PATHWAY, INC.
Enterprise, Alabama

ALABAMA DHR PRE-ADMISSION CHECKLIST

Referral Name _____ County Agency _____

SW Name _____ Telephone _____ Fax _____

Date(s) of File Review _____ Email _____

Documents	NA	Received	Not Received	Comments
Biopsychosocial Assessment*				Need Copy Before Admission
Psychological Evaluation:*				Need Copy Before Admission
A. Psychometrics				
B. Personality				
Juvenile Court Summary * (If applicable)				
Last Report Card				Need Copy Before Admission
History And Physical Examination**				
Proof of Custody				Need Copy Before Admission
Rights In Special Education/Consent				ONLY A PARENT Can Sign
Birth Certificate				Need Copy Before Admission
Social Security Card				Need Copy Before Admission
Immunization Certificate				Need Copy Before Admission
Medicaid Card And Last EPSDT Screening				Need Original at Admission
Medications – 2 Week's Worth Of All Meds.				MUST HAVE at time of Admission
Healthcare Insurance Card				Need Copy Before Admission
Agency Authorization for Billing *SDHR Requirement-form 724*				Need Copy Before Admission/ MUST HAVE Original at Admissi
Inter-Agency Agreement *SDHR Requirement-form 823*				Need Copy Before Admission/ MUST HAVE Original at Admissi
Placement Agreement *SDHR Requirement-form 824*				Need Copy Before Admission/ MUST HAVE Original at Admissi
Intensive Only- Certification of Need *SDHR Requirement-form 370* MUST HAVE Original signed by a physician at the time of admission				Need Copy Before Admission

OTHER: _____

* REQUIRED for consideration of admission

** The most recent physical health assessment completed on the client is REQUIRED for consideration of admission. In addition, a Medical History and Physical Examination must be completed within 30 DAYS prior to admission, with a copy of the report provided to Pathway no later than the day of admission.

PATHWAY, INC.
Enterprise, Alabama

BIOPSYCHOSOCIAL ASSESSMENT/APPLICATION FOR ADMISSION
Revised October, 2019

I. IDENTIFYING INFORMATION

Client_____ DOB____/____/____ SS#____/____/____

Age _____ Grade _____ Race _____ Sex _____ Height _____ Weight _____

Referral Source:_____County Department of **Human Resources** Case # _____

Social Worker Name_____ Contact #s _____

Address: _____ *CITY* _____ *ST* *ZIP*

_____ County **Juvenile Court Services** JPO Name: _____

Contact #s_____

Address: _____ *CITY* _____ *ST* *ZIP*

☐ **OTHER** (Agency or Name)_____ Contact #s_____

Address: _____ *CITY* _____ *ST* *ZIP*

Parent(s):

Mother's Name_____ Contact #s_____

Mother's Address _____ *CITY* _____ *ST* *ZIP*

Father's Name_____ Contact #s_____

Father's Address _____ *CITY* _____ *ST* *ZIP*

Who/What agency has legal custody of this child? _____

Legal Guardian, ***if not the parent.*** Name:_____ Contact #s_____

Address: _____ *CITY* _____ *ST* *ZIP*

Legal Guardian Email address: _____

Who will visit with this child during treatment? _____

_____

II. DISCHARGE PLANNING

A. Where will the client be placed upon discharge from Pathway? □ Parents/Family □ Foster Parents □ Group Home

□ Day Treatment □ Other_____

B. Plans include to: (check all that apply): □ Return to school □ Seek employment □ Comply with terms of probation

□ Other_____

C. Which, if any, of the following agencies have been involved with the family?
(Check ALL that apply <u>and</u> circle "R" for recently and "P" for in the past.)

