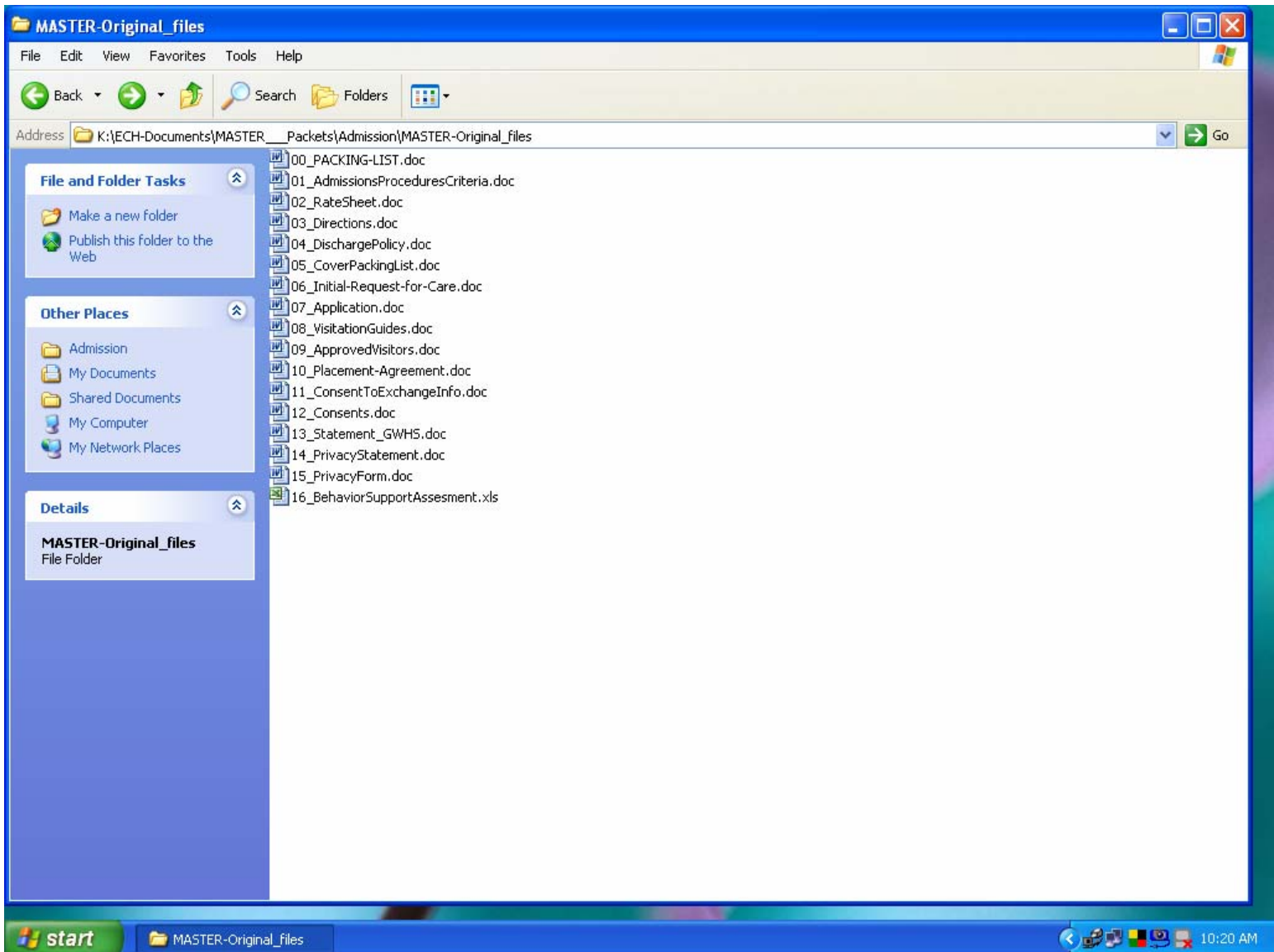


# *Throw this sheet away*

*It is for packet assembly referral purposes only.*



## **ADMISSIONS PROCEDURES & CRITERIA**

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

### **INTAKE CHECKLIST...**

NOTE: We must have the following three (3) forms completed and on file before application is considered complete.

- APPLICATION: Agency application must be completed as completely as possible.
- SCHOOL RECORDS: We need a copy of the last grading period report and IEP's if applicable.
- MEDICAL RECORDS: Include a copy of the latest physical if done within 90 days prior to admission.

### **TYPE OF CHILD/YOUTH ACCEPTED INTO CARE...**

- AGE REQUIREMENT: Ages 5 – 17  
(regardless of race, color, religion, or national origin).
- I.Q. REQUIREMENT: 70 OR ABOVE. CHILDREN WHO HAVE TESTED BELOW 70 MAY BE ACCEPTED IF OTHER FACTORS INDICATE THEY ARE APPROPRIATE FOR OUR PROGRAM.
- UNACCEPTABLE BEHAVIORS: A strong history of physical aggression in regards to pattern or duration, sexual predators, or fire starters cannot be accepted.
- ACCEPTABLE PROBLEMS: Child/youth with a history of physical or sexual abuse issues.  
Mild to moderate substance abuse problems.  
Mild to moderate behavioral and/or emotional disorders.

