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**RIAN HOME & FAMILY SERVICES, INC.
INFORMATION CHECK LIST**

(Some information is needed to complete youth file)

Youth Name: _____ Admitting County: _____

THE FOLLOWING INFORMATION IS DUE UPON INTAKE

1. BIRTH CERTIFICATE
2. SOCIAL SECURITY CARD
3. IMMUNIZATION RECORD
4. MEDICAL PASSPORT (IF APPLICABLE)
5. SCHOOL RECORDS (TRANSCRIPT, WD GRADES, ATTENDANCE RECORDS, ETC.)
6. PSYCHOLOGICAL REPORTS-SOCIAL HISTORY
7. CLOTHING REQUIREMENTS (AT LEAST 7 CHANGES OF CLOTHING)
8. DISCHARGE SUMMARIES (IF APPLICABLE)
9. COURT ORDER/VERIFICATION OF PLACEMENT AUTHORITY
10. REQUESTED CHANGE OF MEDICAID PCP (to Dr. Connelley # 128888-001)

** If above information is unavailable please document reason (s) in the space provided:

(Revised 3/2008)



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IAN HOME AND FAMILY SERVICES, INC. INTAKE STUDY

Youth Name: _____ SSN: _____

Admission Date: _____ Discharge Date: _____

Date of Birth: _____ Medicaid #/Insurance: _____

Home Street Address: _____ County: _____

City, State, Zip: _____

Race: _____ Sex: _____ Height: _____ Wgt: _____ Hair Color: _____ Eye: _____

Legal Status/Custody: _____ Religion: _____

Intake Study Participants: _____

Referral Source: _____

Placing Worker's Name: _____

Primary Worker's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Pager or Emergency #: _____

Father's Name: _____

Address: _____

Phone Number: _____

Mother's Name: _____

Address: _____

Phone Number: _____

Number of days in any Emergency Shelter during the last six months: _____



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INTAKE STUDY

Youth Name: _____ SSN: _____

Visitation/Contact Plans: _____

Persons allowed on visit/contact list: _____

(Only those listed will be allowed contact youth)

Factual Description of the Circumstances Requiring Placement

Brief Social History of the Family

History of Previous Placements Outside the Family



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INTAKE STUDY

Youth Name: _____ SSN: _____

Schools Attended

Current Grade & Classroom Type: _____

Educational Needs & Behavior

Medical History

Date of Last Physical: _____ Does Youth Wear Glasses: _____

Substance Abuse History: _____

Any Current: _____

Psychological history

Therapist/Coun: _____ Phone#: _____

Address: _____

List Any Psychiatric Placements & Reasons for Placement

Current Psychiatric or Emotional Problems

Psychotropic Medications: _____

History of Physical or Sexual Abuse

Permanent Placement Plan



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INTAKE STUDY

Youth Name: _____ SSN: _____

ADMISSION INFORMATION VERIFICATION FORM

The following information was requested from the youth's caseworker or guardian on _____

<u>Document</u>	<u>Requested</u>	<u>Received</u>
Birth Certificate	_____	_____
Social Security Card	_____	_____
Immunization Record	_____	_____
Medical Passport	_____	_____
School Records	_____	_____
Psychological Reports	_____	_____
Social History	_____	_____
Clothing Requirements	_____	_____
Discharge Summaries	_____	_____
Court Order/Verification of Placement Authority	_____	_____

Intake Staff Signature Date

Caseworker's Signature Date

Youth's Signature Date



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WYTERIAN HOME & FAMILY SERVICES, INC.

CLIENT INTAKE INFORMATION
PRESENTING BEHAVIOR PROBLEMS
(To be completed by Caseworker)

Youth Name: _____ Birth date: _____

(X all that apply)

