FOUNDATIONS FOR LIVING
a treatment center for youth

1451 Lucas Road, Mansfield, Ohio 44903
Phone 419-589-5511 Fax 419-589-7599

ADMISSION APPLICATION

Thank you for considering Foundations For Living. Foundations For Living provides treatment for females and males, ages 11-17, who experience a variety of emotional, mental, and behavioral disturbances. Please read through and complete all the information in this packet to make a referral to Foundations For Living. We will do everything possible to assist you in assessing needed services.

Date of Application: _____

Child's Name: _____ Age: _____

(please check one) ☐ Residential Program **or** ☐ Short-Term Assessment Program

PROGRAM MISSION:

The mission of Foundations For Living (FFL) is to provide an environment of safety where youth feel empowered to heal the wounds of the past and build a foundation of hope for the future.

ADMISSION POLICY:

It is the policy of Foundations For Living to carefully review all written material submitted for admission consideration of all potential residents. The material is reviewed by the Intake Coordinator and CEO, as needed, for appropriate placement. Foundations For Living is committed to accepting referrals on a non-discriminatory basis of race, color, religion, gender, sexual orientation, national origin, age, physical disability, and mental disability. Individualized treatment planning enables admission acceptance of a wide range residents. In the event Foundations For Living is unable to accommodate an admission referral indicative of severe mental or physical disability (i.e. extremely fragile medical condition or extremely low IQ), referrals are made to appropriate treatment settings as part of the Universal Health Services National Referral Network, KidLink, with the permission of the referring agency.

INDICATORS OF THE NEED FOR RESIDENTIAL TREATMENT AND/OR REHABILITATION:

The following list denotes potential indicators of the need for residential care. The list is not meant to be exhaustive, nor should any one indicator by itself necessarily justify the need for this level of care. A decision needs to be made by a Multidisciplinary Treatment Team with a thorough assessment of the youth's strengths, dysfunction, and available resources.

- Behavior that constitutes a danger to self and/or others (but does not meet the criteria for acute care) of which the family, foster home, and/or community cannot effectively manage.
- Chronic behavior problems such as aggression, running away, or truancy.
- Chronic substance abuse that cannot be controlled through outpatient treatment.
- Diagnosed mental illness that requires consistent, on-going treatment in a secure environment.
- Need for a step-down from psychiatric hospitalization, detention, or other more restrictive environment, before transitioning to independent living, foster care, or reunification with family members.

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The following documents must be received prior to youth's consideration into a program. If unable to secure, please immediately contact the Intake Coordinator to discuss other possible options. If not received and the youth enters the Short-Term Assessment Program, the length of stay may be lengthened.

- ☐ Most current Psychiatric Evaluation
- ☐ Personality and/or Psychological Assessments
- ☐ Treatment History in the past twelve months
- ☐ Accurate and current list of all medications prescribed
- ☐ Substance Use History
- ☐ Medical History
- ☐ Recent Physical Examinations
- ☐ Family Case Plan
- ☐ Detailed Social History
- ☐ Legal History
- ☐ Official/Legal Custody documents (court custody order)
- ☐ Educational Information to include: IEPs, MFEs, ETRs, report cards and/or transcripts, and a court order identifying the school district responsible for payment

The following copied documents are needed no later than the day of admission:

- ☐ Immunization Records
- ☐ Birth Certificate
- ☐ ICCA
- ☐ Social Security Card
- ☐ Medicaid Card
- ☐ Private health insurance care (copy of front and back)

REFERRING AGENCY INFORMATION: ***(PLEASE PRINT)***

Caseworker Name/P.O.: _____ Job Title: _____

Referring Agency: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Ext: _____ Cell Number: _____

Email Address: _____ Fax Number: _____

Reason for referral: _____

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Please list all contacts and fax numbers for Incident Reporting:

YOUTH'S PERSONAL INFORMATION: ***(PLEASE PRINT)***

Name: _____ Social Security Number: _____

Date of Birth: _____ Place of Birth: _____ U.S. Citizen: YES or NO

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Race/Ethnicity: _____ Religious Preference: _____

Distinguishing Marks, Scars, Tattoos or Piercings (including ears): _____

_____

Primary Address: _____ City/State/Zip: _____

Lived with whom: _____ Contact number: _____

Current Grade Level: _____ Full Scale IQ: _____ AWOL risk? YES or NO

INDIVIDUAL RESPONSIBLE FOR MEDICAL AUTHORIZATIONS: ***(PLEASE PRINT)***

Name: _____ Relation to Youth: _____

Contact Number: _____

Agency Financially Responsible: _____ Name of Contact: _____

Contact Number: _____ Email: _____

LEGAL GUARDIAN/ GUARANTOR ***(PLEASE PRINT)***

Legal Guardian Name : _____ Relation to Youth: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Cell Number: _____