### **THE ADMISSION PROCESS...**

- EMERGENCY ADMISSIONS: Our intake person will receive the preliminary information by phone regarding the child/youth and forward this central intake information to the Program Director or her designee. A decision will be made expediently (within the same day received) to determine acceptance of the child/youth into our program.
- PLANNED ADMISSION: After application is completed and returned to PCHH, it is reviewed by the Coordinating Team to determine if the child/youth would benefit from the programs we offer. If the Coordinating Team feels the child/youth would be appropriate for our long-term residential program a notice will be provided to the referral agent. An interview is then scheduled with the child/youth, parents, and/or legal guardians with the Coordinating Team.

## RATE & SERVICES INFORMATION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.

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P. O. Box 545  
WYTHEVILLE, VIRGINIA 24382  
(276) 228-2861  
(276) 228-8154 (FAX)  
<http://pchh.org> • [info@pchh.org](mailto:info@pchh.org)

### EMERGENCY CARE

\$165.00 per day

### LONG-TERM RESIDENTIAL PROGRAM

Room & Board 105.00 per day

Case Management &  
Service Coordination 35.00 per day

Therapeutic Activity Services \$25.00 per day

Total for Long-Term Residential Care: \$165.00 per day

### EDUCATION COMPONENT

(Billed by Minnick Education Center)

During school calendar year \$125.00 per day

**Rates for: July 1, 2009 – June 30, 2010**

## **DIRECTIONS: PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS**

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*Giving Children Hope & Purpose For The Future*

### **DIRECTIONS TO THE HOME:** *If traveling I-81 North (from Bristol, Abingdon)...*

- take Exit #67 (first Wytheville exit)
- at end of exit ramp, turn left onto Hwy 11
- travel on Hwy 11 approximately 3 miles to Main Street
- turn right at traffic light # 1 (onto Main Street)
- Main Street turns into Hwy 21 South (bear left)
- proceed under railroad overpass (look for pond on right just past underpass)
- turn right onto paved campus road beside pond (campus road begins at Children's Home sign)
- travel up the hill to the administration building (behind the flag pole)

### *If traveling I-81 South...*

- take Exit #73 (first of three Wytheville exit)
- travel on Main Street through downtown Wytheville (exit turns into Main Street)
- Main Street turns into Hwy 21 South (bear left)
- proceed under railroad overpass (look for pond on right just past underpass)
- turn right onto paved campus road beside pond (campus road begins at Children's Home sign)
- travel up the hill to the administration building (behind the flag pole)

### *If traveling I-77...*

- take I-81 exit
- follow above I-81 South directions to the Home

### **FOR MORE INFORMATION:**

- Billy Rice, Executive Director
  - Wynette Yontz, Administrative Director
  - P. G. Rigney, Program Director
  - E. C. Hill, Development Director
- P.O. Box 545  
425 Grayson Road  
Wytheville, VA 24382  
(276) 228-2861  
pchh@naxs.com  
<http://pchh.org>

### PHILOSOPHY

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A successful discharge begins on the day of admission. It is our belief that many of the problems which young people have who come into residential care are a result of the lack of stability in many of their formative years. Because of this, we do not want a discharge to come as a surprise to a resident. We want it to be the result of good planning by all parties, including the resident.

### PROCEDURES

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#### **Planned Discharge**

A planned discharge is one which comes about because of the successful completion of the goals and objectives set forth in the service plan. Normally, a discharge date is set, which allows the staff and resident to say goodbye to each other and plan for aftercare follow-up. It also allows the resident time to say goodbye to friends. A party is usually held by the cottage for the resident in recognition of completing a successful program.

#### **Unplanned Discharge**

An unplanned discharge may be at the request of the legal guardian or placing agency, at the request of Presbyterian Children's Home of the Highlands, Inc. , or at the request of the resident if the resident is 18 years of age or older.

Unplanned discharges at the request of Presbyterian Children's Home of the Highlands, Inc. may be initiated for the following reasons:

1. A resident becomes a threat to him/herself or to others.
2. A resident does not participate in any of the service plan components.
3. A resident runs away and is missing for a period of over three weeks.

Unplanned discharges at the request of the placing agency or legal guardian may at times occur because the resident has been removed to a detention facility, a drug rehab facility or a short term psychiatric facility. In such situations, the Home's staff will stay in close communication with the placing agency to determine if the best plan of care for the resident is to return to the Home.

### Emergency Discharge

Emergency discharges are extremely rare. An emergency discharge requires the resident to be removed within 24 hours. This type of discharge may occur if the child becomes extremely violent or is seriously suicidal. In these types of situations, the discharge is in the best interest of the residents. Once they have been stabilized, the Home's staff will work with the placing agency's staff to determine if a return to the Home is the best plan for the resident.

### FREQUENTLY ASKED QUESTIONS

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**Q.** *If a resident runs away, does the Home take them back?*

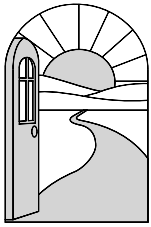
**A.** Usually, yes. Each incident is different and is handled separately.

**Q.** *If a resident has charges filed against them, will he/she need to leave the Home?*

**A.** It depends. Each situation is reviewed separately to determine what is best for the resident. It may be determined that a short placement in detention is warranted.

