



### PRTF Admission Application Packet

Date of Application: \_\_\_\_\_ Date Service Needed: \_\_\_\_\_

Please do see the Referral Check List Page 11 of this document. These documents are necessary for placement.

#### 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 Number: \_\_\_\_\_ Email: \_\_\_\_\_

#### CONSUMER'S NETWORK INFORMATION

Network/ MCO: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_






**MEDICAL INFORMATION**

Allergies: \_\_\_\_\_

Special Dietary Needs: \_\_\_\_\_

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

- |                                  |                    |                        |
|----------------------------------|--------------------|------------------------|
| Lice                             | Bulimia            | Eczema                 |
| Anemia                           | Anorexia           | Asthma                 |
| Drug / Alcohol Abuse             | Measles            | Hay Fever              |
| HIV / AIDS                       | Mumps              | Convulsions            |
| Sexually Transmitted Disease     | Chicken Pox        | Sinus Problems         |
| Ringworm                         | Sickle Cell Anemia | Diabetes               |
| Tuberculosis                     | Migraine Headaches | Hepatitis              |
| Chronic Urinary / Bowel Problems | Rubella            | Traumatic Brain Injury |

Other: \_\_\_\_\_ Other: \_\_\_\_\_ Other: \_\_\_\_\_

Name and Address of Pediatrician: \_\_\_\_\_

Name and Address of Dentist: \_\_\_\_\_

Date of Last Phys. Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Dental Appliances:    Yes    No                      Contacts / Glasses:    Yes    No

**ADDITIONAL INFORMATION**

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**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:** \_\_\_\_\_

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**PRESENTING PROBLEMS / REASON FOR REFERRAL**

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<b>PLACEMENT HISTORY</b>		
<b>Placement (Begin w/Current Placement)</b>	<b>Dates (From – To)</b>	<b>Reason for Discharge</b>

<b>CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS</b>		
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
Homeless	Hyperactive	Impulsive
Lying	Low Self-Esteem	Loss / Grief Difficulties
Physical Impairment	Mental Retardation	Parent Neglect Issues
Perception of Reality	Phobic Behavior	Physical Disability
Self-Destructive Behavior	Sibling Related Difficulty	Oppositional
Social Immaturity	Sexually Inappropriate Behavior	Stealing
Suicidal	Running Away	Truancy
Unruly / Ungovernable	Cruelty to Animals	Hygiene / Cleanliness Issues
Problems with Sleep	Gang Related Activity	History with Weapons
Other: _____		
<b>ADDITIONAL INFORMATION</b>		



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**AGGRESSIVE OR VIOLENT BEHAVIOR ALERT**

Please describe the nature of the acting out behaviors:

Verbally Aggressive      Frequency: \_\_\_\_\_

Description: \_\_\_\_\_

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Physically Aggressive      Frequency: \_\_\_\_\_

Description: \_\_\_\_\_

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Property Destruction      Frequency: \_\_\_\_\_

Description: \_\_\_\_\_

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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:

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Main Targets of Aggression:    Peers    Authority Figures    Family Members (Please be specific)

Please Describe the most recent episode of aggression:




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**FAMILY INFORMATION**

Biological Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: 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.



<b>Criminal Activity</b>	<b>Child Abuse</b>
<b>Inappropriate Sexual Behavior</b>	<b>Treatment Disruption</b>
<b>Psychiatric Illness</b>	<b>Substance Abuse</b>
<b>Suicide</b>	<b>Other:</b>

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 _____	
Any history of truancy? _____	Grades Repeated: _____
Current IEP?      Yes      No      Date: _____	
Current 504?      Yes      No      Date: _____	
Suspensions / Expulsions: _____	
Choice of High School Curriculum: (if 16 or older)	Regular      GED / High School Equivalent





Special Communication needs?	Yes	No	_____
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<b>COURT HISTORY</b>
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Does Consumer have a criminal record:	Yes	No	Tried as a	Juvenile	Adult
<b>Offenses:</b>	<b>Convictions:</b>				
_____	_____				
_____	_____				
_____	_____				
Pending Charges: _____					
Is Consumer on Probation? _____ Name of Court / Probation Officer _____					
Phone: _____ Email Address: _____					
Is placement court ordered? Yes No (If "Yes, attach court order) Other information regarding court proceedings (next court date, if consumer is to appear): _____					
_____					

