



Placement Date: \_\_\_\_\_ Anticipated Length of Placement: \_\_\_\_\_ Referring County \_\_\_\_\_ Paying Agent \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Program \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Reason for placement: \_\_\_\_\_

Physical Description of child: Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Distinguishing Features: \_\_\_\_\_ Additional Insurance/Group #: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Ethnicity: Hispanic-Latino  Non-Hispanic or Latino

Race: American Indian or Alaskan Native  Asian  Black or African American  White

Native Hawaiian or other Pacific Islander  Other

Head of Household (Name): \_\_\_\_\_ M  F  Household receives SSI/SSDI? Y  N

Number of People in Household \_\_\_\_\_ Income Range \$10,000-\$25,000  25,000-40,000  Above 40,000

**Household information is not mandatory; however it is confidentially used for billing, grant-writing and fundraising efforts for Shiloh House. "Household" is defined by the primary caretaker and intended permanent placement option.**

Regular Education:  Special Education:  Current IEP: Y  N  Current Grade \_\_\_\_\_

Last School Attended/Address: \_\_\_\_\_

Expelled? Y  N  Reasons: \_\_\_\_\_

Client been suspended: Y  N  Currently has unexcused absences: Y  N  Currently passing classes: Y  N

Mother's Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_

### Containment Information:

County Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**After Hours DHS Emergency Contact and Phone:** \_\_\_\_\_

Probation Officer: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

G.A.L: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Doctor: \_\_\_\_\_ Address \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Dentist: \_\_\_\_\_ Address \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Eye Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Therapist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Session: \_\_\_\_\_

List any medical problems: e.g., seizures, asthma, allergies, diabetes, heart disease, respiratory illness, drug reaction:



Are there any present signs of illness, symptoms of abuse or presence of vermin:

\_\_\_\_\_

Describe behaviors: such as suicide attempts, runaway, violent outbursts, depression, stealing, fire setting, excessive crying, or enuresis:

\_\_\_\_\_

\_\_\_\_\_

Court Date: \_\_\_\_\_ Judge \_\_\_\_\_ Division \_\_\_\_\_

Other Appointments/Dates: \_\_\_\_\_

\_\_\_\_\_

Previous Placements (starting with most recent):

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_

Approved contacts other than previously listed above:

Name of Contact	Relationship	Phone Number	Type of Contact (phone, visit or both)
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

All information included in this application is accurate and complete to the best of my knowledge. I received a copy of parent and HIPAA information.

\_\_\_\_\_  
Parent/Legal Guardian Signature      Date  
Date

\_\_\_\_\_  
Temporary Custodian/Caseworker      Date

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

\_\_\_\_\_  
Temporary Custodian/Caseworker      Date

\_\_\_\_\_  
Staff Conducting Intake      Date



Date: \_\_\_\_\_ \*To be completed at intake, monthly or whenever privilege changes.

<b>CLIENT'S NAME:</b>	<b>DOB:</b>
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Please send privileged or treatment documentation to:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

By signing below I verify that the above listed persons are permitted to receive documentation pertaining to this case. The person (s) signing below agree \_\_\_\_\_ holds privilege.

Caseworker	Printed Name	Signature	Date
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GAL	Printed Name	Signature	Date
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Parent/Guardian	Printed Name	Signature	Date
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Parent/Guardian	Printed Name	Signature	Date
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Client	Printed Name	Signature	Date
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Shiloh House Representative	Printed Name	Signature	Date
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**Physical Management Authorization**

I give Shiloh House and its authorities permission to physically manage my child in the event that he/she poses a danger to himself/herself and/or others and will be used only as a last resort. I understand that the CPI method of therapeutic crisis intervention will be used. I certify to the best of my knowledge that my child does not have a medical condition that would be a threat to the health of my child during a physical management.