<u>Presenting Problem</u>	<u>Identified Problem</u>	<u>Not a Treatment Goal</u>
Depression/Withdrawal	_____	_____
Hyperactivity/Attention Deficit	_____	_____
Inappropriate Boundaries	_____	_____
Inappropriate Behavior w/ Opposite Sex	_____	_____
Inappropriate Behavior w/ Same Sex	_____	_____
Sexual Problems	_____	_____
Language or Speech Disorders	_____	_____
Out-of-Control Parental Figure	_____	_____
Peer Relationship Problems	_____	_____
Physical Assault toward Adults	_____	_____
Physical Assault toward Peers	_____	_____
Developmental Delay	_____	_____
Possession of Weapon	_____	_____
Running Away	_____	_____
School Attendance Problem	_____	_____
School Behavior Problem	_____	_____
School Learning/Academic Problems	_____	_____
Self-Injurious Acts	_____	_____
Self-Injurious threats	_____	_____
Theft	_____	_____
Verbally Aggressive Towards Peers/Adults	_____	_____
Vandalism	_____	_____
Drug/Alcohol Abuse Substance Involvement	_____	_____
Mental Retardation	_____	_____
Murder	_____	_____
Setting Fires/Arson	_____	_____
Suicide Attempts	_____	_____
Suicide Threats	_____	_____
Victim of Physical Abuse	_____	_____
Victim of Sexual Abuse	_____	_____
Criminal Activity	_____	_____
Eating Disorder	_____	_____
Enuresis	_____	_____
Failure to Thrive	_____	_____
Failure to Follow Instruction of Authority Figures	_____	_____
Other _____	_____	_____



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ARIAN HOME & FAMILY SERVICES, INC.
INTAKE INFORMATION

(to be completed by Caseworker)

Youth Name: _____ Birth date: _____

1. What was the client last Placement and reason for being removed?

2. How many formal placements has client had?

3. Within the past two years, how often has the client moved?

4. Has the client been arrested? If yes, give date(s) and reason:

5. How has client relationship been with family members?

6. Any other information about the client and/or family members that we should know that is not listed above?



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**RIAN HOME & FAMILY SERVICES, INC.
AND MEDICAL HISTORY**

Youth Name: _____ DOB: _____ Date: _____

Completed by: _____ Source (s) of Information: _____

Insurance Company/Medicaid Number: _____

	Date of Exam/Appt.	Name/Address of Dr./Dentist
Physical Examination	_____	_____
Eye Examination	_____	_____
Hearing Examination	_____	_____
Dental Examination	_____	_____
Psychiatric Appointment	_____	_____
Therapist or Counselor	_____	_____

Please circle the following and give the approximate date/age you had any of the following:

Childhood Diseases:

Mumps	yes	no	Age: _____
Measles	yes	no	Age: _____
Chicken Pox	yes	no	Age: _____
Rheumatic Fever	yes	no	Age: _____
Polio	yes	no	Age: _____
Sickle Cell Anemia	yes	no	Age: _____
Other:	_____		

Medications: _____

Allergies (food, medications or any other substance): _____

Hospitalizations or Surgery (include type and date): _____

Family History (who):

Diabetes _____
Tuberculosis _____
Cancers _____

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Heart Disease	_____
Allergies	_____
Mental Problems	_____
Anemia	_____

Current Physical Symptoms (please check the appropriate box)

	Yes	No		Yes	No
Fainting	___	___	Seizures	___	___
Nausea	___	___	Nervousness	___	___
Diarrhea	___	___	Joint Pain	___	___
Constipation	___	___	Nightmares	___	___
Urinary Infections	___	___	Difficulty Sleeping	___	___
Headaches	___	___	Difficulty Relaxing	___	___
Stomach Aches	___	___	Temper	___	___
Skin Problems	___	___	Other: _____	___	___

Comments: _____



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VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.

EMERGENCY SHELTER, RESIDENTIAL TREATMENT AND DYS TRANSITIONAL PROGRAM INTAKE CONTRACT AND STATEMENT OF NEED

Youth Name: _____ DOB: _____ Admit Date: _____

Projected Discharge Date: _____ Actual Discharge Date: _____

(Maximum of 45 day stay under current contracts-may be discharged with 10 days notice for shelter placement and 30 days for residential if priority placement is requested. Priorities are mandated through current contract.)

Alternatives/Options for placement upon discharge:

Youth: I, _____, agree to abide by the Shelter Program/Residential Treatment/DYS Transitional Program rules and expectations until I am discharged from the program.

Youth Signature Date

Placement Agent: I agree to participate in the Placement Program of _____ by maintaining weekly contact with the Teaching Parents, following through with discharge planning, and helping provide for the youths basic needs.

Placement Agent's signature Date

The placement of _____ at Vera Lloyd Presbyterian Home is voluntary.
Early discharge can be requested by the placing agent, the legal guardian of the youth or Vera Lloyd Presbyterian Home Staff.