**Q.** *If a resident refuses medical treatment, will he/she be discharged?*

**A.** Refusal of medical treatment which has been prescribed by a doctor is a serious problem. Each case will be judged on its own merits. However, in all cases where refusal to follow prescribed medicine or therapy may be life threatening, the resident will be discharged. For example: failure to take insulin.



PRESBYTERIAN  
CHILDREN'S HOME  
OF THE HIGHLANDS, INC.

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## ADMISSION PACKET

The Presbyterian Children's Home of the Highlands, Inc. is pleased to provide this Admission Packet. Please call (800) 987-0301 and ask for our Intake Worker or our Program Director if you have any questions.

This packet includes the following materials:

LEFT SIDE OF FOLDER

- ❑ Admission PROCEDURES & CRITERIA
- ❑ RATE SHEET
- ❑ DIRECTIONS TO PCHH
- ❑ Discharge Policy

RIGHT SIDE OF FOLDER

- ❑ Application
- ❑ Social History
- ❑ VISITATION GUIDELINES
- ❑ APPROVED VISITORS
- ❑ PLACEMENT AGREEMENT
- ❑ CONSENT TO EXCHANGE INFORMATION
- ❑ CONSENTS
- ❑ STATEMENT FOR GWHS
- ❑ BEHAVIOR SUPPORT ASSESSMENT

You will receive prompt attention to your referral and you will be contacted by one of our Coordinators as soon as possible.

P.O. Box 545 • WYTHEVILLE, VA 24382

(276) 228-2861 • (800) 987-0301 • (276) 228-8154 fax • <http://pchh.org> • [info@pchh.org](mailto:info@pchh.org)

**INITIAL REQUEST FOR PLACEMENT**

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
PO Box 545 · WYTHEVILLE, VA 24382 · (800) 987-0301 · (276) 228-2861

DATE: \_\_\_/\_\_\_/\_\_\_ TIME: \_\_\_:\_\_\_ am / pm COTTAGE: \_\_\_\_\_

**PERSONAL INFORMATION...**

CLIENT'S FULL NAME: \_\_\_\_\_ PERSON REQUESTING PLACEMENT: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

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

AGENCY PHONE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ CUSTODY CURRENTLY HELD BY: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_ FT \_\_\_ IN

DOB: \_\_\_/\_\_\_/\_\_\_ WEIGHT: \_\_\_ LBS

SEX: \_\_\_ MALE \_\_\_ FEMALE EYE COLOR: \_\_\_\_\_

SSN: \_\_\_-\_\_\_-\_\_\_\_ HAIR COLOR: \_\_\_\_\_

RACE: \_\_\_\_\_

IDENTIFYING MARKS: \_\_\_\_\_

**EXHIBITING BEHAVIORS...**

VERBALLY ABUSIVE: \_\_\_\_\_

PHYSICALLY ABUSIVE: \_\_\_ NO \_\_\_ YES AGAINST WHOM: \_\_\_\_\_

HOW: \_\_\_\_\_

\* FIRESETTING: \_\_\_ NO \_\_\_ YES MOST RECENT FIRESETTING: \_\_\_\_\_

\* RUNAWAY: \_\_\_\_\_ RUN FREQUENCY: \_\_\_\_\_

\* SEXUAL BEHAVIOR: \_\_\_\_\_

CONCERNS: \_\_\_\_\_

SPECIFY: \_\_\_\_\_

FAMILY DISCORD: \_\_\_\_\_

**PREVIOUS PLACEMENTS...**

<u>DATE</u>	<u>FACILITY</u>	<u>TYPES</u>
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

**PSYCHOLOGICAL / EMOTIONAL INFORMATION...**

CURRENT COUNSELING: \_\_\_ YES \_\_\_ NO WITH WHOM: \_\_\_\_\_

PSYCHOLOGICAL ILLNESS / DIAGNOSIS: \_\_\_\_\_

BY WHOM: \_\_\_\_\_

**INITIAL REQUEST FOR PLACEMENT**

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
PO Box 545 · WYTHEVILLE, VA 24382 · (800) 987-0301 · (276) 228-2861

ADHD: \_\_\_ YES \_\_\_ NO

DATE OF LAST APPOINTMENT: \_\_\_/\_\_\_/\_\_\_

**SCHEDULED APPOINTMENTS...**

\_\_\_/\_\_\_/\_\_\_ WITH WHOM: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_ WITH WHOM: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**PSYCHOLOGICAL NEEDS** AT PRESENT...

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

**SUBSTANCE ABUSE:** YES \_\_\_ NO \_\_\_

DRUG OF CHOICE: \_\_\_\_\_ OTHER: \_\_\_\_\_

CURRENT **NEEDS:** \_\_\_\_\_  
\_\_\_\_\_

**SCHOOL INFORMATION...**

LAST SCHOOL ATTENDED: \_\_\_\_\_ GRADE: \_\_\_\_\_

CURRENT **NEEDS:** \_\_\_\_\_

SPECIAL ED: \_\_\_\_\_ TRUANCY: \_\_\_\_\_

BEHAVIOR IN SCHOOL: \_\_\_\_\_

RESPONSE TO AUTHORITY: \_\_\_\_\_

SUSPENDED: \_\_\_\_\_ EXPELLED: \_\_\_\_\_

SPECIFIC **SCHOOL NEEDS** AT PRESENT: \_\_\_\_\_  
\_\_\_\_\_

**HEALTH INFORMATION...**

**ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_

SPECIFIC **HEALTH NEEDS** AT THIS TIME: \_\_\_\_\_

CONDITIONS REQUIRING OBSERVATION / TREATMENT: \_\_\_\_\_  
\_\_\_\_\_

SCHEDULED HEALTH CARE APPOINTMENTS:

