioral Treatment  Medication/Pharmacological Review

Diagnoses:

Level of Intellectual Disability: \_\_\_\_\_ Determined by (type of testing, etc.): \_\_\_\_\_

Date of Testing: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Psychiatric:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Medical:

Attending Physician: \_\_\_\_\_

Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Community Psychiatrist: \_\_\_\_\_

Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Current Pharmacy: \_\_\_\_\_

Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Comments:

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Hospitalizations During the Last Two Years (attach information if available):

Hospitalization \_\_\_\_\_

Psychiatric Hospitalization \_\_\_\_\_

Surgery \_\_\_\_\_

Comments:

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Immunizations: DT: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last PPD: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PPD Result: \_\_\_\_\_

Flu: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Pneumonia: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ H1N1: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hepatitis B:  1st \_\_\_\_ / \_\_\_\_ / \_\_\_\_  2nd \_\_\_\_ / \_\_\_\_ / \_\_\_\_  3rd \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Other: \_\_\_\_\_

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Dietary Needs/Special Requirements (Diet Order):

Food Allergies: \_\_\_\_\_

Current Medications	Reason (Attach MAR)

Current Medications	Reason (Attach MAR)

Medication Allergies:

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Psychiatric Medication History (For the Last Two Years if Available):

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Sexual History:

Last Menstrual Cycle: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are there any criminal charges pending?  Yes  No If yes, explain.

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Based upon your knowledge of the individual, is he/she capable of requesting his/her own admission to the facility?  Yes  No

Presenting Issues (behaviors, goals, abusive problems, substance use, etc.):

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Community Residential Providers/Placements During the Last Two Years (include date resided with provider):

_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____
_____	From: ____ / ____ / ____	To: ____ / ____ / ____

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Alternative Community Options Explored:

Education (if under age 22): \_\_\_\_\_

Activities of Daily Living (ADL) Skill Level/Supports Needed With Personal Care:

Adaptive Devices Used:  Wheelchair  Helmet  Eating Utensils  Other: \_\_\_\_\_

Comments:

 Individual's Likes (or attach current Person-Centered Plan)

 Individual's Dislikes (or attach current Person-Centered Plan)

Outline Preliminary Discharge Plans and Post-Discharge Follow-Up, (may be required by the individual upon return to the community):

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Date Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Community Services Board (Name): \_\_\_\_\_  
Facility Fax #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_      Case Manager (Print): \_\_\_\_\_  
Case Manager Signature: \_\_\_\_\_

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**Required Attachments:**

- Free of Communicable Disease Statement
- Current Psychological - 12VAC 35-200-20 (4)
- Social History - 12 VAC 35-200-20 (3)
- IEP for School Aged Children - 12 VAC 35-200-20 (5)
- ISP & SIS (if currently in Waiver or ICF/MR Services)
- Vocational Assessment - 12 VAC 35-200-20 (6)
- Statement from CSB that respite care is not available in the community - 12 VAC 35-200-20 (7)
- Statement from CSB regarding arrangements to return to community pursuant to 12 VAC 35-200-20 (8)
- Statement from the individual, a family member, or AR specifically requesting services in the training center - 12 VAC 35-200-20 (9)
- Copy of court order for guardianship if individual has a legal guardian