VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

PROGRAMS TRANSFER OF PHYSICAL CUSTODY

INTAKE

Date: _____

This is to certify that _____
(Youth's name)

From _____County has been delivered into the physical custody of VLPFS for admission.

Time of arrival: _____ a.m. p.m.

_____
Signature of Transporter

_____
Signature of VLPFS Staff

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

INTAKE STUDY

ADMISSION INFORMATION VERIFICATION FORM

Youth Name: _____ SSN: _____

Admitting County: _____

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

Document	Received
Medical Passport	_____
Birth certificate	_____
Social Security Card	_____
Immunization Record	_____
Last Physical Exam	_____
Medicaid PCP changed (to Mainline Monticello)	_____
School Records	_____
Youth Case Plan	_____
Psychological Reports	_____
Social History	_____
Discharge Summaries (if applicable)	_____
Court Order/ Verification of Placement Authority	_____
Clothing Request (7 changes of clothing)	_____

_____ _____

Intake Staff Signature Date

_____ _____

Caseworker/Parent/Guardian Signature Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

INTAKE STUDY

Youth Name: _____ SSN: _____

Admission Date: _____ Admission Time: _____ Discharge Date: _____

Date of Birth: _____ Medicaid #/Insurance: _____

Home Street Address: _____ County: _____

City, State, Zip: _____

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

Legal Status/ Custody: _____

Intake Study Participants: _____

Referral Source: _____

Placing worker's Name: _____

Primary Worker's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Cell Number: _____

Fax Number: _____On-Call Number or Emergency #: _____

Attorney Ad Litem _____ Phone # _____

Father's Name: _____

Address: _____

Phone Number: _____

Mother's Name: _____

Address: _____

Phone Number: _____

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

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

INTAKE STUDY

Youth Name: _____ SSN: _____

Schools Attended

_____
_____
_____

Current Grade & Classroom Type: _____

Educational Needs & Behavior

_____
_____
_____
_____

Psychological History

Therapist/ Counselor: _____ Phone #: _____

Address: _____
_____

List any Psychiatric Placements & reasons for Placement

_____
_____
_____
_____
_____
_____

Current Psychiatric or Emotional Problems

_____
_____
_____
_____
_____

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

CLIENT INTAKE INFORMATION
PRESENTING BEHAVIOR PROBLEMS

Youth Name: _____ SSN: _____

PRESENTING PROBLEM	IDENTIFIED	NOT A TREATMENT GOAL
Depression/Withdrawal	_____	_____
Hyperactivity/ Attention Deficit	_____	_____
Suicide Attempts	_____	_____
Suicide Threats	_____	_____
Physical Assault toward Adults	_____	_____
Physical Assault toward peers	_____	_____
Verbally Aggressive towards peers/adults	_____	_____
Self-Injurious Acts	_____	_____
Self-injurious threats	_____	_____
Victim of Sexual Abuse	_____	_____
Victim of Physical Abuse	_____	_____
Inappropriate Boundaries	_____	_____
Inappropriate Behavior w/ Opposite Sex	_____	_____
Inappropriate Behavior w/ Same Sex	_____	_____
Sexual Problems	_____	_____
Peer Relationship Problems	_____	_____
School attendance Problem	_____	_____
School behavior Problems	_____	_____
School Learning/ Academic Problems	_____	_____
Language or Speech Disorders	_____	_____
Developmental Delay	_____	_____
Mental Retardation	_____	_____
Running Away	_____	_____
Criminal Activity	_____	_____
Murder	_____	_____
Setting Fires/Arson	_____	_____
Possession of Weapon	_____	_____
Theft	_____	_____
Vandalism	_____	_____
Drug/Alcohol Abuse Substance Involvement	_____	_____
Eating Disorder	_____	_____
Enuresis	_____	_____
Dysfunctional Parental Figure	_____	_____
Failure to Thrive	_____	_____
Failure to Follow Instruction of Authority	_____	_____
Other _____		

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

CLIENT INTAKE INFORMATION

Youth Name: _____ SSN: _____

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?