\_\_\_/\_\_\_/\_\_\_ WITH WHOM: \_\_\_\_\_

**COMPLETE FORM — DO NOT LEAVE ANY LINES BLANK**

**INITIAL REQUEST FOR PLACEMENT**

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
PO Box 545 · WYTHEVILLE, VA 24382 · (800) 987-0301 · (276) 228-2861

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

PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**CURRENT MEDICATIONS...**

<u>TYPE (NAME)</u>	<u>DOSE</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**METHOD of PAYMENT for MEDICAL BILLS...**

INSURANCE: \_\_\_\_\_ NUMBER: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

**HISTORY WITH POLICE...**

POLICE RECORD: \_\_\_\_\_

EXPLAIN: \_\_\_\_\_

PROBATION: \_\_\_\_\_

TERMS OF PROBATION: \_\_\_\_\_

SCHEDULED POLICE / COURT APPOINTMENTS:

\_\_\_\_/\_\_\_\_/\_\_\_\_ WITH WHOM: \_\_\_\_\_

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

PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**WOULD THIS CHILD POSE ANY SIGNIFICATE RISK TO...**

HIM / HER SELF: YES \_\_\_ NO \_\_\_ RESIDENTS: YES \_\_\_ NO \_\_\_ STAFF: YES \_\_\_ NO \_\_\_

IF SO, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

This applicant... is \_\_\_ is not \_\_\_ ...suitable for the PCHH program.

*— Check to make sure there are NO lines blank anywhere in this form! —*

INFORMATION TAKEN BY: _____	____/____/____	TIME: ____:____ AM / PM
INFORMATION RECEIVED BY CASE MANAGER: _____	____/____/____	TIME: ____:____ AM / PM
ACCEPTED ___	DENIED ___	COTTAGE ASSIGNED: _____

**COMPLETE FORM — DO NOT LEAVE ANY LINES BLANK**

**APPLICATION FOR ADMISSION**

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
"Giving Children Hope and Purpose For The Future"

**CLIENT'S FULL NAME:** \_\_\_\_\_

**PERSONAL INFORMATION...**

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

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

Last Known 911 Address: \_\_\_\_\_

Why is this child in need of this residential placement:

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

**LEGAL INFORMATION...**

◇◇◇ COPY OF **SOCIAL SECURITY CARD** AND **BIRTH CERTIFICATE** ARE **REQUIRED** ◇◇◇

List Court, Police Record, Foster Care, Previous Group Home Placements, Psychiatric Hospitalizations:

Out-of-Home Placements	Dates	Reasons for Discharge

**PARENTAL INFORMATION...**

Parental Rights Terminated: Yes \_\_\_\_ No \_\_\_\_

**Father:** \_\_\_\_\_

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

\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

**COMPLETE FORM — DO NOT LEAVE ANY LINES BLANK**

**APPLICATION FOR ADMISSION**

---

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Father's  
Involvement \_\_\_\_\_  
With Child: \_\_\_\_\_

**Mother:** \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Mother's  
Involvement \_\_\_\_\_  
With Child: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY...**

Siblings	Ages	History of abuse, if yes, describe

Step-Parents, if any: \_\_\_\_\_

**MEDICAL INFORMATION...**

Assessment of current Health status

Allergies (medication or environmental): \_\_\_\_\_  
\_\_\_\_\_

Illness/injuries: \_\_\_\_\_

---

**COMPLETE FORM – DO NOT LEAVE ANY LINES BLANK**

**APPLICATION FOR ADMISSION**

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
"Giving Children Hope and Purpose For The Future"

Communicable diseases: \_\_\_\_\_

Current **Medical/Physical Needs**: \_\_\_\_\_

Current **Dental Needs**: \_\_\_\_\_

Was medication **BROUGHT** with the resident on date of admission: YES \_\_\_ NO \_\_\_

If so, what: \_\_\_\_\_

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

◇◇◇◇ **PLEASE PROVIDE A COPY OF IMMUNIZATION RECORD** ◇◇◇◇

**Physician Last Seen:** \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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

**Dentist Last Seen:** \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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

PHYSICIAN

**WYTHE MEDICAL**  
Dr. Cho / Cathy Spears  
360 Virginia Avenue  
Wytheville, VA 24382  
(276) 228-2191

DENTIST

**DR. NATHAN S. HOUCHINS**  
190 Tazewell Street  
Wytheville, VA 24382  
  
(276) 228-0006

EYE DOCTORS

**DR. AMANDA B. SMITH**  
530 West Ridge Road  
Wytheville, VA 24382  
(276) 228-0033  
  
**DR. GORDON JENNINGS**  
310 East Main Street  
Wytheville, VA 24382  
(276) 228-2771

PSYCHIATRIST

**DR. MARIA ABELEDA**  
770 West Ridge Road,  
Suite 220  
Wytheville, VA 24382  
(276) 223-3202

**SOCIAL HISTORY...**

History of Child:

Significant Developmental Delays: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Describe Social/Recreation/Religious Interest:

\_\_\_\_\_

**APPLICATION FOR ADMISSION**

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

List any Current **Mental Health Needs**: (Include drug/alcohol use or abuse)

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List recent Psychological, Personality, IQ, Achievement Test, etc. (Attach copies)

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Describe below Current Behavioral Problems:  
(Include strengths, talents, and problems)

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**Protection Needs** (as defined under code... if any): \_\_\_\_\_  
\_\_\_\_\_

**All Scheduled Appointments** (use back if necessary):

With Whom	Date	Time	Place / Address / Phone Number	Reason
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____

**Application Completed by:** \_\_\_\_\_  
Placing Agency & Representative  
  
\_\_\_\_\_  
PCHH Representative Accepting Application  
  
\_\_\_/\_\_\_/\_\_\_  
Date

## VISITATION GUIDELINES

---

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

Presbyterian Children's Home of the Highlands, Inc. encourages appropriate and positive contact between a resident and his/her family. The placing agency or legal guardian shall provide a list of approved visitors. This list may be updated as needed.

The frequency and length of visits will be determined by the cottage team and placing agency's staff or legal guardian. The service plan shall reflect any goals and objectives pertaining to visitation as it relates to family reunification or relationship building.

For an approved visitor to arrange a visit, he/she needs to call the resident's social worker and make the appropriate arrangements. Unapproved visitors must first seek the permission of the placing agency or legal guardian. The Home's staff cannot give permission to unapproved visitors.

For visits by approved visitors:

1. Arrive on time or call if you are going to be late.
2. Don't bring other visitors unless they are also approved.
3. Don't give money to a resident unless it is approved.
4. No alcohol or drugs are allowed on campus. Our staff is required to report any violations.
5. Visitors are asked to cooperate with staff. If problems exist, please let us know.
6. Visitors may not invite other residents to go with them unless it has been approved in advance.
7. Weekend or overnight visits must be approved in advance by social workers.
8. If the resident is on any medication, the person responsible for supervising the home visit must ensure the medication is given properly and accounted for. Failure to do this may result in a CPS complaint being filed.
9. Do not return from a visit early unless you call in advance. Often, the cottages are locked due to other staff and residents being off campus. You may not leave a resident at the Home unless the cottage is open and staff present.

We/I have read and understand each of the above guidelines. We/I understand that frequent or severe violations may result in suspension of visitation at the Presbyterian Children's Home of the Highlands, Inc.

Resident also certifies that they have received a copy of the PCHH Resident Handbook.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Resident                      Date                      PCHH Representative                      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent                      Date                      Placing Agency Representative                      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

---

# APPROVED VISITORS

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

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

Consent granted by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Approved Visitors

Name	Relationship	On Campus	Off Campus	Overnight	Phone Number

### Restricted Visits / Contacts

Name	Relationship	Comments

# PLACEMENT AGREEMENT

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

In consideration of acceptance of \_\_\_\_\_ into care of the Presbyterian Children's Home of the Highlands, Inc. (hereafter referred to as the Children's Home), Wytheville, Virginia, I/we, the undersigned legal guardian of this child, do hereby agree and promise:

1. To grant the Children's Home the right of returning this child to me at any time that it appears to be in the best interest of the child or the Children's Home that this child be discharged.
2. \*To obligate myself to pay for fees as scheduled for the following services:  
Residential Program \$165.00 per day
3. To grant the Children's Home complete authority to authorize routine medical, psychological and dental treatment and to secure immunizations deemed necessary for the care of this child. The Children's Home further agrees to contact the legal guardian if (non-billable) major or surgical treatment is needed for the child.

Every reasonable effort will be made to contact the legal guardian if emergency medical / dental treatment has to be given to a child. If there is insufficient time to contact the legal guardian to obtain their consent, the Children's Home is hereby authorized to grant approval for all necessary emergency procedures and the guardian will be contacted as soon as possible thereafter.

4. Placing agencies will inform this facility of long term goals for resident. They will also participate in the discharge planning for each youth.
5. Residents may have visits on and off campus by permission of the legal guardian. All home visits will require approval by the resident's legal guardian. Residents will be allowed to participate in off campus activities under the supervision of facility staff. If activities occur outside of the state, permission will be gained by the legal guardian prior to the activity.
6. In the event a child leaves campus and is reported as a runaway, PCHH will hold their place and will bill for the days they are absent until notified by the placing agency of the resident's discharge.
7. The Guardian accepts PCHH's audio/video policy of video monitoring in common areas, such as the living rooms, hallways, and offices of the cottages and the central dining hall. Video monitoring is prohibited in the bedroom and bathroom areas.

Presbyterian Children's Home of the Highlands, Inc. agrees to provide each resident with residential services, case management, Christian education, recreation, socialization, vocational education, transportation, behavioral management, educational programming on campus or in the Wythe County Public School System.

Public School: \_\_\_\_\_

On-campus School: Minnick Education Center

Student will be enrolled by \_\_\_\_\_ who will also obtain needed educational information.

