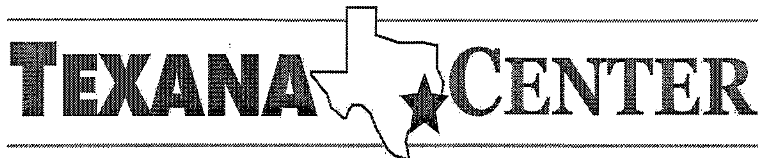

Providing Behavioral Healthcare and Developmental Disabilities Services

1818 Collins Road
Richmond, TX 77469
Phone: (281) 239-1140 or 1800-304-6047
Fax: (281) 239-1144 or 1-800-344-1758

Application for Residential Services

Thank you for your interest in the Behavior Treatment and Training Center (BTTC). The BTTC provides short-term Residential Services to Medicaid eligible children who meet the following criteria.

1) **Age:** 8 years old to 17 years old. Each child must have a legally authorized representative for consent purposes (example: parent, guardian, or managing conservator).
2) **Diagnosis:** A diagnosis of Mental Retardation, Autism, or Pervasive Developmental Disorder is required. An adaptive behavior level of II, III, or IV is required for individuals who are diagnosed with Autism or Pervasive Developmental Disorder.
3) **Behavior:** Behavior must threaten continued residence in the family home or group home, pose imminent risk of injury, or severely disrupt current programming or services in the community.
4) **Service Area:** All Texas Counties.
5) **Discharge Site:** Prior to admission, each family must agree to take the child back in the home.
6) **Family Involvement:** Family must be willing to make a time commitment to learn and practice specific skills necessary for the child's behavior to continue improving even after discharging from the BTTC. This will involve regular meetings at the BTTC.
7) **Payment:** Child should be receiving Medicaid benefits or be able to meet all financial and medical criteria to qualify for Medicaid once admitted without Medicaid.

Please complete the following application for services as thoroughly as possible and attach all appropriate documentation as noted. For assistance in completing this application, contact your service coordinator from the Mental Retardation Authority. For information about the BTTC, email Peter Khwatenge at peter.khwatenge@texanacenter.com or Tracy Woods at tracy.woods@texanacenter.com. You may also call Peter or Tracy at 1-800-304-6047

Residential applicants must enclose copies of the following:

1. ICAP Computer Printout and copy of ICAP booklet (completed by local MRA).
2. Determination of Mental Retardation (completed by local MRA).
3. Psychiatric Hospitalizations Discharge Reports.
4. Copy of current month's Medicaid form letter.
5. Copy of current private health insurance card: (front & back).
6. Copy of birth certificate.
7. Copy of Social Security card.
8. Immunization Records (including Hepatitis B series vaccine).
9. Legal documents (if caregiver is not the natural parent or if child has joint custody).
10. One recent close up picture of the child (showing chest and face).
11. One recent picture of child showing the full body.

Once a child is accepted into the residential program, the following information shall be needed. Do not send the items below with the application:

1. DMR Update – not older than 3 Months at time of admission (completed by MRA).
2. Hard copy of permanency planning tool (PP) for children.
3. Copy of the approved Permanency Plan from the care screen 249. Do not complete at time of application. (Completed by local MRA).
4. Proof of current TB skin test (not older than 1 year at time of admission).
5. Documentation of current tetanus shot (not older than 10 years).
6. Copy of current physician's orders for all medication(s) the child is taking. PRN medications are not permissible.
7. Current of Medicaid form letter.
8. Copy of private health insurance card (front & back).
9. Current school ARD/IEP objectives.

Texana Center/BTTC
1818 Collins Rd
Richmond, TX 77469

Today's Date: ______ MM | ______ DD | ________ YYYY

IDENTIFYING INFORMATION:

Name of Child: ____________________ **D.O.B:** __________ **Age:** ______ **Race:** __________

SS#: ______________ **Sex:** ______ **County:** ____________ **MRA:** ________________

Medicaid #: ______________ **CARE ID #:** ____________ **Height:** ______ **Weight.** ______

Medicaid Type: ___ Regular ___ CPS/Adoption Subsidy ___ TX Star Plus ____ Other ____________

Legal Status ________________ **Parent's email:** ______________________________

Parent's Name & Address

____

____

____

Phone: ______________________________

Service Coordinator's (SC) Name & Address

____

____

____

Phone: ______________________________

Email: ______________________________

MRA Administrator/Liaison: ______________________________ **Phone #:** ______________

MRA Administrator/Liaison email address: ______________________________

SERVICES BEING REQUESTED:

Briefly describe what is currently happening. Why do you want the services? ______________________

____

____

____

____

____

BEHAVIOR STATUS: Please tell us if each of the following behaviors are currently occurring.