   _____
   _____
   _____

7. Visitation/contact plans: Phone only_____ Visit_____ Visit and phone_____

8. Persons allowed on visitation/contact list: _____

   _____

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

HEALTH 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	_____	_____
Therapy or Counseling	_____	_____

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

Childhood Diseases

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

Other: _____

Medications: _____

_____

_____

_____

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

_____

_____

Hospitalizations or Surgery (include type and date): _____

_____

_____

Does youth wear Glasses? _____

Other devises: _____

HEALTH AND MEDICAL HISTORY

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: _____		

If yes: Is there a medical plan ____Yes ____No

Comment _____

_____

Family History (who):

Diabetes: _____

Tuberculosis: _____

Cancers: _____

High Blood Pressure: _____

Kidney Disease: _____

Heart disease: _____

Allergies: _____

Mental Problems _____

Anemia: _____

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

DCFS PROGRAM INTAKE CONTRACT AND STATEMENT OF NEEDS

Youth Name: _____ DOB: _____ DATE: _____

Projected Discharge Date: _____ Actual Discharge Date: _____

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

Alternatives/Options for placement upon discharge: _____

Would you like the youth to be add to our long-term residential program waiting list? _____

Permanent Placement Plan: _____

The placement of the youth at Vera Lloyd Presbyterian is voluntary.

Early discharge can be requested by the placing agent, legal guardian of the youth or VLPFS staff.

Youth: I agree to abide by program rules and expectation until I am discharged from the program.

Caseworker/Parent/Guardian: I agree to participate in the placement program of my client by maintaining weekly contact with the House Parents, following through with discharge planning, and helping provide for the youth basic needs.

_____ _____
Youth Date

_____ _____
Caseworker/Parent/Guardian Date

_____ _____
VLPFS Staff Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

PCP CHANGE FORM

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 VLPFS WITH A CURRENT AND ACTIVE MEDICAID NUMBER AND NOTIFY THE FACILITY WITHIN 24 HOURS OF ANY CHANGES REGARDING THE MEDICAID NUMBER.

_____ _____

Caseworker/Parent/Guardian Date

I have changed _____'s PCP number to Mainline Health Systems
Effective for date of intake.

_____ _____

Caseworker/Parent/Guardian Date

_____ _____

VLPFS Staff Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

MEDICAL CONSENT

I, the Caseworker/Parents/Guardian of _____,
do hereby give consent to VLPFS, 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 VLPFS 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 an 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 Caseworker/Parents/Guardian to give consent. In this event, I give consent for surgery which is recommended by VLPFS 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 VLPFS. I authorize the medical or dental provider to send all bills to the DCFS office. I further acknowledge that VLPFS is in NO way liable for any medical or dental billing incurred by my child.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

_____ _____
Caseworker/Parent/guardian Date

_____ _____
Witness Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
PURSUANT TO HIPAA

Child's Full Legal Name: _____ DOB: _____

Parent/Legal Guardian: _____

I, am the legal custodian(s) of the aforementioned child, so hereby request the health information regarding the care and treatment of my minor child to be released as set forth on this form:

In accordance with the Arkansas State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information related to ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and other health information regarding my minor child.
2. If I am authorizing the release of alcohol and drug treatment, or mental health treatment information, VLPFS is prohibited from disclosing such information without my authorization unless permitted to do so under federal and state law.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on the authorization.
4. I understand that signing this authorization is voluntary.
5. THIS AUTHORIZATION IS LIMITED TO THE RELEASE OF INFORMATION TO VERA LLOYD PRESBYTERIAN FAMILY SERVICE, INC. AND ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

6. Name and address of health provider or entity to release this information:

7. Specific Information to be released: (include by initialing)
_____Medical Records for (insert date) _____to (insert date) _____
_____Alcohol/Drug Treatment
_____Mental Health Treatment
_____Psychiatric/Psychological testing and Evaluation Records
_____Social /Behavior Management Progress Reports

8. Authorization to Discuss Health Information
By initialing here _____I authorize _____
(Initials) (Name of health care provider)
To discuss the health information of my child with agents of the Vera Lloyd Presbyterian Family Service, Inc.