These additional services may be provided as needed: counseling for resident and family, tutoring, and computer training.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Guardian: \_\_\_\_\_

PCHH Representative: \_\_\_\_\_

**\* If party responsible for payment is other than the legal guardian, signature of responsible party is required below.**

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

Agency: \_\_\_\_\_

# CONSENT TO EXCHANGE INFORMATION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
"Giving Children Hope and Purpose For The Future"

*I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide these services or benefits.*

I, \_\_\_\_\_, am signing this form for  
(full printed name of consenting person or persons)

\_\_\_\_\_  
(full printed name of client)

Client's Name: \_\_\_\_\_

Client's birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client's SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

- |  |  |  |                         |  |                             |
|--|--|--|-------------------------|--|-----------------------------|
| YES <input type="checkbox"/> NO <input type="checkbox"/> | Assessment Information                                 | YES <input type="checkbox"/> NO <input type="checkbox"/> | Medical Diagnosis       | YES <input type="checkbox"/> NO <input type="checkbox"/> | Educational Records         |
| <input type="checkbox"/> <input type="checkbox"/>        | Financial Information                                  | <input type="checkbox"/> <input type="checkbox"/>        | Mental Health Diagnosis | <input type="checkbox"/> <input type="checkbox"/>        | Psychiatric Records         |
| <input type="checkbox"/> <input type="checkbox"/>        | Benefits / Services Needed<br>Planned, and/or Received | <input type="checkbox"/> <input type="checkbox"/>        | Medical Records         | <input type="checkbox"/> <input type="checkbox"/>        | Criminal Justice<br>Records |
|  |  | <input type="checkbox"/> <input type="checkbox"/>        | Psychological Records   | <input type="checkbox"/> <input type="checkbox"/>        | Employment Records          |

Other information (write in):

I want                    The Presbyterian Children's Home

\_\_\_\_\_  
(name and address of referring agency and staff contact person)

as well as the following other agencies to be able to exchange this information:

Minnick Education/Wythe County Schools/Mt. Rogers Mental Health

More agencies are listed on the back of this sheet...    Yes     No

## CONSENT TO EXCHANGE INFORMATION

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
"Giving Children Hope and Purpose For The Future"

I want this information to be exchanged ONLY for the following purpose(s):

- Service Coordination and Treatment Planning
- Eligibility Determination.
- Other \_\_\_\_\_

I want information to be shared (check all that apply):

- Written Information
- In Meetings or by Phone
- Computerized Data

I want to share additional information received after this consent is signed:    Yes     No

This consent is good until: \_\_\_\_\_

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s) Consenting Person(s): \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person Explaining Form: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Witness (if required) Signature: \_\_\_\_\_

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

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

## CONSENTS

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

	NO	YES	ONLY WITH SPECIFIC APPROVAL
1. Photographs *	_____	_____	_____
2. Transport for activities outside VA (Day activities ONLY — does not apply to overnight travel)	_____	_____	_____
3. Participate in chapel services	_____	_____	_____
4. Drug testing	_____	_____	_____
5. HIV testing	_____	_____	_____
6. Participate in fund raising activities	_____	_____	_____
7. Participate in horseback riding	_____	_____	_____

NOTE:

THE PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS BELIEVES IT IS IMPORTANT TO NOT ONLY PROVIDE ALL THE MATERIAL, EMOTIONAL AND SPIRITUAL SUPPORT FOR EACH RESIDENT BUT TO OFFER WAYS TO POSITIVELY BUILD THEIR SELF-ESTEEM. PHOTOGRAPHS OF RESIDENTS USED IN A POSITIVE MANNER IN OUR NEWSLETTER, DISPLAY AND INFORMATIONAL MATERIALS ARE ONE AVENUE WE USE TO ACCOMPLISH THIS. OF COURSE WE MAKE SURE EACH RESIDENT HAS PERSONAL COPIES OF PHOTOGRAPHS THAT HELP THEM RETAIN GOOD MEMORIES. OUR SELECTION AND USE OF PHOTOGRAPHS ARE DONE WITH GREAT CARE AND DETERMINATION THAT IT WILL BE VIEWED IN A POSITIVE WAY. WE APPRECIATE YOUR UNDERSTANDING AND COOPERATION WITH THIS MATTER.

Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## REQUIRED STATEMENT FOR STUDENTS ENTERING GEORGE WYTHE HIGH SCHOOL

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.  
*"Giving Children Hope and Purpose For The Future"*

Virginia law requires that, prior to admission to any public school of the Commonwealth of Virginia, a school board shall require the parent, guardian, or other person having control or charge of a child of school age to provide, upon registration, a sworn statement or affirmation indicating whether the student has been expelled from school attendance at a private school or in a public school division of the Commonwealth or in another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person. Any person making a materially false statement or affirmation shall be guilty upon conviction of a Class 3 misdemeanor. The registration document shall be maintained as a part of the student's scholastic record. (Code of Virginia 22.1-3.2)

Please complete and sign the applicable statement below...

I, \_\_\_\_\_, affirm that \_\_\_\_\_ has not been expelled from school attendance at a private school or public school in Virginia or another state for an offense in violation of school board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

Parent, Guardian, or Person  
Having Control Or Charge Of Child: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I, \_\_\_\_\_, affirm that \_\_\_\_\_ has been expelled from school attendance at a private school or public school in Virginia or another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.

Parent, Guardian, or Person  
Having Control Or Charge Of Child: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION  
PLEASE REVIEW IT CAREFULLY*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issue a new notice.

**Our commitment to your privacy.** We are responsible for the information that we collect about you, and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information. We understand how important it is to protect your privacy and we will continue to make this a priority.

**Our legal duties.** We are required by applicable federal and state laws to keep certain information about you private. An example of this is your medical information. We treat your medical and demographic information that we collect as part of providing counseling and psychological services, as "Protected Information." It is our policy to maintain the privacy of Protected Information in accordance with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. Any terms not defined in this Notice will have the same meaning as they have in the HIPAA privacy regulation.

The HIPAA Privacy Regulations generally do not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard that we are required to follow. For example, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, HIV or AIDS, etc.

We reserve the right to change the terms of this notice. We may make the new notice provisions effective for all the Protected Information that we maintain. This includes information that we created or received before we made the changes. Any revised notice will be provided to you by mail or in person at your next appointment in our office.

Anyone may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us as specified at the end of this notice.

Our primary uses and disclosures of your Protected Information. We may use and disclose your Protected Information without your specific authorization for the purposes of treatment, payment, and health care operations. To illustrate:

- Treatment activities are activities performed by a health care provider related to the provision, coordination or management of health care provided to you. An example of this would be telling your insurance company how many office visits and what type of office visits you have had to date.
- Payment activities are activities undertaken to obtain reimbursement for services, confirm health care coverage, bill for services rendered, perform collecting activities, and perform utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations activities include the business aspects of running our practice, such as business planning and development, quality assessment and improvement, submission of claims, obtaining legal and auditing services, and cost-management analysis. We may also use your Protected Information to give you information about treatment alternatives or other health-related services that may interest you.

When using and disclosing your Protected Information in our health care and billing operation activities, we may only request, use, and disclose the minimum amount of your Protected Information necessary to complete the activity.

We may contract with others to assist us with treatment, billing or health care operation activities that involve the use of your Protected Information. Such third parties are referred to as our business associates. We require business associates to agree, in writing, to contract terms. These terms are specifically designed to safeguard Protected Information before it is shared with them. We may also have business associates assist in the activities described in the following section that involves permitted uses and disclosures.

**Other uses and disclosures of your Protected Information.** We must disclose your Protected Information to you. This is described in the Individual Rights section of this notice below. You may also give us written authorization to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or disclose your Protected Information without your specific written authorization.

**Family and friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

**Research, death, organ donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulations. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

**Public health and safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious imminent threat to your health or safety or the health and safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contracts, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, domestic violence or other crimes.

**Required by law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected Information to comply with workers' compensation or similar laws.

**Legal process and proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.

**Law enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

**Military and national security.** We may disclose to military authorities the Protected Information of Armed Forces personnel under certain circumstances specified by the HIPAA privacy regulation. We may also disclose to authorized federal officials Protected Information required for lawful intelligence, counterintelligence, and other national security activities.

## **INDIVIDUAL RIGHTS**

**Access.** You have the right to inspect and obtain copies of your Protected Information for as long as your information is maintained in our designated record set. Our designated record set includes records from our billing, claims, treatment planning, and medical management and treatment systems, as well as any other records we maintain in order to make decisions about providing health care services. Your right of access to Protected Information does not extend to certain information. This includes information contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative proceeding. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We reserve the right to charge a reasonable fee for copies of Protected Information that we provide. Any request to exercise your individual right of access to your Protected Information must be in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will respond to your request within 30 days of receiving the request. If all or any part of your request is denied, our response will detail any appeal rights you may have with respect to that decision. Notwithstanding the formal process for your right of access, certain information related to claims processing may be available to you by contacting us as part of our normal insurance billing business procedures.

**Amendment.** You have the right to request that we amend your Protected Information that we keep in our designated record set if you believe it is incorrect. A request that your Protected Information be amended must be done in writing. You may obtain a form to request amendment by using the contact information listed at the end of this notice. We will respond to your request for amendment within 30 days of receiving the request. If we accept your request to amend the information, we will notify you. We will make reasonable efforts to inform other person, including those identified by you as having any future disclosure of that information. If we deny your request for reasons permitted by the HIPAA privacy regulation, our notice to you will explain any appeal right you may have with respect to that decision. Notwithstanding the formal process for your right of amendment, certain information related to claims processing may be corrected by contacting us as part of our normal insurance billing business procedures.

**Disclosure accounting.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures. The most significant types include: any disclosures made prior to April 14, 2003; disclosures for treatment, payment or health care operations activities; disclosures to you or pursuant to your authorization; disclosures to persons involved in your care; disclosures for disaster relief, national security or intelligence purposes; disclosures that are incidental to a permitted use or disclosure. To request an accounting of disclosures, you must submit the written request by using the contact information listed at the end of this notice. You may request one such accounting at no charge every 12 months. You

may request that the accounting cover up to 6-year period of reportable disclosures from the date of your request. We will respond within 60 days of your request. We reserve the right to impose a reasonable charge for requests made more than once per year.

**Confidential communications.** You may believe that you will be in danger if we communicate Protected Information to you at your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by an alternate form of communication. We will make reasonable efforts to accommodate your request if you specify an alternate address. To request a confidential communication, you must direct your request to the contact office listed at the end of this notice.

