DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

APPLICATION FOR VOLUNTARY ADMISSION TO A STATE FACILITY IN VIRGINIA

TO: The Director _____
(Insert name State Facility)

I, _____, hereby voluntarily apply for admission to your facility.
(Name of applicant)

I ☐ do or ☐ do not have an advance directive, WRAP Plan or similar crisis plan to help guide my treatment.

☐ I do want _____, _____,
(Name of Individual) (Phone Number)

_____
(Mailing Address)

notified of my general condition, location and any subsequent transfer to another facility.

☐ I do not want anyone notified of my general condition, location and any subsequent transfer to another facility

Date: _____, _____, _____
(Applicant Signature) (Type or Print Applicant Name)

_____ _____ _____ _____
(Permanent Address/Street, Route No.) (City/County) (State) (Zip Code)

Resident of _____ ☐ County ☐ City

☐ Prescreening evaluation has been made and the report recommending hospitalization is attached.

I, the Director or authorized admitting physician, certify that the provisions regarding the rights of a voluntary patient have been explained and the above named applicant has been examined and is in need of treatment. The above named applicant is accepted as a voluntary patient.

Signed _____
(Director or Admitting Physician)

Date Admitted _____20_____Hour _____ a.m./p.m. Register Number _____