



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

Dear Parent/Legal Guardian:

Your child "*used to identify the child receiving services regardless of the relationship*" has been referred to receive services through our short stay program. The program provides brief respite breaks to give families of children with special needs and treatment needs planned breaks from the demands of parenting.

Enclosed is an intake application package consisting of:

- Program Participation Agreement.
- Referral/Intake Application or update for Short Stay Program.
- A physical examination form to be completed by child's physician. Physical must be current within 6 months and include the immunization record.
- Psychiatric and/or Psychological Information. To be completed by your attending physician/therapist or psychiatric if child is receiving medication management or attending therapy.
- Services and Program Fee Agreement
- Authorization to obtain and release information. *This release gives us permission to receive and release information to your funding source, Department of Social Services when applicable, resource parent with HOPE, Inc and other providers who are participating in your child's treatment such as school, physician, therapist and psychiatric.*
- HIPPA form
- Treat and Transport. *This form gives HOPE, Inc. permission to obtain emergency care for your child when we are unable to reach you. It also authorizes members of the agency including resource parent permission to provide transportation for your child while they are in our care.*

If you have any questions or need any further information, please feel free to give me a call at (804) 684-2555. Thank you for your interest in our program.

Sincerely,

Intake and Placement Staff
Enclosures

Short Stay Participation Agreement

In order that the agency may ensure that we provide the best services possible for your child while participating in the short stay program the agency requires your agreement and understanding of the below listed items prior to child's participation. Please read, initial each item and signed the bottom of the form.

Coordinating Your Child's Short-Stay

- Each stay must be coordinating through the HOPE, Inc. office by calling 804-684-2555 and speaking with Keith Ingram, Marketing and Referral Manager. Mr. Ingram will work with your to establish a respite schedule that best meets the needs of your family.
- Your child may return to the same respite provider when possible, however the respite provider is not permitted to accept your child for respite services through the Short Stay Program without a written agreement from the agency.

Drop-off and Pickup Time

- Agency staff must be present during each drop-off. A mutual drop-off and pickup time will be coordinated by HOPE, Inc., parent and respite provider. An agency staff member must be present at each arrival. If you will not arriving for drop off or pick-up at the designated time, please contact the agency to notify staff of your change in plans.

Positive Discipline

- Your respite provider and agency staff is not permitted to use corporal punishment of any kind. Parents and staff have received specialized training to enable them to provide positive therapeutic re-direction and discipline.

Medication Authorization

- Agency must be aware of the type of medication which the child will be bringing to the home. During each respite, an agency staff member will verify the medication that the child is bringing to the home.
- Child must be observed taking medication by respite provider and will provide you with a medication log at the end of the stay.
- If your child refuses to take the medication, agency staff will notify you by phone and create an incident report which will be provided to you and funding source. Continued refusal can result of staff requesting you to remove your child from the program.

Clothing

- It is the responsibility of the parent/guardian to provide clothing for the child. Agency staff and resource parent will verify that child has clothing suitable for the season.
- To ensure that your child returns home with all his/her belonging, an inventory will be completed by the child, respite provider and parent at placement.

Allowance, Recreational and Personal Care Expenses

- The parent/guardian is responsible for providing the child with spending money/allowance during the short stay.
- It is the responsibility of the parent/guardian to provide money for child's recreation/personal care items while participating in the program.

Dietary Preference

- Parents will ensure that your child receive a nurturing, balanced meal while participating in the program. If your child has dietary preference, not based on medical needs, reasonable accommodation may be made, but child should understand that parents might not accommodate their preferences.

Child's Behavior and/or Refusal to Stay

- If your child refuses to remain in the home with the identified parent, the agency will visit the home and attempt to resolve the situation. When this happens, you will be notified by phone and will receive a report of the incident. If child continues to refuse to stay and the agency does not have additional resources to accommodate the child, you will be notified of the need for the child to leave the program.
- Child is not permitted to bring weapons, alcohol or other illegal substance to the home.

Emergency Contact Person

- In additional to the emergency contact person listed on your application, at the time of placing your child in the home, you will be asked to complete an exchange of information form with the respite provider. Form will include your contact information and the contact information of person to call if the agency is unable to reach you. Failure to provide valid contact information can jeopardize future placement in the program.

Contact during Short Stay:

- HOPE, Inc. strongly encourages parent/guardian to use this opportunity to take a break from the daily demands of parenting. However, it is your right to have contact with your child and the right of your child to maintain contact with you, unless otherwise communicated. Phone contact is permitted without any special accommodations. If you desire to visit your child face to face, please contact the office during and after hours by calling: 804-684-2555 and arrangements will be made for the visit. If you become concerned about your child or if your child contacts you with a concern. Please use our 24-7 on-call support system to report your concern. On-call is reached by calling 804-684-2555.

Child Visits

- Your child is required to obtain the permission of the respite provider prior to placement to have any visitor in the home. If child has scheduled outings planned during the stay, please provide that information to the agency staff and the respite provider.

Child Safety:

- HOPE, Inc. staff and parents are committed to keeping your child safe during their stay. Your cooperation is greatly appreciated in communicating to your child the need for them to follow all program participation guidelines to include receiving permission to go on outings, “unless previously agreed upon”, and informing the respite provider of their whereabouts when not at the home.
- The respite provider is required to contact the on-call system to report the unauthorized absence of a child from the home.
- The agency is required to contact the police to report unknown absence of children from the home for any reason including if they do not return to the home as scheduled from outings.

Mandated Reporter

- HOPE, Inc. staff and parents are mandated reporters and as such are required to report all allegations of abuse or neglect to the CPS unit.
- Child abandonment is a crime and must also be reported if you fail to pick up your child as agreed upon. If you incur any problems meeting the agreed upon pick-up time, please contact the on-call staff.

I have read the above list of expectations and guidelines for participation in the program and agree to abide by them.

Parent/Guardian Signature: _____ Date: _____



Parent Placement Referral/Intake Application Package

Child's Identifying Information:

"description of child's appearance and medical history"

Name: _____ DOB: _____

Sex: _____ SS#: _____ Race: _____ Height: _____ Weight: _____

Hair Color: _____ Eye Color: _____ Identifying marks/tattoos/burns/bruises/piercings:

Describe child's behavior in the home? _____

Child's developmental and medical history "including birth if known":

List all complications during birth? _____

Date of last physical: _____ "please attach form"; Allergies: _____

Chronic diseases? _____

Past medical conditions/illness : _____

Current medical conditions/illness/problems? _____

Did child meet all developmental milestones? _____, if no. Please explain: _____

Medical Doctor:

Name of Physician: _____

Name of Practice: _____

Address: _____

Phone number: _____ Date of last visit: _____

Previous Placements Outside of the Home:

The child's previous placement history

_____ My child is not currently taking any medication:

Parent Signature: _____ Date: _____

Child's Educational History

Describe child's adjustment to school: _____

Does child have an IEP, if so under what category: _____

Is child currently enrolled and attending school? _____ if no, explain" _____

List name of school, grades and dates attended:.

Name	Grade (s)	Date

Family Information:

Parent/Guardian Name: _____ Relationship to Child: _____

Address: _____

Phone Contact:

Best number to reach you during the day: _____ in the evening: _____

Home: _____ Cell: _____ Work: _____

Emergency contact information "when you can't be reached":

Name: _____ Relationship: _____

Address: _____

Phone Contact for Emergency Contact person:

Best number to reach you during the day: _____ in the evening: _____

Home: _____ Cell: _____ Work: _____

Household Composition

Family structure, relationships and involvement with the child

Name	Relationship to Child	"Involvement – including how child get along with this person"	Type contact permitted during stay

Education, employment and medical information for birth and adoptive parents if applicable:

*If information is unknown – please include statement “unknown”

“The education and occupation of parents and medical history”

Name	Relationship to child	Highest grade completed	Placement of Employment	Any known illness

Other relative medical illness – include relationship to child:

List all mental illness/concerns in the family – include relationship to child :

Other Service Providers Involved with Child

Name	Address	Phone Number	Frequency
Psychiatrist “name and practice”			
Therapist ‘name and practice”			
Other:			
Other:			

Child Needs Questionnaire

Please help us determine the type home best suited for caring for your child by answering the following questions about your child.

Activities of Daily Living and Communication:

- 1. Is your child able to feed, dress and clean him or her self? ___ Y ___ N
- 2. Is your child able verbalize his or her needs? ___ Y ___ N
- 3. Please describe any assistance your child needs in communicating or caring for themselves:

Specific Behaviors:

1. Have your child now or in the past had any of the following behaviors? Circle all that apply:
- a. Biting
 - b. Kicking others
 - c. Spitting
 - d. Pinching
 - e. Drug use of any kind
 - f. Smoking cigarettes
 - g. Stealing
 - h. Runaway
 - i. School truancy
 - j. Verbal aggression toward adults
 - k. Verbal Aggression toward Peers
 - l. Physical Aggression toward Adults
 - m. Physical Aggression toward Peers
 - n. Sexual inappropriate behaviors "including touching"
 - o. Hygiene problems

Health/Diet:

1. Does your child have a medical condition? _____ Y _____ N
If yes, please describe:

2. Does condition require special care? _____ Y _____ N
If so, please describe:

4. Will your child require special dietary needs? _____ Y _____ N
If so, please state the need and how the need is to be met.

Completed by: _____ Date: _____

Relationship to Child: _____

REPORT OF PHYSICAL EXAMINATION

Name of Child: _____ Birth date: _____

Part I (To be completed by agency, or parent 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 “or attach current immunization record”

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	_____ MO Day Yr Live Virus Vaccine? Yes / / No / /	Serological Confirmation of Immunity _____ MO Day Yr			
Rubella	_____ MO Day Yr	Serological Confirmation of Immunity _____ MO Day Yr			
Mumps	_____ MO Day Yr				
Measles, Mumps, Rubella (MMR)	_____ MO 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 _____
 - d. Handicaps _____
10. Lead Exposure Screening: _____
11. Normal Evaluation: Yes _____ No _____
12. If not describe abnormal or handicapping conditions:
- a. _____
 - b. _____
 - c. _____
13. Recommendations:
- a. Permitted/restricted activities:
 - (1) _____
 - (2) _____
 - b. Follow-up:
 - (1) _____
 - (2) _____

Date of Medical Examination: _____ Name of practice: _____

Signature of physician or designee: _____ Date: _____

Diagnosis and Listing of Medications

The child listed below is being seen at my office and has the following diagnosis and is prescribed the following medication:

Child's Name: _____ DOB: _____

♣ Clinical Diagnosis

Axis 1:

Axis II:

Axis III:

Parent/Legal Guardian Name (print): _____ 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 Information

Hope Inc.
P.O. Box 752
Hayes, VA. 23072

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

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 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:** _____

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

PATIENTS' RIGHTS UNDER HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Federal Register 45 CFR Parts 160 and 164, "Standards for Privacy of Individually Identifiable Health Information"; Final Rule dated August 14, 2002, you are entitled to certain rights regarding your Health Information. Your rights are as follows:

- ◆ **You Have The Right To See The Notice Of Privacy Practices for HOPE, Inc.**
- ◆ **You Have The Right To Access Your Individually Protected Health Information (PHI)** which is maintained by HOPE, Inc. We may require you to make such requests in writing and may be charged a reasonable fee to cover the cost of generating the copy.
- ◆ **You Have The Right To Request An Amendment To Your Protected Health Information (PHI)** which is maintained by HOPE, Inc. We may require you to make such a request in writing but we are not required to grant all requests.
- ◆ **You Have The Right To Request An Alternative Means Of Communicating Your Protected Health Information (PHI)** which is maintained by HOPE, Inc. We may require you to make such a request in writing.
- ◆ **You Have The Right To Request Restrictions On Your Protected Health Information (PHI)** which is maintained by HOPE, Inc. We may require you to make such a request in writing but we are not required to grant all requests.
- ◆ **You Have The Right To Request An Accounting Of Disclosures Of Your Protected Health Information (PHI)** which is maintained by HOPE, Inc. and disclosure was not made for treatment, payment, or healthcare operations and where you have not specifically authorized such a release.
- ◆ **You Have The Right To Complain About Our Privacy Practices** directly to HOPE, Inc. and/or the Secretary of the U.S. Department of Health and Human Services if you believe we are not complying with the HIPAA Privacy Rule.

You can file on-line at <http://cms.hhs.gov/hipaa/hipaa2/default.asp>. Or mail your written complaint to the following address:

HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Child Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

"child under the age of 18"

Helping Other People's Enrichment, Inc.
 3063 George Washington Memorial Hwy - PO Box 752, Hayes, VA 23072
 804-684-2555 Fax 804-642-6722

Authorization to Receive Routine Medical/Dental/Mental Health Treatment and Emergency Medical Care

CLIENT IDENTIFYING INFORMATION:

Items	Information	
Child's Name		Date of Birth:
Social Security Number		
Medicaid/ Insurance Number or Policy Number		
Medical Allergies:		
Chronic Illness:		

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Locality		
Social Worker/parent/guardian		
Address		
Phone Number		Fax Number:

MEDICAL/DENTAL INFORMATION

Medical Illness/Problems	
Medication	
Medical Doctor and Contact Information	
Dentist and Contact Information	

MENTAL HEALTH INFORMATION

DIAGNOSIS	
Medication for Diagnosis:	
Date of last Psy Eval	
Therapist	
Psychiatrist	

I authorize Helping Other People's Enrichment, Inc. staff and/or foster parents to assist the above named client in obtaining medical, dental and mental health care. This authorization also includes transportation to a hospital or physician's office and treatment by emergency personnel or a physician other than the personal physician in an emergency when the parent/guardian cannot be reached.

Short Stay Placements: **PARENT/LEGAL GUARDIAN AUTHORIZATION**

The parent/guardian authorizes immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic tests, the use of surgery and/or the administration of drugs to his/her child if an emergency occurs when s/he cannot be located immediately. The parent/guardian assumes full responsibility for the cost of any authorized medical treatment.

 Client's Signature (child 18 & over)

 Date:

 Parent/Guardian/Authorized Representative:

 Relationship to child

 Date: