



Educating  *Mentoring*  *Success*

**1453 Almondberry Place
Richmond, VA 23231
(804) 222-3166**

“Mission Statement”

LTW mission is to develop youths’ sense of work ethic while enhancing their personal and community responsibility.

Dear Parent and Youth:

Listed on this sheet is the Educating Mentoring Success, VA LLC. (EMS) address, telephone number, “Mission Statement”, and general information regarding the Learning To Work Program (LTW). This sheet is for you to take home with you.

If you have any questions regarding LTW, please feel free to contact the EMS office or Donnell Smith at the telephone number listed below.

Thank you for the opportunity to provide this training to your child.

D. Donnell Smith
LTW Coordinator
(434) 996-1499

General Information: (for Parent and Youth)

Satellite: _____
Pick up Time: _____
Drop off Time: _____
Start Date/Day/Time: _____
Meeting Place: _____
EMS Telephone #: _____

GROUP SCREENING/REFERRAL

To be completed by EMS personnel

Date of initial contact: _____

Name: _____

Age: _____ DOB: _____ Gender: _____

Address: _____

Phone number: _____

Presenting needs or situation: _____

Name of screening staff: _____

Type, location, date of each contact:

Fax Referral: _____

Interview Appt: _____

Outcome of screening/interview process: _____

Group dates: _____

Post interview: _____

Recommendations: _____

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LTW APPLICATION FORM

ID#: _____ **Admission Date:** _____
Social Security # & Referring Agency **Pre-Interview**

General Information:

Client's Name: _____

Service Requested: _____

Dates Services Initiated: _____
(Dates of LTW sessions)

Referring Agency: _____

Agency Representative: _____

Date of Referral: _____

Client Information:

DOB: _____ Age: _____ Gender: _____ Marital Status: _____

Social Security Number: _____

School Attending: _____ Grade level: _____

Parent/Guardian: _____

Client's Current Address: _____

Telephone: (home) _____ (cell) _____ (work) _____

1. Describe the client's legal history.

2. Is the client currently on probation?

No

Yes

(Probation Officer's Name)

3. Please give a brief description of the client's significant family history.

(Moves, losses, illnesses, etc.)

4. Does the client have a history of being violent, threatening or destructive to property? No Yes (If yes, please explain)

5. Has the client ever attempted suicide, made suicidal gestures or demonstrated self-destructive behavior? (Please explain)

6. Does the client have a history of inappropriate sexual behavior? (Please explain)

7. Is the client receiving counseling services? (If yes, please give counselor's name)

8. Is the client determined Emotionally Disturbed? ADHD? ADD?

9. Please describe in detail any behaviors or concerns that staff need to know in order to work more effectively with this referral.

Information Provided By

Date

Relationship to Client: _____

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LTW EMERGENCY MEDICAL INFORMATION FORM

The professional staff of EMS has permission
to sign for emergency medical treatment and local dental anesthesia for:

Client's Name: _____

Parent/Guardian Name: _____

Person to call in case of an emergency if parent/guardian is not available:

Telephone Number: _____

Doctor's Name: _____

Telephone Number: _____

Type of Insurance: _____

Policy #: _____

Please answer the following questions:

1. Does the client have any physical problems: Yes No (If yes, please explain)

2. Is the client currently taking medication? Yes No (If yes, please list below)

3. Does the client have any of the following: (If yes, please explain below)

- | | | | |
|------------------|---------------------|------------------|---------------------------|
| ____ Yes ____ No | ADD | ____ Yes ____ No | High blood pressure |
| ____ Yes ____ No | ADHD | ____ Yes ____ No | Hyperventilates |
| ____ Yes ____ No | Allergies | ____ Yes ____ No | Low blood pressure |
| ____ Yes ____ No | Arthritis | ____ Yes ____ No | Menstrual disorders |
| ____ Yes ____ No | Asthma | ____ Yes ____ No | Migraine headaches |
| ____ Yes ____ No | Diabetic | ____ Yes ____ No | Pregnant |
| ____ Yes ____ No | Ear problem/hearing | ____ Yes ____ No | Seizures/convulsions |
| ____ Yes ____ No | Eating Disorders | ____ Yes ____ No | Stomach: spasm/ulcers |
| ____ Yes ____ No | Emotional disorders | ____ Yes ____ No | Thyroid conditions |
| ____ Yes ____ No | Heart condition | ____ Yes ____ No | Tuberculosis |
| ____ Yes ____ No | Hepatitis | ____ Yes ____ No | Vision: glasses, contacts |

*Note: If client has any other significant health problems, please list them on the back of this form. Thanks.

Signature

Date

Relationship to client: _____

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GENERAL PERMISSION FORM

Client's Name: _____

The LTW Coordinator and mentors of EMS VA, LLC have permission to:
(Please initial the following)

- _____ (1) Transport this client to LTW training sites
and/or from LTW training site in
connection with LTW activities.
- _____ (2) Photograph and/or videotape client during LTW
work-training sessions.

The LTW Coordinator and mentors of EMS VA, LLC. have permission to:
(If applicable, please initial the following)

- _____ (3) Obtain required psychological and/or educational
testing results in regards to client from referring
agency.
- _____ (4) Contact client's counseling therapist for
information pertaining to LTW, if necessary.

Signature

Date

Relationship to Client: _____