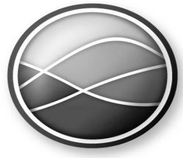

CENTRA
Virginia Baptist Hospital
Bridges

693 Leesville Road
Lynchburg, VA 24502
434-947-5700

APPLICATION FOR ONLINE SITE

Thank you for your interest in our program at Bridges Treatment Center. We hope the following information will be helpful in making application for placement. At any time during the process, please contact Dee Edwards at Bridges Treatment Center at 434-947-5700; voice mail 434-947-5851, ext. 1 or by e-mail at dee.edwards@centrahealth.com if there are questions about the process or the appropriateness of the applicant for our program. Once applications are completed, you can submit them to:

Dee Edwards
Bridges Treatment Center
693 Leesville Road
Lynchburg, VA 24502
FAX: 434-947-5708

Attachments:

1. Application (2 pages) Please include appropriate attachments.
2. Social History Questionnaire—This must be completed by the day of admission by the legal guardian
3. CSA Reimbursement Rate Certification and current rates for services (2 pages).
4. Admission day information (2 pages).

CENTRA
Virginia Baptist Hospital
Bridges

693 Leesville Road
Lynchburg, VA 24502
434-947-5700

Admission Day Information

On the day of admission, please be advised that the average length of time set aside should be three hours. The admission coordinator, attending physician, admitting nurse, utilization review coordinator, therapist, and teacher may need to discuss past history. It is vital that we obtain this information to provide a smooth transition for your child. The following information should be brought, mailed, or faxed ahead (434-947-5708).

- Complete social history form found in the pre-admission packet
- Name, address, phone number and social security number of birth parents and date of birth, when appropriate
- Name, address, and phone number of former physician and dentist
- Medicaid card or other insurance card
- List of current medication (please bring prescription label); additional medications will be supplies by Bridges; do not bring any medications
- Medical information regarding current treatments; i.e., allergies, diabetes. dietary needs, eye glasses, etc.
- School address and contact person; please include phone numbers

_____ * **Immunization record; this must be included or the admission will be delayed**

When packing for your child, please keep in mind that Bridges does not provide storage space. The following list will be of use when gathering your child's belongings:

- A weekend bag/suitcase to remain on campus for the child when passes home are granted; large containers and suitcases will need to be sent back
- 7 days of seasonal clothing; casual clothing may include jeans and tee-shirts
- Sturdy tennis shoes (non-marking soles)
- Bathing suit (all seasons)
- Gym clothing
- Radio, clock, hairdryer, and other electrical appliances (which will need to be found in safe working conditions by Bridges maintenance department)

- Tapes and posters may be brought, however Bridges reserves the right to send articles back that are deemed counter-therapeutic to our environment
- Personal hygiene products

_____ *** Bridges does not provide clothing or spending allowances for the residents. You may leave money for your child with the milieu coordinator. This money will be monitored by staff.**

The following are provided by Bridges Treatment Center:

- Linens
- Laundry facilities and detergents

Please keep in mind that Bridges Treatment Center provides a smoke-free environment for our residents, staff, and visitors, which includes our parking lots. We encourage healthy lifestyles and expect you to further this lifestyle for your child by not using tobacco products during your visit and not providing tobacco products to your child during passes or visits.

Bridges Treatment Center serves children and adolescents from a variety of cultural, ethnic, and religious backgrounds. In order to respect all national and religious holidays, and not to accidentally exclude anyone, Bridges Treatment Center will have seasonal festivals throughout the calendar year. These will incorporate the traditional holidays and customs and will, in some instances, incorporate the school schedule.

While your child is in treatment, please be informed that the use of public transportation (planes, trains, buses, cars) by your child, without guardian/parent accompaniment, will not be allowed.

