www.TimberRidgeSchool.org – (540) 888-3456

Application for Services

Please send fully completed application packet with additional documentation to referral@trschool.org or fax to (540) 888-4511. If you have questions or require further assistance, please call contact one of our Admissions staff at 540-888-3456.

Today's Date					
Referred to TRS before?	Yes		No		
If yes, when?	Date		Service		
Is the student currently at risk for harming self or others?	Yes		No:		
If yes, please provide details of this behavior:					
How did you hear about us?					
Reason for Referral					
Placement/Services needed by:					

Program of Interest	
Enhanced Residential Services (VA Medicaid eligible)	
Dedicated Substance Abuse Unit	
Goal Based Program	
Diagnostic and Assessment Program	
Academic Day School	
Intensive In-Home Services (VA Medicaid eligible)	
In-Home Skill Development Services	

Student Information	
Legal Name	
Nickname	
Social Security Number	
DOB/Age	
Place of Birth	
Gender	
Race	
Height/Weight	
Eye Color/ Hair Color	
Marks/Scars/Tattoos	
Religious Preference	
Contact at Current Address	
Current Address	
Freed for Adoption (TPR date)	
Permanency Plan	
Cultural Issues Requiring Special Service Provision	
Does the Indian Child Welfare Act Apply? (Any Native American Heritage)	

Education	
Local Educational Agency (LEA)	
LEA Address	
LEA Representative	
LEA Phone	
LEA Email	
Home School	
Home School Address	
Home School Representative/Guidance	
Home School Email	
Home School Phone	
Grade	
Is Child in Special Ed?	
Specific Classroom Needs	
Vocational/Independent Living Needs	

Referral Source	
Custodian/Agency/DSS	
Worker/Parent Name	
Address	
Worker/Parent Phone and Extension	
Fax	
Email	
Supervisor Name	
Supervisor Phone #	
Additional Comments/Notes:	

Behaviors			
Current Behaviors (within past 7 days)	At Home, School, etc.	Frequency	Description of Behavior
Interventions in the past that have been effective in addressing these behaviors:			
Is child on Probation? If yes, who is the Probation Officer and his/her contact information? What are the charges? Can youth's probation be violated and placed in detention?			
Other significant behaviors in child's past not noted above:			

Is there a current risk for these behaviors? Why or Why Not?
Is there a history for runaway behavior? If yes, explain.

DSM - V diagnoses:								
Is there a Psychological current within 1 year available? If yes, please send copy.								
IQ Scores:	FSIQ		VIQ		PIQ		WMI	

Current medications			
Medication	Dosage	Prescribing Physician	Frequency

Is youth compliant with medications?	Yes		If no, please explain:
	No		
Psychiatrist Name and Phone			

Medical/physical/ insurance	
Allergies	
Overall Health	
Known Medical Conditions, Illnesses, Medical care or Physical Limitations	

History of Substance Abuse			
Does the child have current medical insurance?	Yes		If yes, please give Insurance company and ID#:
	No		
Medicaid?	Yes		If yes, please give Medicaid #:
	No		
Is medical/dental follow-up required?	Yes		If yes, please explain:
	No		
Does child wear braces?	Yes		If yes, please explain:
	No		
Nutritional and Dietary Needs			

Placement history			
Placement/Service	Start Date	End Date	Successful? /If no, explain.

Strengths/needs	
What are the student's strengths, interest, skills and talents?	
Other comments/needs	

Family	
Reason removed from birth parents	
Parental Involvement?	
Mother's Name	
Father's Name	
Are there siblings? Do they need to be placed together?	
Visitation? With whom? Frequency?	
Does visitation need to be supervised?	
Family Support Systems/Strengths	
Transportation Requirements (role of	

DSS, foster parent and TRS)	
Location of Visitation	
History of Abuse, Neglect or Exploitation in the Family or Child's Past	
Other Essential Family Members	
Is there a social history available? If yes, please send a copy.	
Special Needs or Considerations for Family and their participation in Treatment: (one face to face therapy session with family per month is required if family is the D/C plan)	