Department of Human Resources	R	P
Juvenile Court System	R	P
Community Mental Health	R	P
None of the above		

1. Explain the reason(s) for agency involvement (if not stated previously in this history.)_____

_____

_____

III. *A. PRESENTING PROBLEMS / RESTORATION NEEDS*

	Age of onset	*Supporting detail*
☐ Disrespect/Disobedience to authority figures		
☐ Frequent arguments with parents		
☐ Physical aggression with adults/parent(s)		
☐ Physical aggression with peers		
☐ Property destruction/vandalism		
☐ Stealing/Burglary		
☐ Frequent dishonesty/lying		
☐ Excessive profanity		
☐ Truant from school		
☐ Poor academic performance/School failure		
☐ Suspension from school		
☐ Taking drugs to school		
☐ *Taking a weapon to school		
☐ *Cruelty to animals		
☐ *Suicidal or homicidal ideations/verbal threats		
☐ *Suicide or homicidal gestures/attempts		
☐ *Self-mutilation/Self-injurious behavior		
☐ *Inappropriate sexual behavior		
☐ Alcohol and/or other substance use		
☐ AWOL from other placement(s)		
☐ Running away from home		
☐ Gang involvement/friends in gangs		
☐ Vehicle theft/Unauthorized use		
☐ *Fire starting		

***If checked above, MUST provide explanation/circumstances**

Explanation of any items asterisked: _____

_____

Describe how the behavioral problems changed with age and how this has affected the family: _____

_____

B. SPECIAL TREATMENT NEEDS

1. Has client's behavior escalated to the point that restraint or seclusion was required to manage behavior? ☐ Yes ☐ No

   If yes, EXPLAIN _____

   _____

2. Are there any techniques, methods or tools which could be utilized by staff to avoid such a type of behavior management intervention? **Check all that apply:**

☐ Positive self-talk	☐ Getting involved in activities	☐ A change of scenery
☐ Being alone/taking space (self time out)	☐ Thinking of the consequences	☐ Physical exercises
☐ Deep-breathing exercises	☐ Thinking of something pleasant	☐ Going for a walk
☐ Talking to staff to solve problems	☐ Relaxation exercises	☐ Counting to 10, etc.
☐ Focusing on other things	☐ Other_____	

3. Does client have any pre-existing medical conditions, physical disabilities or abuse issues which would place the client at greater risk during the implementation of a restraint, hold or seclusion? □ Yes □ No If yes, explain.

_____

_____

IV. PSYCHIATRIC TREATMENT/PLACEMENT HISTORY

Please list previous placements and treatment programs, beginning with the most recent.

1. Placement_____ From_____To_____
   Type of placement: □ Hospital □ Residential □ Relative Placement □ Foster Home
   Reason for placement _____
2. Placement_____ From_____To_____
   Type of placement: □ Hospital □ Residential □ Relative Placement □ Foster Home
   Reason for placement_____
3. Placement_____ From_____To_____
   Type of placement: □ Hospital □ Residential □ Relative Placement □ Foster Home
   Reason for placement_____
4. Placement_____ From_____To_____
   Type of placement: □ Hospital □ Residential □ Relative Placement □ Foster Home
   Reason for placement _____

V. FAMILY HISTORY

A. NUCLEAR FAMILY

1. The parents are the client's □ Birth Parents □ Adoptive Parents If adopted, when?_____
2. Parents: □ Are currently married □ Never married □ Are separated □ Are divorced
   If married, for how long?_____ If separated or divorced, for how long? _____
   How many times has father been married?_____ How many times has mother been married? _____
3. What type(s) of discipline are most frequently used by the parent(s)_____
   Who is the primary disciplinarian?_____
4. Is there an immediate family history of suicide or suicide attempts? □ Yes □ No If yes, please explain:

   _____

   _____

5. ***FATHER*** ☐ **Living** ***or*** ☐ **Deceased**
   Name_____ Age_____ Is he employed? □ Yes □ No
   If yes, where, and what does he do? _____
   Does (did) he have, or has he ever had serious (Describe):
   psychiatric problems? _____
   physical health problems?_____drug/alcohol problems? _____
   abuse problems? (physical, emotional, sexual) _____
   Has (was) he ever been arrested or spent time in jail? □ Yes □ No If yes, for what reason(s)?_____

   _____

   Has (was) this or any other child ever been removed from his custody? □ Yes □ No
   If yes, describe the reason(s) _____

Describe the father-child relationship_____

If deceased: Cause of death_____

6. ***MOTHER*** ☐ **Living** ***or*** ☐ **Deceased**

Name_____ Age_____ Is she employed? □ Yes □ No

If yes, where, and what does she do? _____

Does (did) she have, or has he ever had serious (Describe):

psychiatric problems? _____

physical health problems?_____drug/alcohol problems? _____

abuse problems? (physical, emotional, sexual) _____

Has (was) she ever been arrested or spent time in jail? □ Yes □ No If yes, for what reason(s)?_____

_____

Has (was) this or any other child ever been removed from her custody? □ Yes □ No

If yes, describe the reason(s) _____

Describe the mother-child relationship_____

If deceased: Cause of death_____

7. ***STEP-MOTHER*** ☐ **Has or** ☐ **Has NOT adopted this child**

Name_____ Age_____ Length of marriage to father _____

Is she employed? □ Yes □ No If yes, where and what does she do? _____

_____

Does she have, or has she ever had serious (Describe):

psychiatric problems? _____

physical health problems?_____ drug/alcohol problems? _____

abuse problems? (physical, emotional, sexual) _____

Has she ever been arrested or spent time in jail? □ Yes □ No If yes, for what reason(s)? _____

_____

Describe her relationship with her step-child _____

8. ***STEP-FATHER*** ☐ **Has or** ☐ **Has NOT adopted this child**

Name_____ Age_____ Length of marriage to mother _____

Is he employed? □ Yes □ No If yes, where and what does he do? _____

_____

Does he have, or has he ever had serious (Describe):

psychiatric problems? _____

physical health problems?_____ drug/alcohol problems? _____

abuse problems? (physical, emotional, sexual) _____

STEP-FATHER (continued)

Has he ever been arrested or spent time in jail? □ Yes □ No If yes, for what reason(s)? _____

_____

Describe the relationship with his step-child _____

9. ***SIBLINGS***

Have any siblings been removed from the home? □ Yes □ No If yes, describe the circumstances: _____

_____

Have any siblings been involved with the juvenile court system or had difficulties with the legal system? □ Yes □ No

If yes, describe the problem(s): _____

_____

Please list all siblings (full, half, step):

	Age	Sex	Lives With	Describe the nature of the relationship
a.	_____	____	_____	_____
b.	_____	____	_____	_____
c.	_____	____	_____	_____
d.	_____	____	_____	_____
e.	_____	____	_____	_____

B. EXTENDED FAMILY

	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Psychiatric problems	☐	☐	☐	☐
Physical health problems	☐	☐	☐	☐
Drug/alcohol problems	☐	☐	☐	☐
Abuse problems (physical, emotional, sexual)	☐	☐	☐	☐
Deceased	☐	☐	☐	☐

If checked above, please explain: _____

_____

Please describe the client's relationship with maternal and paternal grandparents: _____

_____

VI. FAMILY INVOLVEMENT/EXPECTATIONS FOR TREATMENT

1. How will the client's family be involved during treatment?
   - □ Parental rights have been terminated - no family will be involved
   - □ DHR visiting resource only
   - □ Monthly visitation, telephone contact, and discharge planning
   - □ Monthly visitation, additional on-site family therapy, telephone contact, and discharge planning
   - □ Other_____
2. What is the primary language of the client?_____. What is the primary language of the immediate family? _____
3. Are there any family members or significant others who are **not** supportive of the client's treatment? □ Yes □ No

   If yes, explain_____
4. What does the family/legal guardian consider to be the client's greatest need?_____

   _____
5. What are the client's strengths (things they do well or like about themselves)?_____

   _____
6. What are the areas in which improvement is needed?_____

   _____

VII. RELEVANT MEDICAL BACKGROUND

A. GROWTH AND DEVELOPMENT

1. Was the client born after a full-term pregnancy? □ Yes □ No If no, describe the circumstances:_____

   _____
2. Were there any complications/difficulties during the birthing process? □ Yes □ No If yes, please describe the

circumstances:_____

3. Did the client:

sit	□ at the appropriate age	□ early	□ late
crawl	□ at the appropriate age	□ early	□ late
walk	□ at the appropriate age	□ early	□ late
talk	□ at the appropriate age	□ early	□ late

4. Has the client ever been a victim of physical and/or emotional abuse? ☐ Yes ☐ No

If yes, describe the event(s):_____

_____

B. MEDICAL ASSESSMENT

1. Does the client have allergies to any medicines? To foods? To insect bites? Other environmental factors? □ Yes □ No
If yes, list all known allergies and describe the client's reaction:_____

