Alabama Clinical Schools
Admission Packet

To Whom It May Concern:

Enclosed, you will find an admission packet for Alabama Clinical Schools. Please fill out these forms in *black ink*, enclose the additional paperwork requested, and return these items to me as soon as possible. Once I receive this information, I will put your child on our approved list and will contact you with admission date information.

Please be advised that we must have the Financial Consent Form signed by the authorized representative of the agency/party to be responsible for payment of all outside medical needs. Please include a complete mailing address and phone number of where the bills should be sent. When the child has to visit outside providers, it will be out in the child's name and the referring agency/responsible party. We do not currently have any providers in the Birmingham area that accept out-of-state Medicaid. Therefore, if your child requires medication, dentists, doctors, vision, etc., these services will be billed to the responsible party. If the child is Title IV-E eligible, please include this information in the packet. This resident may apply to receive Alabama Medicaid. If he is granted such Medicaid, you will be advised upon our notification of his new Medicaid coverage; however, please be aware that not all residents will qualify for Alabama Medicaid.

In addition to the consent forms, complete mailing address, IV-E eligibility information, and admission packet paperwork, we must receive the following for the admission to occur:

- Current Immunization Record
- A copy of insurance or Medicaid Card
- Birth Certificate
- Current grades and transcripts
- IEP for special education needs if applicable
- Interagency Agreement (Alabama only)
- 724 (Alabama only)

Thank you for your prompt assistance in completing this information. Please feel free to contact me with any questions you may have.

Sincerely,

Marie Wilbanks, M.Ed., ALC
Intake Coordinator

cc: Jennifer Snyder
Administrator/CEO

Deidra Dickey
Clinical Director

Alabama Clinical Schools
1221 Alton Drive*P.O. Box 100968*Birmingham, AL 35210-0968
Telephone: 205-836-9923*Facsimile: 205-836-9483

ADMISSION/DISCHARGE FORM

PLEASE COMPLETE ALL INFORMATION **ALABAMA CLINICAL SCHOOLS**

Resident Information:

Chart #:_____

Last Name:_____ Middle:_____ First:_____ Admit Date:_____

Sex:_____ DOB _____Social Security #:_____ Race:_____

Admission Type: DYS: _____ DHR: _____ OOS:_____ Marital Status: Single

Admission Diagnosis Code:_____Diagnosis Description:_____

Hearing/ Vision Impairments: ____Yes/ ____No If yes, please describe_____

Discharge Date: _____

Legal Guardian

Name:_____ Relationship to Resident:_____
Address:_____ Work Phone:_____
_____ Home Phone:_____
Legal Status:_____ Emergency #:_____
Other:_____

Case Worker or Probation Officer
Name:_____ Agency Name:_____
Address:_____ Work Number:_____
_____ Fax Number:_____
Legal Status: delinquent or dependent Legal Charges: Yes | No Explain: _____
circle one circle one

If resident has been found guilty or has legal charges pending, please include court order.

For Alabama Residents Only: This resident is permitted to have a roommate when clinically appropriate: Yes | No

School Information

Special Ed. Yes | No Grade: _____
circle one

Name:_____ Contact Person:_____
Address:_____ Work Number:_____
_____ Fax Number:_____

If resident receives Special Education Services, please include the most recent IEP.
Please identify authorized individual assigned to child's educational rights:_____

Medical Insurance Information or Medicaid Information

Card Holder Name:_____ Relationship to Resident:_____
Type Insurance:_____ Policy #:_____
Phone #:_____ _____ Fax Number:_____ Other
Insurance (if different):
Payor:_____ Contact:_____Policy #:_____
Address:_____ Phone #:_____Group #:_____
_____ Fax Number:_____ Cert #:_____

Parent Information if Not Legal Guardian

Name:_____ Phone #:_____
Address:_____ Work #:_____
_____ Other #:_____

In Emergency Contact:___ Legal Guardian_____ Parents _____Case Worker

Alabama Clinical Schools

Education Department Request for Records

1221 Alton Drive ♦ PO Box 100968 ♦ Birmingham, AL 35210-9068 ♦ Telephone 205-836-9923 ♦ Facsimile 205-836-9483

Student Name: _____Social Security #: _____
Date of Birth: _____Date of Admissions to ACS: _____
Race: _____
Last County of Residence: _____

Last School Attended: _____
Grade: _____ Phone _____ Fax _____
Address: _____County:_____
City, State, Zip: _____

History of Special Education Services? Yes or No _____ Exceptionality: _____

- ❖ If yes, we require all Special Ed. Records and Regular Ed. Records listed below.
- ❖ If no, we require General Education Records listed below.

