YOUTH RECORDS FACE SHEET

SECTION I: CHILD INFORMATION

1. Child's Name: _____ 2. _____ 3. _____
(Last) (First) (m. i.)

1a. Permanent Address:_____

_____

4. Date of Birth: _____/_____/_____
(mm) (dd) (yyyy)

5. Placement Date: ___/_____/_____
(mm) (dd) (yyyy)

6. Social Security Number: _____

7. Program: _____
8. Youth# _____
9. Hair color:_____
10. Eye Color: _____
11. Race: _____
12. Referring Worker: _____
13. Referring County: _____
14. DHS Case #: _____
15. Court Case #: _____

SECTION II: OTHER CHILD INFORMATION

14. Funding Source: _____
15. Prior Placement:_____
16. Gender: _____
17. Weight: _____ Height: _____
18. Identifying marks_____
19. Current School Status:_____
20. Last School Attended:_____
21. Last Completed Grade:_____
22. Religious Preference:_____

23. Diagnosis: _____
25. Medical ID #:_____
25. Other Ins. #: _____
26. Ins. Policy #: _____
27. Primary Language:_____
28. Permanency Plan:_____
29. Employment Status:_____
30. Last Living Arrangements:____
_____

SECTION III: LEGAL STATUS:

32. Legal Parental Custody/Guardian: _____
33. Street Address: _____ 34. City: _____ 35. State: _____ 36. Zip _____
34. Court Status:_____

35. Date of Court commitment/referral: _____

36. Last Court Hearing: _____

37. Offense History:_____ Case Classification: _____

SECTION IV: PARENT INFORMATION

38. Biological Father:_____
_____
(last) (first) (m. i.)

39. Address:_____
(st/p.o) (city) (state) (zip)

40. Phone: (h)_____(w)_____

41. DOB:_____Age:_____
(mm) (dd) (yyyy)

42. Marital Status:_____

43. Marriage Date:_____

44. Divorce Date:_____

45. Race:_____

46. Religious Preference: _____

47. Education:_____

48. Occupation:_____

49. Soc. Sec. Number:_____

50. Military/Veteran Status:_____

51. Criminal History:_____

52. Deceased: ☐ Yes ☐ No

53. Biological Mother:
(last) (first) (m.i.)

54. Address:_____
(st/p.o) (city) (state) (zip)

55. Phone: (h)_____(w)_____

56. DOB:_____Age:_____
(mm) (dd) (yyyy)

57. Marital Status:_____

58. Marriage Date:_____

59. Divorce Date:_____

60. Race:_____

61. Religious Preference_____

62. Education:_____

63. Occupation:_____

64. Soc. Sec. Number:_____

65. Military/Veteran Status:_____

66. Criminal History:_____

67. Deceased: ☐ Yes ☐ No

68. Income:

☐ $<10,000	☐ $40,001-$50,000
☐ $10,001-$20,000	☐ $50,001-$60,000
☐ $20,001-$30,000	☐ $60,001-$75,000
☐ $30,001-$40,000	☐ $75,001-100,000

☐ $<10,000	☐ $40,001-$50,000
☐ $10,001-$20,000	☐ $50,001-$60,000
☐ $20,001-$30,000	☐ $60,001-$75,000
☐ $30,001-$40,000	☐ $75,001-$100,00

Significant Others:

69. Name:_____
(last) (first) (mi)

70. Relationship to youth:_____

71. Current Address:_____

72. Phone: (h) _____(w)_____

73. DOB:_____Age:_____

74. Occupation: _____

75.Name:_____
(last) (first) (mi)

76. Relationship to youth:_____

77. Current Address:_____

78. Phone: (h)_____(w)_____

79. DOB:_____Age:_____

80.Occupation:_____

SECTION V: SIBLING INFORMATION

81. Name (last/first)	Gender	Age	Relationship to youth	Current Living Situation	Address	Phone #

SECTION VI: INTERESTED RELATIVES/OTHERS (those who have role in case)

82. Name (last/first)	Relationship	Address	Phone Number	Authorized Contact? (Yes/no)

82-a. Current Family Medical Needs ☐Yes ☐No

82-b. Current Family Social Needs ☐Yes ☐No

82-c. Current Family Financial Needs ☐ Yes ☐ No

82-d. Other Needs ☐ Yes ☐ No

SECTION VII: SUMMARY OF NEED FOR CARE

83. Youth Behavior Check List: ☐

84. Reason For Referral/Circumstances Leading to Need for Care:

85. Psychological History

SECTION VIII: TREATMENT HISTORY

86. Previous Assistance/Placements:

Services Name	Location (city, state)	Dates (from-to)
		___/___
		___/___
		___/___
		___/___

SECTION IX: PREPARATION FOR PLACEMENT

87. Brief description of youth's preparation for placement:

88. Physical, Emotional and Psychological status of child at the time of placement: (healthy, receptive to treatment, previous/current medications)

89. Clothing Needs ☐
90. Planned School Placement: Name of School: _____
91. Date Informed School letter sent:_____
92. Date of Enrollment:_____ Person Enrolling:_____
93. Education Needs:

SECTION X: IMMEDIATE FOLLOW-UP NEEDED
YOUTH NEEDS:

YES NO Last Physical Date:_____ Physician:_____
YES NO Medication :_____ Physician:_____
YES NO Last Dental Date:_____Dentist:_____

YES	NO	Immunization Record	YES	NO	Mental Health Services
YES	NO	Medicaid Application	YES	NO	Clothing Allotment

FAMILY NEEDS: (Explain)
YES NO Medical/Psychological:_____
YES NO Social:_____
YES NO Financial:_____
YES NO Other:_____

Intake Worker:_____ Date:_____
Program Social Worker:_____ Date:_____

INDIVIDUAL SERVICE AGREEMENT

State of Michigan Department of Human Services

INSTRUCTIONS:
- Local DHS office completes form.
- Gives PART 1 to the Contract Agency.
- Retains PART 2 in the case record.