_____

2. Are there any current or past serious health problems to include hospitalizations? □ Yes □ No
If yes, describe:_____

_____

3. Has the client ever been hospitalized? □ Yes □ No If yes, when, what for, and for how long?_____

_____

4. Has the client ever had a head injury or been unconscious? □ Yes □ No If yes, describe the situation, including date(s):

_____

5. Has the client ever had a seizure? □ Yes □ No If yes, describe the event(s), including date(s):_____

_____

6. Are there any problems with wetting the bed or soiling underwear? □ Yes □ No If yes, describe the problem, including how often it occurs:_____

7. Does the client have any physical disabilities? □ Yes □ No If yes, describe them and how they may limit normal childhood activities:_____

8. Is the client **currently** complaining of any pain? □ Yes □ No Any pain in the recent past? □ Yes □ No
If yes to either question, describe the location, type, frequency, intensity and duration of the pain:_____

_____

9. Are client's immunizations current? □ Yes □ No If no, what immunizations are needed?_____

10. List the client's **current** medications. Include name of medication, dosage amount, and when each is taken_____

_____

_____

11. Provide the physician's name, telephone # and location where the last EPSDT was completed: _____

_____

C. INITIAL NUTRITION ASSESSMENT

1. Has the client lost or gained weight (10 or more pounds) in the last 6 months? □ Yes □ No □ Lost □ Gained
2. Is the client's appetite poor? □ Yes □ No Are meals skipped? □ Yes □ No
3. Has a doctor ever ordered a special diet? □ Yes □ No If yes, describe:_____

VIII. EDUCATIONAL ASSESSMENT

1. What is the highest grade level that the client has completed?_____ What grade(s) have been failed?_____
2. Have Special Education Services ever been received? □ Yes □ No During what grade(s)?_____
3. Does the client have an Intellectual Disability? □ Yes □ No

4. Does the client have any specific communication or language needs? □ Yes □ No If yes, describe:_____

_____

5. Has the client been suspended or expelled from school (including in-school suspension, Saturday school, and/or alternative school) during the past year? □Yes □No If yes, when and for what behaviors?

_____

_____

6. What are the client's plans for the future?_____

7. Please list the last two schools attended:

	SCHOOL NAME	CITY/ STATE
1.	_____	
2.	_____	

IX. LEGAL ASSESSMENT

1. Does the client have any legal charges pending? (Waiting to go to court?) □ Yes □ No If yes, explain:

_____

2. How many times has the client gone to court?_____ What were the charges and describe the behaviors that led to those charges: _____

3. Are there any court orders restricting contact with anyone? □ Yes □ No If yes, explain:_____

_____

4. Has the client ever been the victim of a crime? □ Yes □ No If yes, describe:_____

_____

X. EMPLOYMENT/VOCATIONAL ASSESSMENT

1. Has the client ever been paid for working full or part time? □ Yes □ No If yes, describe the employment history

_____

2. Is there any disability that might prevent participation in vocational skill development? □ Yes □ No

If yes, describe:_____

3. Military history? □ Yes □ No If yes, describe: _____

XI. SOCIAL DEVELOPMENT ASSESSMENT

1. Does the client have: □ No friends □ Many friends □ A few friends
2. Does the client belong to a gang? □ Yes □ No □ Possibly What activities were participated in with gang friends?

_____

3. Has the client ever been hurt or hurt anyone else during these activities? □ Yes □ No If yes, describe: _____

_____

4. Given the choice, the client would spend time: □ Alone □ With adults □ With same age friends
□ With older friends □ With younger friends

XII. LEISURE/RECREATIONAL ASSESSMENT

1. What types of recreational activities or special interests does the client participate in for fun? _____

_____

2. Willingness to participate with family in recreational activities: □ Is about the same as it always has been
□ Has decreased since_____
3. Can the client swim? □ Yes □ No

