APPLICATION FOR SERVICE / INTAKE STUDY

TO (Name of Agency):_____

Application For: ☐ Therapeutic Foster Care ☐ Family Foster Care ☐ Residential Child Care

FROM (person/agency making application):_____

_____

(Print name of person making application and name of agency he/she represents)

This complete application, with supporting documentation, provides the information necessary to decide whether to admit the child. If the child is admitted, the documents relating specifically to admission will be required. If additional space is needed for any question, add an extra sheet or write on the back of the application (be sure to give question number for reference).

I. FAMILY INFORMATION

CHILD:

1) Child's Full Name:_____

2) Prefers to be called:_____

3) Date of Birth:_____ 4) Verified? ☐ Yes ☐ No

5) Sex: ☐ Male ☐ Female 6) Race:_____

7) Social Security Number:_____

8) Place of Birth (city):_____ (county):_____

(state or country):_____

9) Currently Living With: ☐ Biological Parents ☐ Relative ☐ Foster Family

☐ Other (Specify): _____

BIOLOGICAL PARENTS:

10) Father's Full Name:_____

11) Social Security Number:_____

12) Address:_____

City:_____ State:_____ Zip:_____

13) Phone Number: _____

14) Date of Birth: _____ 15) Date of Death: _____

16) Marital Status: _____

17) Race: _____ 18) Religion: _____

19) Mother's Full Name:_____

20) Social Security Number:_____

21) Address:_____

City:_____ State:_____ Zip:_____

22) Phone Number: _____

23) Date of Birth: _____ 24) Date of Death: _____

25) Marital Status: _____

26) Race: _____ 27) Religion: _____

CURRENT PARENTAL RELATIONSHIPS: (The persons, if other than biological parents, who will be working in a parental capacity with child while in care):

28) Full Name:_____

29) Social Security Number:_____

30) Date of Birth: _____ 31) Relationship to Child: ☐ Step ☐ Adoptive

☐ Other (Specify):_____

32) Address:_____

City:_____ State:_____ Zip:_____

33) Phone Number: _____

34) Full Name:_____

35) Social Security Number:_____

36) Date of Birth: _____ 37) Relationship to Child: ☐ Step ☐ Adoptive

☐ Other (Specify):_____

38) Address:_____

City:_____ State:_____ Zip:_____

39) Phone Number: _____

40) Have proceedings been initiated to terminate parental rights for this child's: Mother: ☐ Yes ☐ No

Father: ☐ Yes ☐ No

If yes, give the date of the final order terminating parental rights:

of the mother:_____ of the father:_____

41) Has this child been adopted? ☐ Yes ☐ No

If yes, give date(s) of the final adoption order(s):_____

42) CHILD'S SIBLINGS (Include all half siblings, step siblings, adoptive siblings)

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____

Relationship:_____ Presently Living With:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____

Relationship:_____ Presently Living With:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____

Relationship:_____ Presently Living With:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____

Relationship:_____ Presently Living With:_____

43) OTHER RELATIVES:

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

II. CUSTODY

44) Name of Legal Custodian:_____

45) Phone Number:_____

46) Address:_____

City:_____ State:_____ Zip:_____

47) Name of Contact Person:_____

48) Phone Number:_____

49) Is a Voluntary Placement Agreement or CARS Agreement in effect? ☐ Yes ☐ No

If yes, give expiration date:_____

50) Check if there is any ☐ physical, ☐ medical, ☐ developmental, ☐ psychological problem which will require special attention in caring for this child. Attach a description of each problem checked.

51) Name any medications this child is now taking, and for what condition(s):_____

_____

_____

52) Name of child's physician:_____ 53) Phone:_____

54) Address:_____

55) Name of child's dentist:_____ 56) Phone:_____

57) Address:_____

City:_____ State:_____ Zip:_____

III. EDUCATIONAL INFORMATION

(If this form is completed between school terms, please give the information pertaining to the previous school year. If assistance is needed in completing the form, please consult the child's school.)

58) Assigned School Grade:_____ In which grade (s) has the child been retained?_____

59) Attach copy of the child's report card for the latest reporting period.

60) School performance this year is ☐ better than, ☐ equal to, or ☐ poorer than previous year.

61) Education setting: ☐ Regular Class, ☐ Special Education, ☐ Other (Specify):_____

62) Has child been classified as special needs? ☐ Yes ☐ No

If yes specify classification(s): _____

_____

63) Child's appointed Surrogate Parent: Name:_____

64) Phone:_____ 65) Address:_____

City:_____ State:_____ Zip:_____

66) Name of Current/last school attended:_____

67) Phone:_____ 68) Address:_____

City:_____ State:_____ Zip:_____

69) School Transcript: Attached: ☐ Yes ☐ No Promised by date:_____

70) Latest Evaluation Information:

Achievement Evaluation (ex: Woodcock Johnsibm etc.)