I have received a copy of the physical management policy. Yes  No

**Event Participation Release**

As a provider of treatment services, Shiloh House protects the confidentiality of its clients with exceptions being identified at admission. Shiloh House offers events where clients participate in such activities as holiday parties, picnics, public sporting events, Shiloh House community fundraising events and community entertainment activities. Community members/media may be in attendance of any/all of these events. My child has permission to participate in the events/activities listed above. Yes  No

**Photograph Release**

Photographs may be taken at some events or outings. These photos may be shared with community members for the purpose of fundraising, community education/outreach and/or exclusively used within Shiloh House. In addition, clients may be photographed with other clients and/or staff at these events.

I give my permission for my child to be photographed and for the photographs to be used for purposes stated above. Yes  No

**Recreational Activities**

I give permission for my child to participate in both onsite and offsite recreational activities during placement at Shiloh House. Activities may include: riding bicycles, camping, Tae Kwon do, walks, fishing, weight lifting, backpacking, snowshoeing, swimming, yoga and recreational sports (individual/team).

Yes  No

**Sex Education**

I give permission for my child to participate in on-going classes related to sex education and sexually transmitted diseases. Yes  No

**Internet Release**

I give permission for my child to access the internet during he/her stay at Shiloh House. I understand that all youth are monitored by staff and all computers have parental controls to help ensure that inappropriate sites are not accessed.

Yes  No

**Travel Release**

I give permission for my child to travel to events/outings, etc. with authorities of Shiloh House. I also hereby release Shiloh House of any and all liability in the event injuries are sustained.

I have received a copy of the family grievance procedure and the family letter. Yes  No

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



I, \_\_\_\_\_, authorize the following agencies to release information to Shiloh House re:

**Client:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Information to be used for:**

  
  
  


Assessment  
 Service Planning  
 Continuity of Care  
 Employment

  
  
  


Leaving School  
 Entering School  
 College Admission  
 Other

**NOTICE TO WHOM THIS INFORMATION IS GIVEN:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains. I also herewith release and hold harmless Shiloh House, along with its employees, consultants and agents from all claims and liability that may arise directly or indirectly for releasing such information."

I understand that I may revoke this request for information at any time by giving written notice to Shiloh House. Without such revocation, the date the release expires, not to exceed 90 days from when authorization is given for a one time release of information and not to exceed one year, or as the law or court order requires, when a contracted or cooperating service provider requires the release of information for ongoing service provision. This authorization shall expire on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (date).

\_\_\_\_\_  
**Legal Guardian or Temporary Custodian Signature** **Date**

I hereby revoke this authorization to request information:

\_\_\_\_\_  
**Signature of Legal Guardian or Temporary Custodian** **Date**

A copy of this authorization is as valid as the original.

3/7/2015



## Authorization to Release Information

I, \_\_\_\_\_ authorize Shiloh House/Clerical Support Staff to release/share information re:  
(Legal Guardian(Includes GAL) or Temporary Custodian/Caseworker)

Client Name \_\_\_\_\_

DOB \_\_\_\_\_

Please initial in box below:

GAL

Caseworker/Case Manager/Intake CW

PO

Utilization Manager

School District Representative

Outpatient Therapists

Outside Psychiatrists

Parent/Guardian

Other \_\_\_\_\_

Foster Parents/Group Home Representative

Victim Therapist

CASA

Client's Attorney

Victim GAL/Advocate

**Authorized Non-Privileged Information:**

Treatment Plans

Incident Reports

Educational Records

Court Records/Investigative Reports

Probation Documentation

Medical/Dental Records

Other \_\_\_\_\_

**Authorized Privileged Information:**

Progress in Therapy-Verbal Report

Progress in Therapy-With Reports

Psychological Evaluation

Note: This section is only to be completed by the individual who holds privilege.

**Information to be used for:**

Assessment

Service Planning

Continuity of Care

Employment

Leaving School

Entering School

College Admission

Other \_\_\_\_\_

**NOTICE TO WHOM THIS INFORMATION IS GIVEN:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains. I also herewith release and hold harmless Shiloh House, along with its employees, consultants and agents from all claims and liability that may arise directly or indirectly for releasing such information."