Essential Family Member's Contact Information	
Name	
Relation	
Address	
Home Phone/Cell	
Work Phone and Extension	
Email	
Name	
Relation	
Address	
Home Phone/Cell	
Work Phone and Extension	
Email	
Additional Comments/Notes:	

Form completed by	
Name	
Date	

Documentation required for admission to Timber Ridge School:

- *Certificate of Need* (CON) signed and dated within 30 days of anticipated admission date for Enhanced Unit treatment
- *Child & Adolescent Needs & Strengths* (CANS) report completed within 60 days of admission
- Most recent psychological assessment to include DSM-V diagnoses where applicable
- Tuberculosis test completed within 2 weeks of admission (unless admission is a bed-to-bed transfer from another approved facility who holds current TB documentation)
- Academic transcripts and most recent Individualized Education Plan (IEP)
- Insurance verification (copy of current insurance card)
- Current physical and immunization records (within the previous 6 months)

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL ACADEMIC INFORMATION

This child is referred for admission to ***TIMBER RIDGE SCHOOL***, a Residential Treatment Center for youth between the ages of 10 and 18.

I hereby give my permission to _____
Name of School

_____
Address

To release school reports on _____ Birthdate: _____
Student's Name

TO: ***TIMBER RIDGE SCHOOL***
Attn: Office Manager
P.O. Box 3160
Winchester, Virginia 22604

FAX: 540-888-4511

Please submit a summary of academic information on this child. It is required that a current IEP be included with the school records for students with special education eligibility. If this child is not a special education student, please specify. A transcript of subjects and grades, and any academic testing results, including Standards of Learning, Woodcock-Johnson R, etc. are desired. Teacher observations regarding academic potential and social adjustment are especially helpful also. Any other information that you believe would help in the planning and development of the child's educational program would be appreciated.

As only those applicants supported by complete evaluations can be considered, a comprehensive report is required.

_____ Tri-annual Evaluation
_____ Cumulative Records
_____ Most recent Official Transcript
_____ Immunization Records
_____ Most recent Report Card
_____ Current I.E.P.
_____ Current Assessments

Please return a copy of this release with your report.

I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. I understand what information has been requested and have been explained the benefits/disadvantages of releasing this information. I further understand that the provision of services is not contingent on the release of this information and I voluntarily consent to the release of this information. I understand that I can withdraw this release at any time.

This authorization will be valid from _____ to _____; not to exceed 90 days as one-time release of information; and not to exceed a year for ongoing service provision.

Signature of Parent or Legal Guardian _____ Date _____

Any redisclosure of confidential information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

cc: Parent/Legal Guardian

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL PSYCHIATRIC INFORMATION

The child is referred for admission to ***TIMBER RIDGE SCHOOL***, a Residential Treatment Center for youth between the ages of 10 and 18.

I hereby give my permission to release the Psychiatric Discharge Summary of:

Student's Name: _____ Birthdate: _____

FROM:

Name of Facility _____ Psychiatrist _____
Address _____
_____
Phone Number (_____) _____-_____
FAX Number (_____) _____-_____

TO: TIMBER RIDGE SCHOOL
Attn: Don D. Lee, MD
P.O. Box 3160
Winchester, Virginia 22604
FAX: 540-888-4512

Offering behavior descriptions and dynamics, intellectual assets and deficits, presence and extent of organic manifestations, and general course to date in any of these areas where such information is available. Psychiatric diagnosis along with respective prognosis is important for our planning. Your impressions of treatment needs, ability to benefit from a group living experience, and any other observations would be helpful.

As only those applications supported by complete evaluations can be considered, a comprehensive report is required.

Please return a copy of this release with your report.

I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. I understand what information has been requested and have been explained the benefits/disadvantages of releasing this information. I further understand that the provision of services is contingent on the release of this information and I voluntarily consent to the release of this information. I understand that I can withdraw this release at any time.

This authorization will be valid from _____ to _____; not to exceed 90 days as one-time release of information; and not to exceed a year for ongoing service provision.

Signature of Parent or Legal Guardian _____ Date _____

Any redisclosure of confidential information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

cc: Parent/Legal Guardian

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL PSYCHOLOGICAL INFORMATION

This child is referred for admission to ***TIMBER RIDGE SCHOOL***, a Residential Treatment Center for youth between the ages of 10 and 18.

