



Helping Other People's Enrichment, Inc. (H.O.P.E)
P.O. Box 752, Hayes, Virginia 23072
Phone: 804-684-2555 www.hope-tfc.org/placements.htm Fax: 804-642-6722

PLACEMENT DOCUMENT REQUIREMENTS

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

- _____ Placement Contract (signed by locality representative/social worker/HOPE)
- _____ Foster Home Agreement (signed by Foster Parent/Locality/HOPE)
- _____ Authorization to Place/ERO/Entrustment/Court Order / Non Custodial Agreement
- _____ Treat & Transport Form
- _____ Consent(s) to Release and Obtain Information
- _____ Medical Exam (current within 90 days)
- _____ Dental Exam (Current within one (1) year)

****NOTE: The items indicated in this box must be received before placement of a child can be completed.****

- _____ Most recent Foster Care Service Plan (if applicable)
- _____ Indian Child Welfare Act (ICWA) Acknowledgement
- _____ Copy of Birth Certificate
- _____ Copy of Social Security Card
- _____ Copy of Medicaid Card
- _____ Authorization to Obtain Medical Treatment
- _____ Expedited School Enrollment/Consent to Enroll
- _____ HIPAA Statement (Signed by Client or if unable or underage, the Locality)
- _____ Previous School Information/IEP
- _____ CAFAS/CANS assessment/current w/in 90 days (? Requested ? Received)
- _____ VEMAT

_____ FAPT/IAC Report (? Requested ? Received)

_____ Written Authorization of: ? Family Contact ? Visitation Plan

_____ Locality Documents: ? Social History ? Placement History ? Psychological
? Immunization Records

_____ Psychological/Medication Management

? Yes

? No

? Does not Apply

? Scheduled

Clinician/#/Date: _____

_____ Developmental

? Yes

? No

? Does not apply

? Scheduled

Name/#/Date: _____

_____ List of Current Medications and Dosages



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Indian Child Welfare Act (ICWA)

Public Law 95-608,25 USC Chapter 21

Child: _____ DOB: _____

I, _____ representative of the locality of legal guardianship ascertain that the above named child:

_____ is not of Native American, Alaskan or Aleut Heritage.

_____ is of Native American, Alaskan or Aleut Heritage. I acknowledge that I have received a copy of the Indian Child Welfare Act and authorize HOPE, Inc. to place the above named child in a non tribal foster .

Legal Guardian Representative

Date

HOPE, Inc. Representative

Date

HOPE, Inc.
3063 George Washington Memorial Highway, Hayes, VA 23072
Phone: 804-684-2555; Fax: 804-642-6722

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Section A (Must be Completed In Full for All Authorizations)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations.

Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

Department of Human Services

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management

Information and documentation pertinent to the care of this client

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? _____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [] YES [X] NO

The patient or the patient's representatives must read and initial the following statements:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initials: ____NA____

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

Section C (Must be Completed In Full for All Authorizations)

The patient or patient representative must read and initial the following statements:

I understand that this authorization will expire on _____(DD/MM/YR) **Initials:** _____

I understand that I may revoke this authorization at any time by notifying HOPE, Inc. in writing and if I do revoke it, it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

Printed Name of Patient or Patient Representative

Relationship to Patient (Brother, Sister or Self)

Signature

Date

HOPE, Inc.
3063 George Washington Memorial Highway, Hayes, VA 23072
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Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

School / Child Care

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

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Relationship to Patient (Brother, Sister or Self)

Signature

Date

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Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

Therapist

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management

Information and documentation pertinent to the care of this client

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? _____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [] YES [X] NO

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Initials: _____ NA _____

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Printed Name of Patient or Patient Representative

Relationship to Patient (Brother, Sister or Self)

Signature

Date

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Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

Psychiatrist

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management

Information and documentation pertinent to the care of this client

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? _____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [] YES [X] NO

The patient or the patient's representatives must read and initial the following statements:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initials: _____ NA _____

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

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Printed Name of Patient or Patient Representative

Relationship to Patient (Brother, Sister or Self)

Signature

Date

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Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

Medical Care Provider / Physician

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management

Information and documentation pertinent to the care of this client

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

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Section C (Must be Completed In Full for All Authorizations)

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I understand that this authorization will expire on _____ (DD/MM/YR) **Initials:** _____

I understand that I may revoke this authorization at any time by notifying HOPE, Inc. in writing and if I do revoke it, it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

Printed Name of Patient or Patient Representative

Relationship to Patient (Brother, Sister or Self)

Signature

Date

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3063 George Washington Memorial Highway, Hayes, VA 23072
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PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

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Patient Name _____ **ID#** _____

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

Dentist

Hope Inc.