I understand that I may revoke this request for information at any time by giving written notice to Shiloh House. Without such revocation, the date the release expires, not to exceed 90 days from when authorization is given for a one time release of information and not to exceed one year, or as the law or court order requires, when a contracted or cooperating service provider requires the release of information for ongoing service provision. This authorization shall expire on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (date).

Legal Guardian, Temporary Custodian, Caseworker, GAL or the individual who holds privilege

Date

A copy of this authorization is as valid as the original.

**Shiloh House-6588 W. Ottawa Ave., Littleton, CO 80128, 303-932-9599**

Shiloh House employs licensed and unlicensed psychotherapists to do therapeutic work with clients, individually, in groups and in family therapy. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinicians social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

**The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite #1350, Denver, Colorado 80202, (303) 894-7766.**

**Client Rights and Important Information:**

You are entitled to receive information regarding methods of therapy, the techniques used, the duration of your therapy (if it can be determined), and the fee structure. Please ask if you would like to receive this information.

You can seek a second opinion from another therapist to terminate therapy at any time.

In a professional relationship, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

**(FOR LICENSED PSYCHOTHERAPISTS OR REGISTERED PSYCHOTHERAPISTS PRACTICING UNDER SUPERVISION – see state Grievance Board Rule 12 (e).)**

Generally speaking, the information provided by and to client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to an unlicensed psychotherapist not practicing under the supervision of a licensed psychotherapist is not legally confidential.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (see Section 12-43-218, C.R.S., in particular). Exceptions include; threats of serious harm to self or others, child abuse, suicidal gestures or related actions, and homicidal gestures or related actions. You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy.

**The following are clinicians/psychologists/interns that may work with clients at Shiloh House**

All unlicensed and provisionally licensed clinicians are under the supervision of a Licensed Professional.

All clinicians are registered on the database of the State Grievance Board, aka Colorado Mental Health Grievance Board.

Lizabeth Miller, MSW Colorado License # 989828 Master of Social Work University of Denver Denver, CO	Melissa Larcom, MA, LPC Colorado License # 4127 Master of Arts in Counseling Denver Seminary Denver, CO	Daniel Venman, MA, LPC, NCC Colorado License # 11841 Master of Arts – Clinical Counseling University of Northern Colorado Greeley, CO	Jeanne Cross, MSW Colorado Provisional License #0001212 Master of Social Work University of North Carolina Chapel Hill, NC
Keith Manchester, MA, LPC Colorado License # 6051 Master of Arts in Clinical Psychology The Chicago School of Professional Psychology Chicago, IL	Maranda Davis, LPC Colorado License # 0011442 Master of Arts in Counseling Mid-America Nazarene University Olathe, KS	Page Fischer, MA, LPP Colorado License # 1353 Master of Arts- Forensic Psychology University of Denver Denver, CO	Schuyler Paxton, MA, NCC Registered Psychotherapist #NLC.0104624 Master of Arts in Clinical Mental Health Counseling Denver Seminary Littleton, CO
Ryan Knuth, LCSW, MSW Colorado License # 09923840 Associate Level SOMB Juvenile Treatment Provider Master of Social Work Colorado State University Fort Collins, CO	Chelsie Hopperstad, MSW Provisional Colorado License # 1170 Master's of Social Work University of Southern California Los Angeles, CA	Leigh Anne Butcher, MA, LPC Full SOMB Juvenile Treatment Provider Colorado License # 0011933 Master of Arts in Counseling Denver Seminary Denver, CO	Sam Cade, MA Registered Psychotherapist # NLC0012089 SOMB Juvenile Treatment Provider (Letter of Intent) MA Counseling Psychology Boston College Chestnut Hill, MA
Eliza Gilford, MSW Colorado Provisional License # 1180 Master of Social Work University of Denver Denver, CO	Kim Roesch, MSW Colorado License # 0104985 Master of Social Work Metro State University Denver, CO	Molly Ramirez, MSW Colorado Provisional License # 1205 Master of Social Work University of Denver Denver, CO	Cynthia Corrine Collinsworth, MA, LPP Colorado Provisional License # 1304 Master of Arts in Counseling Denver Seminary Denver, CO

