Renewed Strength, Inc. General Residential Operation Residential Treatment
110 Hambrick Houston, Texas 77060

(REQUIRED INFORMATION FOR ADMISSION)

	Yes	No
Placement Authorization 2085		
Designation of Medical Consent Form		
Designation of Education Decision Maker 2085-E		
Physical Examination		
Dental Examination		
TB Skin Test		
School Portfolio (ARD, Transcript, GED)		
Placement Summary Form K- 908-2279		
Birth Certificate		
Medicaid		
Copy of Social Security		
Immunization Records		
Court Order		
YFT (Current)		
Psychological		
Covid-19 Questionaire		
Calling Card		
Medication (30 Day Supply or Refill Available) **Signature of Case Worker Required:** **X**		

IF YOUR CHILD HAS A CELL PHONE OR A IPOD THAT HAS A CAMERA ON IT PLEASE DO NOT BRING THIS WITH THEM. WE DO NOT ALLOW THESE ITEMS DUE TO HIPAA COMPLIANCE. THESE ITEMS ARE A BREACH OF PRIVACY TO THE OTHER RESIDENTS THAT ARE IN TREATMENT.

Revised June 29, 2020

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281-448-7550

ADMISSION ORIENTATION
INFORMED/CONSENT

I, ____, have been fully oriented to RENEWED STRENGTH program, and have read and understand the following information:

9. **The Client Bills of Right;**
10. **The Grievance Procedure;**
11. **The Program Rules;**
12. **Violations and behavior than can lead to disciplinary action or discharge;**
13. **Any behavior management procedures used to enforce program rules;**
14. **The program's philosophy and treatment objectives;**
15. **Opportunities for family and significant other involvement in the treatment program; and**
16. **Rules about visitation, telephone calls, mail, and gifts as applicable.**
17. **Rules about requesting/asking permission to enter any community areas to ensure appropriate supervision and safety of myself and other residents.**
18. **Childs Preferred De-escalation Process :**

____

____

____

____

Client Name

I understand and have received an explanation of and a copy of the Client Handbook containing the program rules, regulations, client rights, and grievance procedures, and after being fully informed of all of the above, voluntarily consent to treatment.

______________________________	______________
CLIENT	**DATE**
______________________________	______________
LEGAL/FAMILY CONSENTER	**DATE**
______________________________	______________
WITNESS	**DATE**

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RESTRAINT ORIENTATION

I ACKNOWLEDGE ON ___________________________ I RECEIVED
(Date)
RESTRAINT ORIENTATION AT THE TIME OF ADMISION. I WAS GIVEN

VERBAL INFORMATION ON:

9. **DEESCALATION PROCEDURES**
   Residents preferred "De-escalation Method" (must be completed by Resident):
   ____
   ____
   ____
   ____
   ____

   ____
   Resident Name

10. **RESTRAINT USE CRITERIA**
11. **TYPES OF RESTRAINTS AUTHORIZED**
12. **STAFF AUTHORIZED TO RESTRAIN**
13. **WHAT I MUST DO TO END A RESTRAINT**
14. **WHEN A USE OF A RESTRAINT MUST CEASE**
15. **HOW TO REPORT INAPPROPRIATE RESTRAINT**
16. **HOW TO PROVIDE VOLUNTARY COMMENTS ON A RESTRAINT.**

I FULLY ACKNOWLEDGE THAT I WAS GIVEN THIS INFORMATION AT THE TIME OF ADMISSION.

________________________________ __________________
Signature –Resident **Date**

________________________________ __________________
Signature of Staff Administering Orientation **Date**

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CLIENT BILL OF RIGHTS

It is the policy of **RENEWED STRENGTH** that all clients shall be afforded the following rights:

- You have the right to a humane environment that provided reasonable protection from harm and appropriate privacy for your personal needs.
- You have the right to be free from abuse, neglect and exploitation.
- You have the right to be treated with dignity and respect.
- You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
- You have the right to be told about the program's rules and regulations before you are admitted.
- You have the right to be told before admission.
  1. The condition to be treated;
  2. The proposed treatment;
  3. The risks, benefits, and side effects of all proposed treatment and medication;
  4. The probable health and mental consequences of refusing treatment; and,
  5. Other treatments that are available and which ones, if any, might be appropriate for you.
- You have the right to accept or refuse treatment after receiving this explanation.
- I you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
- You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
- You have the right to meet with staff to review and update the plan on a regular basis.
- You have the right to refuse to take part in research without affecting you regular care.