History of Allergies: _____

Records Requested (Please send any and all available. Thank you.)

General Education Records

_____ School Transcript

_____ Report Card (Last grade level/promotion)

_____ Birth Certificate

_____ Social Security Card

_____ Immunization Record

_____ Standardized Test Scores

Special Education Records (if applicable)

_____ Current IEP (Individualized Education Plan)
_____ MEDC Report (Eligibility Determination)
_____ Notice of Proposed Meeting
_____ Permission to Evaluate/Re-evaluate
_____ Permission to Provide Special Education Services
_____ Parental rights (signed)
_____ Intellectual Assessment
_____ Achievement Testing (front page & score page)
_____ Behavior Rating Scales
_____ Psychological Evaluation
_____ Vision/Hearing Screenings
_____ Speech Evaluation
_____ Environmental Checklist
_____ Pre-referral/Referral
_____ Observation

Social Worker: _____
Phone: _____ Fax: _____
Who has legal custody of the student? DHR_____ Parent_____ Other:
Signature of Legal guardian: _____
Address: _____
Phone Number: _____

Alabama Clinical Schools

INFORMED CONSENT

Alabama Clinical Schools (ACS) is a residential treatment facility for males 9-19 with a history of sexually inappropriate behaviors. We have a vision to guide at risk youth and their families along pathways toward safer, healthier futures. In doing so, we will be addressing the residents' inappropriate behaviors in group, individual, and family therapy. You, as the parent/legal guardian, should be aware that there are many possible risks and outcomes of treatment as noted below.

1. ACS expects that when a resident successfully completes treatment at ACS, it will significantly decrease the likelihood of a sexual re-offense. In order to successfully complete our treatment program: 1) the resident has to want to make changes in sexual behaviors, coping mechanisms, and relationship development, 2) the resident must positively participate in all aspects of treatment offered, and 3) the resident needs positive involvement of the family and/or significant others.

2. There is the risk that the resident may sexually act out while at ACS. However, we take all precautions to guard against this possibility.

3. ACS treats adolescent males who often exhibit a combination of behavior problems. This sometimes results in residents being exposed to negative behavior patterns. The resident could be involved in a physical altercation with another resident. However, our treatment strives to reinforce positive behaviors while trying to extinguish negative behaviors.

4. ACS is a locked facility, but there is the risk that the resident could go AWOL and could be injured or injure someone else while outside the facility.

5. Throughout treatment, many significant individual and/or family issues are discussed. As these issues are part of the resident's therapeutic treatment, they will be included in individual and/or family sessions as appropriate. While we strive for positive outcomes, these issues could bring about family conflict or other potentially adverse effects.

6. As part of an adolescent's sexual development, struggle with individual sexual identity may result. During the course of their stay, decisions about their life and relationships may occur.

Name of Resident: _____ MR #_____

Signature of Resident:_____Date:_____

Signature of Parent/Legal Guardian: _____Date:_____

Signature of Agency Representative: _____Date:_____

Alabama Clinical Schools

AUTHORIZATION FOR PSYCHIATRIC/MEDICAL TREATMENT AND EMERGENCY CONDITIONS

MR#_____

RESIDENT'S NAME:_____ DOB:_____

SECTION I: PSYCHIATRIC/MEDICAL TREATMENT

If the clinical team and physician's judgment recommends any (or all) of the following procedures in Sections I & II as necessary for the treatment of my condition(s), then I agree to those procedures being utilized in my (my family member's) treatment

Treatment Procedures: (Initial any Therapeutic techniques for which consent is granted). Consent Granted

A. Routine physical including a genital examination unless refused or clinically contraindicated, Psychiatric and/or related diagnostic tests _____

B. The administration of medication (prior to initiation of psychotropic medications, parent or legal guardian, will be contacted by nursing to obtain consent for specific orders. During this contact, information will be given including reason for medication, potential side effects, and to answer any questions). _____

C. Individual therapy _____

D. Group therapy _____

E. Family Therapy _____

F. The therapeutic milieu activities of the program _____

G. Various forms of programmatic behavior modification. Individualized programs may be developed as required _____

H. Relaxation techniques _____

I. Sand Tray therapy _____

J Recreational therapy _____

K. Treatment techniques that remove a resident from environment which might be contributing to inappropriate/self-harmful behaviors. _____

Break – a short time interval (15 minutes or less) spent in a quiet area allowing the resident to calm down and regain control of his behavior and emotions.

