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
- Court Orders
- A copy of insurance or Medicaid Card
- A copy of social security card
- Birth Certificate
- Current grades and transcripts
- IEP for special education needs if applicable
- Interagency Agreement
- 724
- CFA
- MAT
- ISP
- EPSDT

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, LPC
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
TFC Admissions/Discharge Face Sheet

PLEASE COMPLETE ALL INFORMATION **ALABAMA CLINICAL SCHOOLS**

Client Information:

Chart #:________

Last Name:____________________________ Middle:_________ First:_______________Admit Date:_____________
Sex:___________ DOB __________Social Security #:_____________________________________Race:__________

Admission Type: DHR Admission Status: _____ New ___ Readmit ____Transfer

Hearing/ Vision Impairments: ____Yes/ ____No If yes, please describe:__________________ Primary Language:______________

Discharge Date: ________________

Legal Guardian

Parent Information (if applicable)
Name:______________________________ Phone #:_______________________
Address:______________________________ Work #:_______________________
______________________________ Other #:_______________________

Social Worker
Name:______________________________ Agency Name:_________________________
Address:_____________________________ Work Number:_________________________
_____________________________ Fax Number:__________________________
Legal Status: delinquent or dependent Legal Charges: Yes | No Explain:___________
circle one circle one

School Information

Special Ed. Yes | No Grade: _________
circle one

Name:____ Contact Person:_________________
Address:_______________________________________ Work Number:_______________________________
____ Fax Number:________________________________

If Client 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 Client:__________________
Type Insurance:_____________________________ Policy #:_______________________________
Phone #:___________ ______________________ Fax Number:____________________________________
Other Insurance (if different):
Payor:____________________________ Contact:________Policy #:_______
Address:____________________________ Phone #:_______Group #:_______
__________________________ Fax Number:_________ Cert #:________

Reason for Referral/ Admission/ Transfer: ____

Admission Diagnosis Code:______________________Diagnosis Description:______________________________________

Medications at Admission: ____

EPSDT Referral Date: __________________________ Pre-Placement Dates: __________________________

# of Out-of Home Placements:____________

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

AUTHORIZATION FOR PSYCHIATRIC/MEDICAL TREATMENT AND EMERGENCY CONDITIONS

MR#________________

CLIENT'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 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. Substance Abuse therapy/counseling. _______

L. Retrieval of a client 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 Client home. _______

***Client's Name:* ____*MR#*________________**

SECTION II: EMERGENCY MEDICAL CARE

If a physician's or nursing judgment indicates a client is in need of emergency medical care, I understand that the client 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 client's parent, guardian, or family of medical situation and interventions taken. I understand and authorize the following:

1. Transfer of client 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 client. _______

SECTION III: GENERAL INFORMATION

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

a) 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/home _______

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

c) Throughout treatment, during treatment plan reviews, the case manager will assess my ability to safely manage my own funds, if funds are available. _______

Page Three

Authorization for Treatment

M.R.#_____________

Client Name: ____

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 client'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 Client). 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 Clients participation in the activities/treatments agreed to in this consent form.

____	____
(Client)	(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 Client Rights, Grievance Process, and Description of Program/Rules

Client's Name ____ MR #__________________

Client Confidentiality Agreement

Just as I expect my fellow peers/clients 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 client/resident at this facility or give out any information about another client/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).

____
Client Signature   Date

Parent/Guardian Confidentiality Agreement

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

____
Parent/Guardian Signature   Date

Delivering Bad News

It is possible that while your child is treated at Alabama Clinical Schools, serious life events will occur. We asked that any news such as deaths, illnesses, accidents, changes in discharge plans, parental divorce, etc… be shared with the client's assigned therapist before informing the Client. Informing the client without the support of his therapist could lead to disruptions.

I understand that any bad news to be delivered to a Client should be coordinated through the client's assigned therapist.

__________________________________   __________________

Parent/Guardian Signature   Date

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

Client'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 clients. 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

Client Name: ___________________________ Date: _________ MR#:_____

Alabama Clinical Schools recommends you assess the client'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 Client to ensure safety.

_______ I have received and read the above statement.

_______________________________ ________________
Signature of Legal Guardian Date.

Alabama Clinical Schools
Consent for Discharge Follow-Up

Client's Name: ________________________________ Medical Record #: _________

A Discharge Follow-up Questionnaire is completed at 6, 12, 18, and 24 months intervals after a client 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 client's discharge to ensure the accuracy of contact information. This form will be kept on file in the client'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 Client: ____
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 client'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 Client's status post discharge.

First Alternative Contact	**Second Alternative Contact**
Name: __________________________	Name: _______________________
Relationship to Client: ____________	Relationship to Client: _________
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.

____
Client 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

Client Name: ____________________________________Chart #:_______________
Access Code: __________________

Name	Relation to Client	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 Client.

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

Parent/Guardian Signature _________________________ Date __________
Case Worker Signature______________________________ Date ____________

ALABAMA CLINICAL SCHOOLS

Consent/Insurance Information

Name of Client ______________________________DOB __________
Home State ________

If out of Alabama: Interstate Compact Papers in Packet ___Yes ___No
Is Client 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.
Client'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.

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.

______________________________ __________________
Client's Signature Date

______________________________ __________________
Parent/ Legal Guardian Signature Date