PRINT CLEAR FORM

SUBMIT FORM

Dana's House, Inc.

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DeWitt, Arkansas 72042
Tel 870-946-8303 Fax 870-946-8217
Email jwilliams@danashouse.org
www.danashouse.org

RESIDENT FILE REQUIREMENTS

To be in compliance with state rules and regulations, we request that upon completion of the Admission and Child Intake forms that you provide us with the following:

Copy of Residents:

- Admission Forms (6 pages)
- Receipt and Release of Prescriptions and Over the Counter Medications List
- Consent for Services and Authorization Form
- Placement Authorization Form
- List of Approved Contacts
- Visiting Resources Form
- Release of Liability Form
- School Contact Form
- Medication Upon Admission Policy
- HIPPA Acknowledgement Form
- Birth Certificate
- Social Security Card
- Medicaid Card (if available)
- Immunization Records
- School Records (minimum of school's name, address, and child's grade level)
- Case Plan or Case Plan Review
- Court Order
- DCFS Case Number
- PACE Evaluation
- Copy of CANS

Thank you for your time and assistance. We look forward to working with you.

Typed Name Represents Legal Signature On This Document

Dana's House, Inc.

Admission Form

Date: _____ Time of Arrival: _____

Demographic Information (Child):

Name: _____

First Last Middle

DOB: _____ Gender: _____ SSN: _____

Medicaid#: _____ Religious Preference: _____

Race: American Indian, Asian, Black, Hispanic, White, Other: _____

DCFS Information:

Child's Current Legal Status: _____ County: _____

Legal Guardian/Person Requesting Placement: _____

Address: _____

Street _____City_____State_____Zip Code_____

Phone# (DHS office) _____ On Call # (REQUIRED): _____

DHS FSW email: _____

Legal Information:

Attorney Ad Litem (AAL): _____

Address: _____

Street _____City_____State_____Zip Code_____

Phone# (REQUIRED) _____ Alt. Phone#_____

AAL email: _____

Is the Child Currently on Probation: ☐ Yes / ☐ No

County of Probation: _____

Probation Officer: (PO): _____

Address: _____

Street _____City_____State_____Zip Code_____

Phone# (REQUIRED) _____ Alt. Phone#_____

PO email: _____

If Yes to Probation, EXPLAIN: _____

_____

_____

History of/ Current Family in Need of Services Petition (FINS): ☐ Yes / ☐ No

If yes to FINS, EXPLAIN: _____

_____

_____

Placement History:

Last Placement Before Admission: _____

With Whom Did the Child Last Live/Relationship: _____

Address: _____

Street _____City_____State_____Zip Code_____

Phone#: _____ Work #: _____ Contact List: ☐ Yes / No ☐

Why Child needs Placement Now: _____

_____

Any History of Previous Placement Outside the Family? ☐ Yes / ☐ No

If Yes, Please Explain: When? Where? Why were they removed? _____

_____

_____

Description of Current Circumstances Requiring Removal from Parents:

_____

_____

_____

Family Background Information:

Father: _____

First **Last** **Middle**

DOB: _____ **Gender:** _____

Marital Status: _____ **Religious Preference:** _____

Race: American Indian, Asian, Black, Hispanic, White, Other: _____

Address: _____

Street _____**City**_____**State**_____**Zip Code**_____

Phone#: _____ **Work #:** _____ **Contact List:** ☐ **Yes/** ☐ **No**

Mother: _____

First **Last** **Middle**

DOB: _____ **Gender:** _____

Marital Status: _____ **Religious Preference:** _____

Race: American Indian, Asian, Black, Hispanic, White, Other: _____

Address: _____

Street _____**City**_____**State**_____**Zip Code**_____

Phone#: _____ **Work #:** _____ **Contact List:** ☐ **Yes/** ☐ **No**

Sibling Information:

Name: _____ **DOB:** _____ **Contact List:** ☐ **Yes/** ☐ **No**

Name: _____ **DOB:** _____ **Contact List:** ☐ **Yes/** ☐ **No**

Name: _____ **DOB:** _____ **Contact List:** ☐ **Yes/** ☐ **No**

Educational Information

Last School Attended: _____ Grade: _____

Last School Address: _____

Street _____City_____State_____Zip Code_____

Does the Child Require Special Education Services? ☐ Yes /No ☐

Does the Child Have a Current Individualized Education Plan? ☐ Yes/No ☐

Medical Information

Any Medical Conditions that Require Immediate Attention (explain): _____

_____

Any Known Diagnoses or Illnesses (include mental health): _____

_____

_____

Current Medications (PLEASE complete the attached medication list as well): _____

_____

_____

Any Known Allergies: _____

Any Physical Restrictions: _____

Primary Care Physician/Location: _____

Date Last Seen: _____ Reason for Visit: _____

Dentist/Location: _____

Date Last Seen: _____ Reason for Visit: _____

If Applicable, Psychiatrist/Location: _____

Date Last Seen: _____ Reason for Visit: _____

List Any Health or Dental Concerns: _____

_____

Any Other Medical Information You Think We Should Know: _____

_____

Current Emotional/Behavioral Condition of the Child (crying, depressed, aggressive, etc):

_____
_____

Electronic Privilege Information

Dana's House, Inc. is not a lock-down facility. Our children attend public school and have access to electronics in the community and here at Dana's House. By placing your child here, you understand that we are not responsible if your child contacts someone outside of their contact list. We will make every effort to follow contact list requirements and to monitor electronic use. By placing your child in our program, you understand that the use of electronics cannot be monitored by our staff 24/7. We will do our best to monitor for appropriate usage and enforce consequences as necessary for any violation of rules or misbehaviors. Further, if you allow your child to have electronics, we are not financially responsible for them.

Is the Child Able to Keep Their Own Personal Electronics? ☐ Yes/No ☐

Explain (Type, Suggested Limitations): _____

_____

Is the Child Able to Have a Social Media Account? ☐ Yes/ No ☐

Explain (Type, Suggested Limitations): _____

_____

_____ _____

Legal Guardian Signature Date

For Dana's House Office Use Only:

Placement Type: *Residential* *Emergency* *Foster*

Medical Passport: *Yes/No*

Dana's House
Receipt and Release of Prescription and Over-the-Counter Medications Form

Section I: Receipt of Prescription and Over-the-Counter Medications

Child's Name:	**DOB:**

Current Medication(s):

Name of Medication	Medical diagnosis and purpose	Dosage	Times Taken Daily	Quantity Prescribed	Quantity Present	Prescribing Physician's Name

Section II: Medication(s) Not Received: ☐ Yes /No ☐

If yes, indicate the medication(s):

_____

Were prescriptions for these medications received? ☐ Yes/No ☐

Signature of Person Releasing Medication _____ **Date:** _____

Signature of Person Receiving Medication _____ **Date:** _____

Dana's House
Consent for Services and Authorization Form

As the parent/legal guardian of the following minor, I the undersigned, give my consent to Dana's House, Inc. Children's Emergency and Residential Facility, to provide services to said minor. Said services include but are not limited to: residential care, emergency care, counseling, training, and supervision. Said services may also include organizations working in coordination with Dana's House, Inc. Program. I understand that any services provided on behalf of said minor are the decisions of Dana's House, Inc. staff. I authorize the said youth to be transported off-campus by Dana's House, Inc. staff and volunteers to other locations. I also understand that I may revoke this consent upon written notice to Dana's House, Inc. staff.

I hereby authorize all cooperating agencies, organizations, and individuals including but not limited to physicians, dentists, school personnel, juvenile justice workers, social workers, nurses, and psychologists to perform any treatment or service which you deem necessary and in the best interest of said minor. As the legal guardian of said minor, I release Dana's House, Inc. from any liability of said treatment or service.

I hereby authorize all cooperating agencies, organizations, and individuals to release all information, reports, and professional opinions concerning _____ to Dana's House, Inc. and do hereby release them from any liability for the release of said information. In addition, Dana's House, Inc. may release information generated during the youths stay at Dana's House, Inc. to cooperating agencies and release Dana's House, Inc. from any liability for the release of said information.

I give my consent for the staff of Dana's House, Inc. to gather information on said minor through contact with myself, said minor and/or agency, organization and/or individual with who said minor has had contact for case development and follow up purposes.

_____ _____

Legal Guardian Signature Date

Dana's House
Placement Authorization Form

Youth's Name:	**DOB:**
Date:	**County:**

This authorization enables Dana's House, Inc. Children's Residential and Emergency Facility:

1. Enroll the child in public school or any other educational program and to sign any necessary enrollment forms

2. To provide transportation to the child within the continental United States

3. To seek treatment for this child from private physician, hospital, therapist, or dentist

_____ _____

Legal Guardian Signature Date

Dana's House
Approved Resident Contact List

Resident: _____

Name:	Relationship:	Phone#:

_____ _____

Legal Guardian Signature Date

Dana's House
Visiting Resources

According to the Minimum Licensing Standards for Child Welfare Agencies Handbook; a visiting resource is defined as a non-related situation in which a visit occurs away from the facility, excluding normal age-appropriate activities such as overnight visit with friends, extra-curricular activities, church activities, or short-term summer camps. A visiting resource who takes a child away from a facility shall meet 2 and 3 (below). A visiting resource who takes the child to the visiting resource's home shall meet all the following:

1. Documentation and narrative of at least one (1) home visit for evaluation purposes prior to visitation occurring;
2. At least three (3) character references;
3. Documentation of State Police Criminal Record Checks, FBI Criminal Record Checks, if applicable, and Child Maltreatment Central Registry Checks, if available;
4. Narrative of continuing contact and annual review, in person, of the visiting resource.

