THE FAISON CENTER
1701 Byrd Avenue
Richmond, VA 23230
804-612-1947
www.faisoncenter.org

ENROLLMENT APPLICATION

for The Faison School, Peninsula School, and Behavioral Health Clinic programs

Please Complete and Return This Form to:
The Admissions Office
admissions@faisoncenter.org

Please Complete the Following Application and Provide These Additional Items -
Applications will not be considered complete until all items are received

1) State School Health Entrance Form (including physical exam and immunization record)
2) Most recent/current Individualized Education Program (IEP), IFSP, or 504 Plan
3) Most recent Eligibility meeting minutes (for Special Education services)
4) Most recent psychological evaluation, if applicable (required if student has a mental health diagnosis)
5) Most recent Behavior Intervention Plan, and/or Functional Behavior Assessment, if applicable
6) Other recent evaluations (educational, speech, etc.) from within the last 2 years, if applicable

Thank you for your interest in The Faison Center! Upon receiving a completed application, the team will review this form and accompanying documents. After reviewing this information, we will contact you to set up an intake appointment. If you should have any questions or need assistance, please call us at the above phone number, or send an email to the above address.

PART I - BIOGRAPHICAL INFORMATION

Student/Applicant's Name _____

Nickname_____ **Date of Birth** _____

Gender_____ **County of Residence** _____

Application Completed By _____ **Date Completed** _____

Relation to Applicant _____

Telephone _____ **Email** _____

Parent/Guardian #1
Name_____ **Relation to Applicant**_____

Address_____

Phone_____ **Email** _____

Age_____ **Occupation**_____ **Marital Status**_____

Parent/Guardian #2
Name_____ **Relation to Applicant**_____

Address_____

Phone_____ **Email** _____

Age_____ **Occupation**_____ **Marital Status**_____

Does the applicant live at the same address as parent/guardian? ☐ Yes ☐ No

If Yes, does the applicant reside with both parents/guardians or one?

☐ Both ☐ Only Parent/Guardian #1 ☐ Only Parent/Guardian #2

If No, please specify name of group home/residential facility _____

Address of Residential/Group Facility _____

Contact Person at Facility _____ **Telephone** _____

If Individual is 18 Years of Age or Older, Who Has Legal Custody/Who is Legal Guardian (check one)?

☐ Applicant (has own rights) ☐ Parent/Guardian ☐ Other_____

If applicable, please provide a copy of legal custody documentation with application

PART II - PSYCHOSOCIAL/DEMOGRAPHIC BACKGROUND

Applicant's Race/Ethnicity (check one)
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaskan Native ☐ Other

This information helps Faison obtain monetary support from foundations and corporations that, in turn, helps us provide our specialized services:

Total Annual Household Income (please round to nearest thousand): $_____
Number of Dependents in Household:_____

Education Level	Guardian #1	Guardian #2
No High School Diploma		
High School Diploma or GED		
Associate or Bachelor Degree		
Graduate or Professional Degree		

Who Lives in the Applicant's Residence?

Name	Age	Gender	Relationship

What is the Primary Language Spoken in the Home? _____

If there are Secondary Languages, please write them here: _____

PART III - SCHOOL HISTORY

Current School or Institution _____ **Telephone**_____
County/City _____
Type of School Placement _____ **Teacher/Therapist Name**_____
(Public, Private, Etc.)

In Classroom:
Number of Teachers & Aides _____ **Number of Students** _____ **Does individual have a 1:1 Aide?**_____

Former Schools Attended (list in order, beginning with most recent)

School	Years/Grades Attended	Why did applicant leave?

Please List Community Agencies/Contacts Who Provide Services to the Applicant

Agency	Contact Name	Nature of Service

PART IV - MEDICAL

Does the Applicant Have Medical Insurance? ☐ Yes ☐ No

Name of Insurance Provider_____

Policy # and Subscriber Name _____

Group # _____

Company name (if through employer) _____
If seeking insurance coverage for services, please provide a copy (front+back) of insurance card*

Primary Care Physician _____ **Telephone** _____

List All Current Psychiatric and/or Developmentally-Related Diagnoses

Diagnosis	Year Diagnosed	Diagnosing Physician and Speciality Area

List All Medical Diagnoses/Issues

_____
_____
_____

List All Previous Diagnoses

_____

List Medical Equipment and/or Treatments

_____
_____

ALLERGIES (Food, Medication, and Environmental)

Allergen	What Symptoms Occur with Allergy	Treatment for Allergic Reaction	Formally Tested or Suspected?