Behavior	Yes/No	Behavior	Yes/No
Aggression to Others: Hitting, kicking, scratching, biting, etc.		**Inappropriate Sexual Behavior:** (groping and touching self and others)	
Self Injury: hitting, pinching, head banging, scratching self etc.		Running away or leaving assigned area.	
Property Destruction: Throwing or breaking things.		Ingestion of inedible substances	
Stealing:		Other (explain)	

What is the most severe problem behavior(s)?

	Problem Behavior	Definition
1.		
2.		
3.		

Critical Situations (For the Most Serious Problem Behaviors)

Problem	When did this problem begin?	How often does it happen?		
		Daily	Weekly	Monthly
# 1 Above				
# 2 Above				
# 3 Above				

Describe the situation in which the **most serious** problem behavior is **most likely** to occur.

____

____

____

Describe the situation in which the **most serious** problem behavior is **least likely** to occur.

____

____

____

Is he/she most likely to hit other children, parents, teachers, strangers or does he/she hit all of the persons listed here equally?

____

____

Negative Effects of Most Severe Problem Behaviors

Are there any places you cannot take your child because of his/her problem behavior? If yes, list & briefly explain what has happened:

____

____

Restraint (physically holding child to prevent injury to self or others):
Has restraint been used for these problem behaviors? ___ YES ____ NO. If yes, what type of physical restraint?
____ How often is it used? __________________

____

Has personal restraint been used in the home? _____ YES _____ NO

Has personal restraint been used at school or group? _____ YES _____ NO

What happens soon after the restraint? ____ Child resumes original activity ____ Child is allowed to rest
___ Child is given something ________________ Other: ______________________________

Does child have a behavior management plan? ____ YES ___ NO. If yes, who developed the plan? ________________________________. When was plan developed? ______________________.

What consequences are delivered for misbehavior? ___ Time out ____ Loss of privilege ___ Extinction

____ Other consequences: ________________________________

What reinforcers do you use for appropriate behavior? ________________________________

How effective is the behavior management plan? ___ Very effective ___ Marginally effective ___ Not effective at all.

____ Used to work but not any more: Why do you think the plan no longer works? ______________________

____

Medical Treatment:
Have any of these problem behaviors caused anyone to seek medical treatment for injury? __ YES ___ NO. If yes, please explain. ________________________________

Police Involvement:
Have any of the problem behaviors caused anyone to call the police or law enforcement to intervene? _____ YES

_____ NO. If yes, explain. ________________________________

Has child ever been arrested? ____ YES ____ NO. If Yes, did child see a judge? ___ YES ___ NO

Is child on probation? ___ YES ___ NO. If Yes, how long is the probationary period? _______ Months.

What is the offense child is charged with? ________________________________

Hospitalization:
Have these problem behaviors caused the child to be admitted to a Psychiatric Hospital or other facility? _____ YES _____ NO. If yes, what behavior? What are the places and dates.

Name of Hospital	Date Admitted	Date Discharged

Program Discharge:
Has any of the problem behaviors caused a school, hospital, or residential program to discharge him/her? _____YES ____ NO If yes, give names and dates.

Name of Program	Date Discharged	Reason for Discharge

<u>**Functional Skills**</u>

Please circle **one item** for each question to tell us what your child does.

1. Talks or communicates with:
   Non-verbal signs or gestures / single words / 2-3 words / complete sentences
2. Eating:
   Eats with fingers / uses utensils / prepares own food
3. Toileting:
   Needs toilet training / uses toilet when prompted / self-initiates
4. Teeth Brushing:
   Needs total assistance / needs slight assistance / brushes teeth independently

5. Dressing
   Needs total assistance for dressing / need slight assistance for dressing / dresses self
6. Bathing
   Needs total assistance for bathing / need slight assistance for bathing / bathes self independently
7. Playing
   Does not play with toys / plays appropriately with toys / plays by self / plays appropriately with others
8. How does the child communicate to others a want or need (for attention, food, etc.)? __ Verbal __ Signing
   __ Pictures __ gestures & pointing __ Other:______________________________

9. How does the child communicate a desire to stop an ongoing activity? ______________________
10. How many hours per night does the child sleep? _____ Hrs. Does he/she need medications to sleep? ___ YES
    ___ NO. If yes, what drug is used? ______________________________

11. What adaptive equipment does the child use? _____ Eye glasses _____ Special utensils _____ Wheelchair
    _____ Hearing aid ____ Leg braces ____ Other ______________________________

12. Other: ______________________________

    ____

FINANCIAL INFORMATION:

Supplemental Security Income (SSI): $ __________________ per month.

Child Support Payments: $ __________________ per month.

Adoption Subsidy Payments: $ __________________ per month.

