GREAT FALLS CHILDREN'S RECEIVING HOME
PROGRAM MANAGER CHECKLIST

Name: _____

Intake:

1. Pre-Placement Form
2. Application for Care
3. Placement Agreement Form
4. Social Assessment
5. Additional Information
6. Juvenile Justice History
7. Family Information
8. Medical Information
9. Outing Authorization
10. Transportation Authorization
11. Youth Agreement Form
12. Admit Checklist
13. Search Policy for Youth
14. Youth Rights
15. Emergency Exit Review
16. Additional Records Request
17. ASQ Suicide Screening Questions

Medical:

18. Medical Authorization
19. Youth Medical Emergency Sheet
    a. Immunization Records
    b. Medicaid Insurance Card

Education:

20. Lunch Letter
21. Education Authorization
    a. Educational Records

Personal:

a. Letter from CPS
b. Court Order
c. Guardian Ad Litem Order
d. Birth Certificate

Case Management:

a. Case Management Plan

Discharge:

22. Youth Discharge Sheet
23. Youth Check Out Sheet
    a. Discharge Summary
    b. Child Inventory Sheet

Child Appointment Form

CHILD APPOINTMENT FORM

Name: _____ Insurance: _____

Date of Birth: _____ Insurance #: _____

Date of Placement: _____

Well-Child Last Visit: _____ Next Visit: _____ Date appointment was made: _____	Doctor: _____ Address: _____ Phone: _____
Dental Last Visit: _____ Next Visit: _____ Date appointment was made: _____	Doctor: _____ Address: _____ Phone: _____
Vision Last Visit: _____ Next Visit: _____ Date appointment was made: _____	Doctor: _____ Address: _____ Phone: _____

APPLICATION FOR CARE

Please keep in mind that in accordance with our contract, and in keeping with the requirements of our license, all sections of this application must be completed by the placing worker. If you do not know the answer to a question, please write "N/A", or even simply place a line through the section. You must at least show that you read that section. Any blank areas on this application are a direct violation of our contract. **Failure to fully complete this application will result in the placement being denied.**

Date_____

Child's full name: _____
Last First Middle

Height _____ Weight _____ Religious preference _____

Eye color _____ Hair color _____ Distinguishing characteristics_____

Social Security Number_____

Date of birth _____ Sex _____ Race_____

Name of placing worker_____

Telephone Number _____ Referring agency _____

Signature of Placing Worker _____ Date _____

Please list an emergency contact person

_____Phone # _____

Reason for Placement

_____

_____

_____

GREAT FALLS CHILDREN'S RECEIVING HOME
PLACEMENT AGREEMENT FORM

I, the undersigned, representing the placing agency specified below, hereby agree to the terms and conditions contained herein, that govern the placement of

_____ into the Great Falls Children's Receiving Home.

1) That placement is of a temporary, or short-term basis, not to exceed thirty (30) days. If after 30 days a more suitable placement has not been found, and extension for the child to remain at the Receiving Home must be requested and approved by the Administrator.

2) That for good cause, as determined by the Director in direct consultation with GFCRH staff that said youth's placement would be revoked.

3) Any behaviors exhibited by the youth, which in any way threaten the safety and well-being of the other residents, or the staff of the Great Falls Children's Receiving Home, will result in the offending child's immediately removal from the Receiving Home.

4) According to the contract agreed to by both representatives of the State Department of Public Health and Human Services, as well as personnel from the Great Falls Children's Receiving Home, the Receiving Home will provide routine local transportation. This is defined in the contract as transportation to and from school, at regularly scheduled hours. The Receiving Home staff will not provide transportation for extra-curricular events, nor will they go to the school to pick up a child, except at the end of the regularly scheduled day.
5) DPHHS/CFSD agrees to pay GFCRH the daily rate for all days of placement with exception to the last day of placement.

I understand and agree to the above terms and conditions.

Dated on this, the ____ day of _____, 20____.

_____	_____
Placing Agency (Please print)	Name of Youth
_____	_____
Agency Representative (Please print)	Signature
_____	_____
Receiving Home Staff (Please print)	Signature

SOCIAL ASSESSMENT

Youth's Name: _____ Date/Time of Admission: _____
Date/Time of Report: _____ Date of Birth: _____
Gender: Male _____ Female _____
Ethnicity/Race: _____
Legal Guardian: _____ Relationship to Youth: _____

Family Composition (parents, siblings, significant others to child):

_____
_____
_____

Please List Previous Placements:

_____
_____
_____

Emotional State: Variable _____ Sad _____ Flat or Empty _____ Awed _____ Euphoric _____
Wary and/or Hyper-Vigilant _____ Fearful or Anxious _____ Terrified _____
Irritable _____ Angry _____ Other: _____
Notes: _____
_____

Medical Information: Healthy _____ Sick _____ Poor Hygiene _____ Overweight/Obese _____
Thin/Underweight _____ Evidence of Self-Injury _____ Enuresis/Encopresis _____
Other: _____ Allergies: _____
Injuries: _____
Notes: _____
_____

Developmental Status: Age-Appropriate: _____ Inflexible/Rigid _____ Language Delays _____
Repetitive/Odd Speech _____ Socially Delayed/Immature _____
Other _____
Notes: _____
_____

Social Response: Comfortable _____ Disrespectful _____ Cooperative _____ Attentive _____
Intrusive _____ Apathetic _____ Evasive _____ Defensive _____ Hostile _____
Paranoid _____ Seductive_____ Playful _____
Other: _____
Notes: _____
_____
_____

Behavioral State: Appropriate/Relaxed _____ Apathetic _____ Lethargic _____ Withdrawn _____
Tense _____ Obsessive/Compulsive _____ Focused _____ Hyperactive _____ Agitated _____
Oppositional _____ Combative/Threatening _____ Sexual Gestures or Talk _____
Tics/Tremors_____ Odd or Unusual Behaviors _____ Repetitive Behaviors _____
Suicide Talk or Gestures _____
Needy/Clingy____Other: _____
Notes: _____
_____
_____

Risk Assessment: Suicide _____ Self-Harm _____ Aggression _____ Runaway _____
Other: _____
Notes: _____
_____
_____

Completed By (Print and Sign): _____

_____

Title: _____ Date: _____

ADDITIONAL INFORMATION

Approximate length of stay and projected outcome: _____

_____

What is the goal upon discharge for this child? __ reunification __ permanency __ treatment facility __ foster home __ other

Can you think of anything else that the staff of the Great Falls Children's Receiving Home should know about this child? _____

_____

Does this child have a history with the department of Public Health and Human Services? YES NO

If yes, please explain: _____

_____

Please list all behaviors this child has displayed, such as sexually acting out, cruelty to animals, history of fire setting, etc.: _____

_____

Please use this area to include any additional comments: _____

_____

Please list any goals you may have to this child while residing at the Receiving Home. Also, include any means of measuring such goals. For example: Brushing their teeth daily, making their bed, improving school performance, etc._____

_____

EDUCATION

Grade: _____ School: _____

Currently Enrolled? YES NO

JUVENILE JUSTICE HISTORY

Does this child have a history with the Juvenile Justice System? YES NO

If yes, please describe: _____

_____

_____

YOUTH CHANGEOVER

Case transferred to: _____

_____

Name Phone Date

Case transferred to: _____

_____

Name Phone Date

FAMILY INFORMATION

Mother's Name: _____

Address _____ Phone # _____

Father's name: _____

Address _____ Phone # _____

Siblings	**Name**	**Age**

Other individuals significant to this child

Name	Relationship	Phone Number

Is this child allowed to receive telephone calls? **YES** **NO**

Is this child allowed to make any calls, (long distance calls are allowed only with the Administrator's approval)? **YES** **NO**

If calls are allowed, should they be monitored? **YES** **NO**

Who is this child authorized to speak with on the telephone?

Name	Relationship

MEDICAL INFORMATION

Is this child presently taking any medications? **YES** **NO**

Is this child presently under a doctor's care? **YES** **NO**

Does this child have any known allergies? **YES** **NO**

Any pre-existing medical conditions? **YES** **NO**

Please explain _____

_____

_____

_____

Please count and verify all medications, if any, that have been brought into the Receiving Home

Name Amount

_____

_____

_____

_____ _____ _____ _____

Signature of Placing Worker Date Signature of Houseparent Date

GREAT FALLS CHILDREN'S RECEIVING HOME
AUTHORIZATION FOR OUTINGS

Date_____ CPS Initials_____ HP Initials_____

Outings approved for _____? **YES** **NO**
(name)

CPS permission each time? **YES** **NO**

If allowed what type? _____

With whom can the child leave for an outing? _____

_____With volunteers? **YES** **NO**

Preferred number of hours and time of day for of the outings_____

What is considered "off-limits" as far as any outings go? _____

Change in outing information: Date_____ By Whom_____
(CPS initials)

To Whom_____
(RH initials)

Changes: _____

_____

Reason: _____

_____

_____
Worker Signature Date

GREAT FALLS CHILDREN'S RECEIVING HOME
AUTHORIZATION FOR TRANSPORTATION

I hereby authorize the Great Falls Children's Receiving Home to transport _____ to all supervised outings, as well as to and from
(Child's name)
school to attend mandatory education and educational programs, at regularly scheduled times. I understand that the Receiving Home Staff will transport this child to and from school at the regularly scheduled time. Receiving Home staff will not pick up a child from school for any reason, except at the end of the day.

This child may be transported in a Receiving Home owned vehicle, school provided transportation, or may ride the Great Falls Transit.

This child will be attending _____
(Name of School)

And has my permission for the following:

Can ride the Great Falls Transit to and from school: **YES** **NO**

Can be dropped off and picked up in front of the school: **YES** **NO**

Can walk to and from school (weather and distance permitting): **YES** **NO**

Can be transported to supervised outings? **YES** **NO**

If there are restrictions on transporting this child, please list them in the space below:

_____

_____

_____
Signature of Placing Worker Date

The Great Falls Children's Receiving Home reserves the right to restrict participation in outings as deemed appropriate.

GREAT FALLS CHILDREN'S RECEIVING HOME
YOUTH AGREEMENT FORM

I, _____, agree to abide by the rules and regulations as stated by the Great Falls Children's Receiving Home Board of Directors.

I understand that the Receiving Home property, including my sleeping area, drawers, closets, and any other area on the Receiving Home property may be inspected, provided there is reasonable cause, and without warning, in accordance with the policies and procedures of the Great Falls Children's Receiving Home. Any illegal objects will be confiscated, and my CPS Worker or Probation Officer will be immediately notified.

I further understand that is illegal in the State of Montana for anyone under the age of 21 to possess, and/or smoke cigarettes, or other forms of tobacco. Smoking is not allowed on the Receiving Home property by anyone under the age of 21. I further understand and accept that if I am caught smoking, the Receiving Home staff may notify my Social Worker and possibly the Police Department. This may result in my immediate removal from the Great Falls Children's Receiving Home.

I understand that the Receiving Home is not responsible for possessions that I may leave behind or lend to another person. The Receiving Home is also not responsible for any debts I may incur while residing at the Home; including, but not limited to, school fines. I have been notified that all of my money, or anything else of value I possess, can be safely stored by the staff in a locked storage area.

_____ _____

Signature of Youth or CPS Worker/P.O. Date

_____ _____

Signature of Houseparent Date

ADMIT CHECK LIST

(To be completed by the program manager and placed in the youth's file)

Name of Child:_____

Age:_____ D.O.B_____

Worker:_____

Admit Date:_____

Answer "Y" for Yes "N" for No:

_____ Were all items that came in with the youth inventoried?
_____ Did staff go through expectations and list of rules if the child is over 5?
_____ Did the staff go through our discipline policy with youth?
_____ Did staff show the child fire exits and what to do in the event of an emergency or fire?
_____ Did staff inform child that staff is able to conduct searches, if warranted?
_____ Did staff inform child about hygiene expectations?
_____ If over the age of 5, was it documented that the staff and child went through orientation procedures? Please make sure, if yes, it was signed and dated.
_____ If over the age of 5, did staff go over Youth Rights Policy/ Summary?
_____ Has attempt been made to provide opportunity and encouragement for youth to identify with his/her culture or religious preferences?

Please phone/email Worker and ask what the behavior expectations are for this child. Please Note:

_____

_____

Date of Initial Case Plan: _____
Are there any behavior management issues with this child? _____

If behavior issues, please explain:

_____

_____

_____ Date
Youth Signature (over 5 yo)

_____ Date
Program Manager Signature

SEARCH POLICY FOR YOUTH:

SEARCHES:

- Except for those articles of personal property belonging to the resident/child, all other property, equipment, and furnishings located in and at the Receiving Home constitute property of the Home. At no time does the Home relinquish its exclusive control of such property, which has been provided for the convenience and comfort of the residents. Periodic general inspections of such property may be conducted by agents or staff at any time, without notice, without resident/child consent, and without a search warrant. With respect to personal property the child as expected above, inspections which are reasonable related to contraband, may be conducted by agents or staff of the Home without consent and without a warrant. Any and all contraband located in the course of such searches shall be immediately seized by the Home and surrendered immediately to local law enforcement authorities. All information will be provided to Social Workers. Written or Verbal Permission must be given for a search for child by the Child's Social Worker. If Social Worker cannot be located and all efforts were made, approval must be given, by worker, within 24 hours. All items confiscated will be documented.

YOUTH SIGN AND DATE IF OVER THE AGE OF 5:

_____

RECEIVING HOME STAFF SIGN AND DATE Verifying that staff have informed child of this procedure:

_____

YOUTH RIGHTS

All youth residing at the Great Falls Children's Receiving Home shall be protected in such a way as that their fundamental rights (safety, shelter and well-being) civil rights, constitutional rights and statutory rights are preserved and respected.

EACH YOUTH HAS THESE GUARANTEED RIGHTS:

1. Freedom from abuse, neglect and unnecessary physical restraint.
2. Education services pursuant to Montana state law.
3. Recognition and respect in delivery of services.
4. Receive care according to individual needs.
5. Personal privacy, when it is not contrary to the treatment and safety needs of the youth.
6. Family contact by mail and phone, as long as it is not contrary to the treatment and safety needs of the youth.
7. Consideration of the youth's opinions and recommendations when developing the youths case plan with documentation of the youth's input.

Youth's Signature Date

GREAT FALLS CHILDREN'S RECEIVING HOME
EMERGENCY EXIT REVIEW

Name of child or adolescent_____

Date of Birth_____

Age_____

Date of placement_____

Staff reviewing the emergency exits_____

Although I may never need to use an emergency exit, I have been shown a map of the Great Falls Children's Receiving Home and have seen the exits.

Please sign and date (if age appropriate).

_____ _____

Name Date

HOUSE RULES

- Be respectful to other children and staff.
- During changeover and quiet time all children are required to be in their rooms, the playroom, or tutor area. NO EXCEPTIONS!
- During new admits, children need to stay out of the dining room.
- Cussing is not permitted and repeat offenses will result in loss of privileges. Examples: outings, cell phones, tv time, video games.
- Authority for unsupervised walks and time out of the Receiving Home can only be made by your guardian, whether it be a CPS worker or JPO.
- Unless specifically invited into the office, no child is allowed in the office, period!
- No child is to get into the cabinets or the refrigerator without staff approval.
- If you are told no by a staff member, do not go to another staff member because you did not like the answer.
- No boys in the girls' area and no girls in the boys' area.
- Electronics are a privilege, no child is guaranteed any amount of time for watching television, playing video games, playing on computers/tablets, and/or cell phones.