1:1 – resident assigned individual staff member to continuously assess and provide required interventions.

Room Program – resident confined to room for specified period of time with 1:1 staff to continuously assess and provide required interventions.

L. Substance Abuse therapy/counseling. _____

_____

M. Physical Interventions such as physical hold (standing) and/or physical restraint (hold on floor) are utilized when resident's behaviors are out of control and aggression results in a safety hazard for themselves, others, or severe property damage. The time limit is limited to the minimum required for the resident to regain physical control.

Resident's Name: _____ MR#_____

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N. Retrieval of a resident who is absent without leave (AWOL) from Alabama Clinical Schools by notifying the police and using Alabama Clinical Schools staff to search for and return resident to facility._____

SECTION II: EMERGENCY MEDICAL CARE

If a physician's or nursing judgment indicates a resident is in need of emergency medical care, I understand that the resident will be transferred to the required level of medical care for evaluation and/or treatment. Alabama Clinical Schools will make every reasonable effort to notify the resident's parent, guardian, or family of medical situation and interventions taken. I understand and authorize the following:

1. Transfer of resident to a facility better able and equipped to render the medical/emergency care needed. _____

2. Release of pertinent medical records and information (written and/or verbal) to the facility providing the medical/emergency care to the resident. _____

SECTION III: GENERAL INFORMATION

The conditions for search are developed to safeguard every resident from exposure to dangerous items. These conditions for search are essential to protect the rights of all residents to an environment that strives to be free from threat or danger.

a) I understand that during admission, after returning from a pass following visitation, or when there is an indication of contraband on the unit, my person, my room, my clothing, and other belongings may be searched. _____

b) I understand that items with potential for harm to me or others will be considered contraband and will be removed. Contraband items such as weapons or unprescribed drugs will be confiscated, contraband items such as glass containers, mirrors, sharp objects, etc., may be locked up for up supervised use, sent home, or disallowed in the facility. _____

c) I understand that any item given to me by a visitor will be inspected to ensure safety. _____

d) I understand that every effort will be made by Alabama Clinical Schools' staff to conduct searches in a manner that is respectful and sensitive to my privacy. _____

e) I understand that resident's are not to have personal money in their possession while at ACS. I further understand all personal funds shall be kept by the Business Office Manager. Throughout treatment, during treatment plan reviews, the therapist will assess my ability to safely manage my own funds while on outings/passes outside of ACS, if funds are available. _____

Resident Name: _____ M.R.#_____

SECTION IV: GENERAL INFORMATION

Pursuant to federal state, and local guidelines concerning my rights to confidentiality, I can expect that both Alabama Clinical Schools and the facility/staff treating the emergency will respect and protect my (the resident's) privacy and take all measures necessary to maintain the confidentiality of all clinical and personal information shared in the pursuit of any medical/emergency care
I agree and authorize that the procedures as defined in sections II and I may be administered to me (the resident). If a physician so directs, other clinical staff, consultants and/or contractors of Alabama Clinical Schools may also be involved in administering the needed emergency care.

I certify that I have read and fully understand the above consent, that the explanations referred to were made to me and that all blanks requiring completion were filled before I signed this document. I hereby agree that I have been fully informed about these methods in language I can understand and have had the opportunity to discuss any concerns or have answered any questions I may have. I also acknowledge that there are no physical conditions/limitations that prevent my (the residents participation in the activities/treatments agreed to in this consent form.

_____ _____
(Resident) (Date/Time)

_____ _____
(Parent/Guardian) (Date/Time)

_____ _____
(Witness) (Date/Time)

ALABAMA CLINICAL SCHOOLS
1221 Alton Road Birmingham, AL 35201

Agreement to Abide by Confidentiality Standards and Receipt of Resident Rights, Grievance Process, and Description of Program/Rules

Resident's Name _____ MR #_____

Resident Confidentiality Agreement

Just as I expect my fellow residents and the staff of Alabama Clinical Schools to respect my rights and observe the laws regarding confidentiality, I agree not to disclose the name or presence of any resident at this facility or give out any information about another resident to anyone other than Alabama Clinical Schools staff. I understand that patient confidentiality is covered by Federal Law (42 C.F.R., Part 2).

_____
Resident Signature Date

Parent/Guardian Confidentiality Agreement

I agree not to disclose the identity, presence in treatment, or any information pertaining to another resident. I acknowledge disclosure of any information about the residents of Alabama Clinical Schools is prohibited by Federal Confidentiality Laws (42 C.F.R., Part 2).