Note to child placing agencies: This form is not to be used for adoption services.

In accordance with the DHS Foster Care Master Contract and Service Agreement the following agreement for the purpose of:

☐ Child Placing Agency Services ☐ Child Caring Institution Services

Has been entered between:	Local DHS Office Name	and:	Name Contract Agency

Contract Agency Address (number, street, city, state, zip code)	Provider Number

The Contract Agency Agrees to provide services, as specified in the Master Contract and Service Agreement, for the child identified as:

Name of Child	Birth Date	Case Number

Specific Services Included:

Required Reports:

The Contract Agency agrees to submit the following child specific reports: Initial Service Plan in 30 calendar days, Updated Service Plan every 90 days thereafter, Placement Change Reports, Termination Report, Other

Date of Anticipated Next Placement (if more than ten months, this agreement is to be renegotiated and a new one signed before the end of the tenth month.) ▶	Anticipated Next Placement

The Local Department of Human Services agrees to:

1. Comply with the terms of the Master Contract and Service Agreement and with the policies and procedures published in the Department's Services Manual.
2. Local Agency placing the youth will be responsible for the following services:
3. Local Agency in the county where provider is located, will be responsible for the following services:
4. Provision of the appropriate payment documents based on the child's legal status:

☐ Court Ward — Primary funding is through the individual county payment process; a DHS-626 will be provided by the local DHS office **if** the child becomes eligible for federal funds

☐ State Ward — The Department of Human Services is responsible for payment; a DHS-626 will be provided by the local DHS office.

If a child's legal status changes during the term of this individual service agreement, a new agreement must be negotiated and signed by both the agency and the local DHS office.

REIMBURSEMENT RATE

The Department agrees to pay the Contract Agency the established per diem rate for the above service.

If the child is placed in family foster care, the Department further agrees to pay the age appropriate per diem rate for foster parent reimbursement, or such other amount as may be authorized by the Department subsequent to the signing of this individual service agreement.

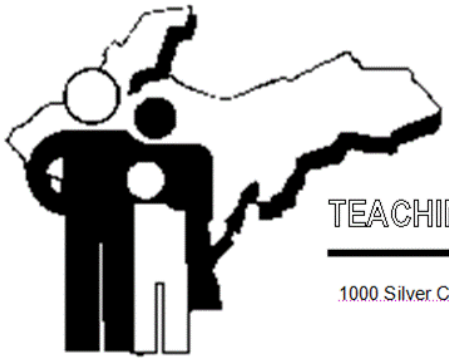
REQUIRED DOCUMENTATION:

- **Contract Agency -** The Contract Agency agrees to retain documentation to support all charges and expenditures and to immediately report changes to the Department which may affect the payment status of the child. Documentation of Agency prior approval for any nonscheduled payment is to be maintained by the Contract Agency.

- **Local Department Office -** The Department agrees to submit the following documentation: Referral Material as required in the Master Agreement. Payment Authorization/Billing Document, Acknowledgment of Receipt and approval of Initial Service Plan and Updated Service Plan, a Quarterly Report if providing primary family services

APPROVALS	DHS Local Office Director or Designee Signature (*If two offices involved, both signatures required*)	Signature Date
	Contract Agency Director or Designee Signature	Signature Date

AUTHORITY: Public Act 280, 1939 COMPLETION: Required. PENALTY: No payment for services	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.



TEACHING FAMILY HOMES OF UPPER MICHIGAN

1000 Silver Creek Road • Marquette, MI 49855 • 906-249-KIDS (5437) • Fax: 906-249-5438
www.teachingfamilyhomes.org

PLACEMENT AGREEMENT

The undersigned, being the custodial parent(s) of the legal guardian(s) of

_____ _____

(Child's Full Name) (Date of Birth)

I/We agree and understand that placement of my/our child by the _____ in a Teaching-Family Group Home for treatment, care, and education is in the child's best interest and therefore, the following agreement is made: (or if placement is by the Court of Agency, please attach a copy of the Court Order or Agreement with the custodial parent(s) or legal guardian which authorizes the placement.)

I/We recognize that proper care and education cannot be given to the child if authority over him/her is divided, and therefore I consent to abide fully by the direction and judgement of the Family-Teachers and Teaching-Family Home personnel in whatever they feel is in the child's best interest so long as this Placement Agreement is in effect.

It is further understood with Teaching-Family Homes of Upper Michigan that unless this Placement Agreement is terminated as provided below, the child will not be placed in any program other than one administered or approved by Teaching-Family Homes of Upper Michigan.

Teaching-Family Homes of Upper Michigan staff, have my/our full and free consent to seek services, including hospital, dental, medical, psychiatric and surgical services as may, in the judgement of a licensed physician, dentist, or psychiatrist, be advisable for the health and general welfare of the child. I/We hereby release Teaching-Family Homes of Upper Michigan and staff, both jointly and severally from any and all liability, expressed or implied, which may result from such services.