Proposed Plan:

Youth Date Placing Agent Date

VLPH Staff



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CHANGE FORM FOR VERA LLOYD PRESBYTERIAN HOME

Date: _____

Youth's Name: _____

County of Transfer: _____

Caseworker or Transfer Worker: _____

Caseworker Contact Number: _____

Medicaid Number: _____

Previous DR. Name and PCP Number: _____

County PCP will change from: _____

I AGREE TO PROVIDE VLPH WITH A CURRENT AND ACTIVE MEDICAIDE NUMBER AND NOTIF THE FACILITY WITHING 24 HOURS OF ANY CHANGES REGARDING THE MEDICAID NUMBER.

Caseworker

Date

I have changed _____'s PCP number to Dr. Connelly # 128888-001 effective on date of Intake.

Caseworker

Date

Vera Lloyd Presbyterian Home Staff

Date



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Medical Consent

I, the parents/guardian/custodian of _____, do hereby give consent to Vera Lloyd Presbyterian Home and Family Services, Inc., or its duly appointed representative for my child to receive such medical/dental services which may be recommended by a duly licensed medical doctor or dentist, and which is considered necessary for my child by Vera Lloyd Presbyterian Home and Family Services, Inc, Staff.

In the event surgery is needed, I hereby reserve the right to give consent at the time surgery is necessary, UNLESS-1) Said surgery is and emergency where delay might endanger the life of the child or possibly cause permanent damage to the child's health, 2) It is virtually impossible to reach child's parents, guardian, custodian to give consent. In this event, I give consent for Surgery which is recommended by Vera Lloyd Presbyterians home and Family Services, Inc, staff, and licensed medical doctor. Furthermore, in the event emergency surgery is required I am to be notified at the earliest possible opportunity.

I also accept the responsibility for all the medical and dental bills incurred by my child while he or she is placed at Vera Lloyd Presbyterian Home and family Services, Inc. I authorize the medical or dental provider to send all bills to the address listed below. I further acknowledge that Vera Lloyd Presbyterian Home is in NO way liable for any medical or dental billing incurred by my child.

Send bills to: Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Parent/Guardian/Custodian

Date

Witness

Date



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VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.

1 Warren Rd. Monticello. Ar.71655
Telephone: (870)367-9035
Fax: (870)367-9038

Release of Therapeutic Services

Name: _____ Date of Birth: _____
SSN # _____

I hereby give permission for Vera Lloyd Presbyterian Home to provide therapeutic services for the above named minor child or youth for whom I am parent or legal guardian.

_____ Individual Therapy

_____ Group Therapy

_____ Family Therapy

I understand that Vera Lloyd Presbyterian Home reserves the right to refuse any requested services that are deemed unnecessary, and that VLPH will keep me informed of progress in treatment, and any additional treatment recommendations in a timely manner. It is further understood that all records are to be kept confidential and will not be released to other persons or agencies without my permission.

Signature

Date

Relationship to Client

Witness



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VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.

1 Warren Rd. Monticello. Ar.71655
Telephone: (870)367-9035
Fax: (870)367-9038

Release of Information

Name: _____ Date of Birth: _____
SSN # _____

I hereby give permission for Vera Lloyd Presbyterian Home to release information concerning the treatment of a minor child or youth for whom I am parent or legal guardian to: _____

I understand the information specified below will be released:

I understand the information and records released are to be kept confidential and will not be released to other persons or agencies without my written permission. This release applies for the duration of youth's stay with Vera Lloyd Presbyterian Home.

Signature

Date

Relationship to Client: _____

Witness: _____



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VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.

1 Warren Rd. Monticello. Ar.71655
Telephone: (870)367-9035
Fax: (870)367-9038

Release for Records

Name: _____ Date of Birth: _____
SSN # _____

I hereby give permission for Vera Lloyd Presbyterian Home to receive information concerning the treatment of a minor child or youth for whom I am parent or legal guardian to: _____

I understand the information specified below will be released:

I understand the recipient of the above information will keep the records confidential and will not be released to other persons or agencies without my written permission. This release applies for the duration of youth's stay with Vera Lloyd Presbyterian Home.

Signature Date

Relationship to Client: _____

Witness: _____



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ELIGIBILITY FORM

YOUTH NAME: _____ DOB: _____ DATE: _____

COMPLETED BY: _____

DATE ADMITTED: _____ DATE: DISCHARGED: _____

VLPH STAFF SIGNATURE

DATE