**OPTIMUM YOUTH SERVICES**

**ADMISSION APPLICATION**

(must be completed in its entirety, including attachments

**Email Referral To:** [**hello@optimumyouths.com**](mailto:hello@optimumyouths.com)

PLEASE SPECIFY:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| THERAPUETIC  GROUP HOME | RESTORE MENTORING REFERRAL | ADDITIONAL DAILY SUPERVISION |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| CLIENT NAME | DOB | SOC SEC NO |
|  |  |  |
| RACE | SEX | IMMIGRATION STATUS |
|  |  |  |
| GUARDIAN/RELATIONSHIP | WORK PHONE | FAX |
|  |  |  |
| GUARDIAN ADDRESS | E-MAIL |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FUNDING SOURCE *(CSA Locality)* | | |  | | |
| CSA COORDINATOR CONTACT INFO | | |  | | |
| REFERRING WORKER NAME | | |  | | |
| REFERRING WORKER PHONE NUMBER | | |  | | |
| REFERRING WORKER FAX NUMBER | | |  | | |
| REFERRING WORKER ADDRESS | | |  | | |
| AFTER HOURS LOCALITY NUMBER | | |  | | |
| VA MEDICAID RECIPIENT  MEDICAID NUMBER | | | YES NO | | |
| OTHER INSURANCE | | |  | | |
| PLACE OF BIRTH | | |  | | |
| CURRENT PLACEMENT | | |  | | |
| CONTACT PERSON TO SCHEDULE | | |  | | |
| DATE OF INTERVIEW | | |  | | |
|  | | |  | | |
| ADMIT DATE: |  | | DATE PLACEMENT IS NEEDED: | |  |
| **ADMISSION APPLICATION**  REASON CURRENT PLACEMENT IS ENDING *(please be specific)* | | |  | | |
| CURRENT PLACEMENT CONTACT INFO | | |  | | |
| PERMANENCY GOAL | | |  | | |
|  | | |  | | |
| **DSM 5 DIAGNOSIS** | | |  | | |
|  | | |  | | |
|  | | |  | | |
| **CURRENT MEDICATION: None currently but needs a medication management consult** | |  | |  | |
|  | |  | |  | |
| MEDICATION NAME | | DOSAGE | | INSTRUCTIONS | |
|  | |  | |  | |
| MEDICATION NAME | | DOSAGE | | INSTRUCTIONS | |
|  | |  | |  | |
| MEDICATION NAME | | DOSAGE | | INSTRUCTIONS | |
|  | |  | |  | |
| MEDICATION NAME | | DOSAGE | | INSTRUCTIONS | |

|  |  |
| --- | --- |
| MEDICATION ALLERGIES |  |
| ENVIRONMENTAL ALLERGIES |  |
| SIGNIFICANT MEDICAL CONDITION |  |
| SUBSTANCE ABUSE HX | YES NO |
| SUBSTANCES USED |  |
| SEXUAL OFFENDER | YES NO |
| HAS COMPLETED SO TREATMENT | YES NO |
| CURRENT/PENDING CRIMINAL HISTORY  CURRENTLY ON PROBATION | YES NO |
| PO CONTACT INFO |  |

**ADMISSION APPLICATION**

CURRENT EDUCATIONAL PLACEMENT:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| SCHOOL NAME | ADDRESS | | PHONE |
| DATES OF ATTENDANCE | |  | |
| GRADE | |  | |
| FULL SCALE IQ | |  | |
| IEP  IEP TYPE | | YES NO  OHI  AUTISM  ED  ID  SLD  OTHER | |
| TYPE OF SCHOOLING NEEDED | | PUBLIC  ALTERNATIVE  GED  PRIVATE DAY | |
| LAST PUBLIC SCHOOL ATTENDED  HOME SCHOOL DIVISION NOTIFED | | YES NO | |

**REQUIRED ATTACHMENTS**

|  |  |
| --- | --- |
|  | **FAPT and Current Treatment Plans** |
|  | **Social History** |
|  | **Psychological Evaluation** |
|  | **Medicaid/Insurance Card** |
|  | **Birth Certificate** |
|  | **Social Security Card** |
|  | **School Transcripts** |
|  | **Current IEP**  NA |
|  | **Immunization Record** |
|  | **Physical Exam Date:** |
|  | **Sex Offenders: Psychosexual, or Risk Assessment**  NA |
|  | **Therapist recommendation if stepping down from higher level of care**  NA |
|  | **Certificate of Need** *needed by DOA* |
|  | **CANS** *needed by DOA* |
|  | **School Discipline Records**  NA |

