Eliada Assessment Center
Application for Services

Student's Name: _____ Record # _____
Date of Birth: _____ Race: _____
Biological Sex: ☐ Male ☐ Female
Gender Identity: ☐ Male ☐ Female ☐Transgender/Non-Binary _____
Date Placement Needed: _____ SSN: ___-___-_____

Legal Custodian: Name, Address, Phone, Email	
Parent: Name, Address, Phone, Email	
Current Living Arrangement:	
MCO:_____ **Care Coordinator Info:**	Name:
	Phone number:
	Email address:
	Mailing Address:
Case Responsible Agency: _____	Case Responsible Professional (required):
	Email Address:
	Address:
	Office Number/Cell/ Fax Number:
	Case Responsible Professional (required):
Current Mental Health Team:	Therapist Name:
	Therapist Phone Number:
	Therapist Email Address:
	Psychiatrist Name:
	Psychiatrist Phone Number:
	Psychiatrist Email Address:

CURRENT STATUS

I. CURRENT BEHAVIORS/PRESENTING PROBLEMS AND REASON FOR REFERRAL

_____

_____

_____

	Diagnosis	**Diagnostician**	**Date**
Diagnoses/ Diagnosticians:			

	Medication: List all current medications	**Dose**	**Frequency**
Medications:			
Prescriber: _____			

Eliada Assessment Center
Application for Services

STUDENT NAME: **RECORD NUMBER:**

II. CURRENT STRESSORS (Please check those that apply and describe in related sections)

Legal Problems	□ Yes	□ No	Physical Assault	□ Yes	□ No	Addiction	□ Yes	□ No
Medical Problems	□ Yes	□ No	Relationship Problems	□ Yes	□ No	Abuse History	□ Yes	□ No
Sexual Assault/ Rape	□ Yes	□ No	Separation/Loss	□ Yes	□ No	Other	□ Yes	□ No

III. HEALTH CONCERNS and MEDICAL CONDITIONS

A. Physical disorders or diseases:	Please describe the nature of the disorder or disease, as well as necessary treatment: _____ _____ _____ ☐ Contagious Disease?
B. Disabilities: (senses, physical, other)	Please describe the nature of the disability and any necessary accommodations:
C. History of Seizures, Head Injury, or Other Traumatic Injury:	Please provide any history of seizure disorder, head injury, or other traumatic injury sustained by the student. Are there any on-going medical concerns or treatments related to these events? _____ _____ _____

IV. ABUSE HISTORY

Has the client been a victim of abuse? ☐ Yes ☐ No If yes, ☐ Physical ☐ Sexual ☐ Emotional
Has the client been a victim of neglect? ☐ Yes ☐ No
How old was the client? _____ Was this reported to DSS? _____
What was the legal outcome? _____
Please describe the nature of the abuse/ neglect, including the perpetrator, duration of abuse/ neglect, etc.:
_____
_____
_____
_____

V. HISTORY OF AGGRESSIVE BEHAVIOR

A. **Please describe the nature of the student's acting out behaviors:**

☐ Verbally aggressive Frequency:_____ Description:_____
_____

☐ Physically aggressive Frequency:_____ Description:_____

Has this behaviors resulted in injury to others? Criminal Charges? Please describe? _____

☐ Property destruction: Frequency: _____ Description:_____
_____

☐ Cruelty to animals Frequency: _____ Description:_____
_____

☐ Fire Setting Frequency:_____ Description:_____
_____

Aggression is: ☐ impulsive ☐ planned ☐ instrumental ☐ triggered by fearfulness

B. **Where is the client aggressive**: _____

C. **Known triggers, please describe**: _____

D. **Main targets of aggression:** ☐ Peers ☐ Authority figures ☐ Family members Please be specific: _____

E. **Please describe the most recent episode of aggression:** _____

VI. HISTORY OF SELF INJURIOUS AND SUICIDAL BEHAVIORS (Check all options that apply)				
Self-Injury:	☐ Cuts on body		☐ Conceals cutting surfaces	
	Preferred cutting surfaces:		Preferred Cutting Implement:	
	☐ Other forms of self injury (please describe) _____			
	Has self-injury ever required medical attention? Explain. _____			
Suicidal Characteristics:	Check all that apply:	☐ Suicidal Ideas	☐ Suicidal Gestures	☐ Suicidal Plans
		☐ Suicide Attempts	☐ Number of previous attempts: _____	
	Describe: _____			
	Methods used in previous attempts (please describe) _____			
	Were attempts planned? ☐ Yes ☐ No ☐ Sometimes			
	Does the client know someone who has committed suicide (describe relationship to child): _____			

VII. History of Running	☐ Runs away from home or placements In the past year, how many times has the student run? ____ Impulsive or planned? _____ Average duration of run: _____ Where does the student go and what do they do? _____ How do they return home/placement? _____

VIII. Substance Abuse History	**Type of Substance used**	**Frequency**	**Last Use**	**Type of Substance used**	**Frequency**	**Last Use**
	☐ Marijuana			☐ Inhalants		
	☐ Cocaine			☐ Hallucinogens		
	☐ Crack			☐ Alcohol		
	☐ Heroin/ Opiates			☐ Tranquilizers		
	☐ Amphetamines			☐ Other _____		
	Has the client received Substance Abuse treatment? _____					
IX. Sexualized Behaviors	Please describe any sexualized behaviors exhibited by the student (i.e. exposure, sexual acting out, predatory behaviors, etc.): _____					

Eliada Assessment Center
Application for Services

STUDENT NAME: **RECORD NUMBER:**

XI. Psychotic Behaviors	Has the client experienced any hallucinations or paranoid ideation: ☐ Y ☐ N If yes, what type? ☐Auditory ☐ Visual ☐ Other Please describe the nature of the hallucinations and/or paranoia, including the frequency and treatment provided. _____ _____ _____

XV. FUNDING: ***Include copies (front and back) of all insurance cards applicable to the student.***

Please check all applicable funding sources available for the student. Include all applicable numbers (subscriber, group, etc.) associated with each funding source. For private insurance, include the SSN and DOB of policy holder.