_____
Parent/Guardian Signature Date

Receipt of Resident Rights, Grievance Process, and Description of Program/Rules

I have been given a Resident Handbook, which contains a copy of the Resident's Rights, the grievance process available to utilize if I believe a right has been violated, and description of the program and rules. The Resident's rights and grievance process have been explained to my understanding.

_____ _____
Resident Signature Date Parent/Guardian Signature Date

_____
Staff Witness Signature Date

Staff: If Resident is unable to sign the above agreement, state reason below and sign. Document in progress notes. Efforts must be made to secure Resident's signature as soon as he is able to understand staff expectation of his rights.

_____

_____

_____
Staff Witness Signature Date

ALABAMA CLINICAL SCHOOLS
1221 Alton Drive Birmingham, AL 35210

RESIDENT'S NAME: _____ MR#_____

CONDITIONS OF ADMISSION

INSTRUCTIONS TO PARENT OR LEGAL GUARDIAN: PLEASE READ CAREFULLY AND INITIAL AND SIGN THE NECESSARY AUTHORIZATION, RELEASES AND AGREEMENTS SO THAT WE MAY PROCEED WITH THE CARE, TREATMENT AND SERVICES NEEDED.

_____ **Security Acknowledgement:** I have been advised that Alabama Clinical Schools uses digital video recording surveillance to monitor residents/employee activities in order to maintain a safe and secure environment. Video Surveillance is limited to area in which individuals have no reasonable expectation of privacy such as public areas, parking lots, hallways, classrooms, dayrooms, building entrances and exits, loading docks, storage rooms, electronics rooms, repair shops, and play areas.

_____ **Authorization for Routine Medical Care:** I hereby authorize referral of the resident by the Medical Director of Alabama Clinical Schools (also hereinafter referred to as "the facility") to any physician, surgeon, dentist, podiatrist, optometrist, or other similar practitioner to consult, diagnose, treat, and prescribe medications for such circumstances as may develop during the course of the resident's stay at Alabama Clinical Schools and for which the services of the practitioners is deemed necessary. I understand the facility does not pay for external medical services unless otherwise stated by contract.

_____ **Authorization for Emergency Medical/Psychiatric Services Transportation and Treatment**: In the event the resident requires emergency medical treatment at a hospital and I cannot be reached immediately by telephone, I give my consent to Alabama Clinical Schools to transport the resident to the receiving hospital to admit and deliver necessary emergency medical treatment. Every effort will be made to inform me by telephone of emergency services required. I understand hospital emergency care will be initiated as authorized facility medical personnel deem necessary and that I will be advised of the outcome. My additional consent may be required should the medical treatment of the resident require hospitalization and/or surgical procedures. I understand that the cost of such treatment shall be borne by Alabama Medicaid, any applicable private insurance and/or financial guarantor. Alabama Clinical Schools is not financially responsible for medical/psych services required outside of Alabama Clinical Schools.

_____ **Authorization to Leave Facility Grounds:** The resident has my permission to attend therapeutic activities off Alabama Clinical Schools' grounds. I understand that there exists the possibility that persons not affiliated with Alabama Clinical Schools grounds may be encountered on these outings. I agree that the resident's attendance at such activities is not in any way a violation of confidentiality or of his rights of privacy.

_____ **Notice of Judicial Contact in Event of Elopement**: I understand Alabama Clinical Schools will contact the City, County, and/or State police and an all points bulletin might be placed by authorities should the resident run away from the facility due to the level of risk to the community's safety.

_____ **Consent to Photograph:** I authorize photographing of the resident for identification purposes. Photograph will be returned at the time of discharge, if requested.

_____ **Personal and Valuable Articles:** I understand that Alabama Clinical Schools is not responsible for either lost or stolen items. It is the policy of the facility that no expensive possessions be brought to Alabama Clinical Schools. I accept responsibility for any personal and valuable articles left in the facility for the resident.

I further understand that the conditions of this consent for admission are for the length of the resident's stay unless revoked by me in writing to the Director of Clinical Services.

Signature of Parent or Legal Guardian: _____

Signature of Resident: _____

Staff Signature _____ Date: _____

ALABAMA CLINICAL SCHOOLS
1221 Alton Drive
Birmingham, AL 35210
(205) 836-9923 Fax (205) 836-9483

Resident's Name _____ MR #_____

Dear Parent/Guardian

As part of our admission process, we are required to have documented proof of immunizations on each of our residents. In order to accommodate this, we need you to send a copy of his immunization record.