Date: _____ Assessment/Test:_____

Results:_____

Psychological Evaluation (ex: WISC-III, etc,)

Date: _____ Assessment/Test:_____

Results:_____

71) Attendance record for school year:

Number of days in attendance:_____ Number of excused absences:_____

Number of unexcused absences (suspension, expulsion, truancy, etc):_____

Explain:_____

72) Academic strengths:_____

73) Academic weaknesses:_____

74) School behavioral strengths:_____

75) School behavioral weaknesses:_____

76) Recommended school information pertinent to this application:_____

_____

77) Recommended educational plan/program (IEP, etc.):_____

_____

78) Other special needs/talents, including extra-curricular activities and interests:_____

_____

_____

79) Additional school information pertinent to this application:_____

_____

IV. SOCIAL HISTORY / ASSESSMENT

The following information will help agency staff understand the child's and family's needs and how best to meet these needs. If a written social history is available, it may be substituted for Section IV (questions 80-90). Answer any of the questions below which are not addressed in the social history.

80) Tell what is going on in the family at this time. Describe the significant events which effect this family and child:_____

_____

_____

_____

_____

81) Give a brief description of this family's:

Strengths:_____

_____

Weaknesses:

82) Give a brief description of the child's:

Strengths:

Weaknesses:

83) What and/or who make this child:

Glad?

Sad ?

Mad?

Fight?

Run?

84) From what agencies/professionals has the family sought or been given help? Specify services and results:

85) What religious resources/support systems are available to this child and family? (Name/phone of contact person)

86) Why must this child now live away from his/her parents?

_____

_____

_____

87) Out-of-Home Placements:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

88) Is there history of delinquent behavior? ☐ Yes ☐ No If yes, attach description including history of core involvement and a copy of any court order currently in effect.

89) Is this child suicidal? ☐ Yes ☐ No If yes, attach history with description of attempts.

90) Identify the current needs of the child and family to which the agency is asked to respond:_____

_____

_____

_____

_____

V. PLANNING

This section requires equal attention to the family and the child in answering the questions. If the child is in DSS custody attach a current copy of the out-of-home family services agreement.

91) What is the permanent plan for this child?_____

_____

92) Is there a current need to revise the permanent plan? ☐ Yes ☐ No If yes, explain:_____

_____

_____

_____

93) State the goals toward which the family and child are working to achieve the permanent plan:_____

_____

_____

_____

_____

94) What specific services of the agency are being requested on behalf of this family and child:_____

_____

_____

_____

95) How will the requested services help the family and child achieve their permanent plant?_____

_____

_____

_____

96) Identify <u>in the order of your priority</u> all agencies to which this application is being made:

1:_____ 2._____

3:_____ 4._____

97) Give the name/role of other volunteers/professionals assigned to this child (Guardian ad Litem, Child Advocate, Court Counselor, etc.):_____

_____

_____

_____

VII. SIGNATURE(S)

I (we), the undersigned, hereby apply to the (Name of agency) for services named above on behalf of the named child for whom I (we) hold legal custody and/or placement authority. I (we) certify that the information contained in this application and the attachments is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information pertinent to this application as requested by the agency. I (we) also agree to cooperate with the agency and to support the plan of service to which we mutually agree.

_____ Date:_____
Print Name of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian

_____ Date:_____
Signature of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian

Voluntary Placement Agreement:

Name of Agency holding Voluntary Placement Agreement:_____

_____ Date:_____
Print Name of Representative of Agency holding Voluntary Placement Agreement

_____ Date:_____
Signature of Representative of Agency holding Voluntary Placement Agreement

CARS Agreement:

Name of Agency with whom CARS Agreement was signed:_____

_____ Date:_____
Print Name

_____ Date:_____
Signature

_____ Date:_____
Print Name of Representative of Agency with whom CARS Agreement was signed

_____ Date:_____
Signature of Representative of Agency with whom CARS Agreement was signed

Client Record # _____

Consent Forms:

_____ (Initial here once informed) **Restrictive Interventions**

I, give permission to the above-mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above-mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Suspension and Expulsion from Service**

I , understand the if I do not comply with the rules outlines by the agency and becomes a possible threat to others served within this agency he/she maybe possibly suspended or expulsed from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

_____ (Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of me/my child's living area may occur. I, also give permission to the agency to perform random planned or unplanned searches and seizures on me/my child's belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

_____ (Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance who assumed the role of the (GACPD) , the state wide agency designated under federal and state law to protect and advocate the rights of person with disabilities.

_____ (Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

_____ (Initial here once informed) **Agency Rules**

I understand the rules that I am/my child is expected to follow and possible penalties for violation of the rules.

_____ (Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

_____ (Initial here once informed) **Consent regarding Treatment**

I give permission to **Precious Haven, Inc.** to obtain a copy of my/my child's treatment / Habilitation plan and/or other information that relates to him/her in order for the agency to adequately serve.

_____ (Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assess by my/my child that Medicaid does not cover as it relates to the treatment of me/my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

Client Record # _____

_____ (Initial here once informed) **Grievance Procedures**

I understand that I/my child has the right disclose any grievances that he/she may have as it relates to the agency. I understand that **Precious Haven, Inc.** will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACPD)/or the Local Mental Health LME.

_____ (Initial here once informed) **Informed of Client Rights**

I understand and have been informed and received a copy of the Client Rights handbook. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and had been explained my Rights to Privacy. **Precious Haven, Inc.** gave me a copy of the Client Rights handbook and I understand these rights, which are designed to protect the privacy of me/ and/or my child.

_____ (Initial here once informed) **Social Integration**

I give **Precious Haven, Inc.** my permission to allow me/my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. I /my child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

_____ (Initial here once informed) **Emergency Medical Treatment**

I give **Precious Haven, Inc.** my permission to seek emergency care for me/my child from a hospital or physician. I also give **Precious Haven, Inc.** the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that **Precious Haven, Inc.** will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

_____ (Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy **Precious Haven, Inc.** Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Financial Release**

I have been informed and received a copy **Precious Haven, Inc.** may use confidential information about me to bill and be paid for services. I hereby consent **Precious Haven, Inc.** to release information to Value Options (the State of NC managed care vendor) and/or the referring Area Program.

_____ (Initial here once informed) **Transport**

I have been informed and received a copy **Precious Haven, Inc.** to provide transportation to my child, and agree to hold **Precious Haven, Inc.** harmless for any accident/injury that results from the provision of transportation.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client)

_____ _____
Signature of legally responsible person Date

Client Record # _____

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

Client Name: _____ Record Number: _____
Date of Birth: _____ Social Security #: _____

I, _____ authorize _____ to use or disclose to with ____
Precious Haven, Inc . _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to initial beside data to be used or disclosed)

____ Assessments ____ Service Notes ___ Substance Abuse/Treatment
____ Psychiatric Evaluations ____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis ____ Discharge Summary ___ Social History
____ Developmental History ____ Financial/Reimbursement ___ Medical History
____ PCP ____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual ____ Assessment/Evaluation
____ Coordination of Service ____ Court Proceedings ____ Determination of Benefits

Information requested should be mailed to this address:
_____

REDISCLOSURE:
Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Area Program/LME's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

_____
(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:
I understand that I may refuse to sign this authorization form. I understand that Precious Haven, Inc. will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client:
___ Power of Attorney ____ Guardian
___ Other: _____

_____
Staff Signature

Client Record # _____

Provider Choice Agreement

Consumer Name: _____

I have received information regarding services that I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of the services and providers.

I understand that by completing and signing this form, I choose, *Precious Haven, Inc.* as my services provider (service specified below):

____ Residential Treatment Level III

____ Therapeutic Foster Care Placement Level I and II

____ Diagnostic Assessment

____ Outpatient Treatment Services

_____ _____
Consumer Signature Date

_____ _____
Legally Responsible Person Signature Date

Client Record # _____

Face Sheet

_____

First Middle Last

Social Security # _____ Date of Birth: _____

Race: _____ Gender: _____

Marital Status: _____(s-single; m-married; d-divorced)

Admission date: _____ Discharge date: _____

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Screening and Assessment date: _____ (if available)

Treatment/Habilitation Plan date received: _____ (if available)

_____ _____
Client Signature: Date:

_____ _____

Client Record # _____

Legally Responsible Person Signature: Date:

Witnessed By: Date:

Emergency Contact Information:

Consumer Information:

First Name Middle Name Last Name

Address City State

Person to be Contacted:

Telephone Numbers (of person to be contacted in case of sudden illness)

Name of Person to be contacted

Address of Person to be contacted

Client's Preferred Physician Information:

Name of Physician

Address of Physician

Telephone Number of Physician

MH | DD | SAS

_____'S PERSON-CENTERED PROFILE

Name:	DOB: / /	Medicaid ID:	Record #:
(Non - CAP-MR/DD Plans ONLY) PCP Completed on: / /	(CAP-MR/DD Plans ONLY) Plan Meeting Date: / /		Effective Date: / /

WHAT PEOPLE LIKE AND ADMIRE ABOUT....
WHAT'S IMPORTANT TO....
HOW BEST TO SUPPORT....
ADD WHAT'S WORKING / WHAT'S NOT WORKING

Name: DOB: Medicaid ID: Record #:

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies that were effective. (List everything that can be done to help this person AVOID a crisis):

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.)

Specific recommendations for interacting with the person receiving a Crisis Service:

Client Record # _____

Admissions Assessment:

_____
First Middle Last

Social Security # _____

Date of Birth: _____ Race: _____ Gender: _____

Client's Presenting Problems: _____

Client's Needs: _____

Client's Strengths: _____

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Pertinent Social/Family/ Medical History: _____

Evaluations or Assessments (i.e. psychiatric, substance abuse, medical or vocational): _____

Strategies to address client's presenting problems: _____

_____ _____
Client Signature: Date:

_____ _____
Legally Responsible Person Signature: Date:

_____ _____
Witnessed By: Date

Mission Statement

Precious Haven's Mission is to help children become productive members of society.

We offer children the necessary time, structure, attention, and nurturing needed to encourage positive actions and interactions.

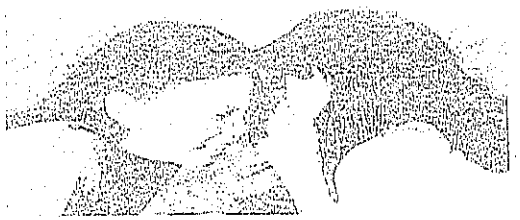
Program Components

Precious Haven's program components are designed for the redirection of inappropriate behavior and the improvement of academic performance. Offering children choices and rewards, and as well as holding them accountable via consequences for inappropriate behavior, help encourage independence, productiveness, and responsibility. A Board of Directors oversees our program.

Services Offered

Due to Behavioral and Emotional challenges often diagnosed in the children we serve, the members of our organization have designed the following therapeutic supports to assist children with these areas of need:

- Anger Management
- Behavior Modification
- Social Skills Enhancement
- Conflict Resolution
- Decision Making
- Alcohol & Substance Abuse Supports
- Individualized Tutorials
- Daily Behavioral Logs
  (Signed by Teachers as needed)



Precious Haven, Inc.

Dear Parent/Guardian,

Precious Haven, Inc. is a Residential Treatment Facility for high-risk children and adolescents. The children we serve are often behaviorally and/or emotionally challenged, and therefore demand consistent structure, time, and attention. Our program offers just that. We are dedicated to children, and the members of our organization work diligently to provide exemplary services to them.

Our organization consists of a Board of Directors, Administrator, Residential Technicians, Consultants, and Licensed Professionals—all of whom share a passion for children.

We consider our organization at the cutting edge of the Human Services field. As such, we have designed our program to offer numerous therapeutic supports to help children behaviorally, socially, and academically.

We are proud to say that education is a high priority, and we therefore place emphasis on a child's success in this field. We offer individualized tutorials, designed by our Educational Specialist, to assist the child in their academic performance.

We feel that no child is beyond help, and we therefore graciously look forward to serving your therapeutic needs.

Sincerely,

Precious Haven, Inc. Management

Membership of the Organizations

Board of Directors

Administrator

LCSW

QMHP

Associate Professionals

Para Professionals

Residential Technicians

Services Provided

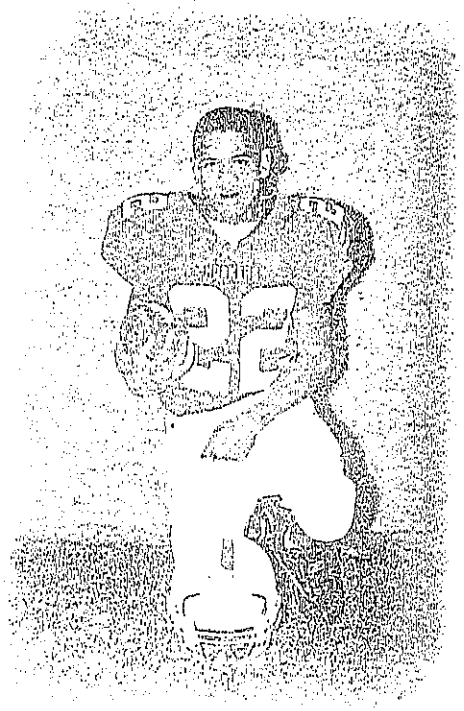
Residential Treatment

Child Placement Agency

Diagnostic Assessments

Our Commitment

Precious Haven, Inc. embraces diversity. Our commitment to children~regardless of race, color, or creed. The practice of discrimination of any form is not tolerated. Honor, dignity, respect, and courtesy are the driving forces of our agency. Family involvement ,welcomed, expected, and appreciated.



PH

Precious Haven Inc.

Embracing Diversity
Inspiring Positive Change

"Treating others as we would like to be Treated"

6302 Raeford Road
Fayetteville, NC 28304
Office (910) 868-6092
Fax (910) 868-8882
Melissa McAllister, Administrator
precioushaven@aol.com
www.precioushaven.com