Gift of Hope
Residential Services Application

Phone: 540-776-2858
Fax: 540-776-3018
www.giftofhopeservices.com

Applicant Information					
Applicant Full Name:		DOB:		Age:	
Address:					
Sex: ☐ Male ☐ Female ☐ Transgender		Place of Birth:		SS#:	- -
Medicaid MCO:		Medicaid Number:			
Primary Insurance:		Policy Number:			
Secondary Insurance:		Policy Number:			
Policy Holder's Name:		Policy Holder DOB:			

CSA Information			
Worker Name:		CSA Division Name:	
Contact Phone:		Email:	

Legal Guardian Information			
Guardian Name:		Agency Name:	
Contact Phone:		Email:	

Aggression	☐ No aggression behaviors have been reported.		
The referral's aggression takes the form of:	☐ Hitting ☐ Kicking ☐ Biting ☐ Spitting ☐ Threats ☐ Rage ☐ Homicidal	☐ Unprovoked Violence ☐ Violence towards Adults ☐ Violence towards Peers ☐ Instigation/Bullying ☐ Weapon Making/Using ☐ Inciting Group Violence	☐ Homicidal ☐ Posturing ☐ Property Destruction ☐ Throwing Items ☐ Animal Cruelty ☐ Fire Setting
At its worst, the referral's aggression has looked like:			

How often does referral present with physically aggressive behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly ☐ None
Has aggression required physical restraint?	☐ Yes ☐ No
If yes, when was the last physical restraint?	
If yes, how often is physical restraint required to maintain safety?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly ☐ None
Has anyone ever been injured due to physical violence?	☐ Yes ☐ No
Has 1-to-1 supervision been required to manage aggression?	☐ Yes ☐ No
Has PRN medication or medical restraint been required to manage aggression?	☐ Yes ☐ No
Has hospitalization from an RTC or JDC been required to manage aggression?	☐ Yes ☐ No

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Suicidality/Self-Harm History	☐ No suicidality/self-harm behaviors have been reported.		
The referral's self-harm or suicidality takes the form of:	☐ Suicidal Ideation ☐ Suicide Planning ☐ Suicide attempts ☐ Overdose ☐ Burning ☐ Sharps Seeking	☐ Cutting ☐ Skin Picking ☐ Hair Pulling ☐ Restricting ☐ Med Seeking ☐ Hitting Self	☐ Ingestion of Inedible Items ☐ Threats to Harm Self ☐ Threats to Kill Self ☐ Strangulation ☐ Binging ☐ Purging
At its worst, the referral's self-harm or suicidality has looked like:			

How often does referral engage in self-harm or suicidal behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly ☐ None
Has aggression required physical restraint?	☐ Yes ☐ No
If yes, when was the last physical restraint?	
If yes, how often is physical restraint required to maintain safety?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly ☐ None
Has anyone ever been injured due to individual's self-harm/suicidality?	☐ Yes ☐ No
Has 1-to-1 supervision been required to manage self-harm/suicidality?	☐ Yes ☐ No
Has PRN medication or medical restraint been required to manage this behavior?	☐ Yes ☐ No
Has hospitalization from an RTC or JDC been required to manage this behavior?	☐ Yes ☐ No

Sexual Aggression	☐ No sexual aggressions have been reported.		
The referral's sexual acting out takes the form of:	☐ Sexual comments ☐ Sexual gestures ☐ Sexual note passing ☐ Paying for sexual acts ☐ Sexual threats ☐ Sodimization ☐ Rape ☐ Stalking	☐ Public masturbation ☐ Excessive masturbation ☐ Use of phone sex line ☐ Excessive pornography use ☐ Sexually violent fantasies ☐ Sexual aggression to family ☐ Sexual aggression to peers ☐ Sexual aggression to strangers	☐ Sexual aggression toward adults ☐ Sexual aggression to younger peers ☐ Grooming younger/weaker peers ☐ Brushing up on others intentionally ☐ Sexual assault by threat of violence ☐ Sexually aggressive pornography Use ☐ Digital penetration/Oral Sex ☐ Pornography use on public computers
At its worst, the referral's sexual aggression has looked like:			

How often does referral engage in sexual aggressive behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly ☐ None
Has this referral ever had a psychosexual risk assessment?	☐ Yes ☐ No
If yes, what was the level of risk identified in the psychosexual?	☐ Mild ☐ Moderate ☐ High

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If yes, what setting(s) does the psychosexual indicate that level of risk is in?	☐Multiple times a day ☐Daily ☐Weekly ☐Monthly ☐None
Has referral engaged in sexual aggression in a RTC, JDC, or inpatient setting?	☐If stay in the community ☐If in a secure treatment setting
Has 1-to-1 supervision been required to manage self-harm/suicidality?	☐Yes ☐No
Does referral require a single room due to risk of sexual acting out?	☐Yes ☐No
Is referral permitted to be around younger peers?	☐Yes ☐No

Other High-Risk Behaviors	☐No psychosis ☐No sexual reactivity/risk taking ☐No AWOL/Out of Area (OOA) has/have been reported.		
The referral's behaviors take the form of:	☐ Psychosis ☐ Audio Hallucinations ☐ Visual Hallucinations ☐ Command Hallucinations ☐ Delusional Thinking ☐ Flashback/Nightmares ☐ Dissociation ☐ Paranoia ☐ Disorganized Thinking	☐ Boundary Issues ☐ Sexual Reactivity/Risk Taking ☐ Sexual Comments or Gestures ☐ Sexual Preoccupation ☐ Multiple sexual partners ☐ Sex While AWOL or Intoxicated ☐ Sexual Trafficking ☐ Sexting/Use of Social Media for Sex	☐ AWOL/Out of Area (OOA) ☐ Premeditated AWOL or OOA ☐ Leaves home without permission ☐ Leaves school without permission ☐ AWOL from previous placements ☐ AWOL with intent of substance abuse ☐ AWOL with intent of sexual behaviors ☐ AWOL as an escape when dysregulated
At its worst, the referral's behaviors have looked like:			

How often does referral engage in AWO L or OOA?	☐Multiple times a day ☐Daily ☐Weekly ☐Monthly ☐None
How long do AWOL or Out of Area Incidents last?	☐Less than 1 hr ☐1 hr-6 hrs ☐6 hrs-24 hrs ☐More than 24 hrs
What setting(s) does sexual risk taking/reactivity present in?	☐ Community ☐School ☐Inpatient/JDC/RTC
How often does referral engage in sexual risk taking/reactivity?	☐Multiple times a day ☐Daily ☐Weekly ☐Monthly ☐None
What gender is sexual risk taking/reactivity geared toward?	☐Males ☐Females ☐Both Genders
What frequency does referral present with psychotic symptoms?	☐Multiple times a day ☐Daily ☐Weekly ☐Monthly ☐None
How incapacitating are psychotic symptoms for the referral when present?	☐Unable to complete ADLs ☐Able to complete ADLs with assistance ☐Not incapacitating to ADLs

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Other Behavioral Concerns (Check all that Apply)

☐ Lying	☐ Deceitfulness	☐ Stealing	☐ Frustrates Easily
☐ Reactive Attachments	☐ Oppositional	☐ Attention Seeking	☐ Sleep Issues
☐ Depression	☐ Disruptive	☐ Unmotivated for Treatment	☐ Weight Gain
☐ Inattention	☐ Anxiety	☐ Bullying Others	☐ Weight Loss
☐ Hyperreactive	☐ Fearful	☐ Bullied by Others	☐ Poor Self Esteem
☐ Mania	☐ Obsessive	☐ Attention Seeking	☐ Poor Hygiene
☐ Mood Swings	☐ Compulsive	☐ Truancy	☐ Poor Social Skills
☐ Explosive Reactions	☐ Somatic Symptoms	☐ Avoidant	☐ Gang Involvement
☐ Manipulating	☐ Tantrums	☐ Social Isolation	☐ Self-Sabotage
☐ Other:			

Placement/Intervention History

What setting(s) is the referral currently residing?	☐ Home ☐ Therapeutic Foster Home ☐ Group Home ☐ Detention	☐ Residential Treatment: ☐ Inpatient Acute: ☐ Shelter

List placement/intervention history starting with most recent and working backwards

Placement/Intervention	Level of Care	Date Started - Date Ended	Successful?
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No
		-	☐Yes ☐No

Please describe why any placement was marked as unsuccessful.	
Has this referral ever been discharged from a Residential Treatment Center due to dangerous behaviors or treatment noncompliance?	☐Yes ☐No
If yes, to the question above, please describe where and the circumstances surrounding the discharge.	

Education

Current School Attending?	
Current Grade Level	☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐College
IEP Designation	☐Regular Education ☐504 ☐ED ☐OHI ☐LD ☐ASD ☐ID ☐Other:
Most Recent FSIQ	

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Psychiatric Information				
List Current Psychiatric Diagnoses.				
Psychiatric Services Provider Name:			Phone:	
Date of last psychiatric appointment:		Date of next psychiatric appointment:		

Trauma History	☐ No trauma history has been reported.
Has this referral ever been physically abused?	☐ Yes ☐ No
If yes, please describe.	
Has this referral ever been sexually abused?	☐ Yes ☐ No
If yes, please describe.	
Has this referral ever been the victim of neglect?	☐ Yes ☐ No
If yes, please describe.	
Is there other trauma that we should be aware of?	☐ Yes ☐ No
If yes, please describe.	
Has all known abuse and neglect been reported to CPS?	☐ Yes ☐ No
Has DSS/CPS ever been involved with this referral and the family?	☐ Yes ☐ No
If yes, please describe.	
Is DSS/CPS Currently Involved with this Family?	☐ Yes ☐ No
If yes, please describe.	

Substance Use History	☐ No substance history	☐ No alcohol history has/have been reported.
☐ Alcohol	☐ Speed/Amphetamine	☐ Phencyclidine
☐ Marijuana	☐ Club Drugs	☐ Hallucinogens
☐ Nicotine/Vape	☐ Opioid	☐ Inhalants
☐ Cocaine	☐ LSD	☐ Sedative/Hypnotics
☐ Other:		

Medical Information			
List Any Current or Historical Medical Conditions/Diagnosis (e.g., Asthma, Seizures, Surgery, Scoliosis, Fractures, etc.).			
Is this referral currently receiving hormonal therapy?	☐ Yes ☐ No		
If yes to the question above, please explain.			
Chronic Conditions:			
Communicable Diseases:			
Communication Problems:			
Are there restrictions on the referrals level of physical activity?	☐ Yes ☐ No		
If yes to the question above, please describe restrictions and how they are currently managed.			
PCP Name:		Phone:	
Date of last Physical Exam:		Date of Next Physical Exam:	
Dental Services Provider Name:		Phone:	
Date of last Dental Exam:		Date of Next Dental Exam:	

Current Medications	☐ No medications are prescribed at this present.	
Name	Dosage	Frequency
Ineffective Medications in the Past:		

Allergies (Food, Medication, and/or Environmental)	☐ No allergies have been reported.
Allergen	Reaction

Legal History	☐ No legal history has been reported.		
Charges	Date	Conviction	Description
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
Community Services Status:	☐ Ongoing ☐ Completed		
If it is ongoing, please explain.			
Restitution Status:	☐ Ongoing ☐ Completed		
If it is ongoing, please explain.			

Is referral currently on probation?	☐ Yes ☐ No	Date of Probation Started:		The reason for Probation:	

Probation Officer Name	Phone #	Address
Guardian-ad-Litem Name	Phone #	Address

Scheduled Appointments (Upcoming Court, FAPT, Medical or other meetings) ☐ No appointments scheduled at this present.		
Type of Meeting	Date	Location

Family Information			
Mother's Name:		Stepfather's Name:	
Address:		Phone:	
Father's Name:		Stepmother's Name:	
Address:		Phone:	

Siblings' Name	Age	Gender	Address

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Describe history of family involvement (compliant & non-compliant with treatment).	

List the name and relationship of any person with whom the referral is **NOT** allowed to contact ☐ None

Name	Relationship	Note

Requested Attachment List

Type of Documents	Document Status	Comments
☐ Copy of FAPT Services/Treatment Plan	☐ No Record Available	
☐ Copy of Birth Certificate	☐ No Record Available	
☐ Social History	☐ No Record Available	
☐ Copy of Social Security Card	☐ No Record Available	
☐ Psychological Evaluation	☐ No Record Available	
☐ Most Recent School Transcript	☐ No Record Available	
☐ Copy of Medicaid Card or Other	☐ No Record Available	
☐ Current IEP	☐ No Record Available	
☐ Immunization Record	☐ No Record Available	
☐ Educational Evaluation & Test Scores	☐ No Record Available	

Please list any other information that you think it may be helpful with this placement.

Signature **Title** **Date**

Please submit this application with the requested attachments via **referral@giftofhopeservices.com** or fax to **540-776-3018**. Thank you.

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