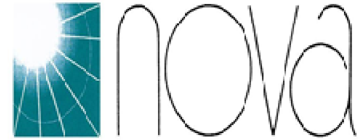

BEHAVIORAL HEALTHCARE CORPORATION

……………..lighting the way to new beginnings

NOVA-IC, Inc.
Admission Application Packet

Date of Application:__________________________ Date Service Needed: __________________________

CONSUMER INFORMATION

Consumer's Name: ______________________ Nickname: ______________ Race:________

Social Security Number: ______________________ Date of Birth:______________ Age: _____ Sex_____

County: ______________________ MCO: ______________________

Type of Insurance: ______________________ ______________________
(Primary) *(Secondary)*

Medicaid Number**:**______________________ Policy Number: ______________________

Consumer's Current Placement: ______________________How Long:______________

GUARDIAN INFORMATION

Legal Guardian ______________________

Relationship: ______________________County of Legal Custody: ______________

Guardian's Address: ______________________

Guardian's Phone Number:______________________

CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: ______________________

Address: ______________________City/State/Zip code: ______________________

Referring Contact: ______________________

Phone #:______________________ Email: ______________________

NOVA-IC, Inc. (office use only)
Date of Review: ______________________
Decision: ______________________
If Denied, Reason:______________________

CLINICAL/DIAGNOSTIC INFORMATION

DSM V Diagnosis/ Medical Diagnosis

Primary:____

Additional:____

Additional:____

Additional:____

Medical: ____

Additional: ____

IQ: ______ **Verbal** _______ **Performance**_____ **Full Scale** _________ **Please include any current evaluations/testing**

DATE OF TESTING: _____________________

ADAPTIVE BEHAVIORAL LEVEL: __________**MILD** __________**MODERATE**__________**SEVERE**

Cause of Intellectual Disabilities: Present at Birth_______**; Head Injury**_______**; Related to Illness/Sickness**________

Medications	Prescribing Physician	Dosage/Frequency	Date Started

MEDICAL INFORMATION

Allergies:____

Special Dietary Needs/Foods Allergies: ____

Medical Conditions (past and present) Please note most recent occurrence:

- ☐ **Lice**
- ☐ **Anemia**
- ☐ **Drug/Alcohol Abuse**
- ☐ **HIV/AIDS**
- ☐ **Sexually Transmitted Disease**
- ☐ **Ringworm**
- ☐ **Tuberculosis: Date of last test**________ **Past Positive** _____**y** ______**n**
- ☐ **Chronic Urinary / Bowel Problems Elaborate**
- ☐ **Problems with sleep**
- ☐ **Bulimia**
- ☐ **Anorexia**
- ☐ **Measles**
- ☐ **Mumps**
- ☐ **Chicken Pox**
- ☐ **Sickle Cell Anemia**
- ☐ **Migraine Headaches**
- ☐ **Rubella**
- ☐ **Use of sleep aids**
- ☐ **Eczema**
- ☐ **Asthma**
- ☐ **Hay Fever**
- ☐ **Convulsions**
- ☐ **Sinus Problems**
- ☐ **Diabetes**
- ☐ **Hepatitis (positive screening)**
- ☐ **Traumatic Brain Injury**

Verbal ____**Yes** ____**No**

Special communication needs: ☐ **Yes** ☐**No**

____
____
____

Other: ___________________________
____
____
____
____

Name and Address of Physician: ____

Name and Address of Dentist: ____

Name and Address of Neurologist/other Specialist: ____

Date of Last Phys. Exam:________________ **Last Dental Exam:**__________________ **Last Eye Exam:**_________________

Dental Appliances: ☐ **Yes** ☐**No** **Glasses:** ☐ **Yes** ☐**No (is Consumer prescribed to wear at all times** ☐ **Yes** ☐**No)**

Physical Impairments: ____

Family Medical History:

____

____

ADDITIONIAL INFORMATION

STRENGTHS/ABILITIES/PREFERENCES

Strength/Capabilities ____

____

Friendships/Social/Peer Support Relationships: ____

____

Religion/Spirituality: ____

Cultural/Ethnic Issues/Information/Concerns: ____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):____________________

____

Goals for Independent Living: ____

____

PRESENTING PROBLEMS / REASON FOR REFERRAL

PLACEMENT HISTORY

Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS

Please describe behavior and include the date of last incident.

