Amos Cottage Therapeutic Day Program
Admission Assessment

Child's Full Name:_____
Date of Birth:_____Race:_____Gender: Male or Female
Social Security Number:_____

Mother's Name:_____Date of Birth:_____
Father's Name:_____Date of Birth:_____
Name and address of person with whom the child resides (include street, city and zip code):_____
_____
County of Residence: _____
Home phone number:_____
Email Address: _____
Parents: (circle one) Married Unmarried Separated Divorced Widowed
Who has legal custody of child?_____

Please list all persons living in child's home and their date of birth:
_____
_____
_____
_____

Mother's occupation:_____Mother's work phone:_____
Mother's employer:_____
Highest school grade completed:_____

Father's occupation:_____Father's work phone:_____
Father's employer:_____
Highest school grade completed:_____

Birth/Medical History
Were there problems during the pregnancy, labor, or delivery? If so, explain:_____
How many weeks or months was the pregnancy?_____Baby's birth weight:_____
Birth was:(please circle) Normal Cesarea Breech Twins or more
Did baby have problems after birth?_____If yes, please explain:_____
_____
Please list any major illnesses or injuries your child has had to this date:_____
Is your child taking any medications regularly? If yes please list below:
_____

(over)

Developmental History
At what age did your child: Roll over_____ Sit Alone_____
Pull up to furniture_____Crawl_____Walk_____
Say single words_____Say 3 word sentences_____
Become toilet trained_____

Referral Concerns
What are your primary concerns about your child?

_____

_____

What have you been told regarding these concerns? (by your child's doctor, etc..)

_____

Has your child received a behavioral or medical diagnosis? If yes please note:

_____

Who referred you to the Therapeutic Day Program?_____

Please **circle** the areas that you have **current concerns** about your child:

Gross Motor Skills:
Running Climbing Unassisted Pedaling a Tricycle Jumping with Good Balance
Using Stairs Alternating Feet Balancing on one Foot Kicking a Ball
Throwing a Ball Overhead Catching a Bouncing Ball Sliding Unassisted

Fine Motor Skills:
Holding a Pencil Copying (Lines/Circles) Using Scissors Opening Wrappers

Self-Help Skills:
Using both Spoon and Fork to Eat Toileting Independently
Undressing Independently Dressing Independently
Washing and Drying Hands Independently

Strength and Muscle Tone:
Loses Balance Clumsy Can't Hold Sitting Position on Floor for 5 Minutes
Muscles Too Tight Muscles Too Loose

Sensitivities:
Avoids Certain Clothing Items Avoids Certain Foods and or Smells Picky Eater
Wears Clothes Incorrectly Bothered by Certain Noises (*Specify Noise*):_____
Becomes Frightened when Feet Leave Ground Avoids Going Barefoot

Please **circle** the areas that you have **current concerns** about your child:

Seeks Sensation:
Chews Clothes Enjoys Strange noises or Makes Noises Can't Sit Still/Fidgets
Becomes Overly Excited during Activities Touches People and Objects
Doesn't Seem to Notice When Hands or Face are Messy

Listening Skills:
Hearing What is Being Said Difficulty Paying Attention
Easily Distracted by Noise in Immediate Setting

Cognitive/Learning:
Understanding Consequences both Positive and Negative
Following and Understanding Rules Stopping and Thinking Before Acting
Learning New Concepts Remembering What He Has Learned
Distinguishing Between Reality and Fantasy (Understanding What is Real and What is Pretend)

Attention/Activity Level:
Overly Active Low Energy/Underactive Appears in Own World
Short Attention Span

Social/Emotional:
Expressing Feelings Verbally: Happy, Sad, Angry, and Afraid
Naming or Identifying a Friend Limited Range of Activities/Toys
Odd Intense Interests Engaging in Cooperative Play
Engaging in Imaginary/Pretend Play Little Interests in Adults
Little Interest in Peers

Other:
Accepts Transitions Insists on Routines Difficulty Separating from Family Members
Repeats Questions When Answers are Provided Appears Worries
Often Complains of Not Feeling Well Likes Things a Certain Way
Doesn't Like When Play Items are Moved Speaks Less in Group Settings
Often Appears Irritable Mood Changes Frequently Unaware of Danger
Sleep Problems

Pre-school/School History

Does your child attend daycare, preschool, or school? If yes, list name and address of program and how long has child been enrolled:

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other)? If so explain:

Does you child have an IEP? Yes No Has the IST Process Started? Yes No
(If your child has an IEP, kindly provide the program a copy of the plan)

Do you think your child needs additional support in school? If so explain:

What would you like to see done for your child during this admission?