**If you have any questions or would like additional information, please feel free to ask.  
I have read the preceding information and understand my rights as a client.**

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date

\_\_\_\_\_  
Signature of Temporary Custodian/Caseworker Date

\_\_\_\_\_  
Signature of Staff Date





Effective Date: 4/14/2003

**THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

.During a client's stay at Shiloh House, a record of care is maintained. Typically, this record contains information regarding behavioral/emotional symptoms, a client's reported thoughts and feelings, results of assessments at Shiloh House, diagnostic information, information about treatment, educational information, a plan for future care or treatment, and billing-related information. Information about a client's family members may also be contained in the record, as such information pertains to the client's treatment. This notice applies to all of the records (hard copy and electronic) of your care generated by Shiloh House, whether made by Shiloh House staff, your Shiloh House clinician or any Shiloh House employee. Shiloh House has an internal website that all staff utilize in daily communications and reporting.

### **Our Responsibilities**

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

### **Uses and Disclosures**

#### **How we may use and disclose Medical/Mental Health Information about you.**

The following categories describe examples of the way we use and disclose medical information:

**For Treatment:** We may use medical/mental health information about you in the provision of treatment or services. We may disclose medical/mental health information about you to treatment counselors, clinicians, administrators and teachers who are involved in your care and are Shiloh Home employees. For example: treatment counselor staff may need to know information about behavioral and/or emotional information about you in order to determine the amount of freedoms/privileges while you are living in a Shiloh Home residence. This would be done to that an appropriate amount of structure and supervision could be in-place to better ensure your safety and that of other clients and staff.

We may also provide other mental health providers, department of human services representatives, probation officers and the courts with copies of various reports that should assist these people in their work with you. This information may be sent by mail, fax or email. Please understand that such releases of information are only with informed consent allowing for the sharing of information. Exceptions to obtaining informed consent would be in case of medical/mental health emergency, the commission of criminal behavior on the part of the client or by court order. In addition, the department of human services has the right to review records for the purposes of licensing.

**For Payment:** We may use and disclose medical/mental health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your care so they will pay us or reimburse you for your treatment at Shiloh House.

**For Health Care Operations:** Shiloh House staff may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all clients we serve. For example, we may combine information about many clients to evaluate the need for new services or treatment. We may disclose information to outside entities for educational purposes. The disclosure of such information will not identify any clients. We may combine medical/mental health information we have with that of other treatment providers to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

We may also use and disclose medical/mental health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- As part of fund raising efforts;
- For Population based activities relating to improving program outcomes or reducing treatment costs; and
- For conducting training programs or reviewing competence of mental health care professionals.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include our accrediting body, which serves to support Shiloh House in maintaining high standards of care. When Shiloh House works with its accrediting body, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical/mental health information about you to a parent, county caseworker, guardian ad litem and/or probation officer who is involved in your treatment. In addition, we may disclose medical information about you to an entity assisting in an emergency situation so that your family can be notified about your condition, status and location. Such disclosures, except in cases of emergency, court order, or where existing laws mandate disclosure, are only done with appropriate consent.

**Research:** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

**Organized Health Care Arrangement:** This practice is presenting you this document as a notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

**Affiliated Covered Entity:** Caregivers at other facilities or practices may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the facility or practice Privacy Official for further information on the specific sites included in this affiliated covered entity.

## **Confidential to Shiloh House**



**As required by law**, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration    Law Enforcement Officials    Health Oversight Agencies    The Courts
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- State and County Departments of Human Services

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**State-Specific Requirements:** Colorado Department of Human Services requires access to all records as part of its role in oversight of day treatment and residential treatment centers.