XIII. ALCOHOL/DRUG USE ASSESSMENT

1. List **all** substances that the client may have experimented with or used. Use the back of this sheet if necessary.

Substance	Age at first use	How Often	Amount	Last Used
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Has any treatment for substance abuse issues been attempted/completed? □ Yes □ No If yes, when, where, and for how long? _____
3. Have there been any health problems related to drinking/drug use? □Yes □ No If yes, describe: _____
4. Have there been any legal problems related to drinking/drug use? □ Yes □ No If yes, describe: _____
5. Has the client ever missed or been late for school or work because of drinking/drug use? □ Yes □ No
6. Has substance abuse caused problems with relationships? □ Yes □ No If yes, explain: _____
7. If substance abuse has been a problem in the past, has the client attended support group meetings in the local community?
   □ N/A □ Yes □ No

XIV. SEXUAL BEHAVIOR ASSESSMENT

1. Has the client exhibited any sexually inappropriate behaviors? □ Yes □ No If yes, explain: _____
2. Has the client ever been a victim or perpetrator of sexually inappropriate behavior? □ Yes □ No If yes, explain:
3. Is the client sexually active? □ Yes □ No □ Unknown If yes, at what age did this first occur? _____
4. Does the client have any children? □ Yes □ No □ Unknown If yes, what age(s) and with whom do they live?
5. Does the client use any form of birth control? □ Yes □ No □ Unknown If yes, what? _____
6. Has there ever been testing or treatment for a sexually transmitted disease? □ Yes □ No If yes, explain:
7. Sexual Orientation: _____

XV. CULTURAL AND SPIRITUAL ASSESSMENT

1. Ethnic Identification: □Anglo-American □African-American □Hispanic □Asian □American Indian □Other
2. Are there any specific cultural factors or practices that cause concern for the client or family? □ Yes □ No
   If yes, describe: _____
3. Has the client ever been involved with a cult of any kind? □ Yes □ No If yes, describe: _____
4. What, if any, is the client's religious preference? _____
5. Has the client attended religious services on a regular basis? □ Yes □ No

INACCURATE OR INCOMPLETE INFORMATION MAY RESULT IN CLIENT'S ADMISSION BEING DECLINED AT ANY POINT DURING THE REFERRAL OR ADMISSION PROCESS.

Assessment form completed by: _____ Date: _____

Relationship to client: _____

DHR-OCG-724
Formerly PSD-BSP-724
Revised 10/86

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
PURCHASE OF SERVICES AUTHORIZATION

Contract Number
COUNTY Number
WORKER Payroll Number

PROVIDER IDENTIFICATION

1 PROVIDER NAME

2. PROVIDER ADDRESS (No. and Street, P.O. Box/RFD; City; State: AL; Zip Code)

AUTHORIZED CLIENTS

1 DHR Case Number	2. Client Name Last	First	MI	3. Category of Eligibility	4. Service Authorized	5. Effective Date	6. Negotiated Rate
				350			

CERTIFICATION

I hereby certify that the person(s) listed above are eligible to receive services authorized herein on or after the effective date until further notice by the Department of Human Resources. Services authorized are not available without cost from other sources.

Social Worker Signature _____ Date Signed _____

SERVICE AUTHORIZED CODES

023 Day Care For Children (Full-Time)
024 Day Care For Children (Part-Time)
039 Homemaker Services For Children
040 Foster Care For Children
140 Protective Services For Children (shelter)
210 Protective Services For Adults
280 Homemaker Services For Adults
301 Day Care For Adults (Full-Time)
302 Day Care For Adults (Part-Time)
350 Residential Care Services For Individuals With Exceptional Needs
360 Residential Care Services For Delinquent Children And Youth
433 WIN Day Care For Children (Full-Time)
434 WIN Day Care For Children (Part-Time)
501 Day Health (Full-Time)
502 Day Health (Part-Time)
580 Homemaker (Medicaid Waiver)
590 Personal Care
591 Respite Care

REASON SERVICE AUTHORIZED CODES

CHILD DAY CARE

A. Disability
B (DHR use only)
C Employment (IE)
D. School
E. Protective Services
F. Employment (ADC/WIN)

ADULT DAY CARE/HEALTH

A. Protection
B. Prevent Institutionalization
C. Respite
D. Deinstitutionalization
E. Caretaker Employment

INTER-AGENCY AGREEMENT

This agreement is entered into between the _____ County Department of Human Resources and the _____
(Name of Child Care Facility)

Under the terms of this agreement, the _____
(Name of Child Care Facility)

agrees to provide group care for the following child (The word "child" as used throughout this agreement also means "Children" where the agreement is for placement of siblings and consequently more than one child is named in the agreement).

