

**SPECIALIZED YOUTH SERVICES OF VA., INC.**

**APPLICATION FOR SERVICES**

Client/Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_  
Race: \_\_\_\_\_ Primary Insurance: \_\_\_\_\_ Anticipated Enrollment Date: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Emergency#) \_\_\_\_\_  
Local Education Authority: \_\_\_\_\_ School: \_\_\_\_\_  
Has youth been found eligible for Special Education Services? Y N Unsure  
Diagnosis(es)/SPED Category(ies): \_\_\_\_\_  
Health Problems/Physical Limitations: \_\_\_\_\_ Ambulatory? Y N  
Reason for Referral: \_\_\_\_\_  
Funding Information: Medicaid # \_\_\_\_\_ CSA 294 Other \_\_\_\_\_  
Person Making Request for Services: \_\_\_\_\_  
Title: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Signature: \_\_\_\_\_

SERVICE(S) REQUESTED *(check all that apply and complete attachments for identified programs)*

**RESIDENTIAL**

Blandford Manor *Residential Treatment Program*  
Cameron House *Therapeutic Group Home*  
Unsure – Please assess for appropriate level of service

Complete Attachment “A” Residential Services

**EDUCATION SERVICES** *Special Education (ED,LD,EMH,OHI) or Alternative Ed.*

Bermuda Run Educational Center *Petersburg/South-Central Virginia*  
Shenandoah Academy *Harrisonburg/Shenandoah Valley/Blue Ridge*  
Regional Alternative Program *Petersburg*

Complete Attachment “B” Education Services

**CHILD & FAMILY GUIDANCE** *Community Based Services*

Intensive In-home Services *Harrisonburg and surrounding areas*  
Intensive In-home Services *Petersburg and surrounding areas*  
Day Treatment Program *Harrisonburg*  
Day Treatment Program *Petersburg*  
Behavioral Aid

Complete Attachment “C” Child & Family Guidance

## ATTACHMENT A

### RESIDENTIAL SERVICES

Making application to:      Blandford Manor      Cameron House      Unsure

For application to the **residential programs**, the following current information is requested:

Application for Services  
Social History  
School Information: *Transcripts/SOL Scores/Special Ed. Eligibility/Current IEP*  
Medical History/Physical/Immunization Record  
Psychological Evaluation (current within one year)  
Discharge Summaries from previous placements/treatment  
Release of Information from Local Education Authority  
Release of Information from most recent service provided

1. Is the adolescent a mild to moderate risk of behaviors endangering to self and/or others?      No      Yes

Describe:

2. If the adolescent is not a Special Education student, would he benefit from individualized instruction in a smaller classroom?      No      Yes
3. Is the adolescent's environment (i.e. social and interpersonal network) conducive to successful day treatment while living at home?      No      Yes
4. Is the adolescent currently not attending school, or is attendance and related truancy such that he is subject to expulsion due to behavioral difficulties?

No      Yes

Describe:

5. List all previous intervention methods and treatment: (i.e. outpatient and/or inpatient treatment)

6. What problems is the adolescent currently presenting?

7. What is the current family situation?

8. With whom does the adolescent live?

Name:      Relationship:

Address:

**ATTACHMENT A**

Page 2

- 9. List any court involvement, to include offense(s), date(s), disposition and probation counselor.
  
- 10. Adolescent's Physician: Telephone:  
Address:
  
- 11. Adolescent's Dentist: Telephone:  
Address:
  
- 12. Past Serious Illness or Infectious Diseases:
  
- 13. Allergies:
  
- 14. Date of last physical exam (please attach):  
Condition:
  
- 15. Date of last neurological evaluation (if applicable, please attach):
  
- 16. Please provide the following information on the family:

**Mother**

Full Name: DOB:  
Present Address:  
Home Telephone: Work Telephone:  
Place of Birth: Marital Status:  
SS#: Serious Illness:  
Occupation: Monthly Salary:  
If deceased, date: place: cause:

**Father**

Full Name: DOB:  
Present Address:  
Home Telephone: Work Telephone:  
Place of Birth: Marital Status:  
SS#: Serious Illness:  
Occupation: Monthly Salary:  
If deceased, date: place: cause:

**ATTACHMENT A**

Page 3

**Siblings**

Name	Sex	Age	Living-Situation	Illness
------	-----	-----	------------------	---------

If the information indicates an appropriate referral to one of the programs, a pre-placement visit will be scheduled. The placing agency representative, the parent(s) and/or legal guardian and the adolescent must be present at the pre-placement visit. Upon admission, the following records will be requested:

Submit complete residential application with attachments to:

Director of Residential Services  
Specialized Youth Services of Va., Inc.  
230 South Crater Road  
Petersburg, Va., Inc. 23803  
Phone: (804) 733-2180 Fax: (804) 733-8502



## ATTACHMENT C

### CHILD & FAMILY GUIDANCE

Making application to:

Day Treatment-Petersburg  
Child/Family Guidance-Petersburg  
Behavioral Aide Petersburg Area

Day Treatment-Harrisonburg  
Child/Family Guidance-Harrisonburg  
Behavioral Aide-Harrisonburg Area

For application to the **community based services programs**, the following current information is requested:

Psychological Evaluation  
Social History  
Current IEP (when applicable)  
Psychiatric Evaluation  
Other:

1. List previous treatment services provided:
2. Identify Goals of the services (in general terms)

Submit complete application with attachments to:

**Petersburg location:**

Director of Clinical Services  
Specialized Youth Services of Va., Inc.  
230 South Crater Road  
Petersburg, Va. 23803  
Phone: (804) 733-2180 / Fax: (804) 733-8502

**Harrisonburg location:**

Regional Director of Community Based Services  
Specialized Youth Services of Va., Inc.  
1000 Chicago Avenue  
Harrisonburg, Va. 23802  
Phone: (540) 433-1374 / Fax: (540) 433-1377