For our residents to get as much one-on-one time as possible, and for them to foster connections within the community, Dana's House, Inc. utilizes visiting resources in the form of volunteers and mentors.

Please sign below that you have read and agree to the above statements.

_____ _____

Legal Guardian Signature Date

Dana's House
Release of Liability

I understand that Dana's House, Inc. is not liable for the loss of damage of any items, such as TV's, computers, electronic devices, etc. that are purchased and/or given to residents. I also understand that access to these items will be at the discretion of Dana's House Administration based upon levels, ages, etc.

Once residents have received their items, it is their responsibility to take care of it and put it up after use.

I also understand that it is the responsibility of DHS to make sure that all items left behind by residents upon their discharge are to be picked up in a timely manner. Dana's House will make three attempts to contact those responsible to pick up the remaining items. Dana's House will hold these items for a length of time not exceeding one month, at which time these items will be disposed of.

_____ _____

Legal Guardian Signature Date

Dana's House
School Contact Form

DeWitt Public Schools:

Please be advised that Dana's House, Inc. is now the current placement guardian of _____.

Please do NOT allow for any of the following individuals to make contact at the school with the above resident at any time, until further notice.

Name:	**Relationship to Student:**

Please contact Dana's House, Inc. with any further questions.

_____ _____

Legal Guardian Signature Date

Dana's House, Inc.

Medication Upon Admission Policy

- Dana's House, Inc. requires that all medications that are currently prescribed to the admitting child be brought with the child when they are admitted. This is to ensure a continuity of care for the child. Valid prescriptions can also be accepted and filled by the facility.
- All medications that are prescribed to the child must be in labelled containers with the child's name and information on them. No medications in alternate containers will be accepted by the staff.
- If a child is admitted without prescribed medications or a valid prescription, medications or a valid prescription must be provided within 24 hours of the child being admitted to Dana's House, Inc.
- If the child is admitted without prescription medications or a valid prescription, emergency medications can be called in by the prescriber to the pharmacy. If emergency medications are called in for the child by the prescriber, a full prescription must be provided by the guardian (DHS) to Dana's House, Inc. within 24 hours of the emergency medication being called in.
- If a child is admitted without prescribed medications or a valid prescription, and medications are not provided within 24 hours, the child will have to be discharged back to their guardian (DHS). This is due to the inability of Dana's House, Inc. to ensure continuity of care for the child if medications and/or a valid prescription are not provided.

By signing below, you are stating that you understand and agree to this medication upon admission policy.

_____ _____

Signature of Legal Guardian Date

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers (e.g., my insurance company); the day-to-day healthcare operations of your practice.

have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name _____

Patient Signature _____ or Legal Guardian

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

Clinician Disclosure Statement
Dana's House, Inc.

DeWitt, AR | P: 870-946-8303 | F: 870-946-8217 | www.danashouse.org

Thank you for choosing Dana's House, Inc. for your outpatient mental health needs. This form has been designed to assist you in understanding the counseling process, what is expected from you, and the professional counseling relationship. Please read this document in its entirety and sign and date at the bottom. We look forward to working with you!

Qualifications

The Dana's House Clinicians are licensed with the Arkansas Board of Examiners in Counseling. They both have training in several trauma focused therapies as well as telemedicine, play therapy, expressive arts, and substance use therapy. Our clinicians have over a decade of experience between them in working in both outpatient and more intensive therapy settings. They specialize in working with children, but they also have years of experience working with adults, families, and groups.

Benefits & Risks of Therapy

Because therapy involves the processing of strong emotions and difficult issues, there can be times when you may feel uncomfortable, scared, or upset. During these times w ask that you communicate how you are experiencing the therapeutic process and allow us to support you in pushing through them. We want you to know that these emotions and discomforts are temporary and are normal during therapy.

Emergencies

If you have a crisis that is related to your mental health, please call 911. Mental health crisis are medical emergencies just as physical crisis are. If you need information about emergency resources, please don't hesitate to ask us!

Confidentiality and Privacy

Social Media Policy:

Because a therapeutic relationship is a different relationship than a friendship or a familial relationship there needs to be professional boundaries so that you as the client are always protected. Because of these boundaries, we cannot be connected on any personal social media accounts or in any other public manner due to violations of your privacy. This can be confusing because the therapeutic relationship is a strong one, but it is still a professional relationship and requires adherence to strong boundaries for both of us.

