



*New Beginnings Development Services, Inc.*  
**Programs for Mommy to Be and Mommy & Me**

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**Group Home for Pregnant Girls**

1523 Des Moines Ave ~ Portsmouth, Virginia 23704 ~ (757) 395-0672

Greetings,

Thank you for being interested in placing your client at New Beginnings Development Services, we look forward to serving your client's needs. The following pages are to be completed fully to the best of your knowledge. If there is something that is unknown or not applicable, please notate that in the space provided. Please be sure all sheets are signed and if items are faxed to NBDS please be sure originals are brought with you upon a visit or tour or placement.

If you have any questions regarding the application please contact the program director, Hope Sinclair, or the CAO, Cynthia McGirt.

Hope Sinclair  
757-967-8371 office

Cynthia McGirt  
757-567-1052

757-580-87966

New Beginnings Development Services, Inc.  
1523 Des Moines Ave  
Portsmouth, VA  
APPLICATION FOR ADMISSION

The following check list is to be used as a guide when sending referral information to New Beginnings Development Services. Our COA and Program Director review each application for appropriateness for our program. It is essential that we receive documentation that is current and presents an overall picture of the potential resident.

We appreciate your support, and look forward to working with you. Should you have any questions, please do not hesitate to call Cynthia McGirt at(757)567-1052 or Hope Sinclair at(757)967-8371.

New Beginnings Development believes in maintaining a highly structured family like environment to accommodate individual needs for both adolescent and child. NBDS can offer various services to get adolescent females prepared for independent living along with a variety of parental skills. NBDS will serve a population of adolescent pregnant females with behavioral management issues such as coping skills, anger management, mood disorders, adjustment disorders, and mild depression between the ages of 13-17. These disorders are usually first apparent in diagnosis an infant, child or adolescent according to the DSM-IV 3rd addition revised. The adolescent's behavior must also be mild to moderate meaning disorders with a minimum IQ of 70 and above.

New beginnings exclusion criteria involve the following: The program is not capable of accommodating residents who are ambulatory, blind or deaf. The facility will not accept an adolescent whom does not fit one of the following criteria: 1) Adolescent must be pregnant or 2) must have an infant or toddler up to the age of four. NBDS will not accept and adolescent with a history from prior group homes placement with severe violent behaviors. NBDS will not accept adolescents who do not attend school and are not willing to adhere to our resident's expectations reviewed prior to admissions. NBDS will not accept children whom demonstrate sex offending behaviors, homicidal or with suicidal attempts. Chemical dependency is an automatic non-acceptance or discharge form NBDS. New Beginnings is not equipped to counsel substance abuse residents. Adolescents must have a minimum IQ level of 70 and above. Each child will be individually evaluated per extenuating circumstances, which may hinder IQ performance. Admissions will be based on a complete application.

The following information should be submitted for initial consideration of admission:

1. Application Form
2. Medical History
3. Educational Information/ Transcripts (Report Cards)
4. Psychological Evaluation within past year
5. Court Documentation
6. Discharge Summaries from previous placements
7. Social Service plan from other placing agencies
8. Consent of third party forms

9. A physical and TB test must be complete within 90 days prior to admission unless proof of one within the last 12 months and documentation of medical treatment during the last 12 months. NBDS Intake Committee will review the above information within a week of its receipt, and, if the information indicates an appropriate referral, a pre-placement interview and visit will be scheduled. An admission decision will be rendered immediately following the pre-placement visit.

Required documents at the time of Admission:

1. Physical examination form (dated no more than 90 days before admission), including complete record of immunizations, allergies, special dietary requirements, restrictions on physical activities, a tuberculosis test dated within the previous year, and documentation of communicable disease.
2. Dental Exam within past 6 months
3. Eye Exam within past year
4. Hearing Exam within past year
5. Medicaid/Insurance Card
6. Copy of Social Security Card
7. Copy of Birth Certificate
8. Most recent report card or official school transcript
9. Purchase of Service Order
10. Photo ID Card
11. Updated immunization record

Once the above information is complete and the resident is approved for placement. The COA will contact the placing agency via phone or letter. If for any reason the resident is denied placement the COA will write a letter to the placing agency within 2 to 3 days after the decision has been made. NBDS will abide by confidentiality policy in receiving and reviewing applicant's information.