<b>HISTORY OF SELF-INJURY AND RISK BEHAVIORS</b>
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<b>Self-Injury</b>	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: _____ _____
<b>Suicidal Characteristics</b>	Check all that apply    Suicidal thoughts    Past Suicide Attempts    Suicidal Plans Describe: _____ _____ Methods used in previous attempts – please describe: _____ _____
<b>Homicidal Characteristics</b>	Check all that apply: Homicidal thoughts    Past Attempts to harm others    Homicidal Plans Describe: _____ Methods used in previous attempts _____ _____
<b>History of AWOL</b>	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? _____



<b>Substance Abuse History</b>	<b>Type of Substance</b>	<b>Frequency</b>	<b>Last Use</b>	<b>Type of Substance</b>	<b>Frequency</b>	<b>Last Use</b>
	Marijuana			Amphetamines		
	Cocaine			Hallucinogens		
	Heroin / Opiates			Alcohol		
	Inhalants			Other:		

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



**REFERRAL CHECKLIST**

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

<b>Canyon Hills, PRTF Application</b>	
<b>Current Person-Centered Plan / Sign Page</b>	
<b>Discharge Summaries from Hospitalizations / Previous Treatment</b>	
<b>School Records / IEP (if available)</b>	
<b>DSS records (if applicable)</b>	
<b>DJJ records (if applicable)</b>	
<b>Psychological Testing</b>	
<b>Sexually Aggressive Youth Evaluation / Sex Offender Specific Evaluation (if applicable)</b>	
<b>Immunization Records</b>	
<b>Birth Certificate</b>	
<b>Copy of Medicaid / Insurance Cards</b>	
<b>Psychiatric Evaluations</b>	
<b>Diagnostic Assessment (or any other assessment completed)</b>	
<b>Court / Custody Orders</b>	
<b>CON-Certificate of Need Signed by the Physician and SOC</b>	

**PRTF Application Addendum: Children with Problematic Sexual Behaviors**

Check any of the sexual behaviors listed below that the child displays:

<b>Public or excessive masturbation</b>	<b>Sex and / or sexual acts with other children</b>
<b>Fondling of other children</b>	<b>Fondling of adults</b>
<b>Poor boundaries</b>	<b>"Accidental" touching of others</b>
<b>Exposing body or private parts</b>	<b>Sexual threats</b>
<b>Interest in pornography</b>	<b>Sexual contact with animals</b>
<b>Forced or inappropriate kissing</b>	<b>"Peeping" / Voyeurism</b>
<b>Rubbing private parts against others and/or furniture</b>	<b>Attempting to initiate sex and / or sexual acts with adults</b>
<b>Sexually explicit comments, conversation, or gestures</b>	<b>Simulating intercourse – with other children, with dolls, etc.</b>
<b>Other:</b>	

**WHEN SEXUAL BEHAVIOR FIRST BEGAN OR WAS FIRST NOTICED:**

<b>Date of most recent sexual behavior:</b>
<b>Frequency of sexual behavior(s):</b> Daily Weekly Monthly
<b>Child's own history of abuse / neglect: please indicate the perpetrator(s):</b>
<b>Physical Abuse:</b>
<b>Sexual Abuse:</b>
<b>Mental / Emotional Abuse:</b>
<b>Neglect:</b>
<b>Exposure to Domestic Violence</b>
<b>Exposure to Pornography or Adult Sexual Behavior in home:</b>



**\*\*For anything reported on this worksheet, please attach any supporting documentation (reports, evaluations, etc.) \*\***

**Please send all completed information to:**

**Canyon Hills Treatment Facility, PRTF**

**Admissions**

**\* Email: [Canyonhillstreatmentfacility@gmail.com](mailto:Canyonhillstreatmentfacility@gmail.com) or**

**\*Email: [chtf2601@yahoo.com](mailto:chtf2601@yahoo.com)**

**\*Physical Address: 769 Aberdeen Rd. Raeford, NC 28376**

**Office: (910) 878-1502**

**Fax: (910) 878-1503**

**mobile: (505) 652-0669**



## ACADEMY ADMISSION LETTER

Canyon Hills Treatment Facility  
796 Aberdeen Rd  
Raeford, NC 28376

Date: \_\_\_\_\_  
Receiving School: \_\_\_\_\_  
Attn: Registrar Office/Data Manager

Dear Registrar,

I am writing to inform you that \_\_\_\_\_ D.O.B \_\_\_\_\_ has been admitted into our Psychiatric Residential Treatment Facility program as of \_\_\_\_\_. Below you will find a list of pertinent information we are requesting in order to provide appropriate services to this student. A release of information is included with this letter. Since this is a temporary placement, the cumulative records should continue to be maintained at the home school. In most cases, the student will return to your school upon discharge. Recommendations will be shared with you upon discharge.