To the best of my knowledge, _____ has received all necessary immunizations/vaccinations required by law. I give my permission for my child to be immunized and brought up to date as deemed necessary by the attending physician.

_____ _____
(Parent/Guardian signature) (Date)

I deny permission to have my child immunized for the following reason(s) _____

_____

_____

_____ _____
(Parent/Guardian signature) (Date)

Admission Statement
Removing/Securing of Weapons, Lethal Medication, and other Self-Harm Means within the Home

Resident Name: _____ Date: _____ MR#:_____

Alabama Clinical Schools recommends you assess the resident's access to weapons, lethal medications, and other Self-Harm Means within the home. These items should be either removed or secured so that they can not be accessed by the Resident to ensure safety.

_____ I have received and read the above statement.

Please circle one:

Y N Does the resident have access to a weapon(s) at home?
If yes, what is the weapon(s) _____.
Y N I agree to remove and secure weapon(s).

Additional Comments:_____
_____
_____
_____
_____
_____

_____ _____
Signature of Legal Guardian Date

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ ____/____/____
Resident's Full Name DOB Social Security Number

MR#_____

Dr. Walter Thomas
Name or Title

Dentist 1516 Center Point Road Birmingham, AL 35215
Agency Street Address City State Zip

To be used for the purpose of: Dental Cleaning, Evaluation and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	____ Progress Notes	____ Treatment Plan Reviews
____ Initial Assessment	____ Psychiatric Evaluation	X Physical Examination
____ Universal Data Base	____ Psychological Testing	____ Laboratory Data
____ Academic Information	____ Doctor's Orders	X Medication Administration Record
____ Discharge Summary		

X The following information: Insurance, Reason for Visit

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ ____/____/____
Resident's Full Name DOB Social Security Number

MR#_____

Dr. James E. Skoney & Associates
Name or Title

Eye Care Associates 1825 Tin Valley Circle Ste. A. Birmingham, AL 35235
Agency Street Address City State Zip

To be used for the purpose of: Eye Exam and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	____ Progress Notes	____ Treatment Plan Reviews
____ Initial Assessment	____ Psychiatric Evaluation	X Physical Examination
____ Universal Data Base	____ Psychological Testing	____ Laboratory Data
____ Academic Information	____ Doctor's Orders	X Medication Administration Record
____ Discharge Summary		

X The following information: Insurance, Reason for Visit

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ ____/____/____
Resident's Full Name DOB Social Security Number

MR#_____

Associates of Orthopaedic Specialists of Alabama
Name or Title

Associates of Orthopaedic Specialists of Alabama, PC 48 Med Center Park East Drive Birmingham, AL 35242
Agency Street Address City State Zip

To be used for the purpose of: Evaluation and Treatment of Orthopaedic Issues

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	____ Progress Notes	____ Treatment Plan Reviews
____ Initial Assessment	____ Psychiatric Evaluation	X Physical Examination
____ Universal Data Base	____ Psychological Testing	____ Laboratory Data
____ Academic Information	____ Doctor's Orders	X Medication Administration Record
____ Discharge Summary		

X The following information: Insurance, Reason for Visit

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ _____/_____/_____
Resident's Full Name DOB Social Security Number

MR#_____

_____
Name or Title

St. Vincent's Hospital East 50 Medical Park East Drive Birmingham, AL 35235
Agency Street Address City State Zip

To be used for the purpose of: Medical Emergency Evaluation and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	_____ Progress Notes	_____ Treatment Plan Reviews
_____ Initial Assessment	_____ Psychiatric Evaluation	X Physical Examination
_____ Universal Data Base	_____ Psychological Testing	_____ Laboratory Data
_____ Academic Information	_____ Doctor's Orders	X Medication Administration Record
_____ Discharge Summary		

X The following information: Insurance, Reason for Visit

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ ____/____/____
Resident's Full Name DOB Social Security Number

MR#_____

Associates of Eastern Health Center
Name or Title

Eastern Health Center- Dental 601 West Blvd. Birmingham, AL 35206
Agency Street Address City State Zip

To be used for the purpose of: Dental Evaluation and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	____ Progress Notes	____ Treatment Plan Reviews
____ Initial Assessment	____ Psychiatric Evaluation	X Physical Examination
____ Universal Data Base	____ Psychological Testing	____ Laboratory Data
____ Academic Information	____ Doctor's Orders	X Medication Administration Record
____ Discharge Summary		
X Other Specify: Insurance, Reason for Visit		