_____ Date of Birth _____
(Name of Child)

_____ Date of Birth _____
(Name of Child)

_____ Date of Birth _____
(Name of Child)

The _____ County Department of Human Resources has temporary custody of the above-named child by order dated _____ and rendered by the _____
(Name of court as it appears on the custody order)

Pursuant to the court order(s) attached hereto and made a part hereof, the _____ County Department of Human Resources hereby gives consent for emergency medical, surgical, dental, and hospital services, treatment and care as determined by a licensed physician, surgeon, or dentist to be necessary for the immediate health and well being of the above-named child, provided effort is made to notify the said County Department of Human Resources. The _____ County Department of Human Resources agrees to keep

_____ informed of current home and business
(Name of Child Care Facility)

telephone numbers of its employee or employees designated to receive notification of the above-described emergency medical treatment for the said child. For ordinary non-emergency or elective medical, surgical, and dental treatment and care, prior permission must be obtained from the _____ County Department of Human Resources by the _____ except that the said child care
(Name of Child Care Facility)

facility is hereby given permission by the said County Department of Human Resources to obtain an annual physical examination and an annual dental examination of the said child (or more frequent examinations when recommended by a physician or dentist), and to obtain medical or dental treatment for said child when he is in pain or is exhibiting other symptoms which show the child's need for medical or dental examinations, treatment or care.

INTER-AGENCY AGREEMENT

The _____ County Department of Human Resources hereby gives permission for the above-named child to participate in such recreational, social, and educational activities offered or approved by the _____
(Name of Child Care Facility)
and taking place inside the State of Alabama. The said County Department of Human Resources gives permission for the said child to participate in such recreational, social, and educational activities outside the State of Alabama when prior approval has been obtained from the _____ County Department of Human Resources by the said Child Care Facility. This permission includes participation in recreational activities approved by the said Child Care Facility and supervised by staff members designated by the said Child Care Facility or by other persons approved by the said Child Care Facility.

The Child Care Facility shall comply with the policies and regulations of the Alabama Department of Human Resources. Payment by the Alabama Department of Human Resources shall be contingent upon compliance with said policies and payment may be withheld if said facility fails to comply with policy. *

It is understood that the parties to this agreement are bound by the court order(s) attached hereto and made a part hereof.

Date: _____ _____ County
Department of Human Resources

By: _____
As Director of the _____ County Department of Human Resources and as agent of the Department of Human Resources of the State of Alabama

Date: _____ _____
(Child Care Facility)

By: _____
As its _____ and agent
(Title)

* This does not apply to children placed by agencies other than the Department of Human Resources.

Certification of Need for Services:
Non-Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name _____ Recipient Medicaid Number _____

Date of Birth _____ Race _____ Sex _____ County of Residence _____

Facility Name and Address _____ Planned Admission Date _____

PHYSICIAN CERTIFICATION:

1. I am not employed or reimbursed by the facility.
2. I have competence in diagnosis and treatment of mental illness.
3. I have knowledge of the patient's situation.
4. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
5. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
6. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Printed Name of Physician _____ Physician Signature _____ Phone Number _____ Date _____

Physician Address _____ License Number _____

Printed Name of Other Team Member _____ Signature _____ Phone Number _____ Date _____

Printed Name of Other Team Member _____ Signature _____ Phone Number _____ Date _____

Form 370 *Revised 10/01/01*
This form can be downloaded from the Alabama Medicaid Agency web site: www.medicaid.state.al.us.