Guarantor Name: _____ Relation to Youth _____

Address: _____ City/State/Zip _____

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Program Name (if applicable): _____ SACWIS No. _____

EMERGENCY CONTACT INFORMATION: ***(PLEASE PRINT)***

Emergency Contact Person: _____ Relation to Youth: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Cell Number: _____

MEDICAL INFORMATION: ***(PLEASE PRINT)***

Has Medicaid/IV-E Medicaid been established? YES or NO Medicaid #: _____

Is youth enrolled in a Health Home program? Yes or No

Allergies (including food, meds, animals, environmental): _____

Does the child have any other illness/physical ailment/disability not previously noted? _____

_____

COURT INFORMATION: ***(PLEASE PRINT)***

Current legal status: *(please check one)* ☐ None ☐ Probation ☐ Detention ☐ Awaiting Charge

☐ AoD Related ☐ Court Ordered to Treatment

History of legal charges: YES or NO If yes, check one: ☐ Status Offense ☐ Delinquency

Upcoming Court Date/Time: _____ Charge: _____

Juvenile Court involvement (related to child abuse/neglect/dependency): ☐ Current ☐ Past

Name & Contact Number of Probation officer (if applicable): _____

Name& Contact Number of GAL and/or CASA (if applicable): _____

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EDUCATIONAL INFORMATION: ***(PLEASE PRINT)***

Last School Attended: _____ Current Grade Level: _____

Does child have an IEP? Yes or No

School District responsible for tuition _____

ADDITIONAL INFORMATION: ***(PLEASE PRINT)***

What are the goals for this child while in treatment? _____

_____

What is the step-down plan for this child (if known at this time)? _____

_____

Is the child aware that he/she is coming to Foundations For Living? YES or NO

What is your county's clothing requirement? _____

Does the child need to return with a certain amount of clothing? _____

How do we handle outgrown/out-of-season clothing? _____

If not stated in master contract, does the county provide clothing vouchers for the child when needed? YES or NO

***Foundations For Living works to ensure the safety and well-being of all residents. Likewise, we need to have an understanding of the child's current environment. **Does the child currently have access to weapons, lethal medications, and/or other means of self-harm in the home? If yes, please describe:** _____

_____

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Residential Treatment Placement Agreement

This agreement is entered into by and between Foundations For Living (FFL) and _____ (Placing Agent), for the benefit of _____ (Resident Name). This agreement commences on _____ (the resident's date of admission) and terminates on the resident's date of discharge.

The following are the terms of the agreement:

1. The "Placing Agent" agrees to compensate Foundations For Living for services rendered. Per Diem begins on the resident's admit date and no per diem will be charged for the discharge date. The applicable charges area as follows:
   $_____per diem, Master Contract Rate or special Individual Child Care Agreement rate will be charged while placed in Foundations For Living. FFL is a Title IV-E eligible facility. Payment is due within thirty (30) days of receipt of the invoice.
   $_____per diem, in addition to the contract per diem for the 45 day assessment program.
2. If the resident leaves FFL for home visit, AWOL, juvenile detention, etc., the "Placing Agent" agrees to continue to pay the per diem outlined in paragraph 1 above based on the Mater Contact agreement under the "hold bed' policy. Hold bed days beyond the Master Contract agreement days must be mutually agreed upon, in writing. Unless otherwise agreed to by FFL and "Placing Agent", neither FFL nor the "Placing Agent" shall be obligated to hold or pay for bed space beyond the contracted "hold bed" policy.
3. FFL agrees to notify "Placing Agent" in writing and verbally, of any changes in its per diem rate. Notification shall be given at least thirty (30) days prior to the change.
4. FFL agreed to notify "Placing Agent" in writing and verbally, of any security deposit required, if any, and any specific monthly charges. Notifications shall be given at least thirty (30) days prior.
5. FFL agrees to notify "Placing Agent" in writing and verbally of any provisions concerning refunds of resident's monthly charges, if any. Notifications shall be given at least thirty (30) days prior.
6. In addition to the FFL regular per diem, "Placing Agent" shall assume financial responsibility for the following:
   a. The resident's school tuition fees and testing (often paid for by the school district from which the resident resides.)
   b. An initial clothing allowance to purchase any required items of clothing not listened on the FFL clothing inventory at the time of the resident's arrival. This allowance must be received within ten (10) days of admittance to FFL.
   c. Medical, dental, vision, hospital/clinical care (including MACSIS billing expenses), psychological counseling and prescriptions not covered by Medicaid and/or the resident's personal insurance; also the "Placing Agent" shall be responsible for all charges if the resident does not have an active Medicaid card or the card is pending over one month (30 days) after admittance.

