GRAFTON
INTEGRATED HEALTH NETWORK
Solutions for Living. Solutions for Life.

APPLICATION

Thank you for your interest in Grafton. Our admissions packet includes a checklist that is to be used as a guide when sending referral information for one of our programs. Please note individuals referred for children's community-based and/or private day school services will be assessed for appropriateness for outpatient clinical services as an integral component of their Grafton treatment process. The Access Department will work in collaboration with you to ensure your referral presents the most accurate picture of the individual in need of services, as well as assist in getting the necessary documentation.

We appreciate your consideration and look forward to working with you. Should you have any questions, please do not hesitate to call the Access Department at 888-955-5205 extensions 6460, 6461, or 7248; fax to 540-542-1721; or email admissions@grafton.org.

SOCIAL AND DEVELOPMENTAL SUMMARY

- ☐ Social history describing family structure and relationship
- ☐ Current DSM-V diagnosis
- ☐ Previous treatment/placement history (staffing reports, discharge summary, treatment plans, psychological/psychiatric evaluations, progress reports, etc.)
- ☐ Psychosexual Evaluation (if applicable)
- ☐ Results of psychological, psychiatric and neurological evaluations

PHYSICAL EXAMINATION/ MEDICAL HISTORY

- ☐ Immunization Record
- ☐ History and Physical
- ☐ Past serious illnesses, infectious diseases, serious injuries
- ☐ Dental Examination Report

EDUCATION

- ☐ Educational evaluation and test scores, if any
- ☐ Individualized Education Program (IEP), if identified as special education

FUNDING

- ☐ Current CANS (where applicable)
- ☐ Certificate of Need (dated within last 30days)/ IACCT Assessment (where applicable)
- ☐ Copy of Insurance Card
- ☐ FAPT Service Plan (if applicable)

Application

Individual's Full Name:	
Name of party requesting placement:	
Relationship to the Individual of party requesting placement:	

SERVICE TYPE/LOCATION:

☐ Cold Spring, Minnesota Psychiatric Residential Treatment Facility		
☐ Berryville, VA Psychiatric Residential Treatment Facility	☐ Berryville, VA Private Day School	
☐ Richmond, VA Private Day School	☐ Richmond, VA Therapeutic Group Homes (Children)	☐ Richmond, VA Adult Services
☐ Winchester, VA Private Day School	☐ Winchester, VA Therapeutic Group Homes (Children)	☐ Winchester, VA Adult Services

IDENTIFYING INFORMATION OF APPLICANT:

Gender:	DOB:		SSN:
Hair Color:	Eye Color:	Height:	Weight:
Race:		Religious Preference:	
Place of Birth:			

GUARDIAN/PRIMARY EMERGENCY CONTACT

Individual's legal guardian:			
Name			
Address			
Phone		Email	

SECONDARY EMERGENCY CONTACT/AFTER HOURS

Name			
Address			
Phone		Email	

PAYMENT INFORMATION:

Primary Insurance Name:	Insurance Phone #:
Insured Name:	Subscriber Name:
Subscriber DOB:	Subscriber SSN:
Subscriber ID #:	Subscriber Group #:
Subscriber Employer:	Subscriber Relationship:

Secondary Insurance Name:	Insurance Phone #:
Insured Name:	Subscriber Name:
Subscriber DOB:	Subscriber SSN:
Subscriber ID #:	Subscriber Group #:
Subscriber Employer:	Subscriber Relationship:

Public Agency/CSA:	Contact Person:

COURT INVOLVEMENT (IF APPLICABLE):

	YES	NO	
Has Individual been found guilty of criminal violations?	☐	☐	Please describe:
Is Individual on probation? If YES, please provide copy of court order and Probation Officer contact information	☐	☐	

CURRENT PLACE OF RESIDENCE OR TREATMENT, IF NOT AT HOME:

Name of Placement:			
Contact			
Address			
Phone		Fax	

PLACEMENT NEED:

Reason individual needs placement:
What is the greatest concern about the individual's behavior:

YES	NO	BEHAVIOR	IF YES, PLEASE DESCRIBE
☐	☐	Auditory and/or Visual Hallucination	
☐	☐	Physical aggression towards others	
☐	☐	Coping with Grief	
☐	☐	Self Injurious Behaviors	
☐	☐	Elopement	
☐	☐	Lack of Safety Awareness	
YES	**NO**	**BEHAVIOR**	**IF YES, PLEASE DESCRIBE**
☐	☐	Disruption	
☐	☐	Property Destruction	
☐	☐	Fire Setting	
☐	☐	Sexual Acting Out	
☐	☐	Threats of Harm	
☐	☐	Significant psychological impairment	
☐	☐	Learning Disabilities	
☐	☐	Suicidal Ideation	
☐	☐	Homicidal Ideation	
☐	☐	Suicide Attempts	
☐	☐	Other	

PRIOR EXAMINATIONS (Please provide copies)

Type of Examination	Date
Psychological Evaluation	
Psychiatric Evaluation	
Neurological Evaluation	
Psychosexual Evaluation	

PLACEMENTS/SERVICES USED IN THE PAST

(i.e. inpatient, outpatient, in-home, residential, etc.)	Dates of Service	Successful
1.		Yes ☐ No ☐
2.		Yes ☐ No ☐
3.		Yes ☐ No ☐
4.		Yes ☐ No ☐
5.		Yes ☐ No ☐

If not successful, please explain:

1.
2.
3.
4.
5.

COMMUNITY SUPPORT:

Is your child receiving community services in your area? Yes☐ No☐ Unknown☐

If yes, please describe the type of community support and the name of the provider (i.e. Case Management, in home support, etc.?

If yes, please provide name and contact information:

Is High Fidelity Wraparound service available in your area? Yes☐ No☐ Unknown☐

If yes, have you used it?

Do you have Intensive Care Coordination (ICC) in your area through the local Community Services Board (CSB)? Yes ☐ No ☐ Unknown ☐

MEDICAL INFORMATION

PCP Name			
Address			
	City: State: Zip:		
Phone		Fax	

MEDICATION HISTORY (Prescriptions in last 6months)

Medication	Dosage	Compliance? Yes/No	Frequency	Start Date	Effective? Yes/No

ALLERGIES

Drug Allergies:	Reactions:
Other Environmental/Food Allergies:	Reactions:

MEDICAL CONDITIONS

YES	NO	MEDICAL CONDITION	If YES, provide further detail
☐	☐	Asthma	
☐	☐	Diabetes	
☐	☐	Seizures (history/current)	
☐	☐	Cardiac Problems	
☐	☐	Head Injury (history/current)	
☐	☐	Visual Impairments	
☐	☐	Hearing Impairments	
☐	☐	Physical Challenges	
☐	☐	Infectious Diseases	

Are there any specific dietary concerns?	Yes ☐ No ☐ Unknown ☐
If yes please describe:	
What is the individual's current sleep pattern?	

EDUCATION

Current Grade:	IEP: Yes☐ No☐	IEP Date:	IEP Eligibility:
IEP Contact:		IEP Contact #:	
School Name:		School Address:	
School Contact:		School Contact #:	

INTELLECTUAL/DEVELOPMENTAL FUNCTIONING

Full scale I.Q. Date:	Verbal I.Q.	Performance I.Q.
☐ Autism Spectrum Disorder		
Describe other developmental challenges:		
Diagnostic or Assessment testing requested:		

LAST DOCUMENTED DIAGNOSES

Primary	
Secondary	

History of abuse/neglect/trauma?	Yes ☐ No ☐ Unknown ☐
If yes please describe:	

INFORMATION ABOUT REFERRAL:

What other information do we need to know in order to serve the individual effectively?
What is the anticipated discharge plan for this individual?

FAMILY HISTORY:

Please indicate any family history of developmental, mental health, or substance abuse concerns: _____
Please indicate how family will be involved in treatment:

Completed by: _____Date Completed: _____

Relationship to Individual: _____

For Office Use Only

Reviewed By: _____