Youth Signature: _____ Date: _____

Staff Signature: _____ Date: _____

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ○ Yes ○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ○ Yes ○ No
3. **In the past week, have you been having thoughts about killing yourself?** ○ Yes ○ No
4. **Have you ever tried to kill yourself?** ○ Yes ○ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ○ Yes ○ No

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

GREAT FALLS CHILDREN'S RECEIVING HOME
AUTHORIZATION/CONSENT TO SEEK MEDICAL CARE, ENROLL IN SCHOOL, AND ACCESS EDUCATIONAL RECORDS

I, the below signed guardian of_____, grant permission and authorization to any staff member of the Great Falls Children's Receiving Home to sign for all necessary medical care. This is to include routine tests, immunizations, and emergency medical or surgical treatment in the event that I cannot be contacted.

I also authorized staff members to dispense medications, both over the counter, and those prescribed by a Physician.

I grant permission and authorization to any staff member of the Great Falls Children's Receiving Home to sign for all necessary educational needs. This is to include enrollment, access to IEP's, progress reports, report cards, parent/teacher conferences and signing of field trip waivers.

I understand that a representative of the Great Falls Children's Receiving Home will attempt to contact me as soon as possible in the event of an emergency involving a child I have placed in their care.

I further understand that the Great Falls Children's Receiving Home does not provide transportation to the Doctor, or the hospital, or any other means of transportation, except for routine local transportation, which has been defined as to and from school during regularly scheduled school hours. In a medical emergency arises involving a child I have placed in the Receiving Home; I understand that Receiving Home personnel may call an ambulance to transport the child to a medical facility.

_____ _____

Signature of Placing Worker Date

_____ _____

Receiving Home Staff Date

GREAT FALLS CHILDREN'S RECEIVING HOME
YOUTH MEDICAL EMERGENCY SHEET

(To be used in the event of an emergency for readily available information)

FULL NAME OF CHILD: _____
First Middle Last

MEDICAL INSURANCE CARRIER: _____

MEDICAL INSURANCE NUMBER: _____

PRIMARY CARE PROVIDER: _____

PCM ADDRESS AND PHONE: _____

DPHHS/CFSD WORKER: _____

DPHHS/CFSD WORKER PHONE: _____

CURRENT MEDICATIONS AND DOSAGES:

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

Med Name: _____ Med Dosage: _____

ALLERGIES: _____

Birth Certificate: **YES** **NO**

(If available please attach a copy)

To whom it may concern,

_____ does not receive any personal income from the State of Montana, or from his/her parents. _____ qualifies for Free Breakfast and Lunch for the duration of time he/she resides at the Great Falls Children's Receiving Home.

Caitlyn Korin

Food Program Manager
Great Falls Children's Receiving Home

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_____ _____

Signature of Placing Worker Date

_____ _____

Receiving Home Staff Date

GREAT FALLS CHILDREN'S RECEIVING HOME
YOUTH DISCHARGE SHEET

Child's Name: _____ Date of Placement: _____

Placing Worker: _____ Discharge Worker: _____

Child released in the custody of: _____

Reason for discharge: _____

_____

Date of discharge: _____ Time: _____

Signature: _____ Date: _____

Please initial…

_____ I have received the following

- Future medical appointments YES NO
- Medications on hand YES NO

_____ I request future appointments and/or medication(s) to be emailed and/or faxed and picked up at a later date.

GREAT FALLS CHILDREN'S RECEIVING HOME
YOUTH CHECK-OUT SHEET

Please ensure the following are done and indicate so using a check mark in the corresponding aera. In addition, please write in the full name of the child, date of discharge and staff completing the form.

Name of Child: _____

Date of Discharge: _____

Staff completing form: _____

_____ All inventoried belongings are packed

_____Coats, Jackets, Shoes

_____ Personal hygiene items

_____ Personal affects in room

_____ Medications

_____ Life Book

_____ Money, cell phones, etc.

_____ School supplies, including school library books, backpack, etc.

_____ Additional items noted by staff in storage/shed

_____ Worker's signature and date pertaining to discharge on Admit form