P.O. Box 752

Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management

Information and documentation pertinent to the care of this client

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? _____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [] YES [X] NO

The patient or the patient's representatives must read and initial the following statements:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initials: _____ NA _____

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

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I understand that I may revoke this authorization at any time by notifying HOPE, Inc. in writing and if I do revoke it, it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

Printed Name of Patient or Patient Representative

Relationship to Patient (Brother, Sister or Self)

Signature

Date

Helping Other People's Enrichment, Inc. (HOPE, Inc.)
PO Box 752
Hayes, Virginia 23072
(804) 684-2555 / Fax (804) 642-6722

REPORT OF PHYSICAL EXAMINATION

Full Name of child: _____ Birth date: _____

PART I

(To be completed by agency, if obtainable)

Health and Developmental History

A. Significant events in the child's developmental history include:

1. _____
2. _____
3. _____

B. Serious illnesses, accidents, operations, nutritional, dental, mental, emotional Problems, or handicapping conditions include:

1. _____
2. _____
3. _____

PART II

(To be completed by Physician)

A. Documentation of Immunizations

Immunizations	Vaccine Doses Administered				
Diphtheria Tetanus Pertussis (DPT)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Diphtheria Tetanus (TD)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Poliomyelitis (OPV)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Measles	___/___/___ Live Virus Vaccine? Yes No Mo Day Yr.			Serological Confirmation of Immunity ___/Month ___/Day ___/Yr.	
Rubella	___/Month ___/Day ___/Yr.			Serological Confirmation of Immunity ___/Month ___/Day ___/Yr.	
Mumps	___/Month ___/Day ___/Yr.				
Measles, Mumps Rubella (MMR)	___/Month ___/Day ___/Yr. ___/Month ___/Day ___/Yr.				

B. Documentation of Medical Examination (*Evaluate each of the following*):

1. Growth and development _____

2. Height _____ Weight _____ B/P _____

3. Vision: W/O Glasses: R20/ _____ L20/ _____
W Glasses: R20/ _____ L20/ _____
Color discrimination: _____

4. Hearing: Right _____ Left _____

5. Urinalysis: _____

6. Hemoglobin: _____

7. Nutritional status: _____

8. Dental status: _____

9. Evidence of freedom from:
a. communicable disease, *including tuberculosis* _____
b. allergies _____
c. chronic conditions _____

10. Other (*specify*) _____

11. Normal Evaluation: Yes _____ No _____

12. If not, describe abnormal or handicapping conditions:
a. _____
b. _____
c. _____

13. Recommendations:
a. Permitted/restricted activities:
(1) _____
(2) _____
(3) _____
(4) _____
b. Follow-up:
(1) _____
(2) _____
(3) _____
(4) _____

Date of Medical Examination: _____

Printed Signature of Licensed Physician

Signature of Licensed Physician

Date of Signature: _____

DIVISION OF LICENSING PROGRAMS
DEPARTMENT OF SOCIAL SERVICES
CHILD PLACING AGENCY REPORT OF DENTAL EXAMINATION

Name of Agency, _____

Address: _____

Full Name of child: _____ Birth date: _____

_____ This is to certify that _____ had a dental

(Name of Child)

examination on _____.

(Date)

Dental work performed, included:

Recommendations, include:

Signature: _____

(Dentist or Dentist Designee)

Date: _____

Expedited Enrollment of Child Placed in Foster Care

(Child school placement changing upon entering or changing foster care placement)

State Law (Ref. *Code of Virginia* 22.1-289 and 63.2-900) requires that within 72 hours of placing a child in foster care, the agency making such placement shall, in writing, notify the appropriate principal and superintendent of the placement and inform the principal of the status of the child's parental rights. Children placed in foster care shall be immediately enrolled in school subject to the requirements of § 22.1-3.4 of the *Code of Virginia*.