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

_____ _____ ____/____/____
Resident's Full Name DOB Social Security Number

MR#_____

_____
Name or Title

America's Best Contacts and Eyeglasses 7001 Crestwood Blvd. Birmingham, AL 35210
Agency Street Address City State Zip

To be used for the purpose of: Dental Evaluation and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	____ Progress Notes	____ Treatment Plan Reviews
____ Initial Assessment	____ Psychiatric Evaluation	X Physical Examination
____ Universal Data Base	____ Psychological Testing	____ Laboratory Data
____ Academic Information	____ Doctor's Orders	X Medication Administration Record
____ Discharge Summary		
X Other Specify: Insurance, Reason for Visit		

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

_____ _____
Resident Date Signed

_____ _____
Staff Witness to Resident's Signature Date Signed

_____ _____
Parent/Guardian/Authorized Representative Date Signed

ALABAMA CLINICAL SCHOOLS
RELEASE OF INFORMATION
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

It has been explained to me and I understand that failure to sign this form will not affect the treatment given to me at Alabama Clinical Schools. I understand the benefits and disadvantage and freely and voluntarily give permission to release information regarding:

Resident's Full Name	DOB	Social Security Number
		/ /

MR#_____

Name or Title

Children's Health Foundation — 1600 7th Avenue South . Birmingham, AL 35233
Agency — Street Address City State Zip

To be used for the purpose of: Dental Evaluation and Treatment

The specific type of information (initial below) is to be disclosed:

X Verbal Communications	_____ Progress Notes	_____ Treatment Plan Reviews
_____ Initial Assessment	_____ Psychiatric Evaluation	X Physical Examination
_____ Universal Data Base	_____ Psychological Testing	_____ Laboratory Data
_____ Academic Information	_____ Doctor's Orders	X Medication Administration Record
_____ Discharge Summary		
X Other Specify: Insurance, Reason for Visit		

The consent is subject to revocation by me at any time except to the extent that action has been taken reliance thereon (Exception: individuals whose release from confinement, probation or parole is conditioned, upon program participation). Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid until my discharge from this program or 24 months from date signed, whichever is the later date. A copy of this consent may be used in place of the original.

Resident	Date Signed
Staff Witness to Resident's Signature	Date Signed
Parent/Guardian/Authorized Representative	Date Signed

Alabama Clinical Schools
Consent for Discharge Follow-Up

Resident's Name: _____ Medical Record #: _____

A Discharge Follow-up Questionnaire is completed at 6, 12, 18, and 24 months intervals after a resident is released from treatment at Alabama Clinical Schools. Information will be collected and compiled to evaluate program effectiveness and to assist with program and business development. Data collected from questionnaires will help guide best practice standards at Alabama Clinical Schools.

Please complete this form and return it with the application packet prior to admission. This form will also be updated prior to resident's discharge to ensure the accuracy of contact information. This form will be kept on file in the resident's medical record. Note: This form does not give permission to release any information with regard to health, counseling, or other protected health information records.

Primary Contact Information Following Discharge

Parent/Legal Guardian: _____
Relationship to Resident: _____
Address: _____
_____
Home Phone: _____ Cell Phone: _____

You may choose to grant Alabama Clinical Schools permission to contact alternative individuals for the purpose of gaining information regarding the previous resident's progress or status following discharge from Alabama Clinical Schools.

I have indicated below the individual(s) or agency representatives to whom Alabama Clinical Schools may obtain information related to the resident's status post discharge.

First Alternative Contact	**Second Alternative Contact**
Name: _____	Name: _____
Relationship to Resident: _____	Relationship to Resident: _____
Address: _____	Address: _____
_____	_____
Phone Number: _____	Phone Number: _____

I understand that I can revoke this release at any time by notifying Alabama Clinical Schools in writing. By signing this form I acknowledge that I have read the above information and consent to discharge follow-up surveys. I am also authorizing Alabama Clinical Schools to speak with alternative contacts for the sole purpose of obtaining information for discharge follow-up.

Resident Signature	Date
Parent/ Legal Guardian Signature	Date
ACS Representative Signature	Date

ALABAMA CLINICAL SCHOOLS

1221 Alton Drive
Birmingham, AL 35210
Phone: (205) 836-9923/ Fax: (205) 836-9483

Approved Contacts and Visitation List

Resident Name: _____Chart #:_____
Access Code: _____

Name	Relation to Resident	Contact Numbers	Address	Monitor Calls Yes or No	Supervise Visit Yes or No

I understand that plans for visitations and phone calls are discussed with the assigned therapist only and that visitations and contact with others are granted when deemed clinically appropriate for the resident.