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CLIENT BILL OF RIGHTS

- You have the right not to receive unnecessary or excessive medication.

- You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others.

- You have the right to have information about you kept private and to be told about the times when information can be released without your permission.

- You have the right to communicate with peoples outside the facility. This includes the right to have visitors, to make telephone calls, and to send and receive sealed mail. This right may be restricted on an individual basis by your doctor or the person in charge of the program if it is necessary for your treatment or for the security, but even then you may contact an attorney or the Department at any reasonable time.

- You have the right to be told in advance of all estimated charges and any limitation on length of services that the facility is aware of.

- You have the right to receive an explanation of your treatment of your rights if you have questions while you are in treatment.

- If you consented to treatment, you have the right to leave the facility within four hours of requesting release unless a physician determines that you pose a threat of harm to yourself or others.

- You have the right to make a complaint and receive a fair response form the facility within a reasonable time.

- You have the right to complain directly to the TDFPS at any reasonable time.

- You have the right to get a copy of these rights before you are admitted including TDFPS's telephone number.

- You have the right to have your rights explained to you in simple terms, in a way you understand, within 24 hours of being admitted.

Client Signature	Date
Legal Consenter	Date
Staff Signature	Date

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CONSENT FOR MEDICAL TREATMENT TO INCLUDE PSYCHOLOGICAL AND PSYCHATRIC SERVICES

I, ______________________________, am the ______________________

of ______________________________, a minor, and have authority to consent to medical treatment for said minor. I hereby authorize the Executive Director of Renewed Strength, Inc. it agents, and employees under the direction to consent to any X-rays examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to said minor under the general or special supervision and on the advise physician or surgeon duly licensed under the law of the STATE OF TEXAS and to consent to an X-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care, to be rendered to said minor by a dentist duly licensed under the general or special supervision and the advise of a psychiatrist duly licensed under the law of the STATE OF TEXAS.

I also authorize the Executive Director of Renewed Strength, Inc., it's agents and employ to administer medication to the above named minor as directed and as prescribed by a duly licensed physician or surgeon.

This authorization shall remain in effect so long as the named minor is in the physical custody, care, and control of the Executive Director of RENEWED STRENGTH, its agent and employees.

___________ Date   ______________________________ Parent, Guardian, Managing Conservator

___________ Date   ______________________________ Signature of Renewed Strength Administrator

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CALLING CARD

CLIENT'S NAME____

CASEWORKER:____________________ **NUMBER:**_____________

EMAIL ADDRESS:______________________________________

SUPERVISIOR:____________________ **NUMBER :**_____________

EMAIL ADDRESS:______________________________________

NO CONTACT WITH (*Name's Only*):

CONTACTS		CALLS		VISITS		
NAME	RELATIONSHIP	TO	FROM	ON	OFF	PHONE #
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

____

CASEWORKER'S SIGNATURE

Revised June 29, 2020

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COVID -19 Questionnaire

Date:_______________

Resident Name: ________________________________ DOB: ____________________

Section 1	
Temperature > 100. :____________	_________ No _______Yes

Section 2 Do you have the following symptoms :		
Recent/ New Onset Coughing (not related to allergy or COPD)	NO	YES
Nasal Congestion (not related to allergies or sinus infection	NO	YES
Recent Onset Sore Throat	NO	YES
Recent/ New Onset Diarrhea	NO	YES
Recent / New onset Shortness of Breath (not related to chronic disease)	NO	YES

Section 3 COVID- 19 Exposure :		
Are you living with someone that is quarantined or furloughed?	NO	YES
Have you been in contact with an individual positive for COVID - 19?	NO	YES

To Be Filled Out By Renewed Strength Personnel at Intake:	
*Temperature:*____________________	*Staff Completing Intake Initial's:*________

Revised June 29, 2020