**ADMISSION APPLICATION**

**PERSONALITY INFORMATION:**

Circle any of the following words which best describe the child:

hyper-active ambitious self-confident persistent nervous hardworking,

impatient impulsive moody excitable good imaginative,

often - blue, calm, serious, shy sensitive easy going

good natured introvert extrovert likable leader quiet

submissive lonely self-conscious active

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the child:

SOCIAL AND DEVELOPMENTAL HISTORY:

HISTORY OF AWOL FREQUENCY**:**

HISTORY OF PREVIOUS TREATMENT FOR MENTAL HEALTH AND INTELLECTURAL DISABILIY, SUBSTANCE ABUSE, AND BEHAVIOR PROBLEMS.**:**

CURRENT BEHAVIORS and/or BEHAVIORAL DISORDERS

CURRENT THERAPY (include the name of any counselor and frequency of visits):

RECURRING BEHAVIORAL PROBLEMS NOTED

DESCRIBE PROTECTION NEEDS**:**

FAMILY INVOLVEMENT:

DESCRIBE YOUTH AND FAMILY’S SPIRITUAL ORIENTATION AND PARTICIPATION:

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**ADMISSION APPLICATION**

**Residential Services Admissions Application**

**Six-Month Medication Profile**

|  |  |
| --- | --- |
|  |  |
| APPLICANT NAME | DATE OF COMPLETION OF FORM |
|  |  |
|  |  |

1. MEDICATION AND ILLICIT DRUGS TAKEN IN THE PAST SIX MONTHS:

(Prescription and nonprescription)

2. HISTORY OF ADVERSE REACTIONS:

3. INEFFECTIVE PHARMACOLOGY RECEIVED:

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**ADMISSION APPLICATION**

**RESIDENT & FAMILY FUNCTIONING DATA SHEET**

Describe resident’s and family’s current behavioral functioning (at home, school, with adults or peers, or individual’s personal issues):

**Strengths/Talents Weaknesses**

Resident Resident

Interests:

Check all that can be identified as current family or resident’s problems:

Family Resident

Physical abuse Substance/alcohol use/abuse

Sexual abuse (including suspected) School truancy, behavior problem

Emotional Academic performance

Domestic violence Runaway

Parenting Anger/aggression

Custody issues Independent living skills

Substance/alcohol use/abuse Social Skills

Neglect, non-nurturing, uninvolved Oppositional/defiant

Other      Personal Hygiene

Is there a history of suicide attempts/gestures/ideations? Yes No If yes, explain:

Is there a history of violent/assaultive behavior? Yes No If yes, explain:

Is there a history of fire setting? Yes No If yes, explain:

**SUBSTANCE USE HISTORY:**

Does resident have history of alcohol or drug use? Yes No If yes, explain:

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**ADMISSION APPLICATION**

# **NUTRITIONAL & PHYSICAL FUNCTIONING SCREENING**

Resident's Name:

Recent weight changes:

Reasons for weight changes:

Current Eating Habits:

Past eating habits (if significant):

Eating Preferences (likes and dislikes):

PERSON SUBMITTING APPLICATION:

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| SIGNATURE | PRINTED NAME |
|  | PHONE: |
| DATE OF APPLICATION | FAX: |
|  | EMAIL: |

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**GABRIELLE’S HOUSE**

**CONTACT LIST**

**Physicians: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # w/extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # w/extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # w/extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # w/extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caseworker Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # w/extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Law Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CASA Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**GABRIELLE’S HOUSE**

**AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION**

Name:       DOB:      SS#:\_

Expiration Date:

**To Whom It May Concern:**

I,      , herby give my consent for Gabrielle’s House to ( ) release and/or ( ) obtain information and /or ( ) from:

Name:       Agency:

Address:       City/State:

This information is being released/obtained for the purpose

**INFORMATION REQUESTED**

Admission Note Educational Information

Psychiatric Evaluation Individualized Education Plan

Birth Certificate  Social History

Psychological Evaluation  Discharge Summaries

Physical Written Verbal Correspondence

Immunization Record  Counseling Notes and Assessments

Treatment Plan/Summary  IACCT

Insurance Card ( ) Diagnosis

Other

I was informed of the information requested/released and the benefits of its release. Notification can be revoked.

