Pathways Youth Services, LLC
Resident Screening Information
2021-2022

Resident Information – Please Print

Full Name: _____

Date of Birth _____ Social Security Number _____

Parent(s)/Guardian _____ Relationship _____

Parent(s)/Guardian _____ Relationship _____

Street Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Screening Information:

Presenting Needs: _____

Referral Source: _____

Checklist for Admission (Circle all that apply)

- Developmental Disorders
- Property Destruction
- Truancy Issues
- Runaway
- Poor Academic History
- Emotional Disabilities
- Juvenile or Criminal Charges
- Behavior Disorders
- Alternative Education

Checklist for Exclusion (Circle all that apply)

- Untreated Psychosis
- Untreated Schizophrenia
- Arsonist
- Rapist
- Pregnant Teens
- Former Substance Abusers (rehabilitated)
- Psychological Issues
- Medication Management

Insurance Company _____ No.

Medication(s):	Dosage:	Time(s):	Medication(s):	Dosage:	Time(s):

Allergies: _____

Home School _____ Grade _____

If Applicable:

Psychiatrist/Therapist _____ Phone # _____

Social Worker _____ Phone # _____

Case Worker _____ Phone # _____

Probation Officer _____ Phone # _____

Pathways Youth Services, LLC
RESIDENT APPLICATION SUBMITTAL FORM

Name of Applicant: _____
Date of Submittal: _____

Name of Preparer of Application/Title: _____

Relationship to Applicant: _____

I have completed the attached Admission Documentation Checklist and provided all the information required to complete the Pathways Youth Service Admission Application. In addition, I have reviewed the information provided regarding Rates, Services Provided, and Discharge Policy.

To the best of my knowledge, all the information provided on this application is complete and true.

_____ _____
Print Name of Person Preparing Application *Signature of Person Preparing this Application/Date*

TO THE PREPARER

Thank you for your interest in Pathways Youth Service, LLC.

Please use the provided Admission Documentation Checklist to ensure that all parts of the application have been properly filled out and that all required items are included in your submission. Please do not leave any item blank. ***If an item is not applicable, write "none" in the provided space.*** This will assist in expediting the processing of your application.

As soon as we receive your complete application packet, we will examine the information and evaluate your Applicant for our program.

If you have any questions, do not hesitate to call me or Patricia Taylor, Program Director.

Doris Chism
Owner

Agency Use Only: **Date Received_____**
Date Reviewed_____
Date Resident interviewed_____
Date Agency notified of acceptance or denial_____

Revised 5/18/06

Pathways Youth Services, LLC
Admission Application

Applicant: _____ **S.S. #:**_____

D.O.B:_____ **Birth Place:** _____

Guardian Address: _____
_____

Work Phone: _____ **Alternative Number:** _____

Funding Source: _____

VA Medicaid Recipient? □ Yes □ No If yes, Medicaid Type: _____

Medicaid Number: _____

Other Insurance Policy Holder & Number: _____

DSM IV: Axis I: _____ **Axis II:** _____

Axis III: _____ **Axis IV:** _____

Axis V: _____ **GAF:** _____

IQ Test Date: _____ **Verbal:** _____ **Performance:** _____ **Full Scale:** _____

Reason for Placement:
_____
_____
_____

Corrective Lenses? □Yes □ No **Military Dependent? □ Yes □ No**

Educational History
Current or Most Recent Educational Placement: _____

Grade: _____ **□Regular Ed** **□Special Ed Classification:** _____

Dates of Attendance: _____

Revised 1/12/10

Applicant Name:

YES	NO	Performance	Grade(s)
		Does Applicant still attend school? If Yes, enter current grade. If No, enter the last grade.	
		Has Applicant been in Special Education or Resource Classes? If Yes, enter grade.	
		Has Applicant ever repeated a grade? If Yes, enter grade repeated.	
		Has Applicant ever skipped a grade? If Yes, enter grade skipped.	
		Has Applicant ever been suspended or expelled? If yes, enter grade.	

Applicant's BEHAVIORAL & EMOTIONAL HISTORY

- ***What are applicant's Behavior Support Needs*:**_____

_____

Yes	No		If YES, DESCRIBE
		Has Applicant ever demonstrated violent behavior?	
		Has Applicant ever has any involvement with the legal system?	
		Has Applicant ever tried to commit suicide, or talked about suicide?	
		Has Applicant ever had any changes in behavior and/or mood (anxious, sad, withdrawn, angry, overly happy, etc.)? If yes, include approximate dates in description.	

