



## APPLICATION FOR ADMISSION

This is an application for admission to Potomac Pathways. Information which you provide on this application allows us to begin the assessment process to determine how to best configure treatment services. After we receive this initial application we may ask you to provide more detailed information related to any emotional/psychological, behavioral, medical, family, or academic issue pertinent to the student's recovery program with Potomac Pathways. Please carefully note and sign the client confidentiality disclaimer at the end of this application.

This application is intended to be completed by the parents. Students are able to communicate their thoughts about their history, current situation and goals for the future during the initial assessment interview, face-to-face. It is essential that the application be filled out completely and accurately and that psychological and behavioral issues pertinent to the student's clinical care be described fully.

If the student is **18 years or older**, it is required that the release form (located on our website), **signed by the student**, giving Potomac Pathways permission to receive confidential information from the parents concerning his/her health care history, accompany this application. Please contact us with any questions you may have about clinical services provided by Potomac Pathways or client rights and confidentiality.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Please give a brief description of the family structure and indicate if the parents are married, separated, divorced, remarried, (or another arrangement not listed here) or if any parent is deceased. If applicable, please describe custody arrangements:

---

---

---

---

---

Mother's Name (*biological mother*): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Fax: \_\_\_\_\_

Step-father's Name (*if applicable, or cross out this section*): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Fax: \_\_\_\_\_

Father's Name (*biological father*): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

(Father's Information, cont'd)

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Fax: \_\_\_\_\_

Step-mother's Name (if applicable, or cross out this section): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Fax: \_\_\_\_\_

Name of High School or College most recently attended by student: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_

School Counselor Name (if available): \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Previous High School or College Name: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_

School Counselor Name (if available): \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Name of educational consultant (*if applicable*): \_\_\_\_\_

Educational consultant address: \_\_\_\_\_

Educational consultant phone: \_\_\_\_\_

Most recent therapeutic or treatment program attended by student (*if applicable*): \_\_\_\_\_

Treatment program Address: \_\_\_\_\_

Treatment program Phone: \_\_\_\_\_

Treatment program counselor Name (*if available*): \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Previous therapeutic or treatment program attended by student (*if applicable*): \_\_\_\_\_

Treatment program Address: \_\_\_\_\_

Treatment program Phone: \_\_\_\_\_

Treatment program counselor Name (*if available*): \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Most recent outpatient counselor/therapist Name (*if applicable*): \_\_\_\_\_

Counselor/therapist Address: \_\_\_\_\_

Counselor/therapist Phone: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Current psychiatrist (*if applicable*): \_\_\_\_\_

Psychiatrist Address: \_\_\_\_\_

Psychiatrist Phone: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Please describe the issues that initially brought the student into therapeutic treatment:

---

---

---

---

---

Please describe any history of trauma, including any history of physical, emotional or sexual abuse, to the best of your knowledge:

---

---

---

---

---

Please list and briefly describe the history of therapeutic treatment including any residential treatment, inpatient treatment, or psychiatric hospitalization (please list treatment provider names and dates of treatment):

---

---

---

---

---

Please list any current medications (*we'll have you indicate dosages and the medication schedule on another form prior to the start of the student's enrollment*):

---

---

---

---

---

---

Please describe any progress you have observed most recently during the course of treatment:

---

---

---

---

---

Please describe, to the best of your knowledge, the history of the student's involvement with substance abuse, if applicable:

---

---

---

---

---

Please describe any substance abuse treatment the student has received:

---

---

---

---

---

Please describe any current recovery or therapeutic program activities the student is involved with or plans to be involved with while at home:

---

---

---

---

---

---

---

Please describe any history of suicidal thoughts or attempts and any treatment interventions (*a history of suicidal ideation does not prevent admission to Potomac Pathways; it is essential that we have accurate information regarding any history of suicidal ideation in order to provide appropriate clinical care and assure the student's safety*):

---

---

---

---

---

Please describe any history of aggression and any treatment interventions (*a history of aggression does not prevent admission to Potomac Pathways; it is essential that we have accurate information regarding any history of aggressive behavior in order to provide appropriate clinical care and assure the students' safety*):

---

---

---

---

---

Please list and describe briefly any relationships with friends, family or community members, religious or community organizations that might serve as a support network for the student:

---

---

---

---

---

Please describe any history of legal involvement and any pending court proceedings, if applicable:

---

---

---

---

---

---

Please describe any significant history of learning differences and briefly describe the most recent efforts to provide educational support:

---

---

---

---

---

Potomac Pathways can provide, in conjunction with educational consultants, a detailed assessment of learning differences, and an educational plan that can be used by the high school or college in formulating an individualized educational plan for the student. Are you interested in learning more about these services?

---

---

---

---

---

What are the greatest strengths which the student possesses-- creative, athletic, academic, social?

---

---

---

---

---

Who will be assuming financial responsibility for the cost of services provided by Potomac Pathways?

---

---

---

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Client Confidentiality**

A message to families concerning confidentiality issues: Potomac Pathways has a commitment to keeping the information you provide and your clinical record confidential. Beyond our commitment to ethical standards, federal (HIPAA) and state law require it. You can give permission to our clinic in writing if you wish your information to be shared with specific persons outside our agency. There are exceptions when we can/must release information without your written permission. Your clinical information will be released without your written consent if: (1) it is necessary to protect you or someone else from imminent physical harm; (2) we receive a valid court order or subpoena that mandates we release your information; or (3) you are reporting abuse to children, the elderly, or persons with a disability.

Clinicians and staff members within the agency may, at times, consult with each other regarding your treatment in order to provide you with the best possible services to meet your needs.

This is to acknowledge that I have read, understood, and agreed with the above information.

Signature of Client/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_