By signing below, I authorize as legal guardian for the resident to have contact and/ or visitation with the above persons as indicated.

Parent/Guardian Signature _____ Date _____
Therapist Signature_____ Date _____

ALABAMA CLINICAL SCHOOLS
Consent/Insurance Information

Name of Resident _____DOB _____
Home State _____

If out of Alabama: Interstate Compact Papers in Packet ___Yes ___No
Is resident IV-E Eligible? ____ Yes ___No
Is IV-Eligibility Form in Packet ____ Yes ____No
Is parent legal guardian? ____Yes ____No

Caseworker
Name _____
Title _____
Address _____
_____
Phone _____
Fax _____

Caseworker's Supervisor
Name _____
Title _____
Address _____
_____
Phone _____
Fax _____

Who is the person that can give consent for medical treatment (medications)?
_____

Can this person also give consent for surgery or procedures? ___ Yes___ No

Who is the person that can give and sign for financial responsibility (surgery, etc)?

Financial Consent
Name _____
Relation/Title _____
Address _____
_____
Phone _____
Fax _____

If not parents, supervisor
Name _____
Title _____
Address _____
_____
Phone _____
Fax _____

INSURANCE

Private Insurance:
Policy # _____ Group # _____
Name of Insured _____
Name of Company _____
Relation _____
Address_____
Phone _____ Fax _____

Alabama Medicaid
Medicaid Number _____
Name on card _____

Out of State- State Insurance Plan
Type of Insurance_____
Policy #_____
Group #

ALABAMA CLINICAL SCHOOLS
FINANCIAL CONSENT REQUIREMENT

Please be advised that my signature on this document indicates that I am the financial responsible party for _____: _____ during his stay at Alabama Clinical Schools.
Resident's Name Social Security #

I am aware that it is <u>my responsibility</u> to pay co-pays, necessary medical, psychiatric, psychological, pharmaceutical, dental, vision, and related fees that may occur during his stay. As of this date there are no providers of medical services that accept out of state Medicaid coverage.

I am aware that Alabama Clinical Schools will be providing a copy of this document to all vendors providing care and services to this child, and ***I hereby instruct your billing department to forward all bills to me as they are my responsibility.*** I am also willing to pay all costs of collection should I not forward payments in a timely manner.

PLEASE FORWARD ALL BILLS FOR SERVICES DIRECTLY TO:

Financial Responsible Party or Agency: _____

Attn: _____

Mailing Address: _____

_____

Insurance Company Name: _____

Cardholder's Name: _____

Policy #:_____Group #:_____

Medicaid Insurance: Cardholder's Name: _____

State: _____ Number: _____

Signature of Financial Responsible Party: _____
(Or Authorized Agent to accept financial responsibility for Agency)
Name of Financial Responsible Party (printed):_____Title:_____

Witness Signature: _____

Witness Name (printed):_____Title:_____

All blanks on this document must be thoroughly completed and returned to the Placement Coordinator at Alabama Clinical Schools prior to admission. Thank you for your assistance.

PROGRAM RULE DEVELOPMENT
RESIDENT/GUARDIAN ACKNOWLEDGEMENT SHEET

Program rules are developed with active participation of the residents and staff. This includes residents being involved through Student Council, written suggestions, findings from grievance process and discussions with therapists, and question/answer periods during general assemblies. Staff are involved through staff meetings, written suggestions, management meetings, annual program reviews, surveys, etc.

Program rules promote individual responsibility and prohibit rules for staff convenience and rules based on one person's behavior. Program rules are based on the Right Protection and Advocacy guidelines for consumer rights and responsibilities.

Program rules address these areas:

A. Visitation hours
- Regular visitation hours are Saturday and Sunday, 1:30-4:30 p.m. Additional visitation hours are available on holidays and as specially arranged by therapists for visitors who are unable to attend regular visitation hours.

B. Sign in/ out requirements
- When leaving the building for passes, residents and the supervising person are required to sign in and out in the pass log located at the nurses station.

C. Bedtime/Curfew
- As a residential facility, we require that residents remain in the facility with the exception of outings, passes, court, medical transports, or other special circumstances. Bedtime for residents is 9:00 pm, with the exception of residents who earn extra free time at night, which may extend bedtime to 10:00 pm.

D. Sexual contact on provider / facility property which respect consumer's dignity, privacy and need for social interaction with others
- As a residential facility for adolescents, sexual contact on the premises is prohibited.