Signature of Parent or LAR:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Gabrielle’s House Media Records Release Form**

As part of our home we will make photographic, audio, and/or video recordings of you while

you are a resident. We are asking your permission to share those photographs/recording in the ways described below. **They will be used in a manner respecting dignity and confidentiality**. Please indicate below by initialing what uses of these records you consent to. This is completely up to you. We will only use the records in the way(s) that you agree to. In any use of these records, your name will not be included.

1. The photographs/recordings can be included in publications and presentations about Gabrielle’s House that are seen by the general public.

Photo \_\_\_\_\_\_\_\_\_\_ Audio \_\_\_\_\_\_\_\_\_\_ Video \_\_\_\_\_\_\_\_\_\_

initials initials initials

2. The photographs/recordings can be stored indefinitely in an archives that will be available, included in publications and presentations about Gabrielle’s House that are seen by the general public.

.

Photo \_\_\_\_\_\_\_\_\_\_ Audio \_\_\_\_\_\_\_\_\_\_ Video \_\_\_\_\_\_\_\_\_\_

initials initials initials

3. The photographs/recordings can be shown in home to residents and staff.

Photo \_\_\_\_\_\_\_\_\_\_ Audio \_\_\_\_\_\_\_\_\_\_ Video \_\_\_\_\_\_\_\_\_\_

initials initials initials

4. Date the resident was notified of when the photographs/recordings will take place\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Date the LAR was notified of when the photographs/recordings will take place\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read this form and give my consent for use of the records as indicated above.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Gabrielle’s House**

## CONSENT FOR MEDICAL TREATMENT

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

I/We      (Parent/Guardian), give Gabrielle’s House and its representatives, permission to meet the medical, dental and vision needs of (child’s name)

## . Additionally, I/We consent to the following (check all that apply):

 The use of local anesthesia as needed for dental procedures (i.e. fillings, root canal, wisdom teeth removal, etc.)

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

Parent/Guardian Signature Date

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

Gabrielle’s House Representative Date

|  |
| --- |
|  |
|  |  |

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**Gabrielle’s House**

**Consent to Treatment**

I acknowledge that I have reviewed, discussed and understand the information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

My signature below shows that I understand and agree with all of the above statements.

Signature of resident Date

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

Printed name

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

Signature of resident’s Legal Guardian Date

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

Printed name

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

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

Signature of therapist Date

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**GABRIELLE’S HOUSE**

Approved Visitor/Communication List

Resident:

Family Members, Adult Siblings for phone contact.

List others whom may have phone contact or visitation and indicate if the individual is approved to **visit (V), or have telephone contact** **(P) by placing a check mark in the spaces provided**.

**APPROVED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| V | P | Name | Relationship | Phone Number | Address |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
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List any Court ordered restrictions on communication / visitation with Parents, Adult Siblings or Adult Extended Family Members? (Attach copy of court order)

List others whom may not have phone contact or visitation and indicate the individual is not approved to visit (V), or have telephone contact (P) by placing a check mark in the spaces provided.

**RESTRICTED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| V | P | Name | Relationship | Phone Number | Address |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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Parent/Guardian Date

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**GABRIELLE’S HOUSE**

This form shall be given, read, and explained (whichever is necessary) to each child, and his/her social worker, parents and anyone else as prescribed by law. The recipient shall sign the form declaring receipt and understanding.

# **RIGHTS OF RESIDENTS**

Each person who receives services from Gabrielle’s House shall be assured of her legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of Gabrielle’s House and is consistent with sound therapeutic treatment. Each person admitted to Gabrielle’s House shall:

* 1. Retain his/her legal rights as provided by state and federal law;
  2. Receive prompt evaluation and treatment or training about which he/she is informed in so far as he/she is capable of understanding;
  3. Be treated with dignity as a human being and be free from abuse;
  4. Not be the subject of experimental or investigational research without his/her prior written and informed consent or that of his/her legally authorized representative;
  5. Be afforded an opportunity to have access to consultation with a private physician at his/her own expense, and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his/her health;
  6. Be treated under the least restrictive conditions consistent with his/her condition and not be subjected to unnecessary physical restraint and isolation;
  7. Use his/her preferred name;
  8. Have access to his/her medical and mental records and be assured of the confidentiality but, notwithstanding other provision of law, such right shall be limited to access consistent with his/her condition and sound therapeutic treatment;
  9. Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel.
  10. To be accorded safe, healthful, and comfortable accommodations, furnishings and equipment to meet his/her needs;
  11. To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with the daily living functions, including eating, sleeping, or toileting, or withholding of shelter, clothing, medication or aids to physical functioning.
  12. To be informed and to have the authorized representative informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the licensing agency’s complaint receiving unit, and of information regarding confidentiality;
  13. To be free to attend religious services or activities of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis;
  14. Not to be put in any room, building, or facility premises by day or night where he/she cannot readily open the door;
  15. Not to be placed in restraining devices;

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Resident Concerns

Name: Date:

Please answer the following questions as completely as possible. You can discuss any areas of concern more fully with your therapist. It is your choice whether to answer any questions, but you are encouraged to respond to most of the items in order to provide your therapist with maximum information.