A placement agreement provided by NBDS must be signed on the day of placement.

New Beginnings Development Services, Inc.  
FACE SHEET

Resident's full name: \_\_\_\_\_  
  First                                    Middle                                    Last

Last known residence: \_\_\_\_\_  
  Address                                    City                                    State                                    Zip

Admission date: \_\_\_\_\_ Type of Admission: \_\_\_\_\_ Regular \_\_\_\_\_ Emergency

Birth date: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Gender: \_\_\_\_ Race: \_\_\_\_\_ Religious Preference: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

**Legal Guardian Information** Name: \_\_\_\_\_  
Addresses: \_\_\_\_\_

\_\_\_\_\_  
                    Physical location                    City                    State                    Zip

Telephone number(s): \_\_\_\_\_

**Placing Agency** Name: \_\_\_\_\_  
Addresses: \_\_\_\_\_

\_\_\_\_\_  
                    Physical location                    City                    State                    Zip

Telephone number(s): \_\_\_\_\_

**Emergency Contacts** Name: \_\_\_\_\_  
Addresses: \_\_\_\_\_

\_\_\_\_\_  
                    Physical location                    City                    State                    Zip

Telephone number(s): \_\_\_\_\_

**If pregnant** Expected date of delivery: \_\_\_\_\_

Hospital to provide delivery services: \_\_\_\_\_

**Discharge**  
Date of discharge: \_\_\_\_\_ Reason for discharge: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and address of persons to whom the resident was discharged: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Forwarding address of resident, if known: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Infants**  
Type of delivery: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_  
Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Current formula: \_\_\_\_\_

\*If not released for adoption please complete last two items.  
Name & Address of biological mother, if known: \_\_\_\_\_  
\_\_\_\_\_

Name & Address of biological father, if known: \_\_\_\_\_  
\_\_\_\_\_

New Beginnings Development Services, Inc.  
PLACEMENT AGREEMENT

On this day \_\_\_ of \_\_\_\_\_, NBDS, located at 1523 Des Moines Ave. Portsmouth, Virginia, 23453, accepts \_\_\_\_\_ as a resident of NBDS. NBDS shall provide case management and treatment services as outlined in this agreement.

\_\_\_\_\_ is a child, DOB \_\_\_\_\_ in the custody of \_\_\_\_\_ (DSS), which has the authority to seek and make placement for said child. It is understood that custody shall remain with the undersigned-placing agency.

1. The placing agency represents that it has legal custody of the child and shall pay services purchased from NBDS which breakdowns as follows:

Room and board      \$230.00 per day  
NBDS agrees to be responsible on a monthly basis for the following financial allocations for residents between the ages of 13-17 years:

Clothing  
Personal Care & Recreation  
Allowance

2. Medicaid will cover the child's medical and dental needs. Any additional medical and/or dental expenses not covered by Medicaid must be pre-authorized by the placing agent and are the responsibility of the placing agency.
3. NBDS shall cooperate with the placing agency to ensure that the child receives routine medical and dental care. NBDS shall act immediately in medical emergencies and notify placing agent as soon as possible. NBDS will obtain permission for all routine medical care.
4. NBDS shall have acquisition of and consent for "any" medical or dental treatment needed by the resident and "to obtain immunizations" from the resident while in the facilities care.
5. NBDS agrees to keep the placing agency aware of progress and concerns. In the event of placement disruption, NBDS will make every effort to give the placing agent a two-week notice prior to the youth being removed from the program. Likewise, NBDS expects to receive a two-week notice of the placing agencies intent to remove the child from the facility.
6. Payment for services provided by NBDS will be billed monthly. It is expected by NBDS that payment for services will be made to NBDS by the 30<sup>th</sup> of each month.
7. Residents of NBDS are expected to cooperate with services and develop to their fullest potential.
8. NBDS requires the placing agent to be involved in resident's treatment by means of visits, telephone calls, participation in staffing, and service plan reviews for as long as the youth remains at NBDS.
9. The placing agency gives permission for the resident to participate in recreational activities, independent living, and other therapeutic services and activities that are a part of NBDS.
10. Visitation of family and friends is encouraged. Visitors are welcome to visit NBDS. A 24-hour prior notice is required, however; visits can be arranged as necessary and appropriate to