If you have any further questions regarding these policies, please contact William H. Gorman. Director

*** Please initial**

Revised 1-98, 4-06, 11-08

CENTRA
Virginia Baptist Hospital
Bridges

693 Leesville Road
Lynchburg, VA 24502
434-947-5700

APPLICATION FOR ADMISSION

Name of Applicant ____
DOB __________________________ SS# ___________________________
Address ____

Legal Guardian ____
Relationship of Applicant ____
Address ____

Referring Agency ____
Address ____
Contact Person ___________________________ Phone # _______________

Please attach information that addresses the following issues and make comments where applicable:

Attached (Y/N)	Required Information	Comments
	Physical Needs (Please specify if allergies, glasses, dental, special medical needs, handicapping conditions.*)	
	Educational Needs (Please attach current IEP or report card if regular education.)	

	Mental Health, Emotional and Psychological Needs (Please attach enclosed Social History Questionnaire and Psychological Testing.)	
	Physical Health Needs (Please attach current Immunization Record and list current medications. **THE ADMISSION WILL BE DELAYED WITHOUT AN IMMUNIZATION RECORD**.)	
	Protection Needs (risk for suicide)	
	Suitability of Admission	
	Behavior Support Needs	
	Information to assist in developing a Service Plan (Please attach current CAFAS, Certification of Need, and Rate Certification form (enclosed).	

Please return with attachments to Dee Edwards, Admissions Coordinator.

693 Leesville Road
Lynchburg, VA 24502
434-947-5700

SOCIAL HISTORY QUESTIONNAIRE

IDENTIFYING INFORMATION

Date of Admission____
Person completing questionnaire ____
Relationship to resident____

Resident Name ________________________________ DOB _____________ Age _____
Address____
SS# ____ Phone _________________________
School most recently attended______________________________ Current Grade _________
Religion (if applicable) ____
Name of Legal Guardian ____
Who does the resident live with? ____

REASON FOR REFERRAL

Who referred the resident to Bridges? ____
Please list the reason(s) the resident was referred for treatment______________________
____
____
____
____
____

DEVELOPMENTAL HISTORY

Was this pregnancy planned?_____ Full Term?_______ If no, how many months? ____
Birth weight? ____lbs ____ozs. Were medications/drugs/ alcohol used during pregnancy? ______ If yes, specify ____

Were there complications during pregnancy and/or delivery? _____ If yes, please explain ____

Delivery: vaginal _____ Caesarian _________

At what age did the resident do the following?

	Sit unsupported		Recognize stranger
	Began to talk		Speak in short sentences
	Began to walk		Walk alone
	Feed self with spoon		Put on clothed
	Begin toilet training		Complete toilet training
	Sleep through the night		

Please comment on any difficulties with the following:

Feeding____
Sleeping____
Talking____
Walking____
Toilet training____

Check all words which describe the resident as an infant:

	Very active		Restless		Normally active		Quiet
	Sluggish		Fragile		Sickly		Crying
	Happy		Cute		Colicky		Good
	Irritating		Healthy		Responsive		Demanding
	Irritable		Easily satisfied		Did not like being held		

Who was the major caretaker before resident began school? (Include parents, daycare, babysitter or relatives)____
____
____
____

Please give name and relationship of any other people who were important in rearing the resident (grandparents, step parents, foster parents, etc). ___________________________
____
____
____
____

At what age did puberty begin? _________ How did the resident react? ____________
____
____

Please check any of the following that are a problem or have been a problem for the resident:

	CURRENT PROBLEM	PAST PROBLEM / AGE
Thumb sucking		
Fire setting		
Destructiveness		
Nail biting		
Soiling pants		
Dressing problems		
Rocking		
Stuttering		
Sexual difficulties		
Nightmares		
Hyperactivity		
Under activity		
Clumsiness		
Too clean		
Bedwetting		
Suicidal thoughts		
Head banging		
Temper tantrums		
Breath holding		
Fears		
Lying		
Nervous twitches		
Stubbornness		
Indecisiveness		
Sloppiness		
Running away		
Drinking		
Drug use		
Stealing		
Cruelty to animals		
Excessive sexual behavior		