This child is being enrolled by the agency having legal custody or its representative:

___ Local Department of Social Services

___ Licensed Child Placing Agency

Name of School: _____

Student's Name: _____

Students Date of Birth: ___/___/___ Sex: ___ State or Country of Birth _____

Foster Parent Name: _____ Tel: _____

Foster Parent Address: _____

Department of Social Services or Licensed Child Placing Agency contact information:

Agency Name: _____

Contact Name: _____ Phone: _____

Custody of this student was placed with the above named agency on _____
Date

Information on status of Parental Rights:

Student's School Status Affirmation:

To the best of my knowledge, _____ has ___ has not been expelled from school attendance at a private school or in a public school division of the Commonwealth or in another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.

032-02-0041-01-eng

To the best of my knowledge, _____ has ___ has not been found guilty or adjudicated delinquent for any offense listed in subsection G of § 16.1-260 of the Code of Virginia or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.

To the best of my knowledge, _____ is in good health and is free from communicable or contagious disease. If documentation of a physical exam, birth certificate, social security number, and/or immunization record is unavailable at the time of enrollment, they must be provided to the school within 30 days of enrollment.

Representative of Custodial Agency

Date

032-02-

NOTICE OF STUDENT RECEIVING FOSTER CARE SERVICES

ATTENTION: PRINCIPAL AND SUPERINTENDENT OF SCHOOLS OR THE DESIGNEE FOR: _____ SCHOOL

State Law (Ref. Code of Virginia 22-I-289 and 63.2-900) requires that within 72 hours of placing a child in foster care, the agency making such placement shall, in writing, notify the appropriate principal and superintendent of the placement and inform principal of the status of the child's parental rights. Children placed in foster care shall be immediately enrolled in school subject to the requirements of §22.11-3,4 of the Code of Virginia)

Student name: _____ DOB: _____ Age: _____

Social Worker/Case Manager: _____

Telephone Number: _____

Foster Parent Name: _____

Telephone Number: _____

Custody of this student was placed with _____ Department of Human Services/Licensed Child-Placing Agency on _____ (date).

_____ Court Order/Other restrictions related to status of parental rights are attached

_____ Child's foster care placement is outside this school district, but it is in the child's best interest to attend the school she/he was enrolled in prior to placement in foster care as determined by the social worker and school officials, taking into consideration all relevant factors.

Representative of Custodial Agency

Date



CLIENT VISITATION AUTHORIZATION

Client Name: _____

Social Worker: _____

I, _____, authorize that the aforementioned client:
(Social Worker Name)

Is not allowed to have visitation with biological family members.

REASON:

Is allowed to have visitation with the following family members (Full Names and relationship to the client):

How often is visitation to occur?

Who will supervise visitations?

Where will visitation occur?

Have all involved family members been advised of this arrangement?

Recommendations/Requests:

Social Worker Name/Date

HOPE, Inc. Representative/Date



CLIENT MEDICATIONS

Client Name: _____

Today's Date: _____

Social Worker/Representative: _____

I, _____, authorize that the aforementioned client has been prescribed the following medications (Please list the medication, the dosage, the reason for the med, the frequency):

List of Medications:

Side Effects Noted:

Please list the name and address of prescribing physician in the box below:

Social Worker/Guardian Name/Date

HOPE, Inc. Representative/Date



Detailed Client Placement History

Placement:

Location:

Start Date:

End Date:

Why did this placement end?

Placement:

Location:

Start Date:

End Date:

Why did this placement end?

Placement:

Location:

Start Date:

End Date:

Why did this placement end?

Placement:

Location:

Start Date:

End Date:

Why did this placement end?

Placement:

Location:

Start Date:

End Date:

Why did this placement end?

*****NOTE: If you have a prepared agency document detailing client's placement history, please forward and disregard this form.**