meet the individual needs of the child if the visitor is approved by the placing agency/guardian. NBDS does require identification of visitors and driver's license to transport resident of NBDS.

11. NBDS staff reserves the right to protect each resident, therefore if there are any "Court Orders" or "Protective Orders" that would assist with the protection needs of the resident, toddler or infant please provide a copy of the order during the time of admissions. Yes\_\_\_\_ No\_\_\_\_\_
12. Residents are permitted to have home visits with "approved" family members. The approved family list will be obtained during admissions.
13. When the resident leaves the facility for a home visit, it is the responsibility of the family member to pick up and return the resident at the agreed time by staff. It is also the responsibility of that family member to presume the responsibility to care for and provide the resident with their daily needs.
14. It is the responsibility of the legal guardian to enroll the adolescent in school within 72 hours of placement.
15. Residents up to the age of 18 must be enrolled in an appropriate school program which meets the residents academic and special needs as provided in the code of Virginia.
16. The CAO/PD will ensure all residents will be allowed 2 hours of homework time Mon-Friday. However a resident may use their free time for additional studies. The PD/CAO will make sure the Resident receives a minimum of 1 hour is designated for study time on weekend however the resident may study more if needed during free time hours which last up to two hours per day. It is also the facilities responsibility to ensure appropriate study time is given to all residents enrolled in an education program.
17. It is the facilities responsibility to ensure the residents are getting the proper guidance and counseling in the selecting courses.
18. In the event that the resident becomes AWOL, NBDS staff will notify the placing agency immediately, along with filing a missing person report with the local police department with-in 24 hours. In the event the resident is missing or AWOL for a period of 7 or more days NBDS reserves to right to discharge the resident.

Wherefore, the undersigned parties are in agreement that the services to be purchased from the provided by NBDS are in the best interest of the child at this time. The undersigned also acknowledged that there are no promises, agreements of any kind whatsoever that exist other than this written agreement and that modification or changes thereon must be in writing and mutually executed by all parties who are signers to this agreement.

\_\_\_\_\_  
Placing Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
NBDS

\_\_\_\_\_  
Date

New Beginnings Development Services, Inc.  
PLACEMENT AGREEMENT FOR INFANT/TODDLER

On this day \_\_\_ of \_\_\_\_\_, NBDS, located at 1523 Des Moines ave. Portsmouth, Virginia, 23453, accepts \_\_\_\_\_ as a resident of NBDS. NBDS shall provide case management and treatment services as outlined in this agreement.

\_\_\_\_\_ is a child, DOB \_\_\_\_\_ in the custody of \_\_\_\_\_ (DSS), which has the authority to seek and make placement for said child. It is understood that custody shall remain with the undersigned-placing agency.

1. The placing agency represents that it has legal custody of the child and shall pay services purchased from NBDS which breakdowns as follows:

For the Child of the Youth:

Ages 0-4 years	\$500.00 per month
	*Foster care Rates

2. Medicaid will cover the child's medical and dental needs. Any additional medical and/or dental expenses not covered by Medicaid must be pre-authorized by the placing agent and are the responsibility of the placing agency.
3. NBDS shall cooperate with the placing agency to ensure that the child receives routine medical and dental care. NBDS shall act immediately in medical emergencies and notify placing agent as soon as possible. NBDS will obtain permission for all routine medical care.
4. NBDS shall have acquisition of and consent for "any" medical or dental treatment need by the resident and "to obtain immunizations" from the resident while in the facilities care.
4. NBDS agrees to keep the placing agency aware of progress and concerns. In the event of placement disruption, NBDS will make every effort to give the placing agent a two-week notice prior to the youth being removed from the program. Likewise, NBDS expects to receive a two-week notice of the placing agencies intent to remove the child from the facility.
5. Payment for services provided by NBDS will be billed monthly. It is expected by NBDS that payment for services will be made to NBDS by the \_\_\_ of each month.
6. Residents of NBDS are expected to cooperate with services and develop to their fullest potential.
7. NBDS requires the placing agent to be involved in resident's treatment by means of visits, telephone calls, participation in staffing, and service plan reviews for as long as the youth remains at NBDS.
8. The placing agency gives permission for the resident to

participate in recreational activities, independent living, and other therapeutic services and activities that are a part of NBDS.

9. Visitation of family and friends is encouraged. Visitors are welcome to visit NBDS. A 24-hour prior notice is required, however; visits can be arranged as necessary and appropriate to meet the individual needs of the child if the visitor is approved by the placing agency/guardian. NBDS does require identification of visitors and driver's license to transport resident of NBDS.
10. NBDS staff reserves the right to protect each resident, therefore if there are any "Court Orders" or "Protective Orders" that would assist with the protection needs of the resident, toddler or infant please provide a copy of the order during the time of admissions. Yes\_\_\_ No\_\_\_
11. Residents are permitted to have home visits with "approved" family members. The approved family list will be obtained during admissions.
12. When the resident leaves the facility for a home visit, it is the responsibility of the family member to pick up and return the resident at the agreed time by staff. It is also the responsibility of that family member to presume the responsibility to care for and provide the resident with their daily needs.
13. In the event that the resident becomes AWOL, NBDS staff will notify the placing agency immediately, along with filing a missing person report with the local police department with-in 24 hours. In the event the resident is missing or AWOL for a period of 7 or more days NBDS reserves to right to discharge the resident.

Wherefore, the undersigned parties are in agreement that the services to be purchased from the provided by NBDS are in the best interest of the child at this time. The undersigned also acknowledged that there are no promises, agreements of any kind whatsoever that exist other than this written agreement and that modification or changes thereon must be in writing and mutually executed by all parties who are signers to this agreement.

\_\_\_\_\_  
Placing Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
NBDS

\_\_\_\_\_  
Date

**New Beginnings Development Services, Inc.  
MEDICAL AND DENTAL EMERGENCY INFORMATION SHEET**

(\*\*This form gives authorization, permission and consent for "Any"  
medical or dental treatment and "to obtain immunizations"\*\*)

Part I

RESIDENT: \_\_\_\_\_  
  First  Middle  Last

PHYSICIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

DENTIST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

NAME OF RELATIVE OR OTHER PERSON(S) TO BE NOTIFIED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

MEDICAID NUMBER: \_\_\_\_\_

CURRENT MEDICATIONS AND DOSAGE USED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALL ALLERGIES, INCLUDING MEDICATION ALLERGIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUBSTANCE ABUSE AND USE:

\_\_\_\_\_  
\_\_\_\_\_

SIGNIFICANT PAST AND PRESENT MEDICAL PROBLEMS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
NBDS Staff Signature/Date

\_\_\_\_\_  
Medical/Dental professional signature/Date

New Beginnings Development Services

Written Consent For Treatment

(\*\*This form acts as authorization, permission and consent for "Any" medical or dental treatment and "to obtain immunizations"\*\*) **700.B.5.**

I, \_\_\_\_\_, (legal guardian/parent/placing agency)

give New Beginnings Development Services permission/consent for "ANY" medical or dental treatment and "to obtain immunizations" and immunization records for Resident: \_\_\_\_\_ and Toddler:

\_\_\_\_\_. This consent letter will remain affective during

the resident's stay with NBDS.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of CAO/and or PD

\_\_\_\_\_  
Date



New Beginnings Development Services, Inc.  
ADMISSION APPLICATION

I hereby apply for admission of this student to New Beginnings Development Services.