d. Any cost (i.e. shipping, packaging, mileage etc.) associated with returning the resident's personal property that was either not taken away from FFL within five (5) business days following the date of discharge.
e. Any costs for uniforms or required special supplies associated with the resident's schooling, employment, or volunteer series. FFL shall be notified the "Placing Agent" of the costs of each applicable item references above. The "Placing Agent" shall then either advance (to FFL) the necessary funds for such purchases, or reimburse FFL upon receipt of their next monthly invoice.

7. FFL and the "Placing Agent" agree to fully cooperate in developing a treatment plan for the resident. The treatment plan shall outline treatment goals, special needs and services, anticipated length of stay, anticipated post plan placement planes and mean of evaluating and reporting the resident's progress and readiness for each stage of development in the treatment plan. FFL and the "Placing Agent" agree to review and monitor the resident's progress, together on a regular basis.
8. The resident shall be responsible for the cleaning of her own room, his/her personal laundry and maintaining an acceptable housekeeping standard in his/her room.
9. FFL will maintain control of the heating and cooling of the residents' room.
10. The resident shall be afforded visitors as approved by the treatment team (i.e., therapists, case worker and/or guardian), with the final decision being made by the resident's guardian. The resident shall be permitted to make phone calls as approved by the treatment team (i.e., therapist, case manager, and/or guardian), with the final decision being made by residents' guardian. The residents shall to send or receive mail subject to the facility's rules regarding contraband and directives from the legal custodian, when such rules and directives do not conflict with Federal Postal Regulations.
11. Residents shall be assisted in their activities of daily living such as personal hygiene, appropriate clothing, social skills and others.
12. At the time of all scheduled discharges, those residents on medications will be provided with any remaining medication and a prescription for thirty (30) days worth of medication. Those residents who are removed from placement against the recommendation of the treatment team, may take their existing supply of medication, but will not be provided with a prescription.
13. All information requests on the application must be received for the 45 day assessment program residents or it will result in a longer stay.
14. If the child wants to earn ½ credits in school, this may result in a longer stay due to the placement date may not coincide with the academic schedule.

Foundations For Living herby affirms its commitment and dedication to adolescent treatment series and specifically _____(resident's name).

_____ _____

FFL CEO/Managing Director Date

_____ _____

Authorized Signature of Placing Agent Date

FFL CONTACT APPROVAL FORM

***Please list all contacts, including minors

Resident Name ______________________________

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Name ______________________
Relationship ______________________
Telephone ______________________
Phone Calls ☐ Yes ☐ No
Visitation ☐ Yes ☐ No

Approved by:______________________ Date:______________________

Revised 8/27/14 DM

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Consent For Treatment

Resident Name: _____ Date of Birth: _____

In accordance with the provisions of the Revised Code of Ohio, consent is hereby given for such necessary care and treatment that may be necessary in promoting the recovery of said resident.

It is specifically understood and agreed that by being admitted to this residential facility:

1. That I authorize the staff of Foundations For Living to utilize any or all those procedures and treatments customarily employed in residential facilities in the treatment of behavior disorders. Customary care may include psychological method such as counseling and psychotherapy, the use of psychiatric and other medication, evaluation and aftercare.
2. That I also authorize the staff to utilize any or all of those procedures and treatments employed in hospitals in the treatment of minor physical disorders. Minor child will be transferred to an appropriate facility if he/she requires different care or treatment than that afforded by Foundations For Living.

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date

*Physicians and some Clinicians providing care in the facility are generally NOT employees of Foundations For Living but are independent contractors or employees of other institutions. For information regarding physicians employed by this facility please contact the CEO.