I hereby give my permission to _____
Name of Psychologist

_____
Address

Phone Number: _____ FAX Number: _____

To release Psychological reports on _____ Birthdate: _____
Student's Name

TO: ***TIMBER RIDGE SCHOOL***
Attn: Office Manager
P.O. Box 3160
Winchester, Virginia 22604

FAX: 540-888-4511

Please submit the protocol, interpretation and results of intelligence, personality, aptitude, interests, and achievement tests of your choice. We are particularly interested in information offering behavior descriptions and dynamics, intellectual assets and deficits, presence and extent of organic manifestations, and general course to date in any of these areas where such information is available, along with respective prognosis. Your impressions of treatment needs, ability to benefit from a group living experience, and your diagnostic observations would be helpful.

As only those applications supported by complete evaluations can be considered, a comprehensive report is required.

Please return a copy of this release with your report.

I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. I understand what information has been requested and have been explained the benefits/disadvantages of releasing this information. I further understand that the provision of services is contingent on the release of this information and I voluntarily consent to the release of this information. I understand that I can withdraw this release at any time.

This authorization will be valid from _____ to _____; not to exceed 90 days as one-time release of information; and not to exceed a year for ongoing service provision.

Signature of Parent or Legal Guardian _____ Date _____

Any redisclosure of confidential information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

cc: Parent/Legal Guardian

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

This child is referred for admission to ***TIMBER RIDGE SCHOOL***, a Residential Treatment Center for youth between the ages of 10 and 18.

I hereby give my permission to _____
Name of Facility

_____
Address

To release Medical Information on _____ Birthdate _____
Student's Name

TO: ***TIMBER RIDGE SCHOOL***
Attn: Health Services
P.O. Box 3160
Winchester, Virginia 22604
FAX: 540-888-4511

Please submit a summary of Medical Information on this child. It is required that a Complete Physical Exam that documents vision, hearing and communicable disease status, in addition to any other tests deemed necessary by the physician, to adequately access the student's health. This exam must not be older than one year. A copy of our Standing Medical Order (Form F-2112.2) needs to be signed and dated by a physician. According to the Virginia Department of Health, a certificate of Immunizations which documents receipt of all vaccinations required for the student's age must be presented at the time of admission. A report of Dental Examination that provides written documentation by a licensed dentist, of the required annual exam of the student and recommended follow-up care. A copy of prescriptions is needed for ALL medications INCLUDING any OVER-THE-COUNTER medications that the student is currently taking. A copy of current insurance card(s) – FRONT AND BACK – is also required. Any other information that you believe would help the child's Health Care would be appreciated.

_____ Complete Physical Exam
_____ Complete Dental Exam
_____ Recent TB Risk Assessment
_____ Prescriptions
_____ Insurance Information
_____ Any Recent Lab Results/Follow-Up Orders
_____ Immunization Records

Please return a copy of this release with your report.

I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. I understand what information has been requested and have been explained the benefits/disadvantages of releasing this information. I further understand that the provision of services is not contingent on the release of this information and I voluntarily consent to the release of this information. I understand that I can withdraw this release at any time.

This authorization will be valid from _____ to _____; not to exceed 90 days as one-time release of information; and not to exceed one year for ongoing service provision.

Signature of Parent or Legal Guardian _____ Date _____

Any redisclosure of confidential information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

cc: Parent/Legal Guardian *(not applicable for In-Home Services)*

Student Health Insurance Information

Please complete the following important information along with front and back copies of insurance cards to include prescription, dental and eye care cards. If insurance coverage changes, please notify Timber Ridge School as soon as possible.

AUTHORIZED PERSON'S SIGNATURE if Timber Ridge School provides services that are eligible for insurance reimbursement, I authorize the release of any medical or other information necessary to process insurance claim of behalf of the student. I hereby authorize Timber Ridge School to apply for payment of benefits on my behalf for covered services rendered by Timber Ridge School for such services.