Resident's Full Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Supervisor: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Emergency#: \_\_\_\_\_

I do hereby certify that I, \_\_\_\_\_, have the right to complete and application on behalf of this resident, \_\_\_\_\_, and that the information furnished is true and complete to the best of my knowledge. I further testify that the legal guardianship of \_\_\_\_\_ is held by \_\_\_\_\_.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Regular admissions \_\_\_\_\_  
Emergency placement \_\_\_\_\_  
Court Order Received \_\_\_\_\_  
Date \_\_\_\_\_

Legal Guardian if not the same as above:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Telephone Numbers: \_\_\_\_\_

RESIDENTS INFORMATION

Present Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Does youth have a child? \_\_\_ Yes \_\_\_ No (if yes, complete infant intake sheet)

Is youth being referred pregnant? \_\_\_ Yes \_\_\_ No

With whom was resident living with prior to placement?

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

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

Religious Preference: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name Coverage Carried Under: \_\_\_\_\_

Past serious illnesses or infectious diseases: \_\_\_\_\_

\_\_\_\_\_

Any/All Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

\_\_\_\_\_

History of substance abuse: \_\_\_\_\_ Treatment received: \_\_\_\_\_

If pregnant anticipated due date: \_\_\_\_\_

Prenatal care received \_\_\_Yes \_\_\_No

Current Medications: \_\_\_\_\_

Medicine Allergies: \_\_\_\_\_

Date of Last Physical/Prenatal Visit: \_\_\_\_\_

Condition: \_\_\_\_\_

Does resident have any **physical needs, or handicaps** that require assistance? If so briefly explain.

\_\_\_\_\_

Psychological Evaluation Date Completed: \_\_\_\_\_

Condition: \_\_\_\_\_

Psychiatric Information (if appropriate): \_\_\_\_\_

DSM IV Diagnosis: \_\_\_\_\_

Resident's Physician: \_\_\_\_\_

Date last seen: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Resident's Dentist: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Resident's Relative or other person to be notified: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Residents OB/GYN \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Address \_\_\_\_\_ Telephone: \_\_\_\_\_

Immunization record updated:            yes \_\_\_\_\_    no \_\_\_\_\_  
Immunization needs: \_\_\_\_\_

Physical Health needs: \_\_\_\_\_  
\_\_\_\_\_

Last Public or Private School Attended: \_\_\_\_\_  
Date Withdrawn \_\_\_\_\_ Current Grade \_\_\_\_\_  
Does child has a history of suspensions or disciplinary problems  
at school? If so, briefly explain:  
\_\_\_\_\_  
\_\_\_\_\_

Does the resident need Special Education resources/ placement?  
Yes \_\_\_\_\_ NO \_\_\_\_\_

If so explain:  
\_\_\_\_\_  
\_\_\_\_\_

**NBDS staff reserves the right to protect each resident, therefore if there are any "Court Orders" or "Protective Orders" that would assist with the protection needs of the resident, toddler or infant please provide a copy of the order during the time of admissions. Yes \_\_\_\_\_ No \_\_\_\_\_**  
**Residents are permitted to have home visits with "approved" family members. The approved family list will be obtained during admissions. When the resident leaves the facility for a home visit, it is the responsibility of the family member to pick up and return the resident at the agreed time by staff. It is also the responsibility of that family member to presume the responsibility to care for and provide the resident with their daily needs. In the event that the resident becomes AWOL,**

**NBDS staff will notify the placing agency immediately, along with filing a missing person report with the local police department with-in 24 hours. In the event the resident is missing or AWOL for a period of 7 or more days NBDS reserves to right to discharge the resident.**

New Beginnings Development Services, Inc.

FAMILY HISTORY

**Mother**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number(s): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Occupation/Employer: \_\_\_\_\_  
Monthly Salary: \_\_\_\_\_  
Serious Illness: \_\_\_\_\_  
If deceased, Date: \_\_\_\_\_ Place: \_\_\_\_\_  
Cause of Death: \_\_\_\_\_  
Court orders as it relates to the child (ex. Family counseling, visitation, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Father**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number(s): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Occupation/Employer: \_\_\_\_\_  
Monthly Salary: \_\_\_\_\_  
Serious Illness: \_\_\_\_\_  
If deceased, Date: \_\_\_\_\_ Place: \_\_\_\_\_  
Cause of Death: \_\_\_\_\_  
Court orders as it relates to the child (ex. Family counseling, visitation, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following questions as completely as possible:**

List all previous out-of-home referrals/intervention strategies tried or used.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the resident presenting problems?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the current family situation.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the resident had any contact with Juvenile Court? If so, list court location, date, offense, and disposition.

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Has the student been referred to a mental health or family-counseling clinic? If so, list states, locations, names of therapists, and diagnoses.

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Please check the behaviors exhibited by the resident:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Poor hygiene         | <input type="checkbox"/> Manipulation     | <input type="checkbox"/> Fighting      |
| <input type="checkbox"/> Lying                | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Alcohol usage |
| <input type="checkbox"/> Stealing             | <input type="checkbox"/> Running away     | <input type="checkbox"/> Fire-starting |
| <input type="checkbox"/> Prostitution         | <input type="checkbox"/> Drug use         | <input type="checkbox"/> Promiscuity   |
| <input type="checkbox"/> Poor impulse control |   | <input type="checkbox"/> Bed-wetting   |
| <input type="checkbox"/> Other                |   |  |

Do you feel that placing the resident at New Beginnings may present a risk factor to staff or other residents? If so briefly explain.

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How does the placing agency, resident and/or legal guardian feel that New Beginnings will be of benefit to the resident?

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What are the resident's behavior support needs? \_\_\_\_\_

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What is the suitability of the resident's admission? \_\_\_\_\_

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New Beginnings Development Services, Inc.  
INFANT/ TODDLER ADMISSION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_ M \_\_ F  
Child of: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Who has custody of the child? Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Court Order Received: \_\_\_\_\_ Date \_\_\_\_\_

Who does or has the infant/Toddler been living with prior to placement?  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Current Formula: \_\_\_\_\_  
Formulas infant cannot tolerate: \_\_\_\_\_

Food Allergies: \_\_\_\_\_  
Any/All Allergies: \_\_\_\_\_  
Intolerance: \_\_\_\_\_

Insurance: \_\_\_\_\_  
Policy#: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treating Physician or Clinic: \_\_\_\_\_  
Immunizations: Yes \_\_\_\_\_ or No \_\_\_\_\_  
Immunization needs: \_\_\_\_\_  
Physical health needs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the individuals who may visit the infant/Toddler:  
\_\_\_\_\_  
\_\_\_\_\_

List any individuals who should not visit or have contact with the  
infant:  
\_\_\_\_\_  
\_\_\_\_\_

Physical needs of toddler: \_\_\_\_\_  
\_\_\_\_\_

Physical health needs of toddler: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



New Beginnings Development Services, Inc.  
PHYSICAL EXAM FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Physical: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Vision Exam: \_\_\_\_\_

Hearing Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_ Restrictions of physical activities: \_\_\_\_\_

Immunizations administered: \_\_\_\_\_

Needed: \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Handicap conditions: \_\_\_\_\_

\_\_\_\_\_

Check blanks that apply for above name individual:

- Chicken pox  infect. Mono.  Viral Hepatitis
- Pneumonia  Measles  German Measles  Mumps  Diabetes
- Malaria  Tuberculosis  Recurrent headache
- RecurCold  Chronic cough  Epilepsy
- Gum or tooth trouble  EyeTrouble
- Ear, nose, throat trouble

**SURGERY:**

- Appendectomy  Tonsillectomy  Hernia Repair  Other
- Hay Fever  Asthma  Sexually Trans.
- Freq. Depression  Freq. Anxiety  Insomnia
- Head Injury  Unconsciousness  Back Problems
- Other Illness  Irregular Periods  Severe Cramps
- Excessive Flow
- Pregnant \_\_\_\_\_ Last Menstrual Period

Have you been physically abused?  Yes  No

Have you ever used any of the following? (Check if yes)

- Alcohol  Marijuana  Inhalants
- Amylnitrate (poppers)
- Crack  Barbiturates  Cocaine  LSD
- Narcotics  I.V. Drugs  Other Nonprescription Drugs

Have you ever had a blood transfusion?  Yes  No

Have you ever been sexually abused?  Yes  No

Have you ever been sexually active?  Yes  No

If yes to sexually active, have you been active with any of the following?

- Person with Aids  IV Drug user  Multiple/Unknown partners
- Male/Female Prostitute  Homosexual  Hemophiliac
- ARC  Positive HIV

Have any of your relatives had any of the following \*Give

relationship\*

Tuberculosis \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Heart Disease \_\_\_\_\_  
 Kidney Disease \_\_\_\_\_  
 Asthma, Hayfever \_\_\_\_\_  
 Epilepsy/Convulsions \_\_\_\_\_  
 Alcohol/Drug Related problems \_\_\_\_\_

Nutritional Requirements \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Diet \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations for further treatment, immunizations, or other  
examinations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

New Beginnings Development Services, Inc.  
PHYSICAL EXAM REPORT

Resident: \_\_\_\_\_ Date: \_\_\_\_\_

Immunizations administered AT TIME OF EXAM: If none please indicate.

\_\_\_\_\_  
\_\_\_\_\_

Vision exam: \_\_\_\_\_ Hearing exam: \_\_\_\_\_

General physical condition (including documentation of apparent freedom from communicable disease including tuberculosis):

\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_ Chronic conditions: \_\_\_\_\_

Handicaps: \_\_\_\_\_

Nutritional requirements (include any special diets, if any)

\_\_\_\_\_  
\_\_\_\_\_

Restrictions on physical activities, if any:

\_\_\_\_\_  
\_\_\_\_\_

Recommendations for further Treatment:

\_\_\_\_\_  
\_\_\_\_\_

Immunizations: \_\_\_\_\_

Other Examinations: \_\_\_\_\_

Date of physical examination: \_\_\_\_\_

\_\_\_\_\_  
Signature of licensed physician

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Physician's designee

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Official of local health department

\_\_\_\_\_  
Printed name

New Beginnings Development Services, Inc.  
DISCHARGE PARTICIPATION FORM

Resident: \_\_\_\_\_ ID #: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Resident

My case manager has reviewed my discharge plan with me and I agree with what is in my plan. I also agree that those issues addressed in my plan are issues and problems that I need to work on.

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

Parent/Guardian

My child's case manager has reviewed the discharge plan with me and I support its content.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Case Manager/Referral Agent

I have reviewed and participated in the discharge with the case manager of NBDS and support its content.

\_\_\_\_\_  
Case Manager/Referral Agent

\_\_\_\_\_  
Date

New Beginnings of Development Services, Inc.  
DISCHARGE SUMMARY

Resident: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Services Provided to Resident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident's Progress toward meeting service plan objectives:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident's continuing needs and recommendations, if any, for further services and care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for discharge:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person to who resident was discharged: \_\_\_\_\_

Signature of Preparer: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date Summary Prepared: \_\_\_\_\_

Date that copy was sent to placing party: \_\_\_\_\_

New Beginnings Development Services  
1523 Des Moines Avenue  
Portsmouth, Virginia

INDIVIDUAL SERVICE PLAN ACKNOWLEDGEMENT OF DISTRIBUTION AGREEMENT

By signing this document you are agreeing that you were distributed a copy of \_\_\_\_\_, individual service plan. Please do not hesitate to contact Mrs. Cynthia McGirt or Ms. Hope Sinclair if there are any questions in regards to the service plan. All records are kept confidential.

