Renewed Strength Inc- DSHS

(REQUIRED INFORMATION FOR ADMISSION)

	Yes	No
Placement Authorization		
Consent for Medical Treatment		
Physical Examination		
Dental Examination		
TB Skin Test		
School Portfolio (ARD, Transcript, Withdrawal)		
Birth Certificate		
Medicaid		
Copy of Social Security		
Immunization Records		
Psychological		
Common Application		
Calling Card		
Covid-19 Questionaire		
Medication (30day supply or refills available) Signature of LAR/ Parent 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.

Renewed Strength, Inc.-East General Residential Operation Residential Treatment Center

2814 Aldine Bender Road
Houston, Texas 77032
281-442-4900

Contract No._____ **Date:** _____

COVER SHEET

PLACEMENT AGREEMENT

CORPORATION: Renewed Strength Residential Treatment Center
2814 Aldine Bender Road
Houston, Texas, 77032
Telephone: (281) 442-4900

CLIENT:
Name: _____
Parent or
Legal Guardian _____
Address: _____

TERMS OF AGREEMENT:
Compensation: **Level of Service:** _____
Clothing Allowance _____**Dollar**
Duration of Placement **From** _____**To**_____

Managing Conservator:
County: _____
Address: _____
Telephone: _____
Contact Person: _____

PROGRAM ADMINISTRATOR:
Name: _____

EMERGENCY NUMBER (S): _____

IN WITNESS THEREOF, under seal, the parties to the attached Agreement have duly executed this Agreement as of the date herein above written.

_____ _____
Signature of Probation Officer Date

_____ _____
Signature of Parent/Managing Conservator Signature of RENEWED STRENGTH Staff

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PLACEMENT AUTHORIZATION

The _____**(Name of Agency)**, of
_____ **(County)** conservator of:
_____ **(Child's Name)**
_____ **(Date of Birth)**
_____ **(Case or Court Number)** hereby authorizes Renewed Strength Inc to:

1. **School Enrollment** – To enroll this child in public school and to sign any necessary enrollment forms.

2. **Travel** - To provide transportation for this child for therapeutic and recreational activities. Approval for trips overnight or out of the county will require prior approval from the Agency.

3. **Payment** – To receive reimbursement of $_____ per day for Level of Care _____ services for _____ months.

4. **Medical Care** – To seek treatment for this child if currently covered by Medicaid from private physicians, hospitals, and dentists who are Medicaid providers.

5. **Clothing** – Appropriate clothing will be provided by the agency placing the child or family per agency guidelines.

_____ _____
Signature - Placing Agency **Date**

_____
Telephone Number

_____ _____
Signature – Renewed Strength **Date**

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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.

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