**Restriction request.** You have the right to request that we restrict the use or disclosure of your Protected Information for treatment, payment or health care operation activities. You also have the right to request that we restrict disclosures to relatives, friends, or other individuals that may be involved in your care or payment for your health care. We are not required to agree to such a request for restriction. To request a restriction, you must direct your request to the contact office listed at the end of this notice.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We maintain and enforce a policy of non-retaliation against individuals who bring breaches, or potential breaches, of this notice to the attention of our privacy officer or the U.S. Department of Health and Human Services.

**How to contact us:**

Presbyterian Children's Home of the Highlands, Inc.  
P.O. Box 545  
Wytheville, VA 24382  
Attention: P. G. Rigney  
(276) 228 - 2861

**For more information about HIPAA or to file a complaint:**

U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, SW  
Washington, DC 20201  
(877) 696 - 6775

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.

**WANDA L LANE M.A., QMHP LPC**  
Masters of Arts in Counseling  
Qualified Mental Health Person  
Licensed Professional Counselor  
Board Certified

**Presbyterian Children's Home of the Highlands, Inc.**  
P. O. Box 545  
Wytheville, VA 24382  
(276) 228-2861

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (Protected Information). I understand that this Protected Information can and will be used to perform:

- **Treatment activities** are activities performed by a health care provider related to the provision, coordination or management of health care provided to you. An example of this would be telling your insurance company how many office visits and what type of office visits you have had to date.
- **Payment activities** are activities undertaken to obtain reimbursement for services, confirmed health care coverage, bill for services rendered, performed collecting activities, and performed utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations activities** include the business aspects of running our practice, such as business planning and development, quality assessment and Improvement, submission of claims, obtaining legal and auditing services, and cost-management analysis. We may also use your Protected Information to give you information about treatment alternatives or other health-related services that might interest you.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my Protected Information. I understand that you have the right to change the Notice of Privacy Practices from time to time and that I may contact your office at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree, then you are bound to abide by such restrictions.

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

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_      INITIALS: \_\_\_\_      REASON: \_\_\_\_\_

**I. Positive Behaviors**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Positive Outlook          | <input type="checkbox"/> Has a Desire to do Well | <input type="checkbox"/> Works Well With Others  |
| <input type="checkbox"/> Good Verbalization Skills | <input type="checkbox"/> Friendly                | <input type="checkbox"/> Has Good Support System |
| <input type="checkbox"/> Easily Calmed             | <input type="checkbox"/> Cooperative             | <input type="checkbox"/> Respectful              |

**II. Negative Behaviors**

- Negative Outlook
- Refusal to Comply with Rules
- Verbally Aggressive
- Physically Aggressive

**III. Goals:**

To increase positive behaviors and decrease negative behaviors.

**IV. Successful Interventions**

- Will talk with staff about areas of life that is stressing and causing problems.
- Will go to a quiet place and rethink options.
- With staff's assistance, will develop new coping strategies.
- Will try to refocus attention by completing craft, coloring, writing, drawing, games, etc.....

**V. Interventions That Might Escalate Behaviors**

- Getting in personal space.
- Touching w/o asking permission.
- Talking loud and/or disrespecting.
- Talking negatively about situation or family.
- Threatening to take or remove property.

**VI. Behavior Triggers**

- |                                      |  |  |  |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Apathy      | <input type="checkbox"/> Arguments       | <input type="checkbox"/> Homesick              | <input type="checkbox"/> Nicotine Withdrawal |
| <input type="checkbox"/> Sadness     | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Negative Interactions | <input type="checkbox"/> Alcohol Withdrawal  |
| <input type="checkbox"/> Agitation   | <input type="checkbox"/> Disorganization | <input type="checkbox"/> Feeling Powerless     | <input type="checkbox"/> Drug Withdrawal     |
| <input type="checkbox"/> Other _____ |  |  |  |

**VII. Successful Intervention Strategies**

- Medication Management
- Cognitive restructuring
- Stress management
- Relaxation technique training
- Other \_\_\_\_\_

**VIII. Management Options for Calming Anger & Anxiety**

- Talking to Staff, Counselor
- Time Out
- Journaling
- Exercise
- Adequate Sleep/Nutrition
- Other \_\_\_\_\_

**IX. Goals for Targeted Behaviors for Emergency Safety Interventions**

- Will review and sign a no-harm agreement to include cutting, piercing, self tattooing, burning or branding.
- Upon arrival will be evaluated by staff or therapist for any threats to self or others.
- Upon completion of initial assessment it will be determined if there is need for psychiatric referral.
- If found to be a risk to self or others, Mt. Rogers Community Services board will be contacted for an emergency evaluation and possible hospitalization.
- In an emergency situation, cottage staff will contact evening shift supervisor for assistance to assist situation and help talk resident down.

Resident \_\_\_\_\_ Date \_\_\_\_\_ Therapist \_\_\_\_\_ Date \_\_\_\_\_

Houseparent \_\_\_\_\_ Date \_\_\_\_\_ Houseparent \_\_\_\_\_ Date \_\_\_\_\_

Houseparent \_\_\_\_\_ Date \_\_\_\_\_ Houseparent \_\_\_\_\_ Date \_\_\_\_\_

Social Worker: \_\_\_\_\_ Date \_\_\_\_\_

cc: Resident's File, Cottage