E. Possession and consumption of legal and illegal substances
- As a residential facility for adolescents, possession and consumption of legal and illegal substances on the premises is prohibited.

F. Possession of weapons
- As a residential facility for adolescents, possession of weapons on the premises is prohibited.

G. Confidentiality
- I agree not to disclose the identity, presence in treatment, or any information pertaining to another resident. I acknowledge disclosure of any information about the residents of Alabama Clinical Schools is prohibited by Federal Confidentiality Laws (42 C.F.R., Part 2).

H. Resident Handbook, Rights and Grievance Process
- I have been given a Resident Handbook, which contains a copy of the Resident's Rights, the grievance process available to utilize if I believe a right has been violated, and description of the program and rules. The Resident's rights and grievance process have been explained to my understanding.

I. Medical Services:
- You will receive a psychiatric evaluation and a physical examination on admission and annually by the physicians at ACS (Psychiatrist and Pediatrician). You will also receive dental cleanings approximately every six months by a local dentist. The psychiatrist and the pediatrician come to the facility weekly to see residents that have needs. If you have a medical problem please notify the nurse of your concern. If they are not able to assess and take care of your problem, you will be placed on the schedule to see the pediatrician on his following visit. If it is an emergency, we can contact him for orders or if necessary you will be transported to a local emergency room for evaluation and/or treatment. You will be routinely scheduled to see the psychiatrist but, if you feel you need to see him prior to scheduled time, please notify the Director of Nursing and she will place your name on his schedule, as appropriate.

Program rules provide for resolution of disputes on an individual basis. When necessary, adjustments are made to the treatment plan. Program rules limit chores to those necessary to maintain personal and treatment areas and prohibit using resident for duties that the provider typically pays to have done unless the resident chooses to do so and is compensated fairly.
The above has been read by or reviewed with the resident and/or parent/guardian, with allowances made for questions and suggestions.

_____ _____
Resident's Signature Date

_____ _____
Parent/Legal Guardian Signature Date

Alabama Clinical Schools
1221 Alton Road, Birmingham, AL 35210
(205) 836-9923

Policies Regarding Hands-On Events

October 2009

Resident's Name _____ MR #_____

Alabama Clinical Schools strives to maintain, monitor, and promote a culture of safety within the facility. This culture facilitates environmental factors as well as the physical and emotional wellbeing of our clients, staff, and visitors. Our goal is always to provide a safe milieu and a learning environment.

With all efforts to maintain the safety of the facility and to avoid using a hands-on intervention with a resident, Alabama Clinical Schools utilizes all least restrictive measures for behavioral management. These least restrictive measures may include behavioral modification techniques such as but not limited to: verbal re-direction, verbal re-direction with assignments, taking a break, verbal de-escalation, use of the sensory room upon request of the resident, conflict resolution, individual time with the therapist/staff member, steps within their special program or their individualized treatment plan, etc.

Education and training is provided to our staff regarding prompt identification of escalating behaviors or conflict, identifying diagnosis specific or behavioral acting out; all of which can lead to potential or actual risks or crisis situations. The staff education and training focuses on utilizing our systems and policies, utilizing a team approach, maintaining program structure and schedules and ensuring that all staff are trained properly.

The ultimate goals of preventing or safely managing a crisis situation is to manage severe acting out behaviors of any resident before that resident(s) loses complete control of their behavior; becoming a potential harm to their self or others. This crisis management thereby helps to reduce and/or eliminate imminent risks or the use of a hands-on intervention/physical hold/restraint.

Only in the event of a milieu emergency or crisis situation is a hands-on intervention/physical hold/restraint, considered. A milieu emergency or crisis situation could be defined as an instance in which there is imminent risk of an individual harming themselves or others, or creating a severe physical panic situation in the milieu. Any hands-on intervention will be discontinued as soon as possible when the resident no longer presents as potentially harmful to himself or others.

If your child is involved in a physical hold or restraint the nursing staff will make every attempt to contact you by phone or per voicemail to notify you of this event. If they are unable to contact you, the therapist will follow-up with this notification during their contacts. If you desire participation in further discussion of this event and/or treatment planning please contact the resident's therapist.

I have read and understand the policies regarding hands-on events at Alabama Clinical Schools.

_____ _____

Signature of Legal Guardian Date

Alabama Clinical Schools

Notice of Privacy Practices

We are required by law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

Your signature below indicates that you have received a copy of Alabama Clinical Schools' Notice of Privacy Practices.

_____ _____

Resident's Signature Date

_____ _____

Parent/ Legal Guardian Signature Date