MEDICAL HISTORY

Does the resident have any current medical or physical problems? __________________
____
____

Please list medications and/or treatment for these ________________________________
____

Please list any allergies the resident has____
____

Please list any illnesses, hospitalizations, convulsions, seizures, high fevers or medications that the resident has had, with age(s) _________________________________
____

EDUCATIONAL HISTORY

Describe the resident's adjustment to pre-school, nursery school or kindergarten _______
____
____

Has the resident had any attendance or behavioral problems in school? _____ If yes, please describe and give age and grade ____
____
____
____

Has resident ever repeated a grade? _____ If yes, which grade(s) __________________

Is the resident in special education classes? ______ If yes, what is the current educational level? ______ Date of last IEP? _____________________

List schools the resident has attended and grades completes at each school (include preschool or nursery school).

SCHOOL	AGE / GRADE	GRADE AVERAGE

Favorite subjects ____
Least favorite subjects ____
Academic strengths____
Academic weakness____

MENTAL HEALTH TREATMENT HISTORY

THERAPIST/PLACEMENT/HOSPITAL	DATE	REASON

Current medication (dosage, frequency) ____
____
____

Has the resident completed psychological testing? ____ If yes, give date(s) and name(s) of evaluator(s). Please include copy of most recent testing.________________________
____
____

STRENGTHS/WEAKNESSES

How is free time spent by the resident (hobbies, talents, sports)? ___________________
____
____
____

Describe the resident's friendships and social network ___________________________
____
____
____

What interests and activities do the resident and family share together? ______________
____
____
____

Has the resident been employed or participated in volunteer work? _____
Describe____
____
____

What would you identify as the support system for this family? ____________________
____
____
____

Do you or your child have any spiritual or religious beliefs that may impact his/her course of treatment while at Bridges? Yes ____ No _____ If yes, please describe ____
____
____

What do you believe are the resident's best qualities? ______________________________
____
____

FAMILY INFORMATION

Type of residence____
Where does the resident sleep____
Indicate family moves____

Mother's Name ______________________________ Age ______ DOB ___________
Address____
Home Phone# ______________________________Social Security #______________
Educational Level ____________________________Religion ___________________
Occupation___________________________________Work Phone#________________
Employer____
Military Service and dates____
If remarried, name if current spouse_______________________________________
If deceased, date and cause of death_______________________________________

Previous Marriages:

DATE OF MARRIAGE	DATE OF DISSOLUTION	REASON

Place of birth and where raised ____
____
____

Mother's Parents:

	NAME	AGE	HEALTH	OCCUPATION	CURRENT MARITAL STATUS
MOTHER					
FATHER					

Mother's Siblings

NAME	**AGE**

Briefly describe relationships between mother, father, siblings in mother's family:
____
____
____
____

Father's Name ______________________________ Age ______ DOB____________
Address____
Home Phone# ______________________________Social Security #______________
Educational Level____________________________Religion ___________________
Occupation__________________________________Work Phone#________________
Employer____
Military Service and dates____
If remarried, name if current spouse______________________________________
If deceased, date and cause of death______________________________________

Previous Marriages:

DATE OF MARRIAGE	**DATE OF DISSOLUTION**	**REASON**

Place of birth and where raised ____
____

Father's Parents:

	NAME	**AGE**	**HEALTH**	**OCCUPATION**	**CURRENT MARITAL STATUS**
MOTHER					
FATHER					

Father's Siblings

NAME	AGE

Briefly describe relationships between mother, father, siblings in father's family ____
____
____

Resident's siblings (brothers, sisters, half, step, living or deceased)

NAME	AGE	RELATIONSHIP	RESIDENCE	EDUCATION	OCCUPATION

Stepmother (if applicable):

Name____ Age ____________
Address____
Phone # _______________________________ Occupation _____________________________

Previous Marriages:

DATE OF MARRIAGE	DATE OF DISSOLUTION	REASON

Stepfather (if applicable):

Name ____
Address ____
Phone # _______________________________ Occupation _____________________________