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Confidentiality

Individuals' records are protected by Federal rule 42C.F.R Part 2, that reads "This information has been disclosed to you from records protected by the Federal Confidentiality Rules. The Federal Rules prohibit you from making further disclosure of this information unless farther disclosed is expressly permitted by the written consent of the person to whit it pertains or as otherwise permitted by 42C.F.R Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

This means:

1. Program staff shall not convey to a person outside of the program that a client attends or receives services from the program or disclose any information identifying a client as alcohol or other drug services client unless the client consents in writing for the release of information.
2. Disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research audit or program evaluation purposes.
3. Federal laws and regulations do not protect any threat to commit a crime, or any information about a crime committed by a client either at the program or against any person who works for the program.
4. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I have read or have had read to me and understand the above information regarding confidentiality.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION
You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION
You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY
You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI
If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI
You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH
You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE
You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?
If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at 1-800-852-3449. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call 1-877-696-6775.

CONTACT FOR ADDITIONAL INFORMATION
If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS
When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

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FOUNDATIONS FOR LIVING AND ITS SUBSIDIARY ORGANIZATIONS

ACKKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTE: We are required by law to provide each patient a copy of our Notice of Privacy Practices, obtain an acknowledgement that the Notice was provided, and keep the acknowledgement in our records. Along with the Notice of Privacy Practices, you will be given a copy of this acknowledgment for your records.

ACKNOWLEDGEMENT OF PERSONAL REPRESENTATIVE

I acknowledge that on the date indicated below, I represented that I am the personal representative of the patient named below and that I was provided a paper copy of the Notice of Privacy Practices of Foundations for Living and its subsidiary organizations on behalf of this patient I understand that this Notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. I understand that I should review the Notices of Privacy Practices carefully.

_____	_____	_____
Name of Personal Representative	Signature of Personal Representative	Date
_____	_____	
Name of Patient	Basis of Personal Representative Status	

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ACKKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF PATIENT

I acknowledge that on the date indicated below I was provided a paper copy of the Notice of Privacy Practices of Foundations for Living and its subsidiary organizations. I understand that this Notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that I should review the Notices of Privacy Practices carefully.

_____	_____	_____
Print Name	Signature	Date

Linda T. Keller
Superintendent

Vanessa Wagner
Education Director
Kathy Scherer
Administrative Assistant

F.I.R.S.T. School
Mid Ohio Educational Service Center
1451 Lucas Road
Mansfield, OH 44903
Phone: 419-589-5511 Fax: 567-247-3231

F.I.R.S.T. School is a vital part of each student's education while in residence at Foundations For Living

AUTHORIZATION TO DISCLOSE INFORMATION

Name of Student:_____ Date of Birth:_____

Foundations For Living is authorized to provide duplicate copies of student packets to F.I.R.S.T. School. The purpose of the disclosure is to insure that all educational information is received to provide a continuum of education while the student is in placement at Foundations For Living.

This consent expires in twelve (12) months.

_____ _____
Signature of Student Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of staff or witness Date

Revocation:

I hereby revoke consent in writing:

_____ _____
Signature of Student Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of staff or witness Date

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Phone 419-589-5511 Fax 419-589-7599

Foundations For Living Policy Residential Restraint Protocol

Foundations For Living strives to maintain a restraint free environment. When/if necessary, a resident may be subject to time-outs, minor aversive behavioral interventions, and physical restraint. Physical restraint will only be used as a last resort by trained, qualified staff to prevent bodily harm to our residents or others. It will never be used for staff convenience or resident discipline. Examples of justification for the use of restraint are: imminent threat of harm to self and/or others. Alternative interventions will be used to assist the resident to control his/her behavior prior to the use of the restraint. If a restraint is used, the resident will be cared for in a way that maintains his/her rights, safety, dignity and well-being as well as the safety of other residents and staff. If a resident is restrained during his/her stay at Foundations For Living, his/her custodian will be notified as soon as possible after the incident.

Restraint, as used here, refers to any method that restricts or reduces the resident's ability to move his/her arms and/or legs freely. At no time, will a restraint obstruct the airway or impair breathing, immobilize or restrict the movement of the head, have the resident in a position that is face down with back pressure, obstruct the resident's vision or ability to communicate, involve the use of pepper spray, mace, handcuffs, or electronic restraints or a drug or medication that is used to control behavior or restrict the resident's freedom of movement that is not a standard treatment for her medical or psychiatric condition.

The possibility of the use of restraint while I am here has been explained to me and I understand when and how it may be used.

I understand this information.

_____ _____

Resident Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

FOUNDATIONS FOR LIVING
a treatment center for youth

Resident Name _____ **DOB** _____

LEGAL GUARDIAN CONDITIONS OF ADMISSION

INSTRUCTIONS TO LEGAL GUARDIAN: INITIAL EACH CATEGORY TO SIGNIFY AGREEMENT. IF YOU DO NOT AGREE WITH A SPECIFIC CONDITION FOR ADMISSION, DO NOT INITIAL THAT SECTION.

