YOUTH RECORDS FACE SHEET

SECTION I: CHILD INFORMATION

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

2. Permanent Address: _____

_____

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

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

5. Social Security Number: _____

6. Program: _____

7. Youth# _____

8. Hair color: _____

9. Eye Color: _____

10. Race: _____

11. Referring Worker: _____

12. Referring County: _____

13. DHS Case #: _____

14. Court Case #: _____

15. MiSACWIS ID#: _____

SECTION II: OTHER CHILD INFORMATION

16. Funding Source: _____

17. Prior Placement: _____

18. Gender: _____

19. Weight: _____ Height: _____

20. Identifying marks _____

21. Current School Status: _____

22. Last School Attended: _____

23. Last Completed Grade: _____

24. Religious Preference: _____

25. Diagnosis: _____

26. Medical ID #: _____

27. Other Ins. #: _____

28. Ins. Policy #: _____

29. Primary Language: _____

30. Permanency Plan: _____

31. Employment Status: _____

32. Last Living Arrangements: ____

_____

SECTION III: LEGAL STATUS:

33. Legal Parental Custody/Guardian: _____

34. Street Address: _____ City: _____ State: _____ Zip _____

35. Court Status: _____ E-mail Address: _____

36. Date of Court commitment/referral: _____

37. Last Court Hearing: _____

38. Offense History: _____ Case Classification: _____

SECTION IV: PARENT INFORMATION

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

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

41. Phone: (h)_____(w)_____
E-mail Address: _____

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

43. Marital Status: _____

44. Marriage Date: _____

45. Divorce Date: _____

46. Race: _____

47. Religious Preference: _____

48. Education: _____

49. Occupation: _____

50. Soc. Sec. Number: _____

51. Military/Veteran Status: _____

52. Criminal History: _____

53. Deceased: ☐ Yes ☐ No

54. Income:

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

55. Biological Mother: _____
(last) (first) (m.i.)

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

57. Phone: (h)_____(w)_____
E-mail Address: _____

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

59. Marital Status: _____

60. Marriage Date: _____

61. Divorce Date: _____

62. Race: _____

63. Religious Preference _____

64. Education: _____

65. Occupation: _____

66. Soc. Sec. Number: _____

67. Military/Veteran Status: _____

68. Criminal History: _____

69. Deceased: ☐ Yes ☐ No

70. Income:

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

Significant Others:

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

72. Relationship to youth:_____

73. Current Address:_____

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

75. DOB:_____Age:_____

76. Occupation: _____

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

78. Relationship to youth:_____

79. Current Address:_____

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

81. DOB:_____Age:_____

82 .Occupation:_____

SECTION V: SIBLING INFORMATION

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

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

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

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

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

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

85-d. Other Needs ☐ Yes ☐ No

SECTION VII: SUMMARY OF NEED FOR CARE

86. Youth Behavior Check List: ☐

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

88. Psychological History

SECTION VIII: TREATMENT HISTORY

89. Previous Assistance/Placements:

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

SECTION IX: PREPARATION FOR PLACEMENT

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

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

92. Clothing Needs ☐
93. Planned School Placement: Name of School: _____
94. Date Informed School letter sent: _____
95. Date of Enrollment: _____ Person Enrolling: _____
96. 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 Medicaid Application
YES NO Mental Health Services
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.

RESIDENTIAL PLACEMENT EXCEPTION REQUEST

Michigan Department of Human Services

Date Completed: County:

ALL SECTIONS OF THIS FORM ARE MANDATORY.

Date of Initial Residential Placement:
Anticipated date for this placement request:
Anticipated length of stay for this placement request:

CHECK the Type of Residential Placement Exception Request Being Made:

NOTE: There should only be more than one INITIAL residential exception for a child if the child is discharged to a community placement for 61 or more days and the child returns to residential.

County Approval

☐ Initial	☐ 3 Months	☐ Placement Exceeds 75 miles
☐ 6 Months	☐ 9 Months	

CWFO Approval

☐ 12 Months	☐ Beyond 12 Months	
☐ Change in Residential Placement	☐ Pre-Ten: Begin Date: _____	End Date: _____

I. CASE INFORMATION

Child's Name	Date of Birth	
Legal Status		
Federal Permanency Goal		
Date entered care	SWSS FAJ Log ID	Case Number
Total number of placements since the date entered care (not including this placement):		
Date MiTeam held – Attach report for this placement request	Date of most recent face-to-face contact with child	
Were MiTeam recommendations implemented? ☐ Yes ☐ No	If No, explain:	

II. CASE WORKER CONTACT INFORMATION

Supervising Agency
☐ DHS Direct ☐ PAFC Provider:

Name of DHS caseworker/DHS Monitor	Contact Phone Number (DHS Direct or PAFC)	E-mail Address (DHS Direct or PAFC)
Supervisor Name (DHS Direct or PAFC)	Supervisor Contact Phone Number (DHS or PAFC)	Supervisor E-mail Address (DHS or PAFC)

Child's Name	Date of Birth	SWSS FAJ Log ID

III. RESIDENTIAL PLACEMENT (Check all that apply):

- ☐ Pre-Ten Waiver
- ☐ Placement in a Residential Program Not Under Contract with DHS
- ☐ Placement Outside of the Contracted Geographic Area
- ☐ Placement Outside of the Contracted Bed Capacity
- ☐ Placement of an Abuse/Neglect Ward into a Residential Foster Care – Juvenile Justice Program
- ☐ Placement of a Juvenile Justice Ward into a Residential Foster Care – Abuse/Neglect Program
- ☐ Age (Program Type Exception – Non Pre-Ten Waiver)
- ☐ One-on-One Supervision Number of hours requested _____ Hourly rate _____
  Begin Date _____ End Date _____

Type of Residential Foster Care Facility

Facility Name

Facility Address

Per Diem	Provider Number	Service Code
$		

1. List the child's diagnosis (Axis I-V, DSM IV TR), Current medications, and any PRN (as needed) medication and frequency of use. Attach current copies of IEP, psychological tests/cognitive function assessment, behavior treatment plans, psychiatric reports, medication reviews, as applicable.

2. List each placement for the child and indicate why each placement was not successful and/or factors contributing to disruption of placement. Include services provided to prevent replacements.

3. List efforts to locate less restrictive or other residential placement(s): list all referrals, including program name, person contacted, date of referral and reason for rejection:

4. List the specific residential treatment components to meet the child's treatment needs at this facility.

5. Attach the most recent court order and Permanency Case Review Form (DHS-643).

6. Is a family identified as the next placement, and what efforts are being made by this county to assist the family in participating with child's program?

PRE-TEN WAIVERS ONLY (reference DHS Policy, FOM 722-3). 90 day approvals

1. Provide a detailed description of assisted care, Wraparound or other interventions that have been used to maintain this child in the community.

Child's Name	Date of Birth	SWSS FAJ Log ID

2. Provide the results of the fetal alcohol spectrum disorder (FASD) pre-screening.

- Placement of children less than ten years of age in residential or other institutional settings will not be authorized for more than three months.
- This child's treatment needs must be reassessed every 90 days, including consideration of the most appropriate and least restrictive placement setting available to meet the child's treatment needs. The assessment must be documented in the Updated Service Plan.
- Attach the most recent Service Plan (ISP/USP) and, if applicable, the RISP/RUSP to this request.

PROGRESS UPDATES SINCE LAST PLACEMENT EXCEPTION REQUEST

1. Please describe in detail the child's recent behaviors and progress in the program since the last request, that necessitates continued residential placement:

2. Seclusion and restraint numbers for last 3 months:

- Attach the most recent Service Plan (ISP/USP) and the RISP/RUSP to this request.

Child's Name	Date of Birth	SWSS FAJ Log ID

IV. SIGNATURES REQUIRED FOR SUBMISSION

Foster Care/POS Monitor/JJ Worker Name	Foster Care/POS Monitor/JJ Worker Signature	Date
Supervisor Name	Supervisor Signature	Date
DHS Monitor Supervisor Name (if applicable)	DHS Monitor Supervisor (if applicable) Signature	Date
Section Manager Name(if applicable)	Section Manager (if applicable) Signature	Date
District Manager Name(if applicable)	District Manager (if applicable) Signature	Date

V. Urban Child Welfare Director/County Director – Decision (Approval required at all levels Initial, 3, 6, 9, 12 month and subsequent reviews)

☐ Approved
☐ Approved with the following conditions:
☐ Denied due to the following circumstances:

Urban Child Welfare Director/Non-Urban County Director Signature _____ Date _____

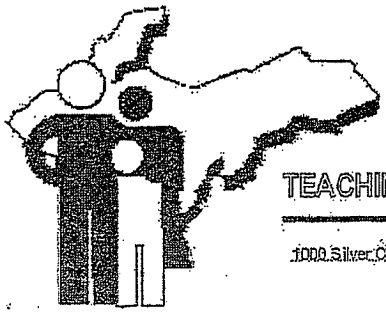
VI. Bureau of Child Welfare Field Operations Director – Decision: (Approval required at levels 12 month and subsequent 90 day reviews and Pre-Ten waivers.)

☐ Approved
☐ Approved with the following conditions:
☐ Denied due to the following circumstances:

Director, Bureau of Child Welfare Field Operations Signature _____ Date _____

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, 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.

cc: Local DHS Director
Private Agency (if applicable)



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:

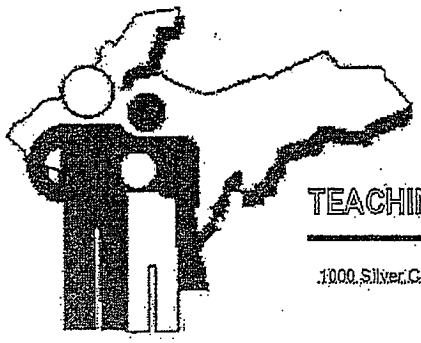
Name of Company_____
Location of Branch Office_____
Contract or Policy Number or Medicaid Number_____

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



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
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:_____

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

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
() 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.

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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

Y:\FORMS\intake forms\Release School Records.doc

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

Public\Forms\GH\Recipient Rights.wpd

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

TEACHING FAMILY HOMES OF UPPER MICHIGAN

YOUTH FINANCIAL INFORMATION

YOUTH NAME : _____

PLACEMENT HOME : _____

PLACEMENT AGENCY : _____

PLACEMENT DATE : ____/____/_____

AGENCY CASEWORKER : _____

AUTHORIZATION

START DATE: ____/____/_____

END DATE: ____/____/_____

FUNDING SOURCE (check one)

/__/ STATE DHS

or

/__/ COUNTY OR OTHER AGENCY: _____

ATTENTION: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

Signature of referring worker: _____

Print or type name of referring worker: _____

Date: _____

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.

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		$

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
CHILDREN 0 – 24 MONTHS OF AGE			
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		

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
CHILDREN 2 – 5 YEARS OF AGE			
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		

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
GIRLS 6 – 12 YEARS OF AGE			
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		

SUGGESTED WARDROBE & QUANTITY		CHILD HAS	CHILD NEEDS
BOYS 6 – 12 YEARS OF AGE			
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.

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.

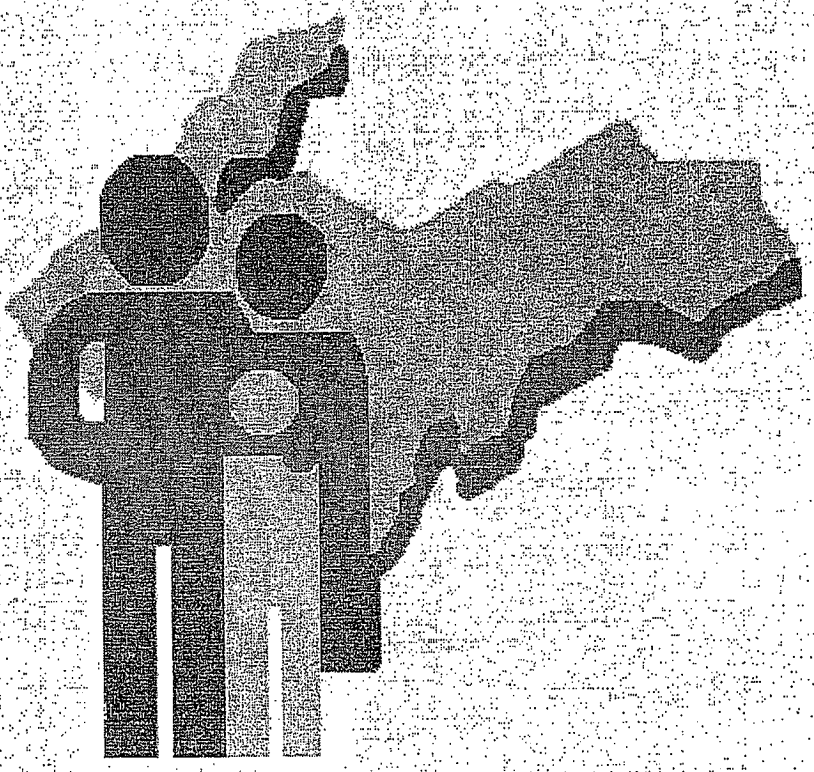
I agree that my family may participate in written, video, audio recording, or pictorial representations made while involved with the Teaching-Family Homes. These may include television, newspaper, brochures, Teaching Family Homes media and the agency website.

Family Representative:_____

Program Staff:_____

Date:_____

Teaching Family Homes of Upper Michigan



YOUTH SAFETY GUIDE

The Basics

While you are at Teaching Family Homes of Upper Michigan (TFH), it is important to us that you remain safe and free from people touching you and talking to you in bad and/or inappropriate ways. We want to help all youth become successful in an environment that is safe.

WHAT'S INSIDE:

This book will help you learn how to stay safe at TFH:

This home is required to comply with Federal PREA standards. This booklet is designed to help you understand your rights under PREA standards and give you important information about your safety. Youth and staff safety is one of the most important values of TFH.

It also tells you how to:

- **Be safe at TFH facilities**
- **Get help if someone touches or talks to you in a bad way.**
- **Take the right steps to report if you are touched or talked to in a bad way.**

TFH Does Not Want Anyone To Get Hurt by Bad Touch or Bad Talk

This means if any youth or staff member is using bad touch or bad talk with you, TFH will investigate what you tell them. The investigation will follow laws and rules in accordance with the state of Michigan and Federal PREA standards.

Definitions

Bad touch and bad talk includes any of the following things that someone may do to you:

(1) Someone touching you in any of your private places with any part of their body.

(2) Someone touching you in any of your private places with something such as a stick or a pencil.

(3) Someone asking you if they can touch your private parts.

(4) Someone asking you to touch their private parts.

(5) Someone telling you that they will hurt you or someone else if you don't let them touch you in your private parts.

(6) Someone asking you to show you their private parts.

(7) Someone showing you their private parts.

(8) Someone peeking at you through a window or door.

(9) Someone asking you or making you watch TV or Movies that show people touching each other or talking to each other in a bad way.

(10) Someone taking pictures of your private parts or showing you pictures of private parts

Definitions

Voyeurism — Someone peeking at you through a door or window to try and see your private parts, or asking you to show them your private parts. This also means someone taking pictures or videos of your private parts.

Sexual Assault — Anyone touching you in your private parts with any part of their body, including hands, feet, or with anything else like a stick, pencil, toy, or doll.

Sexual Harassment — includes:

(1) When someone asks or keeps asking you to let them touch you, or asks you to touch them in their private areas..

(2) When someone keeps telling you that you look nice and they would like to touch you in you private areas, or that they would like you to touch them in their private areas.

(3) If someone keeps making fun of you because you are a girl or a boy and it makes you mad or uncomfortable.

The Problem of Bad Touch and Bad Talk:

Whether you are living in a group home or back in your home town, the possibility always exists that another person may use bad touch or bad talk with you.

It is wrong for anyone to threaten or hurt another person. Everyone deserves to be safe.

Bad touch, bad talk, and bad pictures are against the law and need to be investigated by the police. People who hurt you this way need to have consequences for their inappropriate behaviors.

Bad Touch/Bad Talk

All bad touch and bad talk between staff members, volunteers, contractors, and youth is prohibited and may be against the law. Also, bad touch and bad talk between youth and other youth is prohibited and in some cases is against the law.

TFH Works Hard to Keep You SAFE

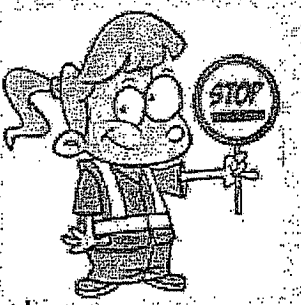
Staff members will do everything they can to prevent bad touch or bad talk.

The actions they will take include:

- Supervise you closely.
- Create and enforce rules to keep everyone safe.
- Hold a person accountable (no matter who they are) if they use bad touch or bad talk with someone else. This means staff members will report bad touch or bad talk so it can be investigated.

Staying Safe

Promoting safety is not only what staff members do, but what you, as a youth must do. Here are some things you can do to remain safe.



PAY ATTENTION TO:

* **Where you are -**

Don't be alone and away from staff members so that they can see you and make sure you are safe.

* **Situations that make you feel uncomfortable -**

Trust your feelings. If you feel funny or uncomfortable about something or someone, report it to a staff member or another adult that you trust.

* **Special attention someone may be giving just to you -**

This may be favors, romantic or sexual advances, gestures or talk. This includes sharing secrets. You need to report this to a staff member or another adult that you trust.

* **Who you tell private information to -**

Report information only to staff or another adult that you trust, such as a parent, foster parent, your legal guardian, or case worker.

Be Safe!

- **Do Not: Accept any offer of protection**

  Someone offering to protect you from consequences or harm from anyone else will want something from you in return

- **Do Not: Accept a loan or gift**

  Do not borrow, or trade anything. Avoid owing anything to anyone.

- **Do Not: Don't let manners get in the way of keeping yourself safe**

  Do not be afraid to shout "NO" or "STOP IT NOW"!

TAKE ACTION!!

- Tell a staff member immediately if someone tried to isolate you, singles you out, gives you anything special, wants to trade or loan an item, or offers you protection.
- It is very important that you report these things to a staff member because they can stop it right away.
- If you think staff member does not take you seriously or does not believe you, tell another staff member above them.

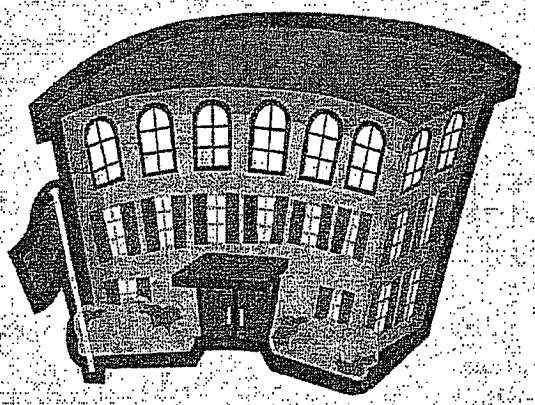
Your Rights

You have the right to be free from anyone hurting you with bad touching or bad talking. You also have the right to be free from receiving negative consequences for reporting incidents of bad touch or bad talk. If someone uses bad touch or bad talk with you or know of someone that this has happened to you need to report it to a staff member immediately. Reporting can be hard to do but it will make sure that you and others are safe from harm. It also means that the person who caused the harm may not harm you or others any more. This is a very important way to make sure where you live is safe.

How to Report Bad Touch/Talk:

Talk to or send a letter or note to any of the following:

- Direct Care Staff
- Counselors
- Consultant/Supervisor
- Social Worker
- Teachers
- Other staff members at your facility



Or, you can make a report by:

- Filing a grievance and putting it in the locked grievance box in the home.
- Calling your attorney
- Asking a staff member to help you research available legal services
- **Contact your PREA Compliance Manager, or**
- **Contact your PREA Coordinator**

If Bad Touch or Bad Talk Occurs:

What are the steps I should take if someone uses bad touch with you?