Duty to Warn

As a licensed therapist in Arkansas, our staff are mandated reporters. This means that if we have information or witness a vulnerable person being hurt or in danger, we have to report it to the appropriate authorities. This may mean that we have to break confidentiality in order to report an incident. The only other times that we may have to break confidentiality is:

- If you are planning to kill yourself.
- If you are planning to hurt or kill someone else.
- If there is information about child abuse or neglect, elder abuse or neglect, or vulnerable persons abuse or neglect.
- If you are planning on destroying someone's property (such as arson).
- If we are ordered by the court.

In all other circumstances, we are bound to you by confidentiality and your privileged communication is protected by law in the state of Arkansas just as information between a lawyer and their client is protected. This law is 17-27-311. Privileged communication.

Court Involvement

There are times when a court or judge will ask for a therapist to be present in court or submit paperwork for court cases. In the state of Arkansas, there is a statute § 17-27-311 - Privileged Communication. This is to protect the therapist and client's communications just as a lawyer and their client's communications are protected. We will not testify in court for custody cases and we are not trained forensic clinicians. We do not provide any kind of testimony beyond a summarization for court reporting purposes with client permission. There may be fees that will apply to any requests for documents for court or our presence in court.

Documentation

Documentation may be requested for court cases, foster child staffing meetings, proof of services, and/or continued care. We discourage requests for therapy notes by guardians or clients unless it is deemed therapeutically appropriate as this can be damaging to an individual if not handled properly. We will provide guardians and clients with clinical summaries or court reports depending on the need for the documentation. This will be determined on a case by case basis.

Reporting

If you believe that something unethical or illegal has occurred during our work together and you do not feel comfortable discussing the situation with me, please contact the Arkansas licensing board and let them know what is going on.

Arkansas Board of Examiners in Counseling
https://abec.statesolutions.us/
1-501-683-5800

Acknowledgement of Understanding

By signing below, you are acknowledging that you understand and agree to the services and requirements detailed above.

Name: _____ Date: _____
Signature of Patient or Patient Guardian

If you are a minor, you cannot give your consent for treatment yourself. I would like to ask for your assent for treatment because it is important that you are a willing participant in this process.

By signing below, you are acknowledging that you understand and give your assent to participate in therapy services.

Name: _____ Date: _____
Signature of Patient if a Minor

Once again, thank you for choosing Dana's House, Inc. for your therapy needs!

Child and Adolescent Trauma Screen-Caregiver (CATS-C) - 7-17 Years

Name_____ Date_____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark No if it didn't happen to the child.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes ☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes ☐ No
3.	Robbed by threat, force or weapon	☐ Yes ☐ No
4.	Slapped, punched, or beat up in your family	☐ Yes ☐ No
5.	Slapped, punched, or beat up by someone not in the family	☐ Yes ☐ No
6.	Seeing someone in the family get slapped, punched or beat up.	☐ Yes ☐ No
7.	Seeing someone in the community get slapped, punched	☐ Yes ☐ No
8.	Someone older touching his/her private parts when they shouldn't.	☐ Yes ☐ No
9.	Someone forcing or pressuring sex, or when s/he couldn't say no.	☐ Yes ☐ No
10.	Someone close to the child dying suddenly or violently	☐ Yes ☐ No
11.	Attacked, stabbed, shot at or hurt badly	☐ Yes ☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed	☐ Yes ☐ No
13.	Stressful or scary medical procedure.	☐ Yes ☐ No
14.	Being around war	☐ Yes ☐ No
15.	Other stressful or scary event? Describe:	☐ Yes ☐ No

Which one is bothering the child the most now?_____

If you marked any stressful or scary events for the child, turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks. Answer the best you can:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always:

1.	Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2.	Having bad dreams related to a stressful event.	0	1	2	3
3.	Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4.	Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5.	Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6.	Trying not to remember, think about or have feelings about a stressful event.	0	1	2	3
7.	Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	0	1	2	3
8.	Not being able to remember an important part of a stressful event.	0	1	2	3
9.	Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10.	Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11.	Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12.	Losing interest in activities s/he enjoyed before a stressful event.	0	1	2	3
13.	Feeling distant or cut off from people around her/him.	0	1	2	3
14.	Not showing positive feelings (being happy, having loving feelings).	0	1	2	3
15.	Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16.	Risky behavior or behavior that could harmful.	0	1	2	3
17.	Being overly alert or on guard.	0	1	2	3
18.	Being jumpy or easily startled.	0	1	2	3
19.	Problems with concentration.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others ☐Yes ☐No
2. Hobbies/Fun ☐Yes ☐No
3. School ☐Yes ☐No
4. Family relationships ☐Yes ☐No
5. General happiness ☐Yes ☐No