____ * **Authorization for routine Medical/Surgical Treatment.** I hereby authorize referral of the resident by the Medical Director of Foundations For Living (herein referred to as "the facility") to any physician, surgeon, dentist, podiatrist, optometrist, or other similar practitioner to consult, diagnose, treat and prescribe medications for such circumstances as may develop during the course of the resident's stay at Foundations For Living and for which the services of these practitioners is deemed necessary.

____ * **Authorization for Emergency Medical Service Transportation and Treatment.** In event the resident which requires emergency medical treatment at a hospital and I cannot be reached immediately by telephone, I give my consent to Foundations For Living to transport the resident to a hospital for emergency services. Further, I give my consent to the receiving hospital to admit and deliver necessary emergency medical treatment. Every effort will be made to contact me by telephone prior to implementing the process outlined above. I understand hospital emergency care will be initiated as authorized facility medical personnel deem necessary and that I will be advised of the outcome. My additional consent may be required should the medical treatment of the resident require hospitalization and/or surgical procedures. I understand that the coverage of such treatment shall be borne by Medicaid and/or any applicable private insurance.

____ * **Authorization to Leave Facility Grounds.** The resident has my permission to attend therapeutic activities off Foundations For Living grounds. I understand that there exists the possibility that persons not affiliated with Foundations For Living may be encountered on these outings. I agree that resident's attendance at such activities is not in any way a violation of confidentiality or his rights of privacy.

____ * **Notice of Judicial Contact in Event of Elopement.** I understand Foundations For Living will contact the City, County, and/or state police and place an all points bulletin should the resident run away from the facility due to the level of risk to the community's safety.

____ * **Consent for Photographs/Video surveillance.** I authorize photographs of the resident for identification and clinical purposes. At discharge, the identification photographs remain in the chart; all others are given to the resident unless contraindicated, in which these photographs will be destroyed. The undersigned also consents to the video surveillance of residents for the purposes of safety. Video is digital and is reviewed on an "as needed" basis.

____ * **Personal and Valuable Articles.** I understand that Foundations For Living is not responsible for either lost or stolen items. It is the policy of the facility that no expensive possessions be brought to Foundations For Living. I accept responsibility for any personal and valuable articles left at the facility for the resident.

____ ***Activities,** I authorize Foundations For Living, to supervise the recreational activities of my child and permit my child to attend and participate in the activities listed below as well as any other outings that the representatives of FFL may see advisable and beneficial. I voluntarily release and discharge Foundations for Living and it's officers, directors, shareholders, employees and agents from any and all claims, demands, actions, suits or proceedings for any injury or losses to the resident caused by any act or omission on his/her part in the course of such activities/outings, except to the extent such injury results from the gross negligence or willful misconduct of FFL or its authorized agents. I understand and agree to indemnify and hold harmless FFL, its medical /residential staff, employees and it's free agents from all claims, costs and losses incurred as a result of any act of the patient while participating in such activities. Activities may include: all sports, baseball, basketball, volley ball etc., picnics, visits to parks and community events.

Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Foundations For Living

RPR, HEPATITIS AND PPD CONSENT FORM

I give my consent for _____to be tested for RPR, Hepatitis and Tuberculosis.

BENEFITS OF THE TEST

The test results can help the physician and youth make better decisions about his or her health care and personal life, and will help with decisions concerning medical treatment. These tests are completed on every new admission to our Residential Treatment Center. We offer this testing as a way to help protect all of our patients and staff from infections. The results of this testing will become part of the patient's permanent record and this record will be available to members of the facility and medical staff who are involved in the patient's treatment, to other individuals in the facility who require access to the record for facility management purposes, and to insurance companies or other third party payers responsible for charges incurred during this treatment. However, the contents of the facility record will not be disclosed to other third parties, unless written permission for disclosure has been given, or disclosure is authorized or required by law.

MORE INFORMATION

By my signature below, I acknowledge that I have read and understood the information provided pertaining to RPR, Hepatitis and PPD testing.

_____

Parent/Guardian Signature Date

_____

Witness Date

_____

Name of Resident

Foundations For Living

Immunization Records

Ohio law requires a certification of immunization be on file at the facility where a minor student is attending school. Thus, I agree to provide Foundations For Living with the immunization records within 30 days.