### Your Health Information Rights

Although your client record is the physical property of Shiloh Home that compiled it, you have the **Right to Inspect and Copy:** You have the right to inspect and copy information that may be used to make decisions about your care. Usually, this is certain mental health and billing records, but does not include psychotherapy notes or other notes which we are legally forbidden to disclose. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to mental health information, you may request that the denial be reviewed. Another mental health care professional chosen by Shiloh House will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Amend:** If you feel that mental health/medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Shiloh Home.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

**An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of the disclosures we make of medical information about you.

**Request Restrictions:** You have the right to request a restriction or limitation on the mental health/medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the mental health/medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could request that information shared about family members not be shared with those family members.

**We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**Request Confidential Communications:** You have the right to request that we communicate with you about mental health/medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we not leave messages on an answering machine, or that notices of treatment staffings be mailed to an alternative location.

**A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

### CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted on the practice's website and include the effective date. In addition, each time you visit the practice for treatment or health care services, we will have available a copy of the current notice in effect.

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Shiloh Home by contacting the main number and asking for Shiloh Home's Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with Shiloh Home, contact the Privacy Official. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

### OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If you have any questions about this notice, please contact the Privacy Official, Maureen Gleason by dialing 303-932-9599 x313

By signing below I acknowledge having received a copy of Shiloh House's "Notice of Privacy Practices". I may ask my clinician or Shiloh House's Privacy Official questions about this form. I may also request another copy of this Notice through Shiloh House's Privacy Official.

\_\_\_\_\_  
Printed Name of Client

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**Confidential to Shiloh House**



### **Consent for Treatment**

I/We, certify that I/we \_\_\_\_\_ give and grant my/our consent that \_\_\_\_\_ will participate in and may receive treatment (individual, family, group, milieu therapies) within a Shiloh House program:

- Outpatient
- Residential
- Day Treatment
- Community Outreach Services
- Shelter
- Offense Specific

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian or Temporary Custodian/Caseworker Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian or Temporary Custodian/Caseworker Date

### **Consent for Assessment and/or Research**

As deemed necessary, clinical assessments and/or testing, psychological testing, educational testing, drug and alcohol assessment, participation in research and/or offense specific testing will be completed to aid in the care and treatment of my/our child provided by Shiloh House. I/We understand that I/we have a right to know the reason for testing, the type of tests to be used, the intended use of the testing, and what test information will be released and to whom. If my/our child is under court jurisdiction, I/we understand and give my/our consent for the test results to be released to court authorities if requested. I/We also give my/our consent to have test reports released to the custodial county social worker and probation officer, if applicable. Information obtained from psychological testing may be released to my/our child's insurance carrier in order to secure reimbursement for the cost of psychological testing. I/We understand that test results will not be released to any person or institution without my/our informed consent unless required by law, and that my/our child's test scores, test results, and reports will be released only to those with a legitimate, professional interest in my/our child's care. I/We understand that I/we will be given an explanation of the test results and recommendations made on the basis of test results. I/We understand that I/we may contact the Clinical Director regarding questions and concerns about sexual offense specific evaluations and clinical assessments/testing or participation in research by calling 303-932-9599.

If client chooses not to participate in research Shiloh House will continue to provide services.

\_\_\_\_\_  
**Client Signature** **Date**

\_\_\_\_\_  
**Parent/Legal Guardian or Temporary Custodian/Caseworker Signature** **Date**

\_\_\_\_\_  
**Parent/Legal Guardian or Temporary Custodian/Caseworker Signature** **Date**



In accordance with the *Admission Policy and Procedure*, each client, within 24 hours of admission, and as part of the orientation, will be given a written description of *Client Rights* and the *Grievance Procedure*. These rights and procedures will be explained to the client in a language or manner of communication, that the client can understand, based on age, language and ability to understand. The client will sign a *Client Agreement* form that indicates understanding and receiving a copy of *Client Rights and Grievance Procedure*.

If a client wished to file a grievance, forms are available above each locked grievance box located in each facility. Clients must state on the grievance form which client right has been violated and place the grievance in the locked box. Once the client has written the grievance the following procedures will be followed:

1. During business hours, the program will remove the locked box from the facility and bring to the administration building to be opened. Chief