☐ **Abandonment Issues**	☐ **Anxiety**	☐ **Arson**
☐ **Alcohol/Drug Abuse**	☐ **Antisocial Behavior**	☐ **Stool/Feces smearing**
☐ **Assaultive (Physical)**	☐ **Assaultive (Sexual)**	☐ **Assaultive (Verbal)**
☐ **Bedwetting**	☐ **Eating Disorder**	☐ **Depression**
☐ **Property Destroying**	☐ **Fire Setter**	☐ **Developmental Disability**
☐ **False Allegations**	☐ **Hyperactive**	☐ **Impulsive**
☐ **Lying**	☐ **Low Self-Esteem**	☐ **Loss/Grief Difficulties**
☐ **Physical Impairment**	☐ **Chronic Constipation**	☐ **Parent Neglect Issues**
☐ **Perception of Reality**	☐ **Phobic Behavior**	☐ **Physical Disability**
☐ **Self Destructive Behavior**	☐ **Sibling Related Difficulty**	☐ **Oppositional**
☐ **Hording**	☐ **Sexually Inappropriate Behavior**	☐ **Stealing**
☐ **Suicidal**	☐ **Running Away**	☐ **Urinary Incontinence**
☐ **Unruly/Ungovernable**	☐ **Cruelty to Animals**	☐ **Hygiene/Cleanliness Issues**
☐ **History w/Weapons**		

History of Abuse: ☐ **Victim of Neglect** ☐ **Victim of Physical Abuse**
☐ **Victim of Sexual Abuse** ☐ **Victim of Emotional Abuse**
☐ **None**

Other____

ADDITIONAL INFORMATION

AGGRESSIVE OR VIOLENT BEHAVIOR ALERT

Please describe the nature of the acting out behaviors:

☐**Verbally aggressive Frequency:_________**

Description:____

____
____
____

☐**Physically aggressive Frequency:_________**

Description:____

____
____
____

☐**Property destruction: Frequency: ________**

Description:____

____
____
____

Has the behavior resulted in injury to others? Criminal charges? Please describe:

Aggression is: ☐ impulsive ☐ planned

Where is the client aggressive:____

Known triggers, please describe:

____
____
____
____

Main targets of aggression: ☐ Peers ☐ Authority figures ☐ Family members Please be specific:

Please describe the most recent episode of aggression:

____
____
____
____
____
____
____
____
____
____
____
____
____

FAMILY INFORMATION

Biological Mother's Name:____

Address:____

Telephone Number: Home: ____________________**Work:** ______________________ **Cell:** ________________________

Ethnicity ___________ **Educ. Level:** ________**Unknown** _______ **Criminal Record:** ________**(Yes/No) Unknown** ________

Biological Father's Name:____

Address: ____

Telephone Number: Home: ____________________**Work:** ______________________ **Cell:** ________________________

Ethnicity ___________ **Educ. Level:** _________ **Unknown** _______ **Criminal Record:** ________**(Yes/No) Unknown** _______

Are Parents: ☐**Married** ☐**Separated** ☐**Divorced** ☐**Never Married** ☐ **Deceased Mother** ☐ **Deceased Father**

Have parental rights been terminated: _____________ **If so, who and when?** ___________________________________

How many siblings does Consumer have: _____________

Age	Gender	Name	Age	Gender	Name

Are siblings in out-of-home placements? _____________

If yes, please specify:

☐**DSS Foster Care** ☐**Relatives** ☐**Incarcerated** ☐**Group Home**

Other: ____

FAMILY DYNAMICS / FAMILY SOCIAL HISTORY

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

☐**Criminal Activity**	☐**Hospitalization**
☐**Inappropriate Sexual Behavior**	☐**Treatment Disruption**
☐**Psychiatric Illness**	☐**Other:**
☐**Suicide**	

RESOURCES

Does the consumer have natural resources? (Parent/Guardian, DSS member, GAL)

Does the consumer have resources for home visits when appropriate? ☐ **Yes** ☐**No**
If so, who? ____

Are there any special conditions/restrictions for visits home? ______________________________

____

Any "no contact" orders? ____

SCHOOL INFORMATION

Last School Enrolled: ____

County/District: ______________________________ **Grade:** ______________

Special Classes: ☐**EH** ☐**LD** ☐**Resource** ☐**BEH** _______
☐**Homebound** **Other:** ______________

COURT HISTORY

Does Consumer have a criminal record? ☐**Yes** ☐ **No** **Tried as a** ☐ **Juvenile** ☐ **Adult**

Offenses : **Convictions:**
______________________ ______________________
______________________ ______________________

Pending Charges: ____

Is Consumer on Probation?___________ **Name of Court/Probation Officer**______________________

Phone:______________________ **Email address:**______________________

HISTORY OF SELF-INJURY AND RISK BEHAVIORS

Self Injury	**Check all that apply** ☐ **cuts on body** ☐ **conceals cutting- indicate area** ☐**other forms of self injury (please describe)** **Has self-injury ever required medical attention? Please explain:** ______________________ ____
Suicidal Characteristics	**Check all that apply** ☐**Suicidal thoughts** ☐ **Past Suicide Attempts** ☐ **Suicidal Plans** **Describe:**____ ____ **Methods used in previous attempts- please describe:** ______________________

Homicidal Characteristics	**Check all that apply ☐ homicidal thoughts ☐ Past Attempts to harm others ☐ Homicidal Plans** **Describe:** ______ **Methods used in previous attempts- please describe:** ______
History of AWOL	**☐ Runs away from home ☐ Has run from previous placements** **In the past year how many times has consumer run?** ______ **Where does he/she go?** ______ **How long is typically AWOL?** ______
Substance Abuse History	(see table below)

Type of Substance	Frequency	Last Use	Type of Substance	Frequency	Last Use
☐ Marijuana			☐ Amphetamines		
☐ Cocaine			☐ Hallucinogens		
☐ Heroin/Opiates			☐Alcohol		
☐ Inhalants			☐ Other:		

Sexualized Behaviors	**Please describe any sexualized behaviors exhibited by consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution):** ______
Psychotic Behaviors	**Please describe any past/present history of psychosis:** ______

REFERRAL CHECKLIST

Please include the following information to help determine whether Nova, PRTF is the appropriate program for your consumer.

Item	
NOVA-IC, Inc. Application	
Discharge Summaries from Hospitalizations/ Previous Treatment	
School Records/ IEP (if available)	
DSS records (if applicable)	
DJJ records (if applicable)	
Psychological Testing	
Sexually Aggressive Youth Evaluation / Sex Offender Specific Evaluation (if applicable)	
Immunization Records	
Birth Certificate	
Copy of Medicaid/ Insurance Cards	
Psychiatric evaluations	
Diagnostic Assessment (or any other assessment completed)	
Court/Custody Orders	

Please send all completed information to: **NOVA-IC, Inc.** **Candra Hill** **Consumer Affairs Coordinator / Admissions Specialist** **Email Address: candrahill@nova-ic.org** **Mailing Address: P.O. Box 11077, Goldsboro, NC 27532** **Physical Address: 2307-G Norwood Ave., Goldsboro, NC 27534**	**Office: (919) 735-7203 ext. 1002** **Fax: (919) 735-7207** **Mobile: (919) 738-2842**