PATHWAY, INC.
Enterprise, Alabama

PHYSICAL HEALTH ASSESSMENT

NAME: _____ DOB: ____/____/____ SS#: ____-___-____ AGE: ____

☐ MALE ☐ FEMALE Are immunizations current? ☐ YES ☐ NO If NO, needs: _____

CURRENT MEDICATIONS: _____ PAST MEDICATIONS: _____
(Including Over-the-Counter Meds) _____ _____
_____ _____
_____ _____
_____ _____

LIST ALL ALLERGIES: _____

HISTORY OF SIGNIFICANT ILLNESS/INJURY **(Explain any YES answer in the NOTES below)**

HISTORY OF	YES	NO	HISTORY OF	YES	NO
Seizures			Kidney Stones		
Asthma/Breathing Problems			Frequent Headaches		
Heart Problems/Murmur			Head Injuries		
Stomach Problems or Special Diet Needs			Diabetes		
Broken Bones			OTHER (explain in NOTES)		

NOTES: _____
_____

TUBERCULOSIS TEST DATE: ____/____/____ RESULTS: ☐ Pos. ☐ Neg. DATE READ: ____/____/____

HEIGHT: _____ WEIGHT: _____ VITAL SIGNS: B/P: _____ PULSE: ____ TEMP: _____

VISION: Right ____/____ Left ____/____ ☐ With ☐ Without CORRECTION

HEARING: Right _____/_____ Left _____/_____ ☐ With ☐ Without CORRECTION

SEXUAL BEHAVIOR HISTORY: RPR – If positive- VDRL _____
History of pregnancy ? : ☐ YES ☐ NO ☐ NA

REVIEW OF SYSTEMS	NORMAL	ABNORMAL	COMMENTS
SKIN			
HEAD & NECK			
EYES			
EARS/NOSE & THROAT			
TEETH & MOUTH			
CARDIOVASCULAR			
ABDOMEN & LYMPHATICS			
LUNGS & CHEST			
GENITALIA / HERNIA			
EXTREMITIES			
MOTOR DEVELOPMENT & FUNCTIONING			
SCOLIOSIS SCREENING			

CLIENT IS: ☐ **CLEARED** ☐ **NOT CLEARED** *For participation in strenuous physical activities associated with Pathway's treatment program.*

PLAN OF ACTION / FOLLOW UP: _____

EXAMINING PHYSICIAN / NURSE SIGNATURE: _____ DATE: ____/____/____

EXAMINING PHYSICIAN / NURSE PRINT: _____

OFFICE ADDRESS: _____ TELEPHONE #: ____-____-____

_____

NS/physhealthasmnt

www.pathway-inc.com
PATHWAY
A NEW DIRECTION

PATHWAY, Inc.
P.O. Box 311206
Enterprise, AL 36331-1206

Main Campus I – T: 334-894-5591 F: 334-894-5264
Campus II – T: 334-445-1285 F: 334-445-1287
Pathway School – T: 334-894-5405 F: 334-894-5408
Pathway of Baldwin County – T: 251-405-3107 F: 251-450-8315

PATHWAY PHYSICAL ADDENDUM (COVID-19)

Patient Name: _____

DOB: _____

Please indicate whether patient has had symptoms of COVID-19 within the past 7 days.

_____

_____

_____

If symptoms are indicated, please describe symptoms and date of onset:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Physician **Date**

www.pathway-inc.com

PATHWAY
A NEW DIRECTION

INSURANCE INFORMATION

Client Name: _____

Name of Insurance: _____

Policy #: _____

Group #: _____

Effective date: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relationship to Client: _____

Secondary Insurance (If applicable)

Name of Insurance: _____

Policy #: _____

Group #: _____

Effective date: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relationship to Client: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pathway, Inc. I also authorize Pathway, Inc to release any information required to process my claims.

Parent/Guardian Signature: _____ Date: _____

DIRECTIONS
to
PATHWAY CAMPUS II

(Moderate and Intensive Residential Programs/Regional Alliance Girls Program)

(334) 445-1285

FROM THE DOTHAN, ALABAMA AREA

Travel US Highway 231 North to Alabama Highway 51 (north of Ozark). Turn left onto Alabama Highway 51 South. Remain on Highway 51 South until you reach Coffee County Road 143, and turn left. Take the first paved road to the left, where you see the Pathway sign. Pass gatehouse ….. into the Pathway parking area.

FROM THE MONTGOMERY, ALABAMA AREA

Travel US Highway 231 South and go through Troy. South of Troy you will come to a flashing caution light at the intersection of 231 South and Alabama Highway 51. Turn right on to Alabama Highway 51 and travel until you come to Coffee County Road 143. Turn left onto County Road 143. Take the first paved road to the left, where you see the Pathway sign. Pass gatehouse ….. into the Pathway parking area.

FROM THE MOBILE, ALABAMA AREA

Travel Interstate 10 East to Florida Highway 79 North (Bonifay Exit). Highway 79 North becomes Alabama Highway 167 at the Alabama state line. Follow 167 North signs toward Enterprise, and follow them around the bypass (this will be 84 West/167 North). Follow Highway 167 North when it turns right to go to Troy. About 6.3 miles north of Enterprise, Highway 167 North intersects with Alabama Highway 51. Turn right onto Highway 51 North, and travel about 8.3 miles. Turn right, onto Coffee County Road 143. Take the first paved road to the left, where you see the Pathway sign. Pass gatehouse ….. into the Pathway parking area.

FROM THE OPELIKA, ALABAMA AREA

Travel Alabama Highway 51 South – all the way through the following counties: Lee, Russell, Bullock, Barbour and Dale, into Coffee County. When you see Coffee County Road 143, turn left. Take the first paved road to the left, where you see the Pathway sign. Pass gatehouse ….. into the Pathway parking area.

* GPS Address: 580 County Rd. 143 Ariton, AL 36311

PATHWAY, INC.
ENTERPRISE, ALABAMA

DHR GIRLS ADMISSION INVENTORY

Revised

NAME: _____ MR#: _____
ADMISSION DATE: _____ $: _____
INVENTORY DONE BY: _____

Client Sizes
Pants: _____
Shoes: _____

Shirts
Womans: S M L XL XXL
Girls: S M L

ITEM	QUANTITY/DESCRIPTION	NEEDS
Black Athletic Shoes (1 pair white sole) **(Valued up to $65.00)**		
Work/Hiking Boots (1 pair)		
Dress Shoes (1 pair)		
Socks (8 pair) **(Hanes) White only**		
Casual Shirts (5) (to wear off-campus outings) **(LOOSE FITTING)**		
Khakis (4 pair) **(No Jeans) (LOOSE FITTING) (No low-cut or hip-hugger or skin tight)**		
Khaki Shorts (4 pair) **(No MORE than 2" above the knee) (LOOSE FITTING)**		
Grey Sweat Pants (2 pair)		
Grey Shorts (2 pair)		
Sleepwear (1) (designated as sleepwear)		
Light Weight Jacket or Coat (1)		
Rain Gear (1 set)		
*Cap/Toboggan (1)		
*Gloves (1 pair)		
*Tights (1 pair) (white only)		
Panties (7 pair) **(No thongs)**		
Bras (2 regular, 2 sports)		
Bath Cloths (3)		
Towels (3)		
Suitcase or Duffel Bag (1)		

PATHWAY, INC.
ENTERPRISE, ALABAMA

DHR BOYS ADMISSION INVENTORY

Revised

NAME: _____ MR#: _____

ADMISSION DATE: _____ $: _____

INVENTORY DONE BY: _____

Client Sizes

Pants: _____

Shoes: _____

Shirts

Mens: S M L XL XXL

Boys: S M L

ITEM	QUANTITY/DESCRIPTION	NEEDS
Black Athletic Shoes (1 pair white sole) (**Valued up to $65.00**)		
Work/Hiking Boots (1 pair)		
Socks (8 pair) **(Hanes) White**		
Dress Socks (1 pair)		
Dress Shirt and Tie (1 each)		
Casual Shirts (5) **(off-campus only)**		
Khakis (4 pair) (No Jeans) **(No baggy pants or sagging)**		
Khaki Shorts (4 pair)		
Grey Sweat Pants (2 pair)		
Grey Shorts (2 pair)		
Dress Slacks (1 pair)		
Sleepwear (1) (designated as sleepwear)		
Light Weight Jacket or Coat (1)		
Rain Gear (1 set)		
*Cap/Toboggan (1)		
*Gloves (1 pair)		
*Long Johns (1 pair) (white only)		
Undershirts (8)		
Underwear (8 pair)		
Bath Cloths (3)		
Towels (4)		
Blanket (1)		
Suitcase or Duffel Bag (1)		