If this happens it is important that you do the following:

* Report what happened to a staff member
* The staff member will separate you from the person who hurt you and ensure that you get medical attention immediately. You will also be able to talk to a counselor.

The following steps help preserve evidence so TFH can take action against the person who is alleged to have touched you. It is important that you avoid the following *until* you get medical attention:

DO NOT:

- Shower or wash
- Use the bathroom
- Eat or drink
- Brush your teeth

What are the steps I should take if someone uses bad talk with you?

If this happens it is important that you do the following:

- Report the bad talk to a staff member.
- The staff member will separate you from the alleged harasser and you will be able to talk to a counselor as soon as possible.

What will happen if I use bad touch or bad talk with someone?

We will investigate what happened and will report it to your guardians, case worker, and counselor. If you are found guilty you could have legal consequences. If you have trouble controlling your actions, seek help so that you don't harm anyone.

What should I do if I witness bad touch or bad talk or even just suspect I witnessed bad touch or bad talk?

You need to report any bad talk or bad touch that you saw or think you saw. An investigation will take place to find the truth. You won't get in trouble if you make an honest report.

What will happen if I make a false report?

TFH takes reports of bad touch or bad talk very seriously. If you choose to make a false report against anyone, it will be discovered. Anyone making a false report will receive some negative consequences. This includes loss of privileges, intensive treatment planning, and possible criminal charges. Our goal is to provide the safest environment possible. Being honest in what you say and do is important in keeping everyone safe.

Resources

Children's Protective Services:

1 (888) 444-3911

Women's Center Crisis Line:

(906) 226-6611

PREA Coordinator

(906) 249-5437

Limits to Confidentiality:

TFH must report all incidents of alleged bad touch and/or bad talk to the appropriate Children Services Agency and other mandatory sources, even if you report an incident in confidence.

Statement of Understanding

I have read the Youth Safety Guide or have had someone explain it to me. I understand the procedures in this guide, and any questions I had were answered. By signing below, I am agreeing that I know the following things:

- ⇒ How to be safe in TFH facilities.
- ⇒ What kind of things staff will do to help keep me safe.
- ⇒ My rights in regards to bad touch, bad talk, privacy, and confidentiality.
- ⇒ What to do and what not to do if bad touch or bad talk occurs.
- ⇒ How to report bad touch and bad talk..
- ⇒ What things are available to help me if bad touch or bad talk occurs..

SIGNATURES:

_____ _____

Youth Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

MEDICAL PASSPORT

Michigan Department of Human Services

CASE NAME: CASE NUMBER: DATE OF BIRTH: SEX:

ADDRESS: County District Section Unit Worker Program Number:

MEDICAID TYPE: SWSS Log

MEDICAL HISTORY/MEDICAL NEEDS

FAMILY MEDICAL HISTORY:

MO=Biological Mother FA=Biological Father BOTH=Biological Parents
(Circle all that apply/or type code on line)

MO/FA/BOTH _____ Heart Problems
MO/FA/BOTH _____ Cancer
MO/FA/BOTH _____ Diabetes
MO/FA/BOTH _____ Asthma
MO/FA/BOTH _____ Allergies
MO/FA/BOTH _____ Sickle Cell Anemia
MO/FA/BOTH _____ Mental Illness
MO/FA/BOTH _____ Strokes
MO/FA/BOTH _____ High Blood Pressure
MO/FA/BOTH _____ Other _____

CHILD'S MEDICAL HISTORY:

Prenatal Care: ☐ Yes ☐ No ☐ Unknown
Alcohol or drugs taken during pregnancy?: ☐ Yes ☐ No ☐ Unknown
If Yes, specify: _____
Full Term Pregnancy: ☐ Yes ☐ No ☐ Unknown
Type of Delivery: ☐ Natural ☐ Cesarean ☐ Unknown
Birth Weight: _____ lbs _____ Oz.

List age when child:

_____ Sat Alone
_____ Crawled
_____ Walked
_____ Spoke First Word
_____ Spoke 2 to 3 Words Together

If child had any of the following, please indicate date of most recent occurrence:

Date		Date	
_____	Measles	_____	Earache/Ear Infection
_____	Mumps	_____	Anemia
_____	Chicken Pox	_____	Meningitis
_____	Whooping cough	_____	Paralysis
_____	Scarlet Fever	_____	Heart Disease
_____	Frequent Colds/Cough	_____	Thyroid Disease
_____	Frequent Sore Throat	_____	Convulsions/Seizures
_____	Tonsillitis	_____	Head Banging
_____	Pneumonia	_____	Breath Holding
_____	Sickle Cell Anemia	_____	Vision Problems _____ Glasses
_____	HIV/AIDS	_____	Hearing Problems _____ Hearing Aide
_____	Kidney/Bladder Infections	_____	Sexually Transmitted Disease
_____	Speech		
_____	Other Medical Conditions, Specify:	_____	
_____	Chronic Illnesses, (Asthma, Diabetes, etc...), Specify:	_____	
_____	Other Forms of Self-Abuse, Specify:	_____	
_____	Allergies, Specify:	_____	
_____	Unusual Reaction to Medicine, Specify:	_____	