Thank you for your assistance in this matter. Please feel free to call with any questions of concern.

Sincerely,

Stephanie McFayden, Education Specialist

**Phone:** (910) 878-1502    **Fax:** (910) 878-1503

### **Please send a copy of the student's:**

- Most recent report card
  - Attendance records
  - Immunization record
  - Most recent standardized test scores
  - Discipline records and/or anecdotal records
  - 504-Plan
  - State Mandated Test Data
  - FBA/BiP
  - Current IEP
- If applicable:**
- **EC Referral**
    - Invitation to conference
    - DEC 1
    - DEC 2 and evaluations/supporting documents
    - DEC 5
  - **Initial Evaluation**
    - Invitation to conference
    - DEC 3 and appropriate worksheets
    - DEC 5
    - DEC 6
    - DEC 4
    - DEC 4a (if applicable)
  - **ALL Re-evaluations**
    - Invitation to conference
    - DEC 7 and evaluations/ supporting documents
    - DEC 2
    - DEC 3 and appropriate worksheets
    - DEC 4
    - DEC 4a (if applicable)
    - DEC 5
  - **Most current Annual Review**
    - Invitation to conference
    - DEC 4
    - DEC 4a (if applicable)
    - DEC 5



### Confidential Request for Educational Records

North Carolina General Statute 122C-450.2 states that upon admission of a child to a Psychiatric Residential Treatment Facility (PRTF), the facility must request copies of a child's most current Individualized Education Plan (IEP) and any other available documents related to the provision of appropriate educational services from the local school administrative unit that last served the child and that to the extent practicable the local administrative unit will provide this information within three (3) business days of receiving this request.

The purpose of this request is to obtain educational records to ensure the delivery of educational services while the student resides in a Psychiatric Residential Treatment Facility (PRTF).

To: \_\_\_\_\_ Date: \_\_\_\_\_  
From: Canyon Hills PRTF Date of Admission: \_\_\_\_\_  
Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand the purpose of the Confidential Request for Educational Records. I understand that I can provide or revoke consent for the release of my child's educational record, in writing, at any time. I also understand that all records are confidential and my consent for the release of my child's educational records expires one year after the date for which consent is provided.

I give my consent for my child's educational records to be obtained from:

\_\_\_\_\_  
(Name LEA, School or Facility)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone) (Fax)

\_\_\_\_\_  
(Printed Parent/Guardian Name) (Date)

\_\_\_\_\_  
(Printed Parent/Guardian Signature)

I DO NOT give my consent for the release of my child's educational records. I understand this may have an adverse effect on the educational services provided to my child residing in PRTF.

\_\_\_\_\_  
(Printed Parent/Guardian Name) (Date)

\_\_\_\_\_  
(Printed Parent/Guardian Signature)



## **Personal Items Check List**

Please see the following list of items allowed at Consumer Intake. During the weekday, all consumers wear Canyon Hills uniforms. Polo styled shirts are provided for the consumer to wear during the school period. After the education period, consumers are provided after school play and sleep wear. No profane or offensive language or images is permitted on any of the personal items.

1. 2 Pairs of Brown Khakis
2. Regular White Tube Socks
3. Plain White T-Shirts
4. 2 pairs of shoes- Tennis Shoes for outdoor activity; Shower Shoes
5. Underwear
6. 1 Light Jacket
7. Heavy Winter Coat
8. 2 Regular Outfits (i.e. one long sleeve shirt and short sleeve shirt, jeans, sweat pants, or short) Toboggan or Fitted Cap
9. Age Appropriate Reading Material
10. Age Appropriate toys (i.e. small trucks, cars, stuffed animals)

Thank you,  
Canyon Hills Administration