Date	Printed Name	Signature

ABOUT STUDENT:

STUDENT'S NAME (Last, First, Middle Initial)	STUDENT'S DATE OF BIRTH

ABOUT INSURANCE:

MEDICAID: SUBSCRIBER'S /POLICY HOLDER'S I.D. NUMBER
SUBSCRIBER'S /POLICY HOLDER'S NAME (Last, First, Middle Initial)
SUBSCRIBER'S /POLICY HOLDER'S ADDRESS (CITY, STATE ZIP)

NON MEDICAID INSURANCE: INSURANCE CARRIER NAME & GROUP/POLICY #		
SUBSCRIBER'S /POLICY HOLDER'S I.D. NUMBER		
SUBSCRIBER'S /POLICY HOLDER'S NAME (Last, First, Middle Initial)		
SUBSCRIBER'S /POLICY HOLDER'S ADDRESS (City, State, Zip)		SUBSCRIBER'S /POLICY HOLDER'S SOCIAL SECURITY NO.
SUBSCRIBER'S /POLICY HOLDER'S DATE OF BIRTH	SUBSCRIBER'S /POLICY HOLDER'S GENDER MALE [ ] FEMALE [ ]	SUBSCRIBER'S /POLICY HOLDER'S EMPLOYER'S NAME
PRESCRIPTION PLAN CARRIER	DENTAL PLAN CARRIER	EYE CARE PLAN CARRIER

OTHER NON-MEDICAID INSURANCE: INSURANCE CARRIER NAME & GROUP/POLICY #		
SUBSCRIBER'S /POLICY HOLDER'S I.D. NUMBER		
SUBSCRIBER'S /POLICY HOLDER'S NAME (Last, First, Middle Initial)		SUBSCRIBER'S /POLICY HOLDER'S SOCIAL SECURITY NO.
SUBSCRIBER'S /POLICY HOLDER'S ADDRESS (City, State, Zip)		
SUBSCRIBER'S /POLICY HOLDER'S DATE OF BIRTH	SUBSCRIBER'S /POLICY HOLDER'S GENDER MALE [ ] FEMALE [ ]	SUBSCRIBER'S /POLICY HOLDER'S EMPLOYER'S NAME

TIMBER RIDGE SCHOOL

EFFECTIVE THROUGH July 1, 2017 – June 30, 2018

Program: Leary Educational Foundation, Inc. d/b/a **Timber Ridge School**

Address: P.O. Box 3160, Winchester, Virginia 22604 **Phone:** (540) 888-3456 **Fax:** (540) 888-3583

Admissions - Virginia States: Tim Elliott, M.Ed. Elliott@trschool.org

Admissions - Non-Virginia States: Derek Unger, M.A. Unger@trschool.org

Business office: Cathy Clayton Clayton@trschool.org

Program	Unit	Enhanced Services *	Substance Abuse- 3.5 *	Goal Based
Residential Room and Board	Day	$ 88.65	$ 88.65	$ 88.65
Residential Daily Supervision	Day	$ 149.46	$ 149.46	$ 91.43
Residential Case Management	Day			$ 11.98
Residential Supplemental Therapies	Day	$ 156.41	$ 156.41	$ 88.10
TOTAL per day, not including school		**$ 394.52**	**$ 394.52**	**$ 280.16**
Residential Education (Does not include tutor/ESL/Speech/OT)	Sch Day	$ 202.14	$ 202.14	$ 202.14
TOTAL per SCHOOL DAYS		**$ 596.66**	**$ 596.66**	**$ 482.30**

***Virginia Medicaid funded program (subject to increase if Medicaid maximum changes)**

Additional Services

SERVICE	RATE
Psychotropic Medical Management* non Medicaid services only - Other	$ 4.46/day
Translating Services	$ 65/hour
Post-Secondary (Work Study/Career Exploration/Job Skills)	$ 125.75/day
Educational Monitoring (Post-Secondary)	$ 500/month
Educational Monitoring (Secondary)	$ 700/month
K2 or other Additional Drug Testing	$ 30/test
1-to-1 Supervision/Tutoring/ESL	$ 26/hour
Speech and Hearing/OT	$ 100/hour
Individual/Family Counseling – Outpatient Services	$103/hour
Group Counseling – Outpatient Services	$ 60/hour