Child's Name: _____

DOB: _____

SWSS Log #: _____

NAME:

VACCINE	#	AGE	DATE	MANUFACTURER	DOSE (ml)
DTP	1				
DTP	2				
DTP	3				
DTP	4				
DTP	5				
Td	1				
Hep. B	1				
Hep. B	2				
Hep. B	3				
Polio	1				
Polio	2				
Polio	3				
Polio	4				
Hib b	1				
Hib b	2				
Hib b	3				
Hib b	4				
MMR	1				
MMR	2				
MMR	3				
Varicella	1				
Varicella	2				
Hep. A					

Non-Administered Vaccine	Date	Reason

Child's Primary Health Care Provider:

Child's Name:

Name	Address		
City	State	Zip Code	Phone Number

PROVIDER	DATE OF SERVICE	SERVICES CODE & NAME	DIAGNOSIS CODE & NAME

Child's Name _____

RECORD ON-GOING MEDICATIONS

Date	Name of Medication	Dosage	Reason for Medication

I certify that I have obtained all known information for the child named above. This is in accordance with the Michigan Department of Human Services policy.

The Medical Passport contains:
A) All medical information required by policy or law to be provided to foster parents.
B) A basic medical history.
C) A record of all immunizations.
D) A record of on-going medications.
E) Other information concerning the child's physical and mental health.

Each of the child's placement providers (foster parent/kinship caregiver, etc.) have been provided a copy of the Medical Passport along with:
- All known history of abuse or neglect of the child;
- All known emotional and psychological problems of the child;
- All known behavioral problems of the child; and
- The documents that verify the above information.

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

cc: Case File
Foster Parent
DHS Monitoring Worker

PSYCHOTROPIC MEDICATION INFORMED CONSENT

Michigan Department of Human Services

Section A – Youth Identifying/Demographic Information (Information may be completed by worker, agency staff, medical staff, etc.)

Identifying Information: Please Print

Child/Youth name:	Date of birth:	Sex: ☐ Male ☐ Female
Assigned Caseworker:	DHS or AGENCY and DHS Local Office or Agency Address:	Telephone:
Legal Status: ☐ Temporary Ward Court ☐ State Ward ☐ Permanent Ward Court	Current Placement: ☐ CCI (residential) ☐ Hospital ☐ Other: ☐ Own Home ☐ Relative ☐ Foster Home	Date of Current Placement:
Birth Parent/Legal Guardian (Temporary Court Ward):	Address:	Telephone:

Existing DHS-1643 Informed Consent For any psychotropic medication currently prescribed to the youth, the assigned caseworker must ensure that:

- The existing DHS - 1643 informed consent is passed on to the current prescribing physician.
- If the informed consent was not completed, is unavailable or expired the required DHS-1643 informed consent process for the medication(s) must be completed.

An existing DHS-1643 Psychotropic Informed Consent for this youth (check applicable box) is:

☐ **Not Applicable.** Youth is not currently prescribed psychotropic medication.
☐ **Attached.** A copy of the DHS-1643 informed consent for the child/youth's current psychotropic medications is included.
☐ Not completed. **A DHS-1643 informed consent has not been completed or is unavailable for the child/youth's current psychotropic medications. The informed consent process must be completed.**

Section B – Health Information (Information to be completed by health care personnel – nursing, MA, PA, etc.)

Appointment Date	Height:	Weight:	Medical Diagnoses:

Non-psychotropic Medications:

Mental Health Diagnoses:

Section C – Consent for psychotropic medications and treatment plan (signed by those with authority to consent)
NOTE: Foster Parents and relative caregivers **cannot** consent to administration of psychotropic medications.

PSYCHOTROPIC MEDICATIONS – Completed by Physician or Medical Staff
See box on page 4 for guidance when a DHS-1643 must be completed

Medication Name	Ongoing No Change	Ongoing Change Dose	New	Discontinued	Dosage Exceeds previous dosage range	Annual Renewal
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

NOTE to licensed physician: If new medication, increased dose beyond previous consent range or annual review, complete page 2.

*I understand that I can withdraw consent at any time during treatment.

Signature of Consenting Party* (Consenter must sign/date in appropriate box below.) New medications or dosage increases beyond previous informed consent cannot be administered until signed consent or court order is received from appropriate consenting party (as indicated below).

Birth Parent/Legal Guardian (for temporary court wards).	Supervising Agency (DHS or Private Agency) Foster Care Worker or Representative (for Act 220 or Act 296 state wards only)	Youth (age 18 and older)

During transition of care where current DHS-1643 is not available, ongoing medication can continue up to 45 days pending completion/ receipt of DHS-1643

DHS Psychotropic Medication Informed Consent

Child/Youth Name:

Section D – Prescribing Physician Information (Information may be completed by caseworker, agency staff, medical staff, physician, etc.)

Prescribing Physician Name (Please Print):	Telephone:
Name of office/facility (if applicable):	Office/Facility Address (include address number and zip code):

Section E – Psychotropic Medication Information (to be completed by licensed physician) include:

- New medication(s),
- Existing medications for which no consent exists,
- Previous DHS-1643 informed consent is expired (renew annually),
- Increasing dosing beyond approved dosing range,
- Discontinuing existing medication, and/or
- Youth reaches age 18.

Medication Name:	Approved Dosage Range: –	Directions for Use:
Target Symptoms(for new or continuing medication or reasons for discontinuing medication):	Potential Side Effects (Information Sheet may be attached):	
Treatment Alternatives:	Pre-treatment/Ongoing Monitoring Recommended:	

CRITERIA TRIGGERING FURTHER REVIEW

To the physician: In compliance with the MDHS Guidelines for the Use of Psychotropic Medication for Children in State Custody, any medication regimen meeting the triggering criteria below will be reviewed by DHS. The review does not denote that treatment is inappropriate, only that further review is warranted. Please check any boxes that apply, and provide the clinical rationale for the medication regimen. You may be contacted after the review.

Does use of this medication fall within the triggering criteria? If any of the following criteria are checked, complete the Rationale field below.

- ☐ Prescribed four or more concomitant psychotropic medications.
- ☐ Prescribed two or more concomitant anti-psychotics.
- ☐ Prescribed two or more concomitant mood stabilizer medications.
- ☐ Prescribed psychotropic medications in doses above recommended doses.
- ☐ Prescribed two or more concomitant anti-depressants.
- ☐ Prescribed two or more concomitant stimulant medications.
- ☐ Prescribed two or more concomitant alpha agonist medications.
- ☐ Prescribed psychotropic medication and child is five years or younger.

Rationale (if applicable)

The above medication was discussed/reviewed with:

Youth	☐ No	☐ Yes	Date	Youth Signature:		
Foster Parent/Relative Caregiver	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone
Birth Parent or Legal Guardian – for temporary court wards	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone
Assigned Foster Care Worker (DHS or Private Agency) – for state wards	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone

Medication Name:	Approved Dosage Range: –	Directions for Use:
Target Symptoms (for new or continuing medication or reasons for discontinuing medication):	Potential Side Effects (Information Sheet may be attached):	
Treatment Alternatives:	Pre-treatment/Ongoing Monitoring Recommended:	

CRITERIA TRIGGERING FURTHER REVIEW

To the physician: In compliance with the MDHS Guidelines for the Use of Psychotropic Medication for Children in State Custody, any medication regimen meeting the triggering criteria below will be reviewed by DHS. The review does not denote that treatment is inappropriate, only that further review is warranted. Please check any boxes that apply, and provide the clinical rationale for the medication regimen. You may be contacted after the review.

Does use of this medication fall within the triggering criteria? If any of the following criteria are checked, complete the Rationale field below.

- ☐ Prescribed four or more concomitant psychotropic medications.
- ☐ Prescribed two or more concomitant anti-psychotics.
- ☐ Prescribed two or more concomitant mood stabilizer medications.
- ☐ Prescribed psychotropic medications in doses above recommended doses.
- ☐ Prescribed two or more concomitant anti-depressants.
- ☐ Prescribed two or more concomitant stimulant medications.
- ☐ Prescribed two or more concomitant alpha agonist medications.
- ☐ Prescribed psychotropic medication and child is five years or younger.

Rationale (if applicable)

The above medication was discussed/reviewed with:

Youth	☐ No	☐ Yes	Date	Youth Signature:		
Foster Parent/Relative Caregiver	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone
Birth Parent or Legal Guardian – for temporary court wards	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone
Assigned Foster Care Worker (DHS or Private Agency) – for state wards	☐ No	☐ Yes	Date	Method of review:	☐ In-Person	☐ Telephone

Prescribing Physician Signature: **Date:**

NOTE: If additional medications are required, save current page 2, and add other medication information on new page 2.

DHS Psychotropic Medication Informed Consent

Child/Youth Name:

Legal Status:

Section F – Caseworker Record To ensure timely access, review and monitoring of the psychotropic medications, the assigned case worker must track the informed consent process. Per DHS policy, upon receipt of the DHS-1643 from the prescribing physician, the assigned worker (or other department/agency designee) must:

- For temporary court wards, obtain parental signature (consent) within 7 business days. If worker is unable to obtain parental signature in 7 business days, all efforts made to obtain parental consent **must be documented** in the Comment Section of the Consent Process below (including dates). After a diligent effort has been made for parental signature with no response, the worker must seek consent by petitioning the court on the 8th business day.
- For state wards (Act 220 or Act 296), ensure that the completed, signed DHS-1643 is returned to the prescribing clinician within 7 business days.
- For permanent court wards (Legal Status 41), the worker must seek consent by petitioning the court within 3 business days.
- For hospital settings, written consent is required in 3 business days. After a diligent effort has been made for parental signature with no response, the worker must seek consent by petitioning the court on the 4th business day.

