Name of Client:____________________________________ Date Application Received:__________________

Windwood Farm PRTF Admission Application

Date of application:____________

Client Basic Information

Client name:________________________________ Client Nickname (if applicable):__________________

Date of birth:______________ Age:________ Client height:___________ Client weight:_______________

SSN # (last four digits):____________________Medicaid number: _________________________________

Medicaid type (i.e. Select Health, Molina, Healthy Blue):____

Parent/Legal Guardian Contact Information

Parent(s)/Legal Guardian(s) Name(s):____

If not parent, list relationship to the client:____

Home Address (include city/county):____

____

Primary phone number: (____)________________________ Work number: (____)__________________

Email address:____

Current Placement Information (If applicable)

Is client currently in facility placement? Yes_______ No______

If yes, please indicate facility name and location:____

Please indicate date when client was admitted to current facility:_________________________________

Is this facility assisting you in referring your child to Windwood Farm PRTF? Yes_______ No_______

If yes, please indicate contact person at that facility:____

Contact person's relationship to client:____

Contact person's phone number:(_____)____________________ Fax:(______)______________________

Contact person's email address: ____

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Statement of Need

Please explain why you are seeking placement in a PRTF for your child (include specific behaviors causing distress for the child and family in the home, school, and/or community, include if there is a risk of harm to himself or others and explain the risk(s) of harm). If additional space is needed, please attach on an additional page with the application:____

Client strengths (check the box for all that apply):

Strong family support		Good social skills/makes friends easily	
Appropriate reading level		On grade level in school	
Resiliency/coping skills		Good verbal/communication skills	
Has hobbies/recreational interests		Good personal hygiene	
Support with others outside of family		Has a religious/spiritual connection	
Average/above average IQ		Commitment to school	

Additional strengths identified by the parent/legal guardian:_______________________________________

What is your hope or expectation when the client completes treatment?____________________________

Family therapy is a required component of PRTF treatment. What problem areas within the family unit should be addressed to help support the client's success in the home?__________________________

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Mental Health Information

If the client has received a Comprehensive/Diagnostic Assessment from a therapist, please include the date of the assessment, who completed the assessment, and where the assessment was completed (if possible, please attach a copy with this application):________________________________

____

Client problems: As it applies, if the behavior has occurred within the last 3 months this will be considered "**current**". If the behavior occurred three months ago or longer this will be considered "**past**", which will be indicated by placing an "x" in the box. If you are selecting a behavior as "**current**" please put one of the following letters in the box which indicates how often the behavior occurs-**D=Daily, W=Weekly, B=Biweekly, and M=Monthly**:

Problem	Current	Past	Problem	Current	Past
Abandoned/Attachment Issues			Enuresis/bed wetting		
Verbally Aggressive/Threats			Encopresis/feces		
Physically Aggressive			Low self esteem		
Sexually Aggressive			Poor coping skills		
Attention Seeking			Trust issues		
Difficulty with authority			Sibling related difficulties		
Smearing feces			Delusional thinking		
Cruelty to animals			Hallucinations		
Impulsive			Loss/grief difficulties		
Manipulative			Anxiety		
Arson/fire setting			Mild depression/sadness		
Destroys property			Moderate depression		
Hyperactive			Severe depression		
Oppositional/defiant			Eating disorder		
Unruly/ungovernable			Antisocial/criminal acts		
Running away			Autism/autism spectrum		
Sexually inappropriate			Manic/mood swings		
Alcohol/drug use			Gang involvement		
Problems in school			Adjudicated sex offender		
Truancy			Chaotic home situation		
Expelled/not in school			Victim/neglect		
Suicidal thoughts or attempts			Victim/physical abuse		
Self-harm behaviors			Victim/sexual abuse		
Lies/not truthful			Victim/emotional abuse		
Poor hygiene			Witness/domestic abuse		
Poor social skills			Language limitations		
Phobic reactions or behavior			Functionally Illiterate		
Needs protection from others			Developmental Delay		

Additional comments (if applicable add other behaviors not listed above):_________________________

____

____

____

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If known, please list any diagnoses the client may have and when/who provided the diagnoses in the box below (if more room is needed, please attach on an additional page):

Diagnosis	Date Given	Source of Diagnosis

Please list any medications the client is taking in the box below (if more room is needed, please attach on an additional page):

Medication	Dosage/Instructions

Please list any past medications the client has taken that gave negative side effects and what the side effects were:____

____

____

____

Please list all previous placements the client has been involved with in the box below (hospitalizations, residential placements). If more space is needed, please attach on an additional page:

Name/Type of Placement	Admit Date	Discharge Date	Successful? Yes or NO

Name of Client:_________________________________ Date Application Received:_________________

Aside from previous hospitalizations or residential services, please list any other previous or current services the client has or is receiving (outpatient counseling, family therapy, behavior modification services, etc) in the box below. If more space is needed, please attach on an additional page:

Type of Service	Provider Name	How Often?	Start Date	End Date

Is the client involved with other agencies (i.e. DSS, DJJ)? If so, please indicate:______________________

____

Client's Medical Information

Primary physician:____ Phone: (_____)_________

Dental provider:____ Phone: (_____)_________

If applicable, vision provider:____________________________________ Phone: (_____)_________

Date of most recent: Physical exam______________ Dental exam______________ Eye exam____________

Allergies:____

Special Dietary Needs:____

List medications client is currently taking for medical conditions (i.e. allergies, asthma, etc):________

____

____

List any current or prior medical conditions, physical disabilities, adaptive devices, or specialty medical care that would have to be accommodated while in placement:___________________________

____

____

____

____

____

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School Information

Official home school district (where parent/legal guardian resides):_________________________

In what grade is the client currently?_______________________

Is the client attending school "in person" or "virtually": In Person_______ Virtually________

If client is not currently attending school, please explain:___________________________________

____

Is client attending school a full day or an abbreviated day? Full Day______ Abbreviated Day_____

Is the client functioning on grade level? Yes_____ No______ Comments:_____________________

____

List up to last five schools attended starting with the current/most recent school:

Name of School	Start Date	Final Date	Grade Level	Completed? Y or N

Has client ever been classified special education? Yes______ No_______ Unknown________

If yes, list his classification:____

Does client have an IEP? Yes_______ No________ If yes, list date of IEP:____________________

Note: If you have a copy of the IEP, please attach with this application.

Does client have a Section 504 Accommodation Plan? Yes____ No____ If yes, date of plan:_________

Note: If you have a copy of the 504 Accommodation Plan, please attach with this application.

Is client currently expelled or under recommendation of expulsion? Yes_____ No_____ If so, please explain circumstances:____

____

If client has received in-school and/or out of school suspensions, please explain why and frequency of suspensions (i.e. weekly, monthly, daily): ____

____

____

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Please list any additional services the client received through school (i.e. speech therapy, occupational therapy): ____

____

Did the client receive psychological testing? Yes_____ No_____ If yes, date of assessment:___________

Note: If yes, please attach a copy of the assessment with the application if possible.

Application Contact Information

Applications can be mailed, emailed, or faxed to the contact information below. Once your application is received it will be reviewed to determine if the client would be appropriate for the Windwood Farm PRTF program. You will then be contacted to discuss if the application will be accepted and, if accepted, next steps to be taken for admission.

Please return applications to:

Alicia Hinson-Deputy Director

Office Number-843-884-5342

Fax Number-843-884-1287

Alicia.Hinson@windwoodfarm.org

Mailing Address: 4857 Windwood Farm Road

Awendaw, SC 29429