How can this program support you as a parent/caregiver?

Please complete the following to assist us in obtaining information needed to plan for your child's treatment

Child's address of Primary Care Physician/Doctor:

Please list any other doctors/evaluators who have treated your child and their addresses:

Has your child ever been hospitalized? Name of hospital? Reason for hospitalization?

(over)

Please complete the following as it applies to your child:
Medicaid, *Medicaid number is:*_____
Insurance, is with_____

Name of person completing this form:_____

I do hereby give my permission at this child's parent or guardian to have him/her treated/evaluated by the Day Treatment Team at Amos Cottage. I understand that this facility is both a service and a training program, and give my consent to have fully supervised students participate in the evaluation.

Parent/Guardian
Signature:_____Date:_____

Kindly fax or mail this form once complete:
Attention: TDP Program Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Amos Cottage Therapeutic Day Program
3325 Silas Creek Parkway
Winston-Salem, NC 27103

Financial Coverage
(*Please Complete*)

Client's Name _____ Birth date: _____

Social Security Number: _____

1. Is client covered by any **private insurance**? Yes No

   Policyholders Name: _____

   Employer: _____

   Name of Insurance Company: _____

   Address and Telephone Number: _____

   Policy Number: _____ I.D. number: _____
   Group Number: _____
   Claims Address:

   _____

   _____

2. Is client covered by **Medicaid**? Yes No

   Medicaid Number: _____

3. Is client approved for outpatient services? Yes No

   Carolina Access Doctor's Name: _____

   Doctor's Carolina Access number (*contact PCP to obtain number*): _____

   Mail To:
   Amos Cottage Therapeutic Day Program
   Attention: TDP Program Assistant
   3325 Silas Creek Parkway
   Winston-Salem, NC 27103

Revised: 09/05

Amos Cottage/United Way
Request for Financial Assistance
For Therapeutic Day Program

Client's Name: _____

Parent/Guardian Name: _____

Number of people in immediate family: _____

Address: _____

Home Phone #_____ Work Phone #_____

Immediate family members in client's household:

Name	Relationship to Client

List all Employers or Source of Income/Reason for None for 12-month period.	Dates: From	To	Yearly Gross Income	Yearly Income After Tax	Documented
		Total Gross Family Income:			
		Fed, State & SS Tax			
		Income after Taxes:			

Total Amount Income after Taxes: $_____

Eligibility for other Programs:
SSI Yes No
Medicaid Yes No
Medicaid #_____
Eligibility Date:_____
Please complete the entire form; partial completion of form can delay the admission process

Applicant's Signature_____

Relationship to client_____ Date_____

Revised 09/05

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: _____ ***(Primary Care Provider)***
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

To be Released to: ***Amos Cottage Therapeutic Day Program***
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address of authorized recipient of information)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
☐ Discharge Summary	☐ Cardiac Catheterization	Mental Health Impressions	☐ Visit History
☐ History & Physical	☐ Pathology report	Previous Referrals	☐ Verbal Exchange
☐ Operative Report	☐ Lab result	Testing	☐ Treatment Plan
☐ Office/Clinic Note	☐ Reason for Referral	☐ Diagnostic/treatment records	☐ Other – Please specify: _____

☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
☐ any other pertinent information to support Day Treatment Program Admission and Treatment

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department):
Amos Cottage Therapeutic Day Program, 3325 Silas Creek Parkway, Winston Salem, NC 27103 (336) 713-7444-p, (336) 765-0842-f

The information will be used/disclosed for the following **purpose:**
☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: pickup, ☐ Paper Copy ☐ CD ☐ MyChart Other:
for the periods from _____ through _____

I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

☐ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

. I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing) Authority to Sign if other than patient ***(written proof may be required)***

This release is limited to the Facility/Practice or Department you specified above.
To obtain information from another Facility/Practice or Department individual authorizations will be needed

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center CareNet, Inc.)

For Office Use Only MRN: _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

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THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(Patient name & date of birth)

To be Released From/By: ***Amos Cottage Therapeutic Day Program***
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

3325 Silas Creek Parkway, Winston Salem, NC 27103, (336) 713-7444, phone, (336) 765-0842, fax
(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: _____ **(Primary Care Provider)**
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_____
(Address of authorized recipient of information)

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Specific records:

☐ Emergency Department	☐ Radiology result	☐ Clinical	☐ Evaluations
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☐ Entire visit (provider notes, results, flow sheets/nursing notes, scanned documents, etc.)
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Requested format: ☐ Electronic Copy ☐ paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

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_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient ***(written proof may be required)***

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MRRO