Other Income Source(s): ______________________________ $__________ per month

Private Insurance Provider: ______________________ Group #: ______________________

Doctor's Visit Co-Pay: $ _______._____ Prescription Drugs Co-Pay: $ ______.___ $ ______.___ $ ______.____

MEDICAL HISTORY QUESTIONNAIRE

Date of Last Doctor Visit: ______________ **Reason:** ______________________________

Date of Last Physical Examination: ______________________________

List of Current Medications: (follow the example given below): List **all** medications prescribed by a physician.

Medication	Strength	Frequency	Reason Medication Prescribed
Depakote ER	500mg tabs	2 tabs twice Daily	Seizure Disorder

Name of Current Psychiatrist: ______________________________ Phone #: ____________________

Does the child take his/her own medications? ___ YES ___ NO. ____________________

Can the child swallow pills? ___ YES ___ NO, Explain how medications are given & the child's cooperativeness: ______________________________

Please List psychotropic drugs that have been tried in the past and the reason(s) for discontinuation: (Attach separate paper as needed).

Medication Name	When Used	Reason Medication was Discontinued

Tell Us About the Current Health Problems or Complaints:

Does child have seizures? ___ Yes. ___ No. If Yes, Date of last seizure? ____________________

Type of seizures: ____________________ How long does seizures last? ______ Seconds. How often do seizures occur?: _______ /day/week/month/year: circle one. What do you do when child has a seizures? ____________

____

Is child under the care of a Neurologist? ___ Yes. ___ No.

Name of Neurologist: ____________________ Phone #: ____________________

Does child have diabetes? ___ Yes. ___ No. If Yes, list the medications being given to child: ____________________

____

Does child have hypertension? ___ Yes. ___ No. If Yes, is child on medication? ___ Yes. ___ No. If Yes, list medications: ______________________________

Does child have Asthma? ___ Yes. ___ No. If Yes, List medications: ____________________

____

Does child have any heart condition? ___ Yes. ___ No. If yes, give the cardiologist's name and telephone #:

Cardiologist Name: ____________________ Telephone #: ____________________

Does child have any other medical/health problems? ___ Yes. ___ No. If Yes, explain: ____________________

____

Does the child have dental problems? ___Yes. ___ No. Explain: ____________________

Date of last dental visit. ______________ Results: ____________________

Has the child been hospitalized (for health reasons) in the last two years? ___ Yes. ___ No

If Yes, Date hospitalized? ______________. For how long? ____________________

Reason for hospitalization: ______________________________

Has the child had any surgeries? ___ Yes. ___ No. If Yes, When? ____________________

Type of surgery: ______________________________

Has child had any significant weight **Gain** or **Loss** in the last 12 months? ___ Yes. ___ No. Explain the weight Gain or Loss: ______________________________

Is the child on a special diet? ___ Yes. ___ No. If Yes, Type of diet: ____________________

____

Does the child have physical limitations? ___ Yes. ___ No. Describe: ____________________

This Section For Female Applicants Only:

Has the child begun her menstrual cycle? ___ Yes. ___ No. Year cycles begun: ______________________

If yes, are the menstrual cycles normal? ___ Yes. ___ No. If No, Explain: ______________________

Is the child on any form of birth control? ___ Yes. ___ No. If Yes, what form of birth control? ____________

Is Child able to care for personal hygiene during menstruation? _____ Yes _____ No. If no, how much assistance does she need? ______________________. Who assists her? ______________________

Complete This Section for All Applicants:

List all the allergies the child has:

Food Allergies	Medication Allergies	Other Allergies

Does Child have Hearing Problems? ___ Yes ___ No. If Yes, does child wear hearing aids? ___ Yes ___ No.

Does Child have Visual Problems? ___ Yes. ___ No. Does child wear prescription glasses? ___ Yes ___ No.

Date of Last Visual Examination: ______________________

Does Child Have Gait or Ambulation Problems? ___ Yes. ___ No. If Yes, Explain. ______________________

Information on the person completing the form:

Name: ______________________ Phone #: (____) ______ -- __________

Relationship to child: ______________________ Cell #: (____) ______--__________

Address: ______________________

______________________ Email: ______________________

Parent Training Preference:

I/We agree to attend training sessions at the BTTC on the following schedule: ___ Weekly ___ Bi-Weekly ___ Monthly

I/We agree to attend a minimum of 40 hours of training during my/our child's stay as follows: ___ 2 Hrs. ____ 3 Hrs. ____ ½ Day ___ Full Day ____ Other Schedule (explain) ______________________ per training session.

If the person completing this application form is other than the parent or Legally Authorized Representative (LAR), the LAR must read the application and sign below acknowledging the accuracy of the information in the application.

I/We acknowledge the information contained in this application to be accurate to the best of my recollection and that I am seeking **short term residential services for my child.**

Signature: ______________________ Relationship to child: ______________________

Mail Completed Form to:

Admissions
Texana Center
Behavior Treatment & Training Center
1818 Collins Road
Richmond, TX 77469-2759