Previous Marriages:

DATE OF MARRIAGE	DATE OF DISSOLUTION	REASON

Describe resident's relationship with his/her parents ______________________________
____
____
____

Describe resident's relationship with sister/brothers (include the names of siblings) ____
____
____
____
____

Describe resident's relationship with relative and significant others __________________
____
____
____

Other people living in same household as the resident _____________________________
____
____
____

Describe any separations from the parents the resident has experiences ______________
____
____
____
____

Mental Health and/or drug and alcohol problems in the family (if relative, specify maternal/paternal)

NAME	RELATIONSHIP TO RESIDENT	DESCRIBE PROBLEM

List any stressors on the family (medical, financial, emotional, etc) _______________
____
____
____

Has the resident lost any family members, friends or pets through death or separation? ______ If yes, please describe ____
____

Physical and/or Sexual Abuse

PHYSICAL ABUSE		**SEXUAL ABUSE**	
By Whom?	At What Age?	By Whom?	At What Age?

Has the resident had any legal or police involvement? __________ If yes, please explain
____
____
____

Does the resident currently have any pets? _____ If yes, please specify _____________
____
____
____

SUMMARY

What are your goals for treatment?

1.

2.

3.

Please include any other comments or special concerns you wish to make or information you feel would be relevant to helping us understand the family.

CSA Reimbursement Rate Certification
Residential Treatment and Treatment Foster Care

Name of Child ____

Medicaid Number ____

Residential Treatment or Foster Care – Case Management Provider:

Bridges Treatment Center 693 Leesville Road Lynchburg, VA 24502

Provider Number: 1629172838

Community Policy and Management Team

County/City ____

Address____
Street

____
City State Zip Code

I certify that the following rate, $_______________ per day has been negotiated for the above child for Medicaid reimbursable (Check one):

__X__ Residential Treatment

_____ Treatment Foster Care – Case Management

The Medicaid rate noted should reflect the negotiated rate minus expected reimbursement from all other payment sources, such as Title IV-E. The total reimbursement from all other sources cannot exceed the Medicaid maximum rate for this service

This rate shall be effective for dates of service beginning ________________________.
MONTH/DAY/YEAR**

CPMT Signature: ____

Print Name: ____

Title: ____

Date: ____

**Date must be current year

RATES PER SERVICE UNIT

Bridges Treatment Center

SERVICE	DAY	YEAR	OFFERED
Room and Board – Title IV-E	$261.80	$95,557.00	365 days
Combined Services	$105.30	$38,434.50	365 days
SUBTOTAL	$367.10	$133,991.50	365 days
Education*	$95.00	$23,940.00	252 days
TOTAL	$462.10	$157,931.50	
Therapies – Individual, Group, Family	$37.00	$13,505.00	365 days
Occupational Therapy Services – Evaluation Occupational Therapy Services – Cognitive Skill Development	$118.00 $47.00	Per Session Per 15 minutes	Per Physician Order Per Physician Order
Speech Therapy Services – Individual Speech Therapy Services – Group	$95.00 $78.00	Per Session Per Session	Per Physician Order Per Physician Order
Physical Therapy – Evaluation Physical Therapy – Therapeutic Activity	$118.00 $47.00	Per Session Per 15 minutes	Per Physician Order Per Physician Order
Psychological*	$126.00	Per Hour	Per Physician Order
Travel Requested/Required by Placing Agency*	$75/hour, plus $.55/mile	N/A	As Needed

Brightwell & Farmville Group Homes

SERVICE	DAY	YEAR	OFFERED
Room and Board*	$80.00	$29,200.00	365 days
Therapeutic Services	$158.93	$58,009.45	365 days
TOTAL	$238.93	$87,209.45	365 days
Medical Management*	$25.00	N/A	As Needed
Travel Requested/Required by Placing Agency*	$75/hour, plus $.55/mile	N/A	As Needed

*Medicaid does not cover

Rates Effective: 7-1-09 to 6-30-10