Applicant's SUBSTANCE ABUSE HISTORY

Yes	No		Current Frequency of Use	Age Usage Began
		To your knowledge, is Applicant currently using drugs or alcohol? IF yes, note date discovered And indicate all substances below:		
		Tobacco		
		Wine		
		Beer		
		Hard liquor (tequila, vodka, etc.)		
		Marijuana		
		Hallucinogens (LSD, PCP, etc.)		
		Stimulants (uppers, cocaine, crack, etc.)		
		Depressants (sedatives, barbiturates, etc.		
		Opiates (meth, heroin, etc.)		
		Inhalants (glue, gasoline, spray paint, etc.)		
		Other:		

Applicant's SEXUAL HISTORY

Yes	No		If YES, Describe
		To your knowledge, has the applicant been sexually active?	
		To your knowledge, has Applicant had any sexual problems?	
		Has Applicant exhibited any inappropriate sexual behaviors (e.g., acting out?)	

		To your knowledge, has the Applicant ever been sexually abused?	

Revised 1/12/10

Applicant Name: _____

Applicant's MEDICAL HISTORY
Immunizations current □ YES □ NO
Immunization needs: _____

Please check items listed below which the applicant has experienced difficulty with:

□Asthma	□Frequent Ear Infections	□Infectious Mononucleosis	□Mumps	□Skin Disorder
□Bronchitis	□German Measles	□Kidney Disease	□Pneumonia	□Tonsillitis
□Chicken pox	□Hay Fever	□Whooping Cough	□Rheumatic Fever	□Measles
□Diphtheria	□Heart Disease	□Meningitis	□Scarlet Fever	□Backaches
□Colds	□Constipation	□Convulsions	□Cough	□Diarrhea
□Fainting	□Headaches	□Hearing Difficulties	□Indigestion	□Insomnia
□Joint Pains	□Nose Bleeds	□Poor Appetite	□Sinus Infections	□Skin Eruptions
□Vomiting	□Sore Throat	□Other:_____		

Applicant's Other Medical History: **Provide Applicants other medical concerns below. If YES, provide age and details.**

Yes	No	Illness	Age	Details
		Allergies (list):		Provide symptoms:
		Surgeries (list):		Explain and provide date performed:
		Accidents: (list):		Explain and provide date occurred:
		Other hospitalizations (list):		Explain and provide date occurred:

Applicant's FAMILY MEDICAL HISTORY
Code: 1-Mother 2-Father 3-Sister 4-Brother 5-Grandparents

Ailment	Code	Details
Asthma		
Cancer		
Meningitis		
Rheumatic Fever		
Hemmorherigic Disease		
Heart Disease		
Epilepsy		
Influenza		
Allergies		
Mental Illness		
Other:		

Admission Application

1. **What is the reason for requesting placement at *Pathways Youth Services*?**

_____

_____

2. **What is the objective for placement at *Pathways Youth Services*?**

_____

_____

3. **What is the residents' proposed goal following completion of *Pathways Youth Service*?**

_____

_____

4. **Will resident's family (parents, foster parents, extended family) be available to participate in ongoing counseling programs and planning?**

_____

_____

5. **Does the resident have a history of violent, noncompliant, or self-injurious behavior? Yes or No (if yes explain).**

_____

_____

6. **Has resident been in a previous group or residential home? (If yes where and how many times?)**

_____

_____

7. **Would placement cause any risk to staff or other residents?**

_____

_____

8. **Does the resident exhibit sexual problems that he needs to be discussed or counseled with during placement?**

_____

_____

9. **Please list outside services you feel are needed for a successful placement at *Pathways Youth Services* (medical, educational, mental health, etc.)**

_____

_____

10. **What are the applicant's behavior support needs?**

_____

_____

11. **Has the resident had any previous psychological testing or counseling? Yes or No (if yes please enclose summaries or reports)**

_____

_____

12. **What is the plan if the resident fails to complete the program or is dismissed for an inability to follow rules and instructions of the program?**

_____

_____

13. **Is this resident currently (or in the past) involved in outside activities in the school or community that may serve as a support for our counseling program?**

_____

_____

14. **Does the client have any physical disabilities or illnesses that would present his participation in a strenuous outdoor program?**

_____

15. Is the client currently on any medication(s)? Yes or No (if yes, list)

_____

_____

16. Protection needs of prospective resident, staff, current residents.

_____

_____

17. Is this resident suitable for the program?

_____

_____

Please return this as soon as possible along with appropriate background information on the client (testing results, psychological school records, social history and etc.)

Legal Guardian_____ **Date**_____

Placing Agency_____ **Date**_____

Facility Signature_____ **Date**_____