All items on this form has been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ _____
Signature of Caseworker/Parent/Guardian Date

_____ _____
VLPFS Staff Date

Revised 7/14/16

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Recreation Consent form

Name: _____ Date: _____

I, the legal custodian of aforementioned child, do hereby give permission for him/her to participate in recreational or athletic activities. If the child is not able to participate I will provide a signed document from a qualified medical professional stating that the resident is physically incapable of participating.

All of my Questions about this form have been answered. In addition, I have been offered a copy of this form.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

_____ _____
Signature of Caseworker/Parent/Guardian Date

_____ _____
Youth Signature Date

_____ _____
VLPFS Staff Signature Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Photograph Consent form

Name: _____ Date: _____

I understand that:

1. Signing this consent is voluntary.
2. Without my consent Vera Lloyd is prohibited from disclosing this information unless permitted to do so under federal and state law.
3. I have the right to revoke this consent at any time.
4. The recording, photograph, film will not be publicized outside of the Vera Lloyd Presbyterian organization.

All of my Questions about this form have been answered. In addition, I have been offered a copy of this form.

_____I, the legal custodian of aforementioned child, do hereby give permission for VLPFS to record, photograph and/or film the child.

_____ I, the legal custodian of aforementioned child, do not give permission for VLPFS to recorded, or film. Photographs are only allowed for the purpose of his/her file.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Youth Signature Date

_____ _____
VLPH Staff Signature Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

COUNSELING SERVICES
CONSENT FOR TREATMENT

Name: _____

Date of Birth: _____

I, the legal custodian of aforementioned child, do hereby give permission for VLPFS to provide counseling services for the above named youth for whom I am parent or legal guardian.

_____ Individual Therapy

_____ Group Therapy

_____ Family Therapy

I understand VLPFS counseling service are contracted with an outside provider. 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.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

_____ _____
Signature of Caseworker/Parent/Guardian Date

_____ _____
Witness Date

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Youth Questionnaire – To be filled out with Intake Packet by youth

Name: _____ Age: _____

Birthday: _____ Grade in School: _____

Favorite Color: _____

Most Important Person in your life: _____

Favorite Shampoo/Soap/hygiene product: _____

Favorite outside Activity: _____

Favorite inside Activity: _____

Favorite Subject in School: _____

Least Favorite Subject in School: _____

Current Strength: _____

Special Interest: _____

Special Skills: _____

What are some areas in your life you need to work on? (examples – getting along with others, making decisions, getting better grades)

_____

If you could have any job in the world, what would it be? _____

If you could choose where you would live, where would it be and with whom?

_____

What is a vacation you would like to go on? _____

What is something you have always wanted to do but have not been able to do it?

_____

What are the main things you want Vera Lloyd to help you with while you stay with us?

_____

VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Youth Questionnaire – To be filled out with Intake Packet by youth (p. 2)

Name: _____

How is your physical health today? (Circle One) Excellent Good Fair Poor

If you chose fair or poor, please explain:

_____

_____

Does any part of your body currently hurt? If so, please describe and explain: _____

_____

Do you need to go to the doctor or dentist for any reason? _____

_____

Who did you live with before coming here? Describe the dwelling you lived in.

_____

_____

Have you ever been homeless? _____

Have you ever been physically or sexually abused? If so, by whom? _____

_____

Did you feel safe when you were at home?

_____

What was your address and phone number? _____

_____

Is there anything else you think we need to know about you to provide the best possible care for you during your stay with us?

_____

_____

_____