I/We promise, to the best of my/our ability or authorization, to pay expenses of hospital, medical, psychiatric, surgical and dental care given to the child. The child is insured by the following health or accident insurance policies:

Name of Company_____
Location of Branch Office_____
Contract or Policy Number or Medicaid Number_____

If the above coverage changes at any time, I/we will immediately inform Teaching-Family Homes of Upper Michigan.

This agreement is in effect beginning_____ 200____, until it is determined by Teaching-Family Homes and placement agency that care shall be terminated. Termination will be based upon completion of individual treatment plans unless otherwise recommended by Teaching-Family Homes of Upper Michigan and placement agency.

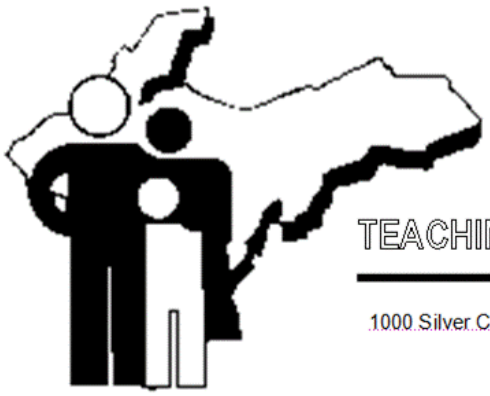
_____ _____
Mother/Guardian Date

_____ _____
Father/Guardian Date

_____ _____
Placement Agency Worker Date

_____ _____
Program Staff Date

Y:\FORMS\intake forms\Placement Agreement.doc



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TEACHING-FAMILY HOMES OF UPPER MICHIGAN
Group Home Program

CONSENT TO YOUTH PARTICIPATION IN ACTIVITIES AND PROGRAMS

The parents and/or legal guardians of all youth enrolled in the Teaching Family program are asked to give permission for the youth to participate in all facets of the program, both at the home and away from the home. The Teaching Home program is able to provide a wide range of activities which all youth can participate in, and in all cases, these activities are supervised by qualified adults.

Program outings may include water skiing, boating, horseback riding, hiking, river canoeing, swimming, water sports, skating and skiing.

Outside activities such as sports and employment, as well as various entertainment activities which include bicycling, skate boarding, roller skating, camping, cooking, and going to amusement parks, are encouraged and conditional upon performance in the Teaching Family program.

General household maintenance activities would typically include lawn mowing and using general household appliances, utensils, and common household devices such as ladders in maintenance and repair (i.e., cleaning and repairing windows, gutters, etc.). A youth may be required to operate equipment as part of vocational training.

The above lists are only examples of some of the activities often included in a Teaching Family program in which youth participate and are not all inclusive. Please sign the form below giving your permission for the youth to participate in all these activities.

……..

As the person legally responsible for_____, a youth
(Name of Youth)
enrolled in the Teaching Family Program, I hereby give permission for him/her to participate in all facets of the Teaching Family program, both at the home and away from the home. I am aware that some of these activities do contain elements of risk even though all activities are properly supervised by qualified staff.

_____ _____
Legal Guardian Date

_____ _____
Program Staff Date

TEACHING-FAMILY HOMES OF UPPER MICHIGAN
INFORMED CONSENT FORM

_____
(Name of Youth)

Youth who become candidates for the Teaching-Family Homes of Upper Michigan program are those who have been having serious problems in their home, school and community and are being considered for long term placement outside their communities. The goal of Teaching-Family Homes of Upper Michigan is to offer a program that will help these youth learn the social, academic, self-care, pre-vocational skills that will aid them in getting along better with their families, peers, and members of the community.

I understand that reasonable precautions will be taken to keep any information collected about my child confidential and to prevent the use or disclosure of information which would identify my child or put my child at risk. I understand that my child has the right to inspect and to receive copies of treatment records and to request an amendment if deemed inaccurate. TFH adheres the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my child will be participating in Teaching-Family Homes of Upper Michigan educational studies. I willingly give permission for my child to participate knowing that the information concerning my child may be used for scientific, educational, rehabilitation or instructional purposes. Identifying information will not be used in such studies.

Research in the Teaching-Family Homes Group Home program includes a collection of information about the behavior of Teaching-Family Homes Group Home residents over such variables as social skills, vocational behaviors, maintenance skills, school behavior, court contacts, etc.

I understand that my child will be representing Teaching Family Homes in activities involving the public. These activities may include--but are not limited to--guest visits, media events, program tours, and testimonials. Efforts will be made to safeguard youth confidentiality and sensitive issues.

I agree that my child may participate in video, audio recording, or pictorial representations made during his/her stay at the Teaching-Family Homes. These may include television, newspaper, brochures, Teaching Family Homes media and the agency website.

_____Yes _____No _____Legal Guardian Initials

I understand, as indicated in my child's treatment plan, that my child will likely be able to visit with me. As a part of my child's treatment plan, I will be expected to participate in my child's treatment through visitation. I understand that if I am unable to provide transportation for such

visits, that Teaching-Family Homes' staff will assist me. I agree to accept responsibility for my child during such periods that he/she is in my care and agree to notify the program immediately if any evidence of difficulty should appear. For example, if my youngster runs away or becomes physically abusive or is arrested, I would agree to contact the staff immediately to inform them of such happenings.

I agree that the placing agency, the supervising agency and the group home shall incur no liability for any injury or harm sustained or caused by my child when he/she is under my care and supervision. My responsibilities for that care and supervision include such times as weekends, holidays, family vacations and any other similar occasions that may occur during my child's residence in the Teaching Family Homes Group Home.

I understand that youth who are placed in the Teaching-Family Homes group home program have been having serious problems getting along with others. Because of a variety of life experiences, these youth have a higher risk of engaging in physically aggressive behaviors. These behaviors may include stealing, property destruction, physical threats or attacks or sexually acting out. Although the staff takes preventive measures, I understand that there is always the possibility that my child may be subjected to such aggression. I also understand that property that my child brings into the program may be damaged or destroyed, and that Teaching Family Homes will not be held responsible for such damage.

Legal Guardian:_____ Witness:_____

Youth:_____ Witness:_____

Program Staff:_____

Date:_____

Teaching-Family Homes of Upper Michigan
Release of Information Consent Form

I, _____, authorize Teaching Family Homes of Upper Michigan to

release _____ and/or request _____ information from the record of _____
(Name of Client) DOB

to the following agency or person:

_____

Name Address City State Zip Code

( ) Academic Testing Results ( ) Psychological Testing Results ( ) Intelligence Testing Results
( ) Behavior Programs ( ) Service Plans ( ) Vocational Testing Results
( ) Case Notes ( ) Summary Reports ( ) Medical Reports
( ) Personality Profiles ( ) Progress Reports ( ) Psychological Reports
( ) Entire Record ( ) Unrestricted two-way communication ( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program ( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program ( ) Case Review
( ) Updating Files ( ) Other (specify) _____
_____

I understand that my treatment is not conditioned on my providing authorization for this request. I understand that I can examine or copy the information being released. If the information being released with result directly or indirectly in remuneration (payment) form a third party, I must receive a statement in writing.

I understand that this consent automatically expires one year from date of signature, or at the time the client completes treatment. I understand that I may refuse to sign the authorization. I understand that I may revoke this consent at any time by providing written notice.

I have been informed what information will be given, its purpose, and who will receive the information. *I understand that clinical records containing information about substance abuse and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) require authorizing initials. _____ (Recipients initials).

Signature of Client _____Date_____

Signature of Parent/Guardian _____Date_____

Signature of Witness (if client is unable to sign)_____Date_____

Signature of Person Informing Client of Rights _____Date_____

* Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.

Teaching-Family Homes of Upper Michigan
Release of Information Consent Form

I, _____, authorize Teaching Family Homes of Upper Michigan to

release _____ and/or request _____ information from the record of _____
(Name of Client) DOB

to the following agency or person:

_____

Name Address City State Zip Code

( ) Academic Testing Results ( ) Psychological Testing Results ( ) Intelligence Testing Results
( ) Behavior Programs ( ) Service Plans ( ) Vocational Testing Results
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( ) Entire Record ( ) Unrestricted two-way communication ( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program ( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program ( ) Case Review
( ) Updating Files ( ) Other (specify) _____
_____

I understand that my treatment is not conditioned on my providing authorization for this request. I understand that I can examine or copy the information being released. If the information being released with result directly or indirectly in remuneration (payment) form a third party, I must receive a statement in writing.

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I have been informed what information will be given, its purpose, and who will receive the information. *I understand that clinical records containing information about substance abuse and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) require authorizing initials. _____ (Recipients initials).

Signature of Client _____Date_____

Signature of Parent/Guardian _____Date_____

Signature of Witness (if client is unable to sign)_____Date_____

Signature of Person Informing Client of Rights _____Date_____

* Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.

Teaching-Family Homes of Upper Michigan
Release of Information Consent Form

I, _____, authorize Teaching Family Homes of Upper Michigan to

release _____ and/or request _____ information from the record of _____
(Name of Client) DOB

to the following agency or person:

_____

Name Address City State Zip Code

( ) Academic Testing Results ( ) Psychological Testing Results ( ) Intelligence Testing Results
( ) Behavior Programs ( ) Service Plans ( ) Vocational Testing Results
( ) Case Notes ( ) Summary Reports ( ) Medical Reports
( ) Personality Profiles ( ) Progress Reports ( ) Psychological Reports
( ) Entire Record ( ) Unrestricted two-way communication ( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program ( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program ( ) Case Review
( ) Updating Files ( ) Other (specify) _____
_____

I understand that my treatment is not conditioned on my providing authorization for this request. I understand that I can examine or copy the information being released. If the information being released with result directly or indirectly in remuneration (payment) form a third party, I must receive a statement in writing.

I understand that this consent automatically expires one year from date of signature, or at the time the client completes treatment. I understand that I may refuse to sign the authorization. I understand that I may revoke this consent at any time by providing written notice.

I have been informed what information will be given, its purpose, and who will receive the information. *I understand that clinical records containing information about substance abuse and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) require authorizing initials. _____ (Recipients initials).

Signature of Client _____Date_____

Signature of Parent/Guardian _____Date_____

Signature of Witness (if client is unable to sign)_____Date_____

Signature of Person Informing Client of Rights _____Date_____

* Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.

TEACHING FAMILY HOMES OF UPPER MICHIGAN
1000 Silver Creek Road
(906) 249-5437

PERMISSION TO RELEASE OFFICIAL SCHOOL RECORDS

NAME OF SCHOOL: _____
ADDRESS: _____

You are hereby authorized to provide Teaching-Family Homes of Upper Michigan with a copy of the school records for the following student:

_____ _____
Name Date of Birth

_____ _____
Address Parent or Guardian

Please send immediately the entire record to Teaching-Family Homes of Upper Michigan at the address listed above.

Please send immediately only the following portions of the student's record:

_____ Official administrative record (name, address, birth date, grade level completed, grades, class standing, attendance record);

_____ Attendance record

_____ Referral/disciplinary record

_____ Health record including immunization record

_____ Copy of last report card

_____ Standardized Achievement Test scores

_____ Intelligence, aptitude, and interest test scores

_____ Special Services (I.E.P. report, speech therapy, tutoring, etc.)

I am aware that these school records are available for my inspection at any time and that I may receive a personal copy if requested.

_____ _____
Name Relationship to Youth

_____ _____
Date Witness

_____
Expiration Date

TEACHING-FAMILY HOMES OF UPPER MICHIGAN
GROUP HOME RESIDENTIAL SERVICES
RECIPIENT RIGHTS INFORMATION

A person shall not be denied services on the basis of race, color, nationality, religious or political belief, gender, age, county of residence, or ability to pay.

I agree to keep Teaching-Family Homes of Upper Michigan informed concerning my child and family situation until services are terminated.

I do hereby verify that *YOUR RIGHTS WHEN RECEIVING MENTAL HEALTH SERVICES IN MICHIGAN* has been presented and reviewed with me.

The rights information was explained because it is part of the program's orientation and required by licensing regulations.

_____ _____

Youth Date

_____ _____

Legal Guardian Date

_____ _____

Program Staff Date

Appendix I

TEACHING FAMILY HOMES OF UPPER MICHIGAN

1000 Silver Creek Road, Marquette, MI 49855
906-249-5437

PRIVACY AND CONFIDENTIALITY

Youth Name _____ Date of Birth _____

Teaching Family Homes of Upper Michigan (TFH) is committed to the privacy and confidentiality of protected health information (PHI), as identified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This commitment means that TFH employees and volunteers will protect the confidentiality of PHI related to the service of your child/family.

Individuals receiving services from TFH are entitled to specific privacy rights regarding their treatment services. As a recipient/consumer of TFH services, you need to be aware that all TFH consumers have the right:

- To have their privacy protected and their treatment records kept private, whether in written or electronic form
- To have their treatment disclosed only with their consent (outside of the TFH Notice of Information Practices).
- To have this authorization revoked, to the extent that action has not been taken, by submitting a written request.

I understand that there are limits to confidentiality that include the following:

- Immediate, grave danger to the client or to others (if, for example, one has reason to believe that the client is suicidal or homicidal)
- Recent or ongoing child abuse or abuse of a dependent adult
- Diagnosis of diseases or conditions subject to mandatory public health reporting

In such cases, it is required by law that reports be made to the necessary authorities, which may include—but are not limited to—public health agencies, the Department of Human Services, the client's local court system, or law enforcement agencies.

By signing below I acknowledge that I have been made aware of my rights and limitations in regards to my privacy and confidentiality as a client and/or family member with Teaching-Family Homes of Upper Michigan.

_____ _____
Signature (Legal Guardian) Date

_____ _____
Signature (Youth) Date

_____ _____
Witness (TFH) Date

Updated 10/05/07

PHYSICAL RESTRAINT

POLICY

Staff must inform the youth and family of the agency's physical restraint policy and procedures when a youth enters the home. Physical restraint should be used only in those situations where the youth's safety is in danger or the youth is endangering the safety of others. The choice whether or not to restrain is dependent upon the concept of least amount of ensuing harm. Physical restraint should be the last resort and the least restrictive measure necessary to keep injury from occurring and should last only as long as the threat of physical harm is clearly apparent. Supervisors should be involved with decisions involving restraint throughout the time the emergency safety situation is occurring, as their involvement will protect the restraining person(s) as well as the youth and ensure necessary follow-up procedures are implemented.

PROCEDURE

1) Upon youth's placement:

   a. Staff must inform the youth and family of the agency's physical restraint policy and procedures when a youth enters the home (See Appendix I).
   b. An assessment of the youth's need for restrictive behavior interventions must be conducted (See Appendix II). Assessment findings should be addressed as necessary in the youth's Initial Service Plan.

2) Suggested pre-restraint techniques:

   There are several techniques that should be tried prior to physical restraint that include physical contact but are not considered physical restraint as defined. These techniques are suggested in an attempt to help the youth control his/her emotions without the need for physical restraint. These techniques include: calm but clear and firm instructions for an immediate change in the youth's behavior; clear reality statements as to what the consequences are for the youth's continued out-of-control or violent behavior; physically positioning oneself between the youth and the potentially threatening or harmful situation (i.e., between the youth and a window when the youth has threatened or intends to break or jump out the window); and, physical guidance by the staff member such as placing a hand on the youth's

shoulder or around the youth's shoulders and walking or directing the youth toward a more appropriate location, or gently holding the youth's arm or hand or guiding him to a more appropriate area for the youth to regain emotional control. This is an attempt to direct body movements in an appropriate direction or to help the youth approximate the instruction and, therefore, avoiding harm with the least restrictive means possible without fully regaining emotional control and without any unnecessary or undue force.

3) Physical Restraint Defined:

The physically holding of a youth's body (arms, legs or torso), in such a way as to prevent injury to himself or to the restraining person or persons around him. The restraining force should be sufficient to restrict the youth's movement of body, arms, or legs to keep the youth from hitting, kicking, biting, or head banging but should not be so restrictive as to obstruct air passages or breathing in any way. It should not restrict vision in any way and should not restrict normal blood flow in any way (i.e., holding of the wrists so tightly that blood does not reach the hands and fingers). The preferred method is to hold the youth in a bear-hug fashion from behind in a standing or sitting position. The youth's arms should be crossed in front of him and held loosely by the hands or wrists at about the youth's front waistline. The legs may be restricted by wrapping the restraining person's legs gently around the youth by overlapping the youth's legs with the restraining person's legs. (CPI Children's Control Position)

Avoid sitting or laying on top of any youth or forcing the youth's face and chest down on a flat surface, especially upon a bed as this may bend the spine backward and cause injury or may force the face into the bed covers and therefore restrict breathing.

Physical restraint should last only as long as the threat of physical harm is clearly apparent. This does *not* include restraining until the youth calms down. The youth may still be out of emotional control and yelling, moving around the area, running, or causing minor property damage, but is no longer a clear threat of physical harm to himself or others and, therefore, making physical restraint not necessary. A physical restraint should never last longer than 15 minutes. Restraints that last longer than 15 minutes are not permitted without the consent of a medical professional.

The restraint should be continually monitored in order to observe the physical and psychological well being of the minor child.

If at any time injury could occur from restraint or attempted restraint, then this procedure should not be used. If injury does not occur from a restraint or attempted restraint, the Program Supervisor should be notified and medical attention secured immediately.

4) If restraint is required:

a. The Program Supervisor and the TFH Licensed Master's Social Worker or Counselor must be called prior to the restraint, if possible; otherwise, as the restraint is occurring. The Licensed Social Worker/Counselor must provide an order for restraint, specifying what techniques are approved and for how long.
b. Upon release of the restraint, complete an assessment of the youth's psychological and physical well being immediately. **If the restraint lasts longer than 15 minutes, a medical professional must complete the assessment.** The licensed medical professional must conduct a face to face assessment of the child within one hour of the onset of the emergency safety intervention and then immediately after the child is removed from physical restraint.
c. Notify the child's parents or legal guardian of the incident, unless it is deemed not to be in the minor's best interest.
d. Within 24 hours, debrief with the youth and complete follow-up teaching.
e. A Physical Intervention Report should be completed and given to the Program Supervisor within 24 hours (See Appendix IV, V & VI).
f. Within 24 hours after the intervention, the consultant should debrief with staff person(s) involved.
g. During the next team meeting, the youth's treatment plan should be updated as necessary.

TEACHING FAMILY HOMES OF UPPER MICHIGAN

ACKNOWLEDGEMENT OF RESTRAINT POLICY

In accordance with Child Care Act 722.112d(5), parents must be provided with a written notification of an agency's policies regarding the use of personal restraint.

I do hereby verify that a copy of the agency's physical restraint policy has been presented and reviewed with me.

Procedures regarding the agency's use of personal restraint were explained to me in a language I understand.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Staff Signature Date

*__NOTE TO STAFF:__ Provide a copy of the restraint policy and this document to the parent upon admission.

APPLICATION FOR FOOD REIMBURSEMENT

Name and Grade of Youth for Whom Application is Made:

_____ _____
Name Admission Date

_____ _____
School Grade Termination Date

_____
Teaching-Family Home

If the child is a resident of a licensed "Child Caring Institution" he or she is considered a single person family and only his/her actual spending money is considered income, list his/her spendable income per month_____.

This application is being made in connection with receipt of Federal Funds by Teaching-Family Homes of Upper Michigan. Federal Officials may verify information on this application. Deliberate misrepresentation of information subjects the applicant to prosecution under applicable state and federal penal statutes.

I hereby certify that all of the above information is true and correct to the best of my knowledge and belief.

_____
Signature of Program Staff

_____ _____
Approved by Program Director Date

CLOTHING INVENTORY CHECKLIST

State of Michigan – Department of Human Services

Use only the section appropriate for child's age and sex.
File in Case record upon completion as outlined in SM Item 902.
NOTE: This is not a mandatory wardrobe, only a guideline for help in determining basic clothing needs. Items and quantities may be modified to meet individual needs.

Case Name					
Case Number					Date
County	District	Section	Unit	Worker	Other ID (as required)

Sex	Age	Amount Allowed for Needed Clothing
☐ Male ☐ Female		$

CHILDREN 0 – 24 MONTHS OF AGE

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
Outerwear			
Daytime Outfits	5		
Jacket	1		
Snowsuit	1		
Blankets – receiving	6		
Blanket – large	1		
Underwear & Nightwear			
*Diapers	48		
*Rubber Pants	6		
Undershirts	12		
Pajamas	4		
Footwear			
Socks	8		
Shoes	1		
Accessories			
Mittens	1		
Hat	1		

CHILDREN 2 – 5 YEARS OF AGE

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
Outerwear			
Daytime Outfits	5		
Jacket	1		
Snowsuit	1		
Bathing Suit	1		
Underwear & Nightwear			
Training Pants or Panties	8		
Undershirts	8		
Pajamas	2		
Footwear			
Socks	8		
Shoes	1		
Sneakers	1		
Boots	1		
Accessories			
Mittens	1		
Hat	1		

GIRLS 6 – 12 YEARS OF AGE

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
Outerwear			
Heavy Coat	1		
Raincoat	1		
Jacket	1		
Sweaters	1		
Dresses	2		
Skirts	1		
Blouses	1		
Shirts	3		
Jeans	1		
Slacks	2		
Shorts	2		
Bathing Suit	1		
Underwear & Nightwear			
Slips	1		
Panties	8		
Bathrobe	1		
Pajamas	2		
Footwear			
Socks	6		
Tights	2		
School Shoes	1		
Sneakers	1		
Boots	1		
Accessories			
Gloves	1		
Hat	1		

BOYS 6 – 12 YEARS OF AGE

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
Outerwear			
Heavy Coat	1		
Jacket	1		
Raincoat	1		
Sweater	1		
Slacks	1		
Jeans	3		
Dress Shirt	1		
Polo Shirt	4		
Tie	1		
Shorts	2		
Bathing Suit	1		
Underwear & Nightwear			
Undershorts	7		
Undershirts	7		
Pajamas	2		
Footwear			
Socks	8		
School Shoes	1		
Sneakers	1		
Boots	1		
Accessories			
Gloves or Mittens	1		
Hat	1		
Belt	1		

*At Foster Parents' discretion, can be initial supply (one economy box) of disposable diapers. Ongoing cost of replacement is included in board and care rate.

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
GIRLS 13 – 18 YEARS OF AGE			
Outerwear			
Heavy Coat	1		
Raincoat	1		
Jacket	1		
Sweaters	2		
Dresses	1		
Skirts	2		
Blouses	2		
Shirts	4		
Jeans	2		
Slacks	2		
Shorts	2		
Bathing Suit	1		
Underwear & Nightwear			
Slips	1		
Panties	8		
Bra	3		
Bathrobe	1		
Pajamas	1		
Footwear			
Socks	5		
Nylons	2		
School Shoes	1		
Sneakers	1		
Slippers	1		
Boots	1		
Accessories			
Gloves or Mittens	1		
Hat or Scarf	1		
Belt	1		

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
BOYS 13 – 18 YEARS OF AGE			
Outerwear			
Heavy Coat	1		
Jacket	1		
Raincoat	1		
Sweater	2		
Slacks	2		
Jeans	2		
Dress Shirt	1		
Polo Shirt	5		
Tie	1		
Shorts	2		
Bathing Suit	1		
Underwear & Nightwear			
Undershorts	6		
T-shirts	6		
Pajamas	1		
Footwear			
Socks	8		
School Shoes	1		
Sneakers	1		
Boots	1		
Accessories			
Gloves or Mittens	1		
Hat or Scarf	1		
Belt	1		

REMARKS:

YOUTH BEHAVIOR CATEGORIES

PRE/POST **Name:**
Date:

	MILD	MODERATE	SEVERE
1. EATING-DIFFICULTIES			
a. Anorexia Nervosa			
b. Bulimia			
c. Pica			
d. Feeding or other Eating problems			
2. SEXUAL CONCERNS			
a. Sexually Active			
b. Masturbation			
c. Sexually Abused			
d. Homosexual Behavior			
3. AGGRESSIVE BEHAVIOR			
a. Assaultive with Adults			
b. Assaultive with Peers			
c. Destructive of Property			
d. Sexually Assaultive Toward Adults			
e. Sexually Assaultive Toward Peers			
4. ADJUSTMENT DIFFICULTIES			
a. Fire Setting			
b. Substance Abuse			
c. Substance Experimentation			
d. Withdrawn			
e. Stealing			
f. Oppositional Behavior			
g. School Truancy			
h. Verbally Abusive			
i. Runaway			
5. SELF-DESTRUCTIVE			
a. Talks about Suicide			
b. Has attempted Suicide			
c. Self-Mutilation			

6. FUNCTIONAL DISORDERS

a. Lacks Age-Appropriate Self-Care Skills _____ _____ _____

b. Encopresis _____ _____ _____

7. ATTENTION DEFICITS

a. Hyperactive _____ _____ _____

b. Attention Span Problems _____ _____ _____

8. AFFECTIVE DIFFICULTIES

a. Depression _____ _____ _____

9.PHYSICAL/
EMOTIONAL/
NTELLECTUAL DISABILITIES

a. Mentally Impaired _____ _____ _____

b. Emotionally Impaired _____ _____ _____

c. Hearing Impaired _____ _____ _____

d. Visually Impaired _____ _____ _____

e. Speech & Language Impaired _____ _____ _____

f. Specific Learning Disability _____ _____ _____

g. Severely Multiple Impaired _____ _____ _____

h. Physical or otherwise Health Impaired _____ _____ _____

i. Epileptic Seizures _____ _____ _____

j. Psychotic _____ _____ _____

DEFINITIONS

MILD

This behavior has occurred only once or twice in the past 12 months with each episode lasting for a short period of time and was mild in its expression.

MODERATE

This behavior has occurred 3-5 times in the past 12 months with each episode lasting for an extended period of time and was moderate in its expression.

SEVERE

This behavior has occurred 6 or more times in the past 12 months with each episode lasting for an extended period of time and was severe in its expression.

YOUTH FINANCIAL INFORMATION

YOUTH NAME : _____

GROUP HOME : _____

PLACEMENT AGENCY : _____

PLACEMENT DATE : _____ / _____ / _____

AGENCY CASEWORKER : _____

AUTHORIZATION DATE : _____ / _____ / _____

FUNDING SOURCE (check one)

/__/ STATE AGENCY
/__/ COUNTY AGENCY
/__/ OTHER AGENCY: _____

THIS MUST BE COMPLETED

Billing should be sent to: Agency: _____

Attention: _____

Street Address: _____

City, State & Zip:_____

Telephone number:_____

Signature of referring worker: _____

Print or type name of referring worker: _____

Date: _____

MEDICAID STATUS

YOUTH:_____

GROUP HOME:_____

DATE OF PLACEMENT:_____

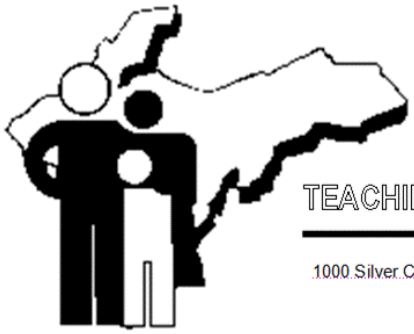
1. My child,_____, is currently receiving Medicaid benefits. The number is _____.

2. My child, _____, is receiving other insurance benefits through _____. The policy number is _____.

3. I do not wish that my child, _____, receive medical benefits and will assume responsibility for any medical, dental, optical, or psychological services which may be incurred while my child is in placement. I understand that I will be informed as these services are recommended.

Parent/Guardian_____

Date_____



TEACHING FAMILY HOMES OF UPPER MICHIGAN

1000 Silver Creek Road • Marquette, MI 49855 • 906-249-KIDS (5437) • Fax: 906-249-5438
www.teachingfamilyhomes.org

Teaching-Family Homes of Upper Michigan
DENTAL/PHYSICAL EXAMINATION UPDATE

Youth Name: _____

Program: _____

The youth's *dental / physical* examination, originally scheduled for _____
(date)

was missed due to _____.
(reason appointment missed)

On _____, a *dental / physical* examination was

scheduled / re-scheduled. The earliest possible date is with _____
(name of Doctor)

and will occur on_____.
(date of appt.)

_____ _____
Supervisor Signature Date

TEACHING-FAMILY HOMES OF UPPER MICHIGAN
MEDIA CONSENT FORM

_____
(Name of Family)

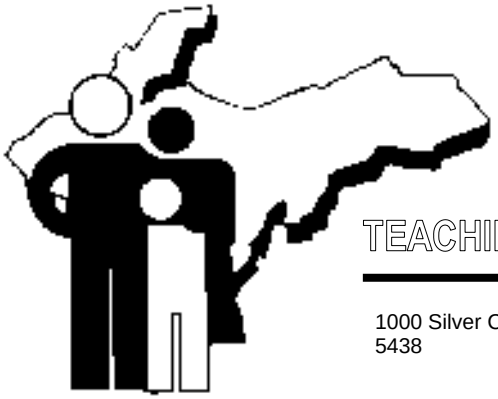
I understand that my family may be representing Teaching Family Homes in activities involving the public. These activities may include--but are not limited to--guest visits, media events and publications, program tours, and testimonials. Efforts will be made to safeguard confidentiality and sensitive issues.

I agree that my family may participate in written, video, audio recording, or pictorial representations made while involved with the Teaching-Family Homes. These may include television, newspaper, brochures, Teaching Family Homes media and the agency website.

Family Representative:_____

Program Staff:_____

Date:_____



TEACHING FAMILY HOMES OF UPPER MICHIGAN

1000 Silver Creek Road • Marquette, MI 49855 • 906-249-KIDS (5437) • Fax: 906-249-5438

To Whom It May Concern:

I hereby verify that _____ _____
First name Last name

is current on all immunizations _____(please use a check mark) as of _____.
Current date

OR

is in need of the following immunization(s). (Please include the time lines needed to be followed):

Signed by:_____ Date: _____

Position: _____

TEACHING FAMILY HOMES OF UPPER MICHIGAN

INTERNAL YOUTH COUNSELING REFERRAL INFORMATION

Date: _____ Name of Youth: _____ Age: ____ DOB: _____

Gender: _____ County of origin: _____ Agency involved: _____

Caseworker: _____ Phone # _____

TFH Referring Worker: _____ Phone # _____

Original case classification: ☐ Delinquent ☐ Abuse/Neglect

Agency financially responsible for counseling: _____

RD/Consultant requesting counseling: _____

Current Placement GrpHm /Home-based /Foster Care: _____

Anticipated start date: _____

Date of Professional staffing (if applicable): _____

Reason for referral: _____

_____

_____

_____

_____

☐ Sexual Offender ☐ Sexual Abuse Victim ☐ Suicide Attempt ☐ Runaway
☐ Suicide Threats ☐ Stealing/Lying ☐ Substance Abuse ☐ Fire setting
☐ Assaultive ☐ Psychotropic Meds: _____
☐ Other _____

Is the child a danger to self or others? Yes ☐ No ☐

Treatment Goal(s) for counseling: _____

_____

_____

Anticipated Length of time: _____

Education Status: Current School: _____
Grade: _____ Special Education: No ☐ Yes ☐ Classification: _____

Permanency Plan:	Anticipated implementation date:

DHS Authorization ☐ PCA # ☐

Signature of Person Taking Referral: _____

Referred to: _____

Assigned Counselor: _____