SHELTER

Placement Agreement & Admission Packet

Seven Stars Emergency Shelter at Place of Hope, Inc.

Placing Hope In A Child's Future™

"Seek justice. Encourage the oppressed. Defend the cause of the fatherless..."
Isaiah 1:17

Child's Name: _____

Most pages in this agreement require some or all of the below signatures:

Dependency Case Manager or Placing DCM/CPI

Client

Attn: Wally

Placement Agreement

This Agreement is provided to establish an understanding and maintain a positive relationship between Place of Hope, Inc. and Child & Family Connections and/or its designee. Place of Hope, Inc. desires to maximize its efforts with that of DCF and/or its designee, to provide for the best possible continuum of care and wellbeing for all clients in care at Place of Hope, Inc.

During a client's placement at Place of Hope, Inc., the following conditions are established by this Agreement:

1. Client Staffings/Service Plan reviews will take place every 90 days, beginning within 30 days admission. Updates on the progress and needs of the client, including any progress or delay in further placement planning, will be reviewed. The DCM will sign off on the updated information relative to the treatment and progress of the client.

2. Place of Hope, Inc. is entitled to be notified of all proceedings, prior to the proceedings, and will be given opportunity to furnish any information relevant to the best interests of the client. It is expected that Place of Hope, Inc. will be included in any and all staffing, hearings and decision making on behalf of the client, pursuant to Florida Statute and Rule 8.225 [c] (2) of the Florida Rules of Juvenile Procedure, as a participant, Section 39.01 (49).

3. All contact between the client residing at Place of Hope, Inc. and his or her family members will be determined by Child & Family Connections (or their designees) and/or a court order. Place of Hope, Inc. will comply with and encourage that which is set forth by the Department/court order. However, Place of Hope, Inc. must be notified of a family visit at least one week in advance, unless a schedule is developed and approved (in advance) on a weekly basis.

4. If it is determined necessary that a change of placement will occur, it is expected that a Child & Family Connections representative and/or its designee give written notice to Place of Hope, Inc. upon receipt of knowledge.

5. If Place of Hope, Inc. determines that a client in care requires an alternative and/or higher level of care and/or their behavior jeopardizes the integrity of our facility, Child & Family Connections, and/or its designee, will be contacted according to contractual guidelines.

6. A client will be discharged only to the client's original applicant or to the party authorized by their original applicant, unless otherwise determined by the court.

7. During a client's placement at Place of Hope, Inc., it is possible for many sources to be the financially responsible parties for each client. A financially responsible party shall be defined as those persons or agencies who will assume the financial responsibility of paying the cost of residential, medical, and dental expenses while in placement at Place of Hope, Inc.

For this specific placement, the financially responsible parties shall include the following:

- Child and Family Connections for placement and any treatments not paid by Medicaid
- Medicaid for medical, dental, and other necessary health care

Medical insurance is available and provided through: **Medicaid**

Policy #: _____

Is Medicaid coverage active? ☐ Yes ☐ No

In lieu of the availability of benefits, Place of Hope, Inc. will provide for the cost of care to the extent practicable. Place of Hope, Inc. is entitled to any reimbursements made when benefits are obtained retroactive, and Place of Hope, Inc. is entitled to use of all benefits available on behalf of the client.

Place of Hope, Inc. will absorb the difference in the full cost of care provided by Place of Hope, Inc. versus payment agreed upon between financially responsible parties to the extent practicable.

Ancillary services will be provided as needed for each client. The cost of these services will be distributed according to the funding available for each client. In the event that there is no funding available from the placing agency, Place of Hope, Inc. will absorb the cost of these services as deemed necessary by Place of Hope, Inc. Administration, to the extent practicable.

The undersigned, being the legal guardian of this client, understands and agrees to all conditions established by this document.

[redacted] _____

_____ _____

Phone Number Agency

The financial terms of this agreement may be altered upon approval of all parties deemed financially responsible, in accordance with the best interests of the client.

Client's insurance card should accompany the child upon admission.

Each client deserves an equal opportunity to be served with regard to the highest standards of care. Each case will be reviewed on an individual basis and ALL REFERRALS from Child & Family Connections and/or its designee will be considered for review. Due to the nature of this setting, heavy consideration is given to the impact each incoming placement will have on the current clients. Place of Hope, Inc. reserves the right to request the discharge of a client and request a higher level of care.

Upon notice of discharge, Place of Hope, Inc. will prepare a written discharge summary. A copy of this discharge plan will be provided to Child and Family Connections within seven days of the discharge date.

Child & Family CONNECTIONS

INTAKE ASSESSMENT FORM (6yr old and older)
EXHIBIT A

General Information

Client's Name: _____ DOB: _____

Date of Intake: _____ Location: Seven Stars Emergency Shelter at Place of Hope

Substance Use Screening

Have you used any of the following in the past?

Tobacco	YES	NO
Alcohol	YES	NO
Cocaine	YES	NO
Other Drugs	YES	NO (if yes, list below):

_____

_____

Are you currently using or under the influence of alcohol or drugs? YES NO

If yes to any of the above, please explain when was the last time used and how much you used? (Additional screening recommended)

_____

_____

If yes, are you currently receiving services for substance abuse? YES NO

If yes, where are you receiving the services at? _____

Risk Screening

1) Are you *currently* or have you *recently thought about* harming or killing yourself?	YES	NO
2) Have you *ever seriously considered* harming or killing yourself (*specific plan*)?	YES	NO
3) Have you *recently attempted* to harm or kill yourself (*past 12 months*)?	YES	NO
4) Have you *ever attempted* to harm or kill yourself?	YES	NO
5) Do you *hear voices or see things* that other people do not see or hear?	YES	NO
6) Are you *currently receiving treatment* or medication for a mental health disorder?	YES	NO
7) Have you *ever seriously considered or attempted* to harm or kill others?	YES	NO
8) Are you *currently* feeling like hurting or killing someone else?	YES	NO

If yes to any of the above, please explain:

_____

_____

Child & Family CONNECTIONS

Client's Name: _____

DOB: _____

NOTE: For ALL clients, if YES to ANY of the questions, follow agency policy in conducting full suicide risk screening to determine appropriate course of action.
If necessary, contact the Place of Hope's Director of Clinical Services.

Are you currently or do you regularly experience any of the following:

Feeling *extremely* sad, hopeless or depressed?	YES	NO
Feeling *extremely* tense, worried, or anxious?	YES	NO
Feeling *extremely* scared, afraid, or panicked?	YES	NO
Feel unable to sleep or eat *on a regular basis*?	YES	NO
Feel unable to control your anger to the point that it may result in hurting others?	YES	NO

If yes to any of the above, please explain:

_____

_____

_____

Other Staff Observations:

_____

_____

_____

Staff Completing Form: _____ Date: _____

Supervisor Approval: _____ Date: _____

This Form Must Be Completed on All Clients Age Six and Older within 24-hours of Admission and Submitted to the Director of Clinical Services at CFC within Seven Business Days.

CHILD AND FAMILY CONNECTIONS AGREEMENT TO PROVIDE SUBSTITUTE CARE FOR DEPENDENT CHILDREN

Child's Name:	Monthly Board Rate: **$120/day**
Name of Substitute Care Parent(s): **Seven Stars Emergency Shelter at Place of Hope**	Total Payment: **$120/day**
Address of Substitute Care Parent(s): **9125 Isaiah Lane, Palm Beach Gardens, FL 33418**	Subsidy of Emergency Shelter Home: **n/a**

As substitute care parent(s) for the Child and Family Connections, we agree to the following conditions considered essential for the welfare of this dependent child placed in our home:

1. The child is placed in our home on a temporary basis and is at all times under the supervision and control of the department.
2. We are fully and directly responsible to the department for the care of the child.
3. We will take no action to acquire legal custody or guardianship of the child.
4. We will hold confidential all information about the child and his family and will discuss such information only with a representative of the department or with appropriate specialists at the request of the department.
5. We will cooperate in arrangements made by the department for visits with the child by his parents(s) or relative(s).
6. We will not give the child into the care or physical custody of any other person(s), including the natural parent(s) without the consent of a representative of the department.
7. We will cooperate in arrangements made by the department for visits with the child by his parent(s) or other relative(s)
8. We will participate with the department in planning for the child, which may include adoption placement, transfer to another foster home or return to parents(s) or relative(s).
9. We will accept dependent children into our home for care only from the department and will make no plans for boarding other children or adults.
10. We will accept the above board rate per month on behalf of the child in accordance with the department's established rate structure for dependent children.
11. We will notify the department immediately of any change in our address, employment, living arrangements, family composition, or law enforcement involvement.
12. We will incur no expenses for which we expect reimbursement with authorization by the department.
13. The department may remove the child from our home at any time but will, whenever possible, give us at least two weeks notice.
14. We may request the department to remove a child from our home but will, whenever possible, give us at least two weeks notice.
15. We will comply with all requirements for a licensed substitute care home as proscribed by the department.
16. We will immediately report any injuries or illness of a child in our care to the department.
17. We will be responsible for maintaining the Child Resource Record for every child placed in our home.
18. We agree to obtain a minimum of eight hours of in-service training per year as approved by the department. We agree to pass and keep current the pediatric CPR training offered by the department which has been approved by the American Heart Association or the American Red Cross.
19. We will abide by the department's discipline policy which we received during the MAPP training.
20. We will abide by the department's policy for training in water safety should we have a swimming pool.
21. We will be available to receive children in our home 24 hours per day, seven days per week, if we are licensed as an emergency shelter home.

Seven Stars Emergency Shelter
Signature of Substitute Care Father

n/a
Signature of Substitute Care Mother

[redacted]

Representative's Title

Date Agreement Signed

Seven Stars Emergency Shelter at Place of Hope, Inc.

ADMISSION CHECKLIST

Child's Name: _____ Date of Intake: _____

Name of SSES staff completing intake: _____

Name of CFC Placing Case Manager or CPI: _____

Name of CFC Dependency Case Manager: _____

Document	Received	Needed
Completed Placement Agreement & Admission Packet	☐	☐
Shelter order or most recent court order	☐	☐
Placement Authorization	☐	☐
Medical & immunization records	☐	☐
Copy of Medicaid Card	☐	☐
Copy of Social Security Card	☐	☐
Copy of Birth Certificate	☐	☐
Lists of medication & dosages and current court order	☐	☐
Any applicable Safety Plan/Safety Contract	☐	☐
Child Resource Record	☐	☐

Please list any other items needed: _____

_____

_____

Complete and make a copy for Dependency Case Manager.
This form serves as a first request for missing documentation.

I have received a copy of this request form:

_____

Placing Worker's Name [redacted]

_____

Date Signed

Child's Name: _____ **Social Security #:** _____

Date of Birth: _____ **Sex:** Male **Race:** _____ **Religion:** _____

Previous Address: _____

Previous Phone Number: _____

Medicaid #: _____ **Other Insurance:** _____

Placing Case Manager (if not child's DCM): _____

Office: _____ **Cell:** _____ **Fax:** _____

Dependency Case Manager (if not placing worker): _____

Office: _____ **Cell:** _____ **Fax:** _____

Dependency Case Manager Supervisor: _____

Office: _____ **Cell:** _____ **Fax:** _____

Any Emergency Information: _____

_____

GENERAL INFORMATION CONTINUED

Guardian Ad Litem: _____

Cell Phone: _____ Office Phone: _____

Email: _____

Fax: _____

Attorney: _____

Cell Phone: _____ Office Phone: _____

Email: _____

Fax: _____

Therapist: _____

Cell Phone: _____ Office Phone: _____

Email: _____

Fax: _____

Targeted Case Manager: _____

Agency: _____

Cell Phone: _____ Office Phone: _____

Email: _____

Fax: _____

Other: _____

_____

_____

CASE PLAN INFORMATION

Case Plan Goal:

☐ Reunification ☐ Long Term Foster Care/APPLA

☐ Adoption ☐ TPR

☐ Permanent Guardianship ☐ Other: _____

Case Plan Goal Date: _____

Next Court Date: _____

Barriers to Permanency: _____

Permanency Plan Details & Target Dates: _____

_____

FAMILY HISTORY

Biological Mother

Name: _____

Date of Birth: _____ **SSN:** _____

Occupation: _____ **Race:** _____

Address: _____

_____

Best Contact Number: _____

Currently Married? ☐ Yes ☐ No

Primary Language: _____

Is child allowed contact with biological mother? ☐ Yes ☐ No

If yes, please attach court order and indicate levels of contact below:

Phone Contact: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Visitation: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Please indicate frequency & level: _____

Biological Father

Name: _____

Date of Birth: _____ **SSN:** _____

Occupation: _____ **Race:** _____

Address: _____

_____

Best Contact Number: _____

Currently Married? ☐ Yes ☐ No

Primary Language: _____

Is child allowed contact with biological father? ☐ Yes ☐ No

If yes, please attach court order and indicate levels of contact below:

Phone Contact: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Visitation: ☐ Yes ☐ No Supervised: ☐ Yes ☐ No

Please indicate frequency & level: _____

Siblings

Name: _____ **Age:** _____

Phone Number: _____

Placement & Address: _____

Last contact with child: _____

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain: _____

_____

Name: _____ **Age:** _____

Phone Number: _____

Placement & Address: _____

Last contact with child: _____

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain: ______

______

Name: ______ Age: ______

Phone Number: ______

Placement & Address: ______

Last contact with child: ______

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain: ______

______

Name: ______ Age: ______

Phone Number: ______

Placement & Address: ______

Last contact with child: ______

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain: ______

______

Name: ______ Age: ______

Phone Number: ______

Placement & Address: ______

Last contact with child: ______

Is child allowed to visit sibling? ☐ Yes ☐ No ☐ Supervised

If not, or if supervised, please explain: ______

PLACEMENT HISTORY

Date of Initial Removal from Home: _____

City of Initial Removal: _____

Number of Placements (including current placement): _____

Complete Placement History in Chronological Order:

Placement	Date Placed	Date Moved	Reason for Move

ACADEMIC HISTORY

Current School: _____

Current Grade Level: _____

School Phone: _____

School Contact Person: _____

Academic Status:

- ☐ Regular Education
- ☐ IEP
- ☐ 504 Plan
- ☐ Alternative Education
- ☐ SLD
- ☐ EBD
- ☐ Speech Language Services
- ☐ ESE
- ☐ ESOL
- ☐ Other:

Has the child ever been retained? ☐ Yes ☐ No

If yes, what age and grade? _____

Current GPA: _____ **Date of Last Report Card:** _____

Full Scale IQ: _____

List Academic Services Identified: _____

List Academic Needs Identified: _____

Date of Last Educational Evaluation: _____

Test Battery Given: _____

Where are these records held? _____

List any school problems (e.g. truancy, excessive absences, suspensions, fighting, refusal, grades, etc.):

_____

_____

List any bus problems or behaviors: _____

List any extracurricular activities: _____

Transportation & Emergency Contact & Care Release

Client Name	Date of Birth	Date of Consent

Transportation

I understand that there are transportation options which Seven Stars Emergency Shelter at Place of Hope, Inc. staff will discuss with me.

I, _____ [redacted], hereby give my permission for staff from Seven Stars Emergency Shelter at Place of Hope, Inc. to provide transportation to the client while they reside in your care.

Emergency Contact and Care

I understand that in the event of an accident or serious injury, Seven Stars Emergency Shelter at Place of Hope, Inc. staff will make every reasonable effort to contact the guardian. I authorize staff to initiate emergency medical care and/or transport the above named child to the nearest hospital emergency room.

I understand that it is my responsibility to notify program staff of any changes in my address, phone number, emergency contact and phone number, medical conditions, allergies, medications or dosages or any other information which may affect treatment.

I have read, understood and agree to follow the above listed guidelines.

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Consent for Release and Exchange of Information

Seven Stars Emergency Shelter at Place of Hope, Inc.

I, as the guardian of _____ [redacted], give my consent to Place of Hope, Inc. to exchange information regarding services rendered during the course of pre or post placement.

All of the following types of information may be discussion for the purpose of promoting the best services for the above named client(s).

- Psychiatric/Psychological Data
- Social History
- Evaluation Results
- Placement History
- School Records
- Progress Notes
- Medical Reports
- Discharge Summaries
- Other, as necessary

I understand that I have the right to refuse this authorization and Place of Hope, Inc. is released from all legal liability that may arise from the release of information required. This information is being disclosed from records whose confidentiality is protected by federal law. Any further redisclosure is prohibited.

This consent shall remain in effect for the period this client is involved with Place of Hope, Inc. or one year from the date of the guardian signature, whichever comes first. This authorization may also be revoked at any time by written notice to the source listed above.

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff _____ Date: _____

Seven Stars Emergency Shelter at Place of Hope, Inc.

The purpose of this letter is to establish an understanding and to develop and maintain a positive working relationship and team effort between Seven Stars Emergency Shelter at Place of Hope, Inc. and Child & Family Connections.

In order to establish this "team" effort, fulfill our mission of purpose, and to exercise our privilege according to Florida statutes, it is crucial that Child & Family Connections respects, values and considers our professional input and suggestions in regard to the decision-making process. As applicable, a Treatment Team Meeting must take place, either by conference call or in person, to discuss the client's future placement options at the earliest time possible. This team will consist of a representative of both Place of Hope, Inc. and Child & Family Connections.

Furthermore, in the event of any change in a client's placement, Place of Hope, Inc. must be notified, in writing, in a timely fashion.

Place of Hope, Inc. is not merely a holding facility where the client "bides" his time, but a residential-style home. A great deal of time is invested in building a loving, nurturing environment, while consistently teaching and training the client to prepare for independence and adulthood.

It is not the intent of Place of Hope, Inc. to dominate any decision made on behalf of the clients, but it is our desire to establish a level of trust and confidence between Place of Hope, Inc. and Child & Family Connections so that both parties are maximizing efforts for the best interest of the child.

It is further understood and agreed that pursuant to Florida Statute and Rule 8.225 (c) (2) of the Florida Rules of Juvenile Procedure, as a participant, Section 39.01 (49), Place Of Hope, Inc. is entitled to a notice of all proceedings, prior to the proceeding, and that Place of Hope, Inc. will be given the opportunity to furnish any information relevant to the best interest of the child and will be included in any and all hearings and decision making.

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Release & Hold Harmless Agreement

Seven Stars Emergency Shelter at Place of Hope, Inc.

Whereas _____ [redacted], as legal guardian with lawful custody of the client, has tendered an application to Place of Hope Inc. for rendition of shelter, counseling, treatment, or other related services for the client named in this agreement, and in order to induce and persuade Place of Hope, Inc. to accept said application and render said services to the client, the following agreement is entered into:

The undersigned party truthfully represents that he or she is the legal guardian with lawful custody of the client and will present proof of lawful custody to Place of Hope, Inc.

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Voluntary Placement Form & Medical Release

Seven Stars Emergency Shelter at Place of Hope, Inc.

I, _____ [redacted], as parent or legal guardian, voluntarily place and hereby give my consent for PLACE OF HOPE, INC. to render such transportation, medical care, and treatment as PLACE OF HOPE, INC. may consider necessary for the health and welfare of _____ [redacted]. I authorize that the above client be given periodic health examinations, tests, immunizations, dental care, personal hygiene and maintenance to include regular nail and haircuts, medication and hospitalization if needed. In the event of any serious illness or accident, I understand that PLACE OF HOPE, INC. will make every effort to communicate with me. PLACE OF HOPE, INC. is authorized to render whatever medical or surgical care is needed to provide for the well being of the above client, whether or not contact is made.

[redacted] Date

Spiritual and Moral Training Policy

PLACE OF HOPE, INC. provides each client with the opportunity to explore their spirituality. Place of Hope's Professional Parents will follow and model the Christian Faith. Place of Hope, Inc. will offer each client the opportunity to participate in daily devotions in each home and to attend a variety of church services and related activities during their stay. Mandatory participation is not required of any client; however family participation in church activities is a component of the Place of Hope Program. I have read and understood the Spiritual and Moral Training Policy and consent on behalf of said client.

[redacted] Date

Publicity Release Statement

From time to time, pictures are taken of the children, including school photos. Pictures will not be taken or used for exploitation, only as part of the family model for each client at PLACE OF HOPE, INC. I hereby grant permission for the name and picture of above said child, for whom I am the Parent or legal Guardian, to be taken by PLACE OF HOPE, INC. of Palm Beach Gardens, Fl; in accordance with Chapter 10C-15.57 of the Rules of the Florida Department of Children and Families, Social and Economic Services Program.

[redacted] Date

Behavior Management and Discipline Policy

PLACE OF HOPE, INC. prohibits the use of corporal punishment. No client will be spanked, paddled or physically punished. Consequences will be assigned appropriate to the behavior and in compliance with any recommended treatment interventions. PLACE OF HOPE, INC. reserves the right to use approved physical restraint and aggression control training in the event that above said client becomes a threat or danger to themselves, others, or property. I understand PLACE OF HOPE, INC. direct care staff are trained and certified to manage aggression in a client. Should such aggression become unmanageable, PLACE OF HOPE, INC. reserves the right to contact Law Enforcement and any other officials necessary to secure the above client and insure for the safety and security of all persons involved including other clients in care. PLACE OF HOPE, INC. acknowledges the right of each client to appropriately disagree and to ask to speak to a PLACE OF HOPE, INC. Administrator at a neutral time to file any grievance.

[redacted] Date

[redacted] Date

[redacted]

Seven Stars Emergency Shelter at Place of Hope, Inc.

I, _____ [redacted], as guardian of _____ [redacted] give my approval to move the said child from their current school to the appropriate school zoned for Place of Hope residents (zoned schools listed below) if I cannot arrange transportation to the child's current school and it is not otherwise specified by their IEP or court order. If the child remains in their current school for the remainder of the school year, I authorize Place of Hope to transfer the child to the aforementioned school at the beginning of the next school year. I give my consent to Place of Hope, with the consent of client's treatment team, to enroll, withdraw, or make schedule changes for this child in the aforementioned school.

Grades K-5: Timber Trace Elementary
Grades 6-8: Duncan Middle School
Grades 9-12: Palm Beach Gardens High School

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Consent for Examination & Required Immunizations

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client's Name	Social Security #	Date of Birth	Consent Date

I hereby give consent for the above named client to be examined by a nurse practitioner or physician.

I understand the examination may involve invasive procedures such as blood drawing or PPD skin testing. This examination may involve invasive vision and hearing screenings, dental screenings, and any other diagnostic testing as ordered and deemed necessary by the attending physician or nurse practitioner.

I understand all of the information and results of the examination are confidential and will be released only according to the confidentiality laws that apply, to include release of information to only legally designated persons or agencies involved in the care and treatment of the above named client.

I have the right to discuss any findings and results with the physician or nurse practitioner in an effort to seek treatment and aftercare.

[redacted] Date

[redacted] Date

I authorize the above named client to receive all the required immunizations and boosters as requested for placement at Place of Hope, Inc. and as required for enrollment in Public School. I understand that I have the right to refuse immunization and must complete the required documentation obtained from the Public Health Department if I so choose to refuse immunization on the grounds of religious or medical exemption.

Please state any immunizations **NOT** authorized:

I will complete all necessary forms of exemption for any immunizations not authorized to include the Place of Hope, Inc. Refusal of Immunization. I authorize all other immunizations, unless otherwise designated.

[redacted] Date

[redacted] Date

Seven Stars Emergency Shelter at Place of Hope, Inc.

Approval for School Page

Client's Name	Social Security #	Date of Birth	Consent Date

I DO NOT authorize the above named child to receive the following immunizations:

IMMUNIZATION:	REASON REFUSED:
☐ Rubella (Measles)	
☐ Rubella (German Measles)	
☐ Mumps	
☐ Poliomyelitis (OPV or IPV)	
☐ Diphtheria	
☐ Tetanus (Lockjaw)	
☐ Pertussi (Whooping Cough)	
☐ Hepatitis B (Hep B)	
☐ Haemophilus Influenza (Type B HIB)	
☐ Tuberculin Test (PPD)	
☐ Varicella (Chicken Pox)	

I understand that I have the right to refuse immunization, however, I may be asked to provide documentation to support my refusal such as a physician's statement, medical record, or religious exemption form from the Public Department of Health. In addition, I understand Place of Hope, Inc. reserves the right to deny placement of any client at Place of Hope, Inc. when the reason for refusal of immunization cannot be provided via requested documentation. Place of Hope, Inc. must consider the welfare of all clients in our care and must comply with all standards and regulations set forth with regard to the highest standards of care for our clients.

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Consent for Medication Administration

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client Name: _____ **Date:** _____

I have been advised that Place of Hope does not maintain a licensed health professional on the premises for the preparation and monitoring of medications. Place of Hope provides "unlicensed" – Direct Care Staff members who have been trained and certified in medication administration to administer medications.

a. "unlicensed" means an individual not currently licensed to practice nursing or medicine who is employed or contracted by the agency and who has received training with respect to administering medication or assisting with the self-administration of medication.

I, _____ [redacted], hereby certify that I have read and understood the consent for medication administration and hereby authorize unlicensed staff of Place of Hope, who have been trained and certified in medication administration, to consistent with the prescription's label or the package directions of an over-the-counter medication to administer medication to the above named individual.

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Over-the-Counter Medication Waiver & Current Prescriptions

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client Name: _____ **Date:** _____

STANDING APPROVAL FOR NON-EMERGENT MEDICAL CONDITIONS

Nutritional: children's multi-vitamin
Headache: non-aspirin products (e.g., Tylenol, Motrin, Advil, etc.)
Low-grade Fever: non-aspirin products (e.g., Tylenol, Motrin, Advil, etc.)
Cough: non-aspirin/non-alcohol cough and cold, Vick's vapor-rub
Sinus Congestion: cold, sinus, and allergy medication (non-aspirin)
Minor skin rashes: triple anti-biotic ointment, bactroban, clotrimazole, calamine, etc.
Toothache: ora-gel
Other:
Other:

Indicate below any over-the-counter medication that you do NOT authorize:

_____

_____

Prescriptions client is currently taking (initial & date each one):	**Dosage, Quantity and Administration Instructions:**
_____	_____
_____	_____
_____	_____
_____	_____

COURT ORDER OR PARENTAL CONSENT FOR PSYCHOTROPIC MEDICATION MUST BE GIVEN TO SEVEN STARS EMERGENCY SHELTER UPON ADMISSION.

Indicate below any known allergies or reactions to any medications:

_____	_____
_____	_____
_____	_____

I authorize the administration of over-the counter medication to the above named client as needed and agree that Place of Hope is not liable for any reactions or complications that may occur as a result. I understand that it is my responsibility to inform Place of Hope in writing of any allergies, possible reactions or medications that are not authorized.

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

[redacted]

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client's Name: _____

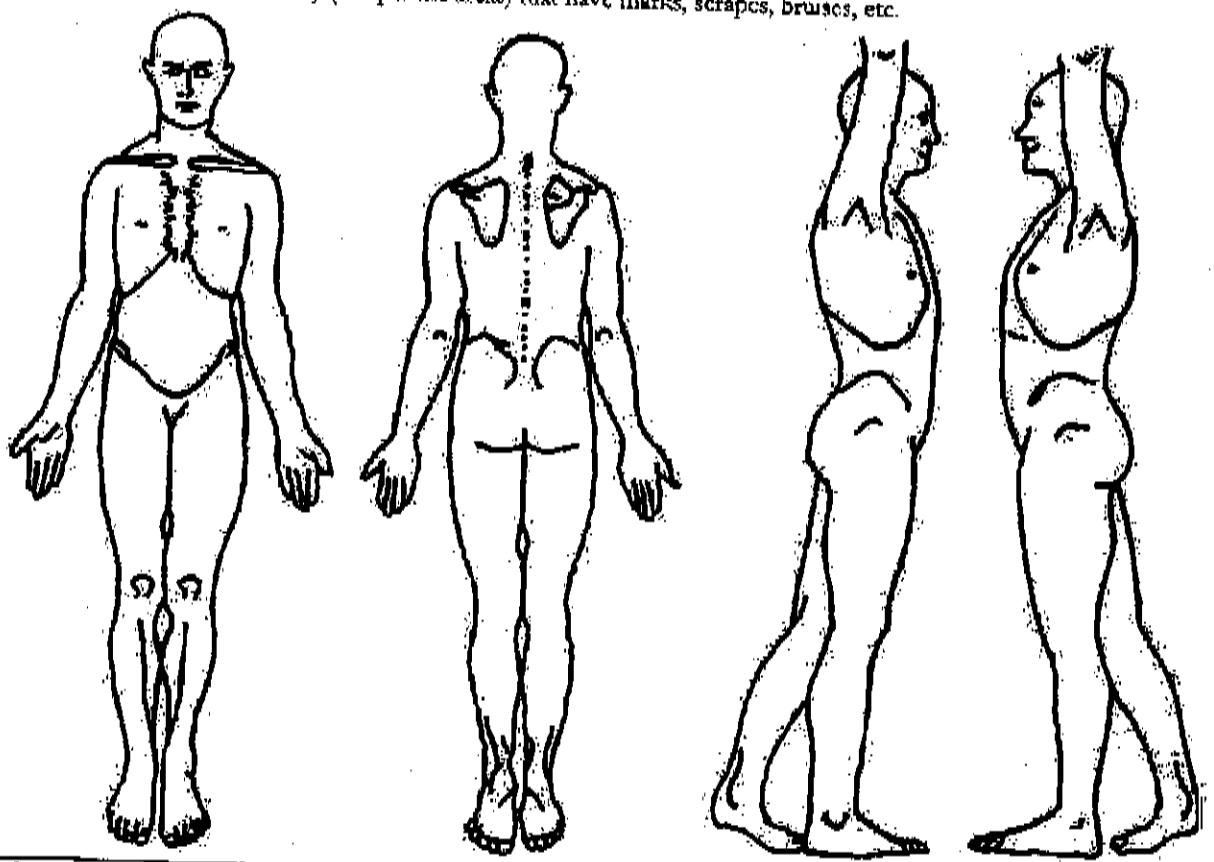
Weight: _____ **Height:** _____ **Temperature:** _____

Scalp Condition: _____

Physical Activity: □ Normal □ Listless □ Withdrawn □ Over-Active □ Excited □ Cooperative □ Combative

Condition of Clothing: □ Clean □ Torn □ Dirty **Overall Condition of Child:** □ Clean □ Dirty

Mark any sections on the body (not private areas) that have marks, scrapes, bruises, etc.



Condition	Yes	No	Location on Body	Describe
Lesions				
Bruises				
Scrapes				
Burns				
Blisters				
Rashes				
Cuts				
Scars				

List any other important physical information and indicate on drawing:

_____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

Client Name: _____ **Date:** _____

All clients under the care of Place of Hope, Inc. are subject to drug screens to be administered by and at the discretion of program staff. Clients that return from runaway status or are repeatedly absent from school without program consent will be tested for drugs upon their return to campus. Random screenings will take place at the discretion of Place of Hope, Inc.

If a client tests positive for illegal or misused legal drugs or is found be selling, distributing or in possession drugs or medication, the following course of action will be followed by Place of Hope:

- First offense: written notice to treatment team.
- Second offense: Palm Beach County Sherriff's Office will be notified and the client's Dependency Case Manager will be requested to make a refetral for the client to receive substance abuse counseling.
    - Refusal to comply with treatment will be considered a third offense.
    - Client will contribute weekly allowance to offset any costs incurred by treatment.
    - Client must comply with all aspects of the substance abuse counseling and any recommendations made by substance abuse counselor. If the client does not successfully complete the substance abuse counseling and/or recommendations made by the counselor, this will be considered a third offense.
- Third offense: 30 day written notice of discharge will be submitted to CFC Placement & Dependency Case Manager.

Refusal to complete a drug screening will be considered a positive test.

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

[redacted]

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client Name: _____ **Date:** _____

Jewelry/Money

_____ Money ($_____)
_____ Necklaces
_____ Bracelets
_____ Watches
_____ Earrings
_____ Rings

Clothing/Shoes

_____ Shorts
_____ Long pants
_____ Pajamas
_____ Bras
_____ Swimsuits
_____ Jackets/Coats
_____ Short sleeve shirts
_____ Long sleeve shirts
_____ Skirts or Skorts
_____ Dresses
_____ Robes
_____ Belts
_____ Shoes
_____ Sandals
_____ Slippers
_____ Underwear
_____ Socks
_____ Hats

Other Items (i.e., books, games, personal hygiene, etc.)

_____ Stuffed animals
_____ Assorted small toys
_____ Large toys
_____ Books
_____ DVD's
_____ DVD player
_____ CD's
_____ CD players
_____ Tapes – video and audio
_____ Remote control toys
_____ Various papers and notebooks
_____ Various pens, pencils and crayons
_____ Board games
_____ Boom box
_____ Skates
_____ Balls
_____ Helmet
_____ iPod/mp3 player
_____ Game Boy/Nintendo DS
_____ Games for Game Boy
_____ Backpack
_____ Suitcase/Duffle bag
_____ Purses
_____ Assorted hair accessories
_____ Various toiletries
_____ Lunch box/Water bottle
_____ Dolls (small/Barbie)
_____ Dolls (large)
_____ Blankets
_____ Decorative pillows
_____ Various knick knacks
_____ Various sports equipment
_____ Bicycle
_____ Scooter

[redacted] _____ Date: _____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____

[redacted]

Seven Stars Emergency Shelter at Place of Hope, Inc.

Client Name: _____ **Date:** _____

Visitors:
The above named client has my approval to have visits with the following individuals:

This individual may:

Visit Shelter:	Take Client Off-Campus:	Name:	Relation:	Phone Number:
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

Phone Calls:
The above named client has my approval to have phone calls with the following individuals:

☐ Include all approved visitors ☐ Include all approved visitors except: _____

Name:	Relation:	Phone Number:	Speakerphone Only:
			☐
			☐
			☐
			☐
			☐
			☐

Notes about Visits and Phone Calls:

_____
_____
_____
_____

[redacted] _____ Date: _____

SSES Staff: _____ Date: _____