I give Foundations For Living permission to begin the immunization process over again if a certification of immunization is not in the chart by the 30th day. I give Foundations For Living permission to administer immunizations according to the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). This includes, but is not limited to, the Hepatitis B Vaccine series for those patients who have not previously received it, the Meningococcal vaccine, the HPV vaccination and the annual influenza vaccine. I understand a medical exemption must be documented in writing by a physician and for a religious exemption, an affidavit must be in the patient's chart.

Upon admission, information will be given to the patient's guardian about Ohio immunizations.

I have read and understand the above information provided pertaining to immunizations.

Parent/Guardian Signature Date

Witness Signature Date

Name of Resident

Foundations For Living

HIV CONSENT FORM

I give my consent for _____to be tested for the Human Immunodeficiency Virus (HIV). This test is not a test for AIDS but only for the presence of HIV.

BENEFITS OF THE TEST

The test results can help the physician and youth make better decisions about his or her health care and personal life, and will help with decisions concerning medical treatment. We offer this testing as a way to help protect all of our patients and staff from infections. The results of this testing will become part of the patient's permanent record and this record will be available to members of the facility and medical staff who are involved in the patient's treatment, to other individuals in the facility who require access to the record for facility management purposes, and to insurance companies or other third party payers responsible for charges incurred during this treatment. However, the contents of the facility record will not be disclosed to other third parties, unless written permission for disclosure has been given, or disclosure is authorized or required by law.

MORE INFORMATION

By my signature below, I acknowledge that I have read and understood the information on this form, that I have been given all of the information concerning the HIV test, its meaning, expected benefits, possible risks, and any alternatives to the tests, and that I have had my questions answered. Further, I acknowledge that I have given consent for the performance of the test to detect HIV.

_____

Parent/Guardian Signature Date

_____

Witness Date

_____

Name of Resident

49730

Patient Account Number / Case ID

Program Code 3603

Child & Adolescent Behavior Assessment - Informant (CABA-I)

Date Completed (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Time of Administration: ☐ Admission ☐ Discharge

Informant (select one): ☐ Parent ☐ Guardian ☐ Staff

To be completed at admission and discharge. Be sure to fill in all choices with**not**

Please answer every item. If you think one of the items doesn't apply, mark it as **"No Problem."**

How much of a problem has the patient had during the past week with:	**No Problem**	**A Little Problem**	**Some Problem**	**A Big Problem**
1. Concentration, paying attention	☐	☐	☐	☐
2. School performance (grades, completing work)	☐	☐	☐	☐
3. Physical health problems (headaches, stomachaches, dizziness)	☐	☐	☐	☐
4. Sleep disturbances (nightmares, trouble sleeping, sleeping more than normal)	☐	☐	☐	☐
5. Restlessness, fidgeting	☐	☐	☐	☐
6. Acting without thinking, being impulsive	☐	☐	☐	☐
7. Participating in daily activities (school, sports, hobbies)	☐	☐	☐	☐
8. Feeling nervous, worried, or anxious	☐	☐	☐	☐
9. Getting along with family	☐	☐	☐	☐
10. Getting along with other kids (not siblings)	☐	☐	☐	☐
11. Getting along with adults (not parents)	☐	☐	☐	☐
12. Not doing as told, being disobedient	☐	☐	☐	☐
13. Change in eating habits (increase/decrease)	☐	☐	☐	☐
14. Feeling fearful or scared	☐	☐	☐	☐
15. Feeling lonely	☐	☐	☐	☐
16. Secrecy/keeping to themselves	☐	☐	☐	☐
17. Feeling unhappy or sad	☐	☐	☐	☐
18. Lying, cheating	☐	☐	☐	☐
19. Losing their temper; yelling/swearing/screaming at others	☐	☐	☐	☐
20. Breaking rules/laws	☐	☐	☐	☐
21. Taking things that are not theirs	☐	☐	☐	☐
22. Bullying or threatening other kids	☐	☐	☐	☐
23. Feeling worthless or useless	☐	☐	☐	☐
24. Being destructive	☐	☐	☐	☐
25. Getting into physical fights	☐	☐	☐	☐
26. Having strange thoughts	☐	☐	☐	☐
27. Sexual acting out	☐	☐	☐	☐
28. Alcohol use	☐	☐	☐	☐
29. Drug use	☐	☐	☐	☐
30. Seeing or hearing things (hallucinations)	☐	☐	☐	☐
31. Talking or thinking about death	☐	☐	☐	☐
32. Hurting themselves	☐	☐	☐	☐