MEDICATION
List All Information for Each *Current* Medication

Drug Name	Date Started	Dosage	Purpose	Has It Been Effective?

What Other Medications Have Previously Been Prescribed But Are No Longer Being Administered?

_____
_____

Does the applicant take any vitamins or supplements? ☐ Yes ☐ No
If so, please list _____

Hospitalizations, Testing & Evaluations

Hospital Name	Month/Year	Reason

Surgeries

Hospital Name	Month/Year	Reason

NEUROLOGICAL
Is There a History of Seizures? _____ Age of Onset _____ Date of Last Seizure _____

How Often Do Seizures Occur Now and How Long Does One Last _____

Describe What Seizure Activity Looks Like _____
_____

Describe Any Other Neurological Problems _____
_____

Date of Last Neurologist Visit _____

Physician's Name _____ Telephone _____

EYES
Are There Any Problems with Vision? _____ If Yes, Explain _____

Glasses (Y or N)? _____ How Often Are Glasses Worn? _____

What issue do the corrective lenses address? _____

EARS, NOSE & THROAT
Are There Any Problems with Hearing? _____ If Yes, Explain _____

Hearing Aid (Y or N)? _____ How Often Is Hearing Aid Worn? _____

DENTAL
Are There Any Problems with Current Condition of Teeth? _____ If Yes, Explain _____
_____

Past Dental Procedures & Dates _____
_____

ADDITIONAL SPECIALISTS (Psychiatry, Cardiology, Orthopedics, GYN, etc.)

Physicians Name	Specialty	Reason for Being Seen

OTHER PREVIOUS MEDICAL TESTS & EVALUATIONS (List Type & Date)
Chromosomes _____
Metabolic Studies _____
Feeding/Swallowing _____
Gastrointestinal _____
Other _____

NUTRITION

Current Weight _____ Current Height _____

Diet (check) ☐ Regular ☐ Chopped ☐ Pureed ☐ Low Fat ☐ Other _____

Describe Any Feeding Problems (chewing, swallowing, choking, eating too fast, vomiting, food aversions, etc.) _____
_____

PART V - PROBLEM BEHAVIOR

Record each problem behavior the applicant displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual, others, and/or property. Please rank in order of concern to yourself or to other caretakers.

Behavior	Description	Occurs How Often	Damage to Self/Others/Property

Estimate the Severity of the Problem Behavior of Greatest Concern (Check One)
☐ Minor ☐ Moderate ☐ Severe ☐ Life Threatening

Has the Applicant Ever Been Sent to the Hospital to Treat an Injury Resulting from the Behavior?
☐ Yes ☐ No If yes, Describe_____

Has the Applicant Ever Injured Someone In Such a Way That Required Them to Seek Medical Treatment?
☐ Yes ☐ No If yes, Describe_____

Has the Applicant Ever Been Hospitalized to Develop a Treatment for These Behavior Problems?
☐ Yes ☐ No If yes, Describe_____

In What Setting Does Problem Behavior Occur (Check all that apply)
☐ Home ☐ School ☐ Community ☐ Other (describe_____

How Long Has the Applicant Been Engaging in the Problem Behavior (check one)?
☐ Within Past 6 Months
☐ More than 6 Months, But Less than 1 Year
☐ More than 1 Year, But Less than 3 Years
☐ More than 3 Years, But Less than 5 Years
☐ More than 5 Years, But Less than 10 Years
☐ More than 10 Years

When is Problem Behavior Likely to Occur (check all that apply)
☐ When Individual is Left Alone or Unattended
☐ When Lots of People are Around
☐ When Demands are Placed on the Individual
☐ When the Individual Cannot Have Something He/She Wants
☐ Time of Day
☐ Mealtimes, Dressing, or Bathing
Other _____