\_\_\_\_\_  
Resident

\_\_\_\_\_  
Parent/ Legal Guardian

\_\_\_\_\_  
Cynthia McGirt, CAO

\_\_\_\_\_  
Hope Sinclair, Program Director

\_\_\_\_\_  
Child Care Staff, NBDS

\_\_\_\_\_  
Other

New Beginnings Development Services, Inc.  
INITIAL OBJECTIVES AND STRATEGIES  
For the first 30 days of care

Name of Resident: \_\_\_\_\_ Date Plan Developed: \_\_\_\_\_

1. Objective:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Objective:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Objective:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Objective:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Distribution of this report:

<u>Party</u>	<u>Date</u>
1 Resident	_____
2 Parent	_____
3 Placing Agency	_____
4 Facility Staff	_____

New Beginnings Development Services, Inc.  
INDIVIDUAL SERVICE PLAN

Resident: \_\_\_\_\_ Date of Plan: \_\_\_\_\_

Resident's Strengths

- 1.
- 2.
- 3.
- 4.
- 5.

Resident's Needs

- 1.
- 2.
- 3.
- 4.

Resident's Current Functioning (bullets or narrative)

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Goals, Objectives, Strategies & Target Dates for Accomplishing Objectives

Goal: \_\_\_\_\_

Objective: \_\_\_\_\_

Target date to accomplish: \_\_\_\_\_

Strategies:

- 1.
- 2.
- 3.

Goal: \_\_\_\_\_

Objective: \_\_\_\_\_

Target date to accomplish: \_\_\_\_\_

Strategies:

- 1.
- 2.
- 3.

Goal: \_\_\_\_\_

Objective: \_\_\_\_\_

Target date to accomplish: \_\_\_\_\_

Strategies:

- 1.
- 2.
- 3.

Goal: \_\_\_\_\_

Objective: \_\_\_\_\_

Target date to accomplish: \_\_\_\_\_

Strategies:

- 1.
- 2.
- 3.

Goals for babies/Toddlers: \_\_\_\_\_

Objectives: \_\_\_\_\_

Target date to accomplish: \_\_\_\_\_

Strategies:

- 1.
- 2.
- 3.

Mother's interaction with infant/baby//toddler (bullet or narrative)

- 1.
- 2.
- 3.

Projected Family Involvement (bullets or narrative)

- 1.
- 2.
- 3.

Status of Discharge Planning (bullets or narrative)

- 1.
- 2.
- 3.

CAO or PD Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

The following parties participated in and received a copy of this report:

	<u>Party</u>	<u>Date</u>
1	Resident	_____
2	Legal guardian	_____
3	Placing agency	_____
4	Facility staff	_____

New Beginnings Development Services, Inc.

QUARTERLY PROGRESS REPORT

Resident: \_\_\_\_\_ Date Report Developed: \_\_\_\_\_

**Resident's Progress on meeting service plan objectives**

1 Objective: (good to re-state the individual objective)

\_\_\_\_\_  
\_\_\_\_\_

• Progress: (narrative would be good here)

\_\_\_\_\_  
\_\_\_\_\_

2 Objective:

\_\_\_\_\_  
\_\_\_\_\_

• Progress:

\_\_\_\_\_  
\_\_\_\_\_

3 Objective: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Progress: \_\_\_\_\_

\_\_\_\_\_

**Family's involvement:**

Continuing Needs of the Resident:

- 1.
- 2.
- 3.

Resident progress towards discharge: (bullets or narrative work here)

Status of Discharge Planning:

Revisions, if any, to service plan

- 1.
- 2.

Signature of staff person who developed report: \_\_\_\_\_

My signature below indicates that I have participated in the development of this plan review and received a copy of this review document:

<u>Party</u>	<u>Signature</u>	<u>Date</u>
Resident	_____	_____
Family or Legal Guardian	_____	_____
Placing Agency	_____	_____
Facility Staff	_____	_____