

HEALTHPLUS THERAPEUTIC SERVICES

APPLICATION

Please fax applications

For residential: 252-974-2123.

For all other services: 252-948-0933

Contact Healthplus Services with any questions at 252-948-0333.

At time of admission the following must be provided to Healthplus Services.

1. Admission Application
2. Signed PCP (including crisis plan)
 - a. identifies Healthplus as service provider
 - b. Includes therapeutic leave in treatment plan for res. services
3. Service Order
4. All assessments and evaluations (including, but not limited to, psychological, educational, behavioral, mental health)
5. Insurance Card
6. IEP/504 (if applicable)
7. Senate Bill 163 (if applicable)
8. For residential – copy of ITR & authorization from ValueOptions or applicable payee

Legal Guardian will be responsible for completing Healthplus documentation before or on admission date including, but not limited to:

1. Release of information forms
2. Consents for treatment
3. Consent for medical treatment
4. Consent to enter treatment

For Healthplus Personnel Use Only:

How can Healthplus Therapeutic Services meet client current needs?

Are services currently available? If not, projected date of possible availability?

Are provided assessments accurate? If not please attach addendum with updated information

CLIENT NAME _____
RECORD # _____

**HEALTHPLUS THERAPEUTIC SERVICES, INC.
ADMISSION APPLICATION/ASSESSMENT**

Date: _____
Client Name: _____ Record #: _____
SS#: _____
Insurance Provider: _____ Policy #: _____
County of Residence: _____

Parents' Names: _____
Address: _____ Contact #s: _____

Legal Guardianship Established: Yes___ No___
Guardian: _____
Address: _____ Contact #s: _____

SCHOOL:

Last Attended: _____
Contact at school: _____
CS Services in School: ___ Yes ___ No
If yes, Provider Agency: _____ Contact #s: _____

Please note any significant school information and/or client behavior in school setting:

MEDICAL INFORMATION:

Psychiatrist: _____
Address: _____ Contact #: _____

Date of last visit: _____ Date of next appointment: _____

Primary Physician: _____
Address: _____ Contact #: _____

Date of last visit: _____ Date of last physical: _____

Current Medications (including over the counter medications):

CLIENT NAME _____
RECORD # _____

Name:

Dosage:

1. _____
2. _____
3. _____
4. _____
5. _____

Identifying Information:

Height: _____

Weight: _____

Eye Color: _____

Hair Color: _____

Allergies: _____

General Physical Conditions: _____

Vision:

No Corrective Lenses

Normal Vision

Undetermined

Some Difficulty Seeing

Wears Glasses

Hearing:

No Hearing Aid

Normal Hearing

Undetermined

Mild Loss

Moderate Loss

Profound Loss (Deaf)

Wears Hearing Aid

Dental:

Good Dental Health

Needs Dental Services

HISTORY:

Social:

Family:

Medical:

Substance Use/Abuse:

Vocational:

Legal:

NEEDS / STRENGTHS:

CLIENT NAME _____

RECORD # _____