

## ADMISSION FACESHEET

Clinical Record #:		Placement Type:	
Admission Date:	Time:	Jurisdiction:	
Reason:			

### Client Information

Client Name (last, first):			Social Security Number:			
Client address, state, zip code:			Client Telephone Number:			
Birth Date:		Age:		Birth Place:		
Height:	Weight:	Eyes:	Hair:	Race:	Sex:	Religion
Education (school, grade, date last attended):						

### Parent / Legal Guardian Information:

Parent/Legal Guardian Name:	Guardian Work & Home Phone #:	Guardian Fax #:
Placing Agency Name:	Supervisor Name:	Supervisor Phone #:
<b>Responsible Billing Agency / Name:</b>	<b>Billing Agency Address:</b>	<b>Billing Agency Phone #:</b>
Other:		

### Family Information:

Name	Relationship	Address, city, state, zip code	Phone #		Emergency		
			Work	Home	Yes	No	

### Medical Information:

Medicaid Card Number:		Allergies:	
Insurance Company:	Insured person:	Policy Number:	
Physician:		Physician Phone #:	

# EPWORTH COMMUNITY SERVICES PRESCRIPTION MEDICATION CONSENT

## I. Prescription Medication

The parent/legal guardian must supply the medication in a properly labeled container from the pharmacy, with those doses to be given at Epworth/Community Service, and with instructions for any special need for storage, e.g. refrigeration. The prescription label will be considered an equivalent of the physician's order. When possible, descriptions of any adverse effects and any applicable emergency instructions should be provided to Epworth/Community Service. The parent/legal guardian must deliver the medication to Epworth/Community Service on the day of admission. Medication supplies should not exceed a 30-day supply.

**YES:**

I, \_\_\_\_\_, (parent/guardian), do hereby give Youth Emergency Service permission to administer the following prescribed medications to \_\_\_\_\_ during his/her stay at Youth Emergency Service.

**TLP/ILP:**

I, \_\_\_\_\_, (parent/guardian), do hereby acknowledge my understanding that \_\_\_\_\_ will be responsible for self-administering his/her medications during his/her stay in Epworth TLP/ILP Program.

Name of medication	Dosage	Time(s) to be given	Number/Amount Received	# of Refills

**The prescribing physician in the community has informed me about the risks and benefits of these medications. I understand these risks and benefits and am giving consent for these medications to be administered. I understand that further information can be obtained from the Epworth Nursing Department by calling (314) 918-3336.**

## II. Medication Refills

Epworth/Youth Emergency Service will hold the parent/legal guardian responsible for filling and supplying the child's medication. Our staff will notify the parent/legal guardian when medication supplies are running out within a three-day window.

TLP/ILP clients will be responsible for getting their own medications. Epworth staff will provide assistance if needed.

I fully understand the contents of this policy involving prescription and refills of medication.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**ACKNOWLEDGEMENT OF PRIVACY NOTICE &  
PERMISSIONS TO SHARE PERSONAL HEALTH INFORMATION**

**ACKNOWLEDGEMENT OF PRIVACY NOTICE**

I have received a copy of the Epworth Children and Family Services Notice of Privacy Practice as the parent/legal guardian of the person receiving services.

Yes     No     Agrees but Refuses/Is Unable to Sign – Describe: \_\_\_\_\_

**NOTIFICATION OF FAMILY AND/OR OTHERS**

I hereby authorize the staff of Epworth to disclose to the following persons information as identified in the table below.

Person to be Notified (name, address, phone)	Notice of Customer Status with Epworth	Information Relating to My Plan	Progress
_____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed
_____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed
_____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Permits but not Signed

\*Information relating to my PHI that may be shared is limited to: medication information, a summary of progress and behavior, and a list of services and personnel available for assistance.

**SIGNATURE FOR NOTICES/PERMITS**

I hereby authorize the use and/or disclosure of my personal information as indicated in the checked boxes above.

Parent/Legal Guardian Signature or Personal Representative	Date
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Printed Name if Representative	
Authority, if Personal Representative	
Witness Signature	Date
Printed Name of Witness	

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## You Have the Right to Receive this Notice

You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

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## How to Complain About Our Privacy Practices

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775. We will take no retaliatory action against you if you make such complaints.

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## Contact Person for Information or to Submit a Complaint

If you have questions about this Notice or any complaints about our privacy practices, please contact an agency representative, or the Epworth Privacy Officer at:

Epworth Children and Family Services  
C/o Privacy Officer  
110 N. Elm  
St. Louis, MO 63119

### Effective Date:

This notice is effective April 1, 2004.

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## Notice of Privacy Practices

This pamphlet describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**EPWORTH**  
Where Kids Find Strength

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## Our Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice though **we reserve the right to change our privacy practices and the terms of this Notice at any time.**

You may request a copy of the new notice from Epworth. It is also posted on our website at

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## How We May Use and Disclose Your Protected Health Information

We use and disclose Personal Health Information for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment and for our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy practices to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following describes and offers examples of our potential uses/disclosures of your PHI.

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## Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

Generally, we may use or disclose your PHI as follows:

**For treatment:** We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, or with our central program staff. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment, such as lab work or x-rays, or for consultation purposes, and/or community mental health agencies involved in the provision or coordination of your care.

**To obtain payment:** We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may contact your employer to verify employment status, and/or release portions of your PHI to the Medicaid program, the DFS central office, other agencies, and/or a private insurer to get paid for services that we delivered to you.

**For health care operations:** We may use/disclose your PHI in the course of your program services. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant for billing purposes. Since we are an integrated system, we may disclose your PHI to designated staff in our other facilities, programs, or our central office for similar purposes. Release of your PHI to the state agencies might also be necessary to determine your eligibility for publicly funded services.

**Appointment reminders:** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

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## Uses and Disclosures of PHI Requiring Authorization

For uses and disclosures beyond treatment, payment, and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

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## Uses and Disclosure of PHI from Mental Health Records Not Requiring Consent or Authorization

The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

**For public health activities:** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

**For health oversight activities:** We may disclose PHI to our central office, the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

**Relating to decedents:** We may disclose PHI related to a death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

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**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm

**For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and or national security reasons, such as protection of the President.

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## Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring Consent or Authorization

The law provides that we may use/disclose you PHI from alcohol and other drug records without consent or authorization in the following circumstances:

**When required by law:** We may disclose PHI when a law requires that we report information about suspected child abuse and neglect, or when a crime has been committed on the program premises or against program personnel, or in response to a court order.

**Relating to decedents:** We may disclose PHI relating to an individual's death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.

**To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

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## Uses and Disclosures Requiring You to have an Opportunity to Object

In the following situations, we may disclose a limited amount of you PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law.

**To families, friends, or others involved in your care:** We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

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## Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

**To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our uses/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

**To choose how we contact you:** You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

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## To inspect and request a copy your PHI:

Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

**To request amendment of you PHI:** If you believe that there is a mistake of missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

**To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or the facility director; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 2004. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

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## MEDICAL AUTHORIZATION

I/We \_\_\_\_\_ hereby authorize Epworth Children & Family Services and its appointed representatives to act in my/our behalf when emergency medical/dental care or surgery is recommended by a licensed physician for the welfare of my/our child. Epworth Children & Family Services will notify me/us in advance of any medical procedure whenever possible.

In cases when non-emergency hospitalization or treatment is necessary and I/we are/am not available, I/we authorize Epworth Children & Family Services staff to act in the best interest of my/our child. I/we authorize Epworth Children & Family Services staff to administer medications, both prescription and/or over-the-counter, prescribed by a Licensed Medical Doctor or Nurse Practitioner during his/her stay at Epworth.

I/we agree to identify and hold Epworth Children & Family Services and its directors, officers, and employees harmless from and against any and all claims, causes of action, liabilities, costs and expenses (including reasonable attorney's fees) brought against or incurred by Epworth Children & Family Services arising out of, or resulting from acts or omissions with respect to this medical authorization, provided, however, such act or omission is not finally adjudged in any action, suit, or proceeding to have been negligent.

Please **INITIAL** one:

\_\_\_\_\_ It is not necessary to notify me of psychotropic medication changes.

\_\_\_\_\_ I wish to be notified over the phone if psychotropic medication(s) is/are going to added or changed.

### CONSENT FOR OVER-THE-COUNTER MEDICATION ADMINISTRATION

Please **INITIAL** any/all of the following over-the-counter medications you are authorizing.

\_\_\_\_\_ Acetaminophen 325 mg. 1 or 2 every four hours for pain or fever

\_\_\_\_\_ Ibuprofen 200 mg. 1 or 2 every six hours for pain or fever **cannot be taken while on Lithium**

\_\_\_\_\_ Pseudoephedrine (Sudafed) 30 mg. 1 or 2 every 4 to 6 hours for nasal/sinus congestion

\_\_\_\_\_ Diphenhydramine (Benadryl) 25 mg. 1 or 2 every 4 to 6 hours for allergy symptoms or insomnia

\_\_\_\_\_ Guaifenesin Syrup 2 teaspoons every 4 hours for congestion

\_\_\_\_\_ Chloraseptic Throat Spray as directed on bottle for minor sore throat

\_\_\_\_\_ Liquid Antacid (Maalox/Mylanta) 2 teaspoons up to 4 times a day for GI distress

\_\_\_\_\_ Chewable antacid tablets (Tums/Rolaids) 2 or 3 every 4 to 6 hours for indigestion

\_\_\_\_\_ Tetrahydrozoline (Visine) Eye drops 2 drops in eye up to 4 times a day for red/burning/itching eyes

\_\_\_\_\_ Antibiotic Ointment (Polysporin/TripleBiotic) topically to minor skin injuries

\_\_\_\_\_ Calamine/Benadryl lotion to minor insect bites/rashes

\_\_\_\_\_ Other (Please specify)

I understand that every effort will be made to contact me in the case of illness or injury. In addition, that I am responsible for securing medical care for the above named person. I understand and give permission for Epworth Children & Family Services to secure medical care if unable to reach me or in the case of an emergency.

I understand and agree that Epworth Children & Family Services is held harmless for any bodily injury or harm incurred by \_\_\_\_\_ during his/her stay as a guest of the organization.

(Youth's name)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**CONTRACT FOR HOUSING – HANDS-OFF POLICY - CONFIDENTIALITY**

**PARENT’S/LEGAL GUARDIAN’S CONTRACT FOR HOUSING**

I understand that my child has been offered an emergency placement at Youth Emergency Service (YES). Further, I understand that he/she will only be able to reside at YES for up to 12 days (private placement) or 30 days (CD placement).

The length of the resident’s stay is determined by his or her compliance with the contract he or she signs at intake. If shelter staff along with the director of the program feels that the resident is not meeting the program guidelines set forth in the resident’s contract and program rules, you will be contacted to discuss the resident’s placement. If the resident is discharged from the program on an emergency basis, you will be expected to be available for pick up of the resident within twelve hours of receiving notice from the YES staff. Understanding, if you do not respond to the staff’s request for an emergency discharge, the University City Police and the Children’s Division will be notified.

Finally, we cannot legally restrict either biological parent from visiting, calling or picking up their child unless we are provided with a court order restricting access.

**HANDS-OFF POLICY**

Due to the voluntary nature of this program, YES will maintain a hands-off approach to treatment delivery. At no time should a resident be “forced” to stay at YES through the use of physical interventions. In the event that a resident becomes physically aggressive with YES staff or other residents, staff may intervene to ensure that the resident does not harm themselves, staff, or other residents. The University City Police will be called. Upon arrival, the officers are to take control of the resident.

You are expected to participate in the treatment plan agreed upon by YES, staff, yourself, and the resident. This treatment plan may include participation in weekly family counseling during the course of the resident’s stay at YES.

**STATEMENT OF CONFIDENTIALITY**

The access of parents, other family members, guardians and other representatives to detailed confidential information about the treatment of Epworth residents and clients is limited. Furthermore, Epworth has an ethical and legal obligation not to make any disclosure that would be harmful to the resident or his/her treatment. Moreover, the law mandates Epworth to report neglect and abuse to the Child Abuse Hotline and violations of the law to the police.

However, parents, guardians, and such persons have the right to know if the resident/client:

- \*Elopes (runs away), \*Is assaulted, \*Is medicated, \*Is truant from school, \*Has threatened staff

The planned discharge date for the resident is: \_\_\_\_\_

Agreed on this date: \_\_\_\_\_

I have read and understand these policies.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Resident/Client

\_\_\_\_\_  
Witness

## VISITOR PERMISSION FORM

Resident's Name: \_\_\_\_\_

Please list the visitor's name and circle N /Y in the desired column(s) to indicate what contact the visitor can have with the resident.

Visitor/Relationship	Address	Phone	Supervised Phone Calls	Phone Contact	On Campus Visits Supervised	On Campus Visits Unsupervised	Off Campus Visits	Overnight Visits	*Date and initials of person deleting information
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____
			N / Y	N / Y	N / Y	N / Y	N / Y	N / Y	_____

NOTE: In signing this form, the legal guardian(s) assume full responsibility for the resident when in the care of those listed above. Epworth does not obtain a police check or references for visitors. Therefore, Epworth does not assume the responsibility for the safety of the child or the visitor listed above while on an off campus visit. **All approved visitors taking residents off campus must sign the resident out and back in.** I fully understand the contents of this form and accept Epworth's disclaimer of liability involving unsupervised visits.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\*Additions or deletions to this form are to be made on the original only by the guardian, the Therapist, Program Manager, Admission Coordinator, Community Services Coordinator, or Director with the guardian's permission. Date and initials of the person making the changes are to be indicated and an updated copy distributed.

## SCHOOL TRANSPORTATION – GROUP INFO – ACTIVITY RELEASE

### SCHOOL TRANSPORTATION

Parent/Guardian is responsible for youth's transportation to and from school. Guardians must notify school that youth is at YES. **Please check one of the following:**

- For youth ages 16 and older, YES will provide bus tickets and bus training (if necessary)
- Parent/Guardian will request all school work to be sent to youth at shelter
- Parent/Legal Guardian will arrange transportation for youth to and from school

### GROUP INFORMATION FORM

Below are descriptions of the various groups that may be conducted with the resident during group time. The purpose of these descriptions is to inform you of the information that may be presented to the resident during group sessions. Signing this form indicates that you have read these summaries and are aware of the material that may be covered with your child.

#### **Art Group**

Group Mural creation  
Family portrait  
Jewelry design  
Personal mask creation  
I am/I feel/I do exercise

#### **Sexuality Group**

Introduction to sexuality  
Teenage pregnancy  
Sexually transmitted diseases  
Sexual orientation

#### **Women's Group**

Women's issues  
Domestic violence

#### **Adolescent Issues Group**

Peer pressure  
Substance abuse  
Gang involvement  
Educational issues  
Relationship issues

#### **Living Skills Group**

Self-esteem issues  
Apartment searches  
Job application process  
Anger management

#### **Substance Abuse Group**

Acknowledgement of problem  
Recognitions of dynamics  
Techniques for refusal  
12-step process

### ACTIVITY RELEASE

All residents of Youth Emergency Services will be expected to participate in a variety of recreational activities such as movies, theater, sporting events, and trips to local points of interest. Often these events will require transportation in a motor vehicle. All Youth Emergency Service sponsored activities are supervised by an adult.

I hereby release Youth Emergency Services, its staff and employees from all actions, cause of actions, claims, or demands which I may have against Youth Emergency Service, its staff or its employee for all personal injuries or illness known or unknown which I or my child may incur by participation in Youth Emergency Services activities, including any personal injuries which may occur while being transported in any Youth Emergency Service owned or Youth Emergency service authorized mode of transportation.

I, the undersigned, have read this release and understand all its terms. I execute it voluntarily with full knowledge of its significance.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Client Name** (print): \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Person Requesting Release of Info** (print): Youth Emergency Services Staff **DOB:** N/A

**Relation to Client:** Epworth Youth Emergency Services Staff

<b>Client Dates of Treatment / Name of Program:</b> Proposed Admission Date: _____ Discharge Date: _____ Program: <u>Epworth Youth Emergency Services</u>									
<b>I authorize the following information to be released (check all that apply):</b> <table style="width: 100%; border: none;"><tr><td><input type="checkbox"/> Integrated Assessment</td><td><input type="checkbox"/> Master Treatment Plan</td><td><input type="checkbox"/> Treatment Plan Updates</td></tr><tr><td><input type="checkbox"/> Discharge Summary</td><td><input type="checkbox"/> Progress Notes</td><td><input type="checkbox"/> Critical Incident Reports</td></tr><tr><td><input type="checkbox"/> Psychiatric Notes</td><td><input type="checkbox"/> Medical Records</td><td></td></tr></table> <input checked="" type="checkbox"/> Other (specify): <u>School work &amp; school attendance</u>	<input type="checkbox"/> Integrated Assessment	<input type="checkbox"/> Master Treatment Plan	<input type="checkbox"/> Treatment Plan Updates	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Critical Incident Reports	<input type="checkbox"/> Psychiatric Notes	<input type="checkbox"/> Medical Records	
<input type="checkbox"/> Integrated Assessment	<input type="checkbox"/> Master Treatment Plan	<input type="checkbox"/> Treatment Plan Updates							
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Critical Incident Reports							
<input type="checkbox"/> Psychiatric Notes	<input type="checkbox"/> Medical Records								
Indicate any exceptions or exclusions, if any, of information you do not want to be released:  									
I authorize the Information To Be Released <input checked="" type="checkbox"/> <b>TO</b> <input type="checkbox"/> <b>FROM</b> (Specify Name, Address, Phone Number): Epworth Youth Emergency Services 6816 Washington Ave University City, MO 63130 314-727-6294									
The authorization for release of information is for the following purpose:  Supervision/receipt of school work and daily attendance follow-up.									
My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a treatment program. This authorization will remain effective for <input checked="" type="checkbox"/> <b>90 days or</b> <input type="checkbox"/> <b>180 days</b> unless an earlier date or condition/event is specified here:									
However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Epworth has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to ( <i>give name / address</i> ): Admission Coordinator 6816 Washington Ave University City, MO 63130									

**Signature of Client :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent /Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTE:** This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

<b>For Office use Only</b> Staff Person Releasing Info: Date Info Released:
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<b>Original to Client File, Copy to Requestor</b>
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Resident Name: \_\_\_\_\_

Adm Date: \_\_\_\_\_

**EPWORTH**  
Where Kids Find Strength

**INFORMED CONSENT FOR TREATMENT**

I/We affirm that I/We have been informed of the treatment programs and services available at Epworth. I/We agree that the agency, its members and agents, have full and free consent to perform such services as are deemed appropriate by the agency's clinical staff in treatment of \_\_\_\_\_.

It is understood that the Epworth staff will take reasonable steps to advise me of the above named resident's welfare during the course of treatment. Epworth also reserves the right, as guided by Epworth policies, to conduct searches for contraband.

Although Epworth believes firmly that the therapeutic services offered to clients will be effective and beneficial, it is important to acknowledge that no treatment is entirely without risks, including the following:

- Therapy and other treatments can be stressful, may temporarily exacerbate symptoms or ongoing feelings of distress, and may stir unpleasant memories or feelings.
- Specific therapies and treatments may not be effective for a given youth, may be only partially effective, or may result in gains that are not maintained over time.
- Related to our role as legally mandated reporters, therapy and other treatments may lead to observations or the sharing of information that require the agency to contact appropriate authorities, including the Child Abuse and Neglect Hotline.

This consent remains valid through the final discharge date of the resident.

\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**VOLUNTEERS – RELIGION – MEDIA RELEASE**

**VISITING VOLUNTEER RESOURCE PERMISSION FORM**

When it is in the best interest of the resident, Epworth Children & Family Services may assign a volunteer/mentor. Before being assigned to a client, the volunteer must undergo an approval process inclusive of a criminal background check. Once approved, this volunteer is allowed to take the resident off campus several times per month and serves as a supportive resource, friend, and a role model. Epworth considers this relationship as part of the overall treatment program, as it can be extremely beneficial to the resident.

**RELIGIOUS IDENTITY INFORMATION**

Epworth Children & Family Services is a corporation under the laws of the state of Missouri, related to certain entities of the United Methodist Church, including the General Board of Global ministries, by written agreements, copies of which are available upon request. As part of our effort to foster the development of the whole person, Epworth seeks to foster the awareness of ethical and moral behavior that enables persons to live constructively and peacefully. Epworth also affirms that religious beliefs are a matter of individual choice. Residents are encouraged to attend religious activities at the religious organization of their choice.

**TAPE RECORDINGS, VIDEO, PHOTOGRAPHS, MEDIA INTERVIEWS**

**Internal Organization Purposes:**

I understand there will be a photograph taken of the client at the time of admission for solely identification purposes. I understand that this may involve video/audio taping and observation through a one-way mirror and that if these procedures are utilized they will be strictly for supervisory and performance improvement purposes.

**External Organization Purposes:**

I agree and consent to allow for all tape recordings, videotaping, photographs and interviews for purposes of public information, to be taken of the above mentioned client and used by Epworth Children and Family Services, its affiliated programs and St. Louis Media. I understand that tape recordings, videotaping, photographs, and interviews are for the purpose of public information, supervision, education, and that these activities are an appropriate and useful part of Epworth Children and Family Services.

I release Epworth from liability for the making or taking of such recordings, videotapes, photographs, or interviews of the client in connection with its counseling, education, treatment, or public information functions. I hereby waive and release all claims for any compensation.

I understand that either the client or guardian/legal parent may request cessation of recording or filming. Clients or guardian/legal parent may rescind consent for use up until 7 days before the recording or filming is used.

Please **INITIAL** one of the following:

I agree to allow media interviews (print, television) with photographs or videotapes of the above stated client.

I do not agree to allow media interviews (print, radio, television) with photographs or videotapes of the above stated client.

I have read and understand these policies.

\_\_\_\_\_  
Parent/Legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **GRIEVANCE PROCEDURES/SAFTETY CONCERNS**

Every effort will be made to resolve any complaint, grievance or safety concern. All client complaints, grievances or safety concerns and the staff's response will be documented in the client case record.

### **CLIENT COMPLAINTS/SAFETY CONCERNS:**

As a client of Epworth, you may make a complaint, grievance or safety concern at any time, through adherence to the following procedure:

- 1) Client must complete a written youth incident report or written statement regarding their issues (assistance from staff or peer is available). Form should be turned into staff.
- 2) Client will receive a response from the therapist, lead youth advisor, or program manager within 48 hours, either in writing or verbally.
- 3) If the response is not satisfactory, the client may request to meet with the staff's supervisor.
- 4) The supervisor will meet with client and/or provide a response (either verbally or in writing) within seven (7) working days, from date of request.
- 5) If the response is not satisfactory, the resident may request to meet with the Program Director or Assistant Director.
- 6) The Program Director or Assistant Director will meet with resident and/or provide a response (either verbally or in writing) within seven (7) working days, from date of request.
- 7) If the response is still not satisfactory, the client may request a meeting with the Associate Executive Director, who will make the final decision.

### **PARENTS AND LEGAL GUARDIANS COMPLAINTS/SAFETY CONCERNS:**

One of Epworth's primary concerns is client safety. A committee of staff meets monthly to discuss any safety concerns and address any issues to create the safest environment possible for clients. If at any time a family, guardian, worker, etc. has any concerns regarding client safety or the safety of the environment, we ask that you report them immediately through adherence to the following procedure:

- 1) As a parent or legal guardian of a client at Epworth, you may submit a verbal or written complaint, grievance or safety concern to the Program Director.
- 2) The Program Director will respond in writing within seven (7) working days. During this time period, the Program Director may request a meeting with you.
- 3) If the response the parent/legal guardian receives is not satisfactory, he/she may request to meet with the Associate Executive Director. The Associate Executive Director will provide a response within seven (7) working days.

If the complainant is not satisfied with the result of the grievance process results, after going through the entire chain of command, their unresolved conflicts can be raised with the Joint Commission's Office of Quality Monitoring. Epworth is accredited through JCAHO and unresolved conflicts may be brought to their attention.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

**\*FOR YOUTH WHO ARE HOMELESS OR IN CHILDREN'S DIVISION ONLY\***

## **Student Transportation Request**

From: EPWORTH – YOUTH EMERGENCY SERVICES (Y.E.S.)  
Phone: 314/727-6294

To UNIVERSITY CITY PUBLIC SCHOOLS  
Office of Pupil Personnel  
8136 Groby Rd. St. Louis MO 63130 \* \* 314-290-4045 \* \* FAX 314-725-0965

Student: \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

**A.M.**      **Pick-Up Address:** 6816 WASHINGTON AVE      63130

**Pick-Up Time:** \_\_\_\_\_

School Start Time: \_\_\_\_\_

School Name & Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

School District: \_\_\_\_\_

**P.M.**      **Dismissal Time:** \_\_\_\_\_

**Start Date:** \_\_\_\_\_ **Proposed End Date (may change):** \_\_\_\_\_

Special Notes: \_\_\_\_\_

\_\_\_\_\_  
Requesting Person (YES staff)

\_\_\_\_\_  
Date Faxed to Pupil Personnel

**I certify that the above student is homeless and/or is currently under official court jurisdiction/protection pending permanent placement.**

*Homeless is defined as not having a permanent residence, living in a hotel/car/shelter, living in a residence with more people than allowed.*

Signed by \_\_\_\_\_

Legal Guardian

(Note: Unsigned forms will be returned to Y.E.S. This is the only form accepted for transportation requests.)

**YOUTH EMERGENCY SERVICE (YES)  
GUARDIAN APPROVAL FOR UNSUPERVISED OFF-CAMPUS  
OUTINGS FOR 17 YEARS OLD AND ABOVE**

Resident: \_\_\_\_\_ D.O.B./AGE: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

The above listed youth is not permitted to leave the shelter unaccompanied by staff for any reason.

Approval is given for the above named youth to leave YES, unaccompanied by staff, for any of the following purposes :

Employment or Employment Search

School or Education Participation

Apartment Search /ILP Preparation

Home Pass

Doctor or Outside Therapist Appointment

Personal/Recreation Time

Other: \_\_\_\_\_

Residents are generally approved for no more that two hours of unaccompanied off-campus outings per shift. If you would like your child to be limited to fewer hours per day, please indicate the number of hours approved: \_\_\_\_\_

ADDITIONAL REQUIREMENTS OF INFORMATION:

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\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Resident

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**YOUTH EMERGENCY SERVICES (YES)**  
**RIGHTS AND RESPONSIBILITIES**

**RIGHTS**

- To be free from abuse and/or neglect
- To contact your legal guardian and have staff assistance in doing so
- To have your rights explained to you in your own language
- To have a staff member express your point of view in situations where you are not present
- To be notified of changes in the dorms and of the people working with you
- To have the rules and procedures of the program explained to you
- To be notified as soon as possible of your discharge plan, court and/or planning dates (unless otherwise indicated)
- To be considered for special task programming
- To have your complaints heard by the Program Director
- To choose to exercise your rights without having services denied, reduced, suspended, or terminated
- To make and receive phone calls
- To have equal opportunity to treatment
- To have an individualized treatment plan
- To have treatment plan reviewed and discussed
- To have all restrictions reviewed at least every seven (7) days (residential only)
- To have privacy
- To receive necessary medical and dental treatment
- To send and receive mail from authorized people
- To visit with family in private
- To wear your own clothing
- To private relationships (confidentiality will be maintained whenever possible)
- To attend church under Pastoral guidelines
- To receive adequate food
- To call the Child Abuse Hotline
- To have services provided without discrimination

**RESPONSIBILITIES**

- To work with staff in developing positive ways to express viewpoint
- To maintain adequate behavior and the resources to do so
- To participate honestly in determining Problem areas
- To demonstrate trustworthy and appropriate behavior when allowed Privacy and to remain in designated areas
- To abide by rules set forth by Epworth and society
- To listen and ask treatment questions and to use information positively to help meet treatment goals
- To not use the Hotline unless truly necessary
- To maintain behavior so treatment opportunities may occur
- To discuss how you are doing with members of your team
- To work toward getting off restrictions
- To cooperate with medical orders
- To pay for more than 3 stamps per week
- To follow Epworth rules at mealtime
- To demonstrate appropriate behavior during church, with peers, and staff.