1. What problem brings you to Gabrielle’s House? When did it begin? How long has it lasted?
2. What other concerns about yourself do you have?
3. What steps have you taken to try to solve these problems?
4. What do you hope to accomplish through your contact with OYS Gabrielle’s House?

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**HIPAA NOTICE OF PRIVACY PRACTICES**

**I. 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.**

**II. It is my legal duty to safeguard your protected health information (PHI).**

By law we are required to ensure that your PHI is kept private. The PHI constitutes information created or approved by Optimum Youth Services LLC (Gabrielle’s House) that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this notice about privacy procedures. This notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this notice.

Please note that we reserve the right to change the terms of this notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this notice and post a new copy of it the Programs. You may also request a copy of this notice from us, or you can view a copy of it in our Programs.

**III. How we will use and disclose your PHI.**

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

**A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent**

We may use and disclose your PHI without your consent for the following reasons:

**1. For treatment:** We can use your PHI within our Programs to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, we may disclose your PHI in order to coordinate your care.

**2. For health care operations:** We may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control—we might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services.

**3. To obtain payment for treatment:** We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you.

**4. Other disclosures:** Examples:Your consent isn’t required if you need emergency treatment provided that we follow previously discussed procedures for emergency treatment.

**B. Certain Other Uses and Disclosures Do Not Require Your Consent**

We may use and/or disclose your PHI without your consent or authorization for the following reasons:

**1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement** Example: We may make a disclosure to the appropriate officials when a law requires us to report information to government agencies, law enforcement personnel.

**2. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

**3. To avoid harm.** We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).

**4. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.**

**5. If disclosure is mandated by the Virginia and Neglect Reporting law.** For example, if we have a reasonable suspicion of youth abuse or neglect.

**6. If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

**7. For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.

**8. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of HHS to investigate or assess my compliance with HIPAA regulations.

**9. If disclosure is otherwise specifically required by law.**

**V. Effective date of this notice**

This notice is in effect as of May 2020

**Acknowledgement of Receipt of Notice of Privacy Practices**

*You may refuse to sign this acknowledgement*

I,      , have received a copy of this agency’s Notice of Privacy Practices.

Please print name:

Legal Guardian Signature

**A close up of a logo

Description automatically generated OPTIMUM YOUTH SERVICES**

**Gabrielle’s House**

**FACE SHEET FOR RESIDENT’S RECORD**

Full Name:      Date of Admission:

Last known residence:       Birth date:

Birthplace:

Gender:  M  F

Race

White (includes Arabian)

Black (includes Jamaican, Bahamians and other Caribbean’s of African but not Hispanic or Arabian descent)

Hispanic (includes persons of Mexican, Puerto Rican, Central or South American or other Spanish origin)

Asian & Asian American (includes Pakistanis, Indians & Pacific Islanders)

American Indians (includes Alaskans)

Social Security No.: OR Unique Identifier:       Anticipated discharge date:

Religious preference of child/family

Legal Guardians (if appropriate)

|  |  |  |
| --- | --- | --- |
| Name | Address | Phone Number |
|  |  |  |
|  |  |  |

Placing Agency Contact

|  |  |  |
| --- | --- | --- |
| Name | Address | Phone Number |
|  |  |  |

Parents (if appropriate)

|  |  |  |
| --- | --- | --- |
| Name | Address | Phone Number |
|  |  |  |
|  |  |  |

Emergency Contact

|  |  |  |
| --- | --- | --- |
| Name | Address | Phone Number |
|  |  |  |

**Discharge Information:**

Reason for Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of person(s) to whom the resident was discharged

|  |  |
| --- | --- |
| Name | Phone Number |
|  |  |

Forwarding address, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transfer Information**: (for residents transferred to facilities operated by the same sponsor)

FOR EACH LOCATION:

|  |  |  |
| --- | --- | --- |
| Address | Dates of placement | Date of transfer |
|  |  |  |
|  |  |  |
|  |  |  |