RITE CARE HOME HEALTH SERVICES

ADMISSION PACKET

INSTRUCTIONS

Please complete this form, and return to **RITE CARE HOME HEALTH SERVICES**
Additional sheets may be attached if necessary.

PLEASE TYPE OR PRINT CLEARLY

Applicant refers to the name of the individual being considered.

It is our policy to admit and treat all applicants without regard to race, color, national origin, religion, age, sex, sexual orientation, ancestry, or physical or mental disability.

Application completed by: _____

Relationship:_____

DATE: _____

BIOGRAPHICAL INFORMATION

Applicant's full name_____

Street_____City_____State____ZipCode_____County_____

Sex: M_____ F_____ DOB: _____

Religion_____Race_____

Place of Birth_____

Social Security # _____

Height_____ Weight_____

Applicant's language_____

Family language_____

Applicant's present residence (check one)

Home_____ Hospital_____ Residential Treatment Center _____Group Home_____

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Foster Home_____ Other (specify) _____

Father's name_____

Relationship to applicant: Natural Father_____ Step-father_____ Adoptive Father_____

Home phone ( )_____ Cell Phone ( ) _____

Home address_____

Work Phone ( ) _____

Mother's name_____

Mother's maiden name_____

Relationship to applicant: Natural Mother____ Step-mother____ Adoptive Mother____

Home phone ( )_____ Cell Phone ( )

Home Address_____

Work Phone ( ) _____

Parent's marital status: Married _____ Single _____ Divorced _____Widowed _____

Deceased: Mother _____ Father _____ Both _____

LEGAL GAURDIAN'S NAME (if different from above)

Relationship to applicant/ AGENCY_____

Business phone ( )_____

Cell Phone ( )_____

Mailing Address_____

Who has custody of applicant? Mother_____ Father_____ Guardian_____

Other individuals that will be involved with this applicant?

Name:

Address:

Phone:

Family Members: Please list all family members who will be involved with applicant:

Name & Address **Relationship** **AGE**

Comment:

Case Manager/ Support Coordinator_____ CSB: _____

Address:

Phone:

Emergency Contact

Name_____ Phone ( )_____

Relationship_____

Address_____

_____

RITE CARE HOME HEALTH SERVICES

MEDICAL INFORMATION

Please list past/present medical problems:

Current Medications:

Allergies

EDUCATIONAL INFORMATION

Please forward applicant's educational cumulative record and/or transcripts and Individualized Education Plan (IEP)

CurrentSchool_____Grade____

Address_____

_____

Phone ( ) _____ Contact person_____

BEHAVIORAL INFORMATION

What are some strategies that have been successful in calming the applicant down when he is upset?

Prior Hospitalizations Date/From-To

DSM IV-R Diagnosis

AXIS I

AXIS II

AXIS III

AXIS IV

GAF current_____ Highest in past year _____

INSURANCE INFORMATION

Insured Person's Name_____

Soc. Sec. #_____

MEDICAL ASSISTANCE NUMBER:

_____

If Private insurance, please fill in below

Address_____

Phone (_____) _____

Relationship to applicant_____

Employer Name_____

Employer Address_____

Phone (_____) _____

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Insurance Company Name_____Through Employer _____ YES ____NO

Address_____

Phone (_____) _____

Policy/ID Number_____

Group Number_____

Medical/Health coverage on applicant _____YES _____NO Dental Coverage _____YES_____NO

HMO/PPO _____YES_____NO Vision coverage _____YES _____NO

The following will (may) need to be submitted along with this application:

1. A statement based on clinical evaluation by a licensed or certified mental health professional that the applicant has a mental disorder and that the applicant otherwise meets applicable admission criteria.
2. A recent history of the applicant's psychiatric or psychological treatment...and involvement with community agencies.
3. Medical records and psychiatric/psychological evaluations describing the applicant's mental disorder and need for placement in therapeutic group home.
4. Signed statements from the child and child's parent or guardian indicating informed consent to the proposed placement.
5. Previous placement reports.