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INTAKE FACE SHEET

Client's Name: _____

Social Security Number: _____ Date of Birth:_____Sex: M F

Ethnicity: _____ Religion: _____

Date of Placement: _____ Placement Location: _____

Place of Birth:_____ Medicaid #: _____

Current Medications: _____

_____

Allergies: _____

Significant Health Conditions: _____

Last Address: _____

Last School Name:_____Last grade: _____

School Address: _____

Placing Agency County: _____

Agency Address: _____

Social Worker/ Case Manager: _____

Phone: _____ Cell: _____

Fax: _____ Email: _____

Legal Guardian's Name: _____

Relationship to client: _____

Address: _____

Phone: _____ Cell:_____Work/Alt: _____

APPROVED VISITORS AND PHONE CALLS

Client's Name: _____

Placing Agency: _____ Case Worker: _____

Office #:_____Cell#:_____Email: _____

NAME	RELATIONSHIP	PHONE	LOOSELY MONITOR	CLOSELY MONITOR	NO MONITOR	OFF GROUNDS

***** Please include everyone able to have contact including siblings, relatives, professionals, etc.**

Prohibited List:

TREATMENT RECOMMENDATIONS

Client's Name: _____

Desired Focus of Treatment:

_____Excessive Dependency
_____Withdrawal / Isolation
_____Parent / Child Relationships
_____Peer Relationship
_____Acceptance of Authority
_____Sexual Appropriateness
_____Excessive Eating
_____Lying
_____Enuresis
_____Encopresis
_____Impulsiveness
_____Poor Academic Achievement
_____Poor Self-Esteem
_____Manipulative
_____Low Frustration Tolerance
_____Property Destruction
_____Hyperactivity
_____Anxiety
_____Verbal Aggression
_____Assault
_____Depression
_____Avoidance
_____Stealing
_____Self-destructiveness
_____Delayed Social Development
_____Other _____

Discharge Plan: Place an (x) next to your answer

Parent _____
Relative _____ Please specify relationship: _____

Other _____ Explain: _____

_____

Estimated Length of Stay: _____

Diagnostic History:

Psychiatric Evaluation? Yes No Psychological Evaluation? Yes No

Name of Evaluator Address Phone Date of Evaluation

_____

_____

_____

_____

NEED FOR CARE

Client's Name: _____

Document Current and Past Community Resources Utilized: Please check all that apply

_____Day Treatment Services
_____Intensive In Home Services or Other Home Bound Services
_____Day School Placement
_____1:1 School Counselor
_____Mental Health Support Services
_____Other: Please Specify_____

_____

_____

Behavior

Client's strengths and talents:

_____

_____

_____

_____

_____

Client's Interests:

_____

_____

_____

_____

Behavior problems or any significant situations that should be disclosed:

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Condition	Client	Mother	Father	Sibling	Sibling	Sibling
Alcoholism	Y N	Y N	Y N	Y N	Y N	Y N
Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Anemia	Y N	Y N	Y N	Y N	Y N	Y N
Arthritis	Y N	Y N	Y N	Y N	Y N	Y N
Asthma	Y N	Y N	Y N	Y N	Y N	Y N
Cancer	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N	Y N	Y N	Y N
Hearing Problems	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Hemophilia	Y N	Y N	Y N	Y N	Y N	Y N
Hypertension	Y N	Y N	Y N	Y N	Y N	Y N
Kidney Disease	Y N	Y N	Y N	Y N	Y N	Y N
Malformation	Y N	Y N	Y N	Y N	Y N	Y N
Malnutrition	Y N	Y N	Y N	Y N	Y N	Y N
Mental Retardation	Y N	Y N	Y N	Y N	Y N	Y N
Obesity	Y N	Y N	Y N	Y N	Y N	Y N
Sickle Cell Anemia	Y N	Y N	Y N	Y N	Y N	Y N
Substance Abuse	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculosis	Y N	Y N	Y N	Y N	Y N	Y N
Ulcers	Y N	Y N	Y N	Y N	Y N	Y N
Venereal Disease	Y N	Y N	Y N	Y N	Y N	Y N
Vision Problems	Y N	Y N	Y N	Y N	Y N	Y N

List other major health considerations of physical limitations: _____

_____

_____

PLACEMENT HISTORY

Client's Name: _____

Name of Placement	Type of Placement	Phone	Date Placed and Date Removed	Reason for Removal

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Resident Name _____ **Date of Birth** _____ **Date of Admission** _____

I hereby freely and voluntarily authorize Transitions for Life to:

☐ Release/disclose records of my health information to:
☐ Obtain records of my health information from:

Individual, Facility, Organization _____ **Telephone Number** _____

Address _____ **City, State** _____ **Zip** _____

The purpose for this disclosure is:

☐ To assist in funding
☐ To assist in treatment planning
☐ To keep the above informed of resident's progress
☐ To assist in educational placement
☐ To coordinate discharge planning/placement
☐ Other (specify) _____

This information to be released/ obtained includes:

☐ Discharge Summary
☐ Lab, X-Rays, EEG, EKG
☐ Psychological Testing
☐ Educational Assessments/ Testing/ Evaluations and Records
☐ Treatment Plans
☐ History and Physical
☐ Immunization Record
☐ Psychiatric Evaluation
☐ Verbal exchange of information
☐ Substance Abuse Treatment
☐ Other (specify) _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recent is a provider who makes a disclosure permitted by law. **This consent expires on (date: month/day/year)_____.**

Client Signature _____ **Print Name** _____ **Date** _____

RIGHTS OF RESIDENTS

Each person who receives services from Transitions for Life shall be assured of his/her legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of Transitions for Life and is consistent with sound therapeutic treatment. Each person

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. To leave or depart the facility at any time, except for house rules for the protection of clients,
15. Not to be put in any room, building, or facility premises by day or night where he/she cannot readily open the door;
16. Not to be placed in restraining devices;
17. To visit the facility with his/her relatives or authorized representative prior to admission;
18. To have his/her relatives or authorized representative regularly informed by Transitions for Life of

activities related to care and supervision.

19. To have communications from his/her relatives or authorized representative answered promptly and completely;
20. To have visitors, including advocacy representatives, visit privately during waking hours provided such visitations do not infringe upon the rights of other clients, unless prohibited by court order or the authorized representative;
21. To wear his or her own clothes, to possess and control his/her own cash resources, to possess and use his/her own personal items, including his/her own toilet articles;
22. To be able to display personal items where appropriate; i.e., living space
23. To have access to individual storage space for his/her private use;
24. To participate in treatment planning at age and developmental level.
25. To have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of telephone in emergencies;
26. To mail and receive unopened correspondence unless prohibited by court order or by the authorized representative and for children to have ready access to letter writing materials and stamps;
27. To receive assistance in exercising the right to vote;
28. To move from Transitions for Life transitional homes in accordance with the terms of the admission agreement.

I, the undersigned, have read, or had read to me, understand, and have received a copy of the Rights of Residents.

_____	_____	_____
Client's Signature	Client's Name Print	Date
_____	_____	_____
Witness Signature	Witness Name Print	Date