☐ Medicaid: _____ ☐ Health Choice: _____

☐ Private Insurance: _____ Policy Number: _____
Subscriber/ Group #: _____ Policy Holder Name: _____
Policy Holder SSN: _____ Policy Holder DOB: _____
(Attach all applicable information on any additional private insurance associated with the student.)

I hereby apply for services on behalf of the child for whom I hold legal custody and/or placement authority. I certify that the information contained in this application/assessment is true and accurate to the best of my knowledge.

_____ _____
Custodian Signature Date

_____ _____
Referring Professional/ Agency Date

Vaya Health

Authorization for Release of Information

Member name:	Last 4 digits of Social Security #:	Date of birth:	Provider ID no. (for use by Vaya records staff only):

1. I, _____, AUTHORIZE THE RELEASE, SHARING AND EXCHANGE OF INFORMATION BETWEEN **VAYA HEALTH** AND THE **INDIVIDUALS AND/OR ENTITIES LISTED AT THE BOTTOM OF THIS PAGE**.

2. The information to be released, shared and exchanged is as follows:
   - ☑ Medical/psychiatric Information included in a designated record set under 45 CFR § 164.524(a). This may include diagnoses, progress notes, diagnostic assessments, person-centered plans, individual support plans, treatment and medical history, medications, discharge summaries, laboratory data, Medicaid/Medicare eligibility information and other information used to coordinate services. Records may include information from providers, but this information may not be complete. Please contact your provider for complete information. You may cross out any items you do not want to be disclosed.
   - ☐ Financial Information: for example, records of payments made to providers, explanation of benefit forms
   - ☐ Psychotherapy notes _____ (member initials required) ☐ Genetic information _____ (Member initials required)
   - ☑ HIV and/or AIDS-related information _____ (member initials required)
   - ☑ Substance use information. _____ (member initials required). This is information that may identify me as a person with a substance use diagnosis (drugs or alcohol) or someone who has received substance use treatment in the past. I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
   - ☐ Information identified in the attached document(s). Please attach any subpoena, cover letter from your attorney or other document.
   - ☐ Other _____

3. Date range of records being requested: within the last 12 months

NOTE: Once this authorization is completed and signed, it cannot be altered or changed in any way. If you wish to change this authorization, it must be revoked, and you must complete and sign a new authorization.

4. The purpose of the release is one of the following:
   - ☑ Care coordination, including, but not limited to, sharing with Community Care of North Carolina and service providers
   - ☐ Legal reasons (e.g., guardianship, appeals, worker's compensation, social services, concealed carry permit)
   - ☐ At my request or request of my legal representative
   - ☐ Other: Admission to the Eliada Assessment Center and completion of a comprehensive evaluation of strengths, needs and services

5. Please release the requested information in the following manner:
   - ☐ Paper documents mailed by regular U.S. mail, sent to the mailing address listed below, or
   - ☑ By facsimile to fax number – please include area code: _____
   - ☑ Electronic documents sent by electronic mail, sent to the following e-mail address: referral@eliada.org
     ****Note that e-mailed documents will be encrypted for security purposes and will require the recipient to set up a password for access.**

6. I understand the *recipient of these records may not protect my information from re-disclosure* ***except*** where this information includes a substance use diagnosis or treatment information or falls within the definition of "psychotherapy notes" or "AIDS-related information" under HIPAA; **in those cases, the recipient may not re-disclose such information without my further written authorization, unless otherwise provided for by state or federal law.**

7. I understand that, if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychotherapy notes or genetic testing, this disclosure will **NOT** include that information **UNLESS** I added my initials next to each item to be disclosed. I further understand that I am not entitled to copies of my psychotherapy notes under HIPAA.

8. I also understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment for my services. I understand that my health information is shared between my provider and Vaya Health for purposes of treatment, payment and healthcare operations unless I specifically revoke authorization for those purposes. I understand that I may be discharged and/or denied services if I revoke consent to a disclosure for such purposes.

9. I understand if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or for up to one year from the signature date, whichever is earlier. I also understand I may revoke this authorization at any time in writing. I further understand any action taken on this authorization prior to the date I revoke it is legal and binding.

10. I further understand I will be given a copy of this form once this authorization has been completed.

Signature	Printed name	Date signed	Expiration date (up to one year if blank)

Signature of legal representative	Relationship to member	Date signed	Expiration date (up to one year if blank)

Contact telephone number for person signing (include area code): _____

AUTHORIZATION REVOKED: _____ **Date:** _____
(Signature of authorized person) **(Revocation effective on date of signature)**

(All items must be completed – please print clearly)

Name: _____
Address: 2 Compton Drive
Asheville, NC 28806
Phone: 828-254-5356
E-Mail Address: referral@eliada.org

Name: _____
Address: _____
Phone: _____
E-Mail Address: _____

Name: Youth Villages North Carolina
Address: 10 Crispin Court, Suite D-203
Asheville, NC 28803
Phone: 828-250-3721
E-Mail Address: kim.moore@youthvillages.org

Name: _____
Address: _____
Phone: _____
E-Mail Address: _____

Name: _____
Address: _____
Phone: _____
E-Mail Address: _____

Name: _____
Address: _____
Phone: _____
E-Mail Address: _____