Are There Any Situations or Environments, When the Problem Behavior Rarely or Never Occurs?
_____
_____

How Do People (Parents, Staff, etc.) Typically Respond When the Individual Engages in Problem Behavior? _____
_____

Is a Formal Program or Intervention Protocol Currently Being Used? ☐ Yes ☐ No

If Yes, Please Include With This Application

How Long Has the Program Been in Place? _____

Estimate the General Trend of Problem Behavior During the Past Year (check one)

☐ Increasing (Behavior Getting Worse) ☐ Stable (About the Same) ☐ Decreasing (Improving)

Does the Applicant Display Aggressive Behavior Toward Staff or Peers? ☐ Yes ☐ No

If Yes, Explain _____

Was the Onset of the Problem Behavior(s) Associated with any Specific Event or Series of Events?

_____

Have the Following Procedures Ever Been Used to Manage or Treat the Problem Behavior(s)?

Restraint (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

Protective Equipment (helmet, gloves, etc.) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

Positive Reinforcement Procedures (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

Time Out (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

Corporal Punishment, Spanking, etc. (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

Other (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success: Poor _____ Fair _____ Good _____ Excellent _____

What other treatments and/or therapies been used, past or present?

_____

_____

_____

_____

_____

_____

PART VI - CURRENT PERFORMANCE

Communication Skills (check any that apply)
☐ Speaks freely and easily ☐ Talks Mainly in Phrases ☐ Uses Single Words ☐ Sign Language
☐ Pictures ☐ Communication Device:_____ ☐ Other:_____

Dressing: ☐ Completely Independent ☐ Requires some assistance ☐ Requires full assistance

Toileting: ☐ Completely Independent ☐ Has occasional accidents ☐ Wears Pull-Up/Diaper
☐ Other:_____

Mobility: Does the applicant have any mobility issues? ☐ Yes ☐ No
If yes, please describe:_____
Does the applicant use any assistive equipment (wheelchair, braces, etc.)? _____

Sleep Habits:
Falls asleep easily? ☐ Yes ☐ Sometimes ☐ No
Sleeps through the night without waking? ☐ Yes ☐ Sometimes ☐ No
Time to Bed (PM) _____ Time to Wake (AM)_____

What Frequency/Type of Supervision is Required (check one)?
☐ Constant (1-on-1) ☐ Individualized (small group) ☐ Large Group ☐ Completely Independent

Can be Left Alone for Brief Periods? ☐ Yes ☐ No
Needs Continuous Monitoring But Can Work in a Group? ☐ Yes ☐ No

Please List Preferred Foods/Activities
Favorite Foods _____
Favorite Toys _____
Favorite Activities _____
Favorite Types of Social Interaction _____

Are there certain items, activities, places, or environments that your child does not like? If so, please list.
_____

What funding source do you plan to utilize for the program?
☐ Public funding through IEP (list county/city)_____ ☐ Medical Insurance ☐ Private Pay
Does the applicant's current IEP indicate Private Day School as the Least Restrictive Environment? _____

If accepted to The Faison Center, what would success look like for the applicant after a year of services?

_____
_____
_____
_____
_____
_____

Please Add Any Other Details You Feel Would Help Us Serve the Applicant

_____
_____
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Please Initial One of the Options Below:

_____ I Give Permission for The Faison Center to Contact any Provider or Facility Listed in this Application.

_____ I Give Permission for The Faison Center to Contact Only These Named Providers or Facilities:
_____
_____
_____

_____I Do Not Give Permission for The Faison Center to Contact Any Provider or Facility Listed.

----------For office use only----------

Complete Application Received by Admissions on _____

Parent/Guardian Contacted for Intake on _____
Intake Scheduled for _____ with _____
Application Reviewed on _____ Accepted or Rejected _____
Program(s) Accepted To_____
Reason for Rejection _____

Acceptance/Rejection Letter Sent On _____
Additional Information Required before Decision:_____
_____
_____

Notes_____
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