Document the following information regarding the DHS-1643.

Activity	Date	Comments
1. CONSENT PROCESS		
DHS-1643 received from prescribing physician.		
Sent to _____ for consenting signature.		
Received from consenting party.		
Returned to prescribing physician.		
Consent Process Requiring Court Order to Administer Psychotropic Medication for: • Temporary Court Wards, birth parent/legal guardian whereabouts are unknown or is unwilling to provide consent and child's physician or psychiatrist has determined there is a medical necessity for the medication. • Permanent Court Wards (Legal Status 41).		
Motion filed with the court by supervising agency requesting court order for the prescription and administration of necessary medication.		
Court order received.		
Copy of court order submitted to prescribing physician.		
2. MEDICATION OVERSIGHT PROCESS		
Review Criteria Triggering Further Review (in Section E)*		
Sent to DHS Central Office (Medical Consultant Review).		
Received from DHS Central Office (Medical Consultant Review).		
3. TRANSITION OF CARE, if and when applicable		
Copy of DHS-1643 submitted to new treating psychiatrist or physician. _____ Provider's name above		
Copy of DHS-1643 submitted to placement facility (CCI, Treatment Facility, Detention, etc.) _____ Facility name above		
Copy of DHS-1643 sent to Hospital _____ Hospital name above		
Use Additional Lines as Needed		

Additional Comments for Medical Consultant:

Assigned Caseworker Name	Assigned Caseworker Email Address

A copy of the completed, signed Psychotropic Medication Consent form must be emailed to the DHS Medical Consultant at PsychotropicMedicationInformedConsent@michigan.gov within 5 business days upon worker receipt.

DHS Psychotropic Medication Informed Consent

Child/Youth Name:

A signed DHS-1643, Psychotropic Medication Informed Consent form is completed for each of the following circumstances:

- Prescribing new psychotropic medications.
- Documenting the current existing medications for children entering foster care.
- Existing DHS-1643 is expired. DHS-1643 must be renewed yearly.
- Increasing dosing beyond the approved dosing range.
- Discontinuing existing prescribed psychotropic medications.
- Youth reaches age 18.

Distribution:
Primary Care Physician (if different from Prescribing Physician)
Placement (foster parent, relative caregiver, residential facility)
Prescribing Physician
Consenter (Parent/Legal File/Youth)
DHS Medical Consultant
Case File

INSTRUCTIONS FOR USE

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

INSTRUCTIONS FOR SCORING

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

REFERENCES

Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasability study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.

Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: http://psc.partners.org.

Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.

Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

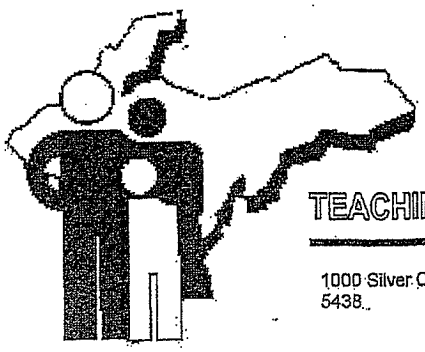
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			



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

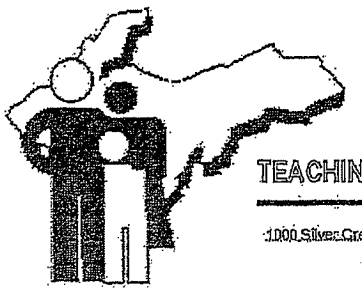
is current on all immunizations _____(please use a check mark) as of _____.
Current date

OR

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

Signed by:_____ Date: _____

Position: _____



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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

Y:\FORMS\intake forms\dentalphysicalupdate.doc

MEDICAID STATUS

YOUTH:_____

GROUP HOME:_____

DATE OF PLACEMENT:_____

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

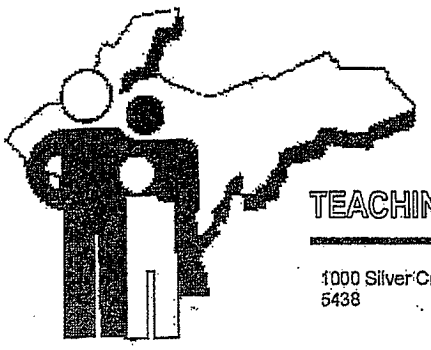
2. My child, _____, is receiving other insurance benefits through _____. The policy number is_____.

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_____

public\forms\gh\medicaid.wpd



TEACHING FAMILY HOMES OF UPPER MICHIGAN

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

TO: Parents/Guardians of Non Court Ordered Clients
FROM: Teaching Family Homes _____
(Program Name)

While your child is at Teaching Family Homes _____ she/he will
(Program Name)
be attending school. Since your child is not court ordered, we need the following statement placed in their file.

I, _____ hereby place my son/daughter,
(Parent/Guardian's Name)
_____, born on _____.
(Child's Name) (Date of Birth)
at Teaching Family Homes _____ for the purpose of securing a
(Program Name)
suitable home and education.

_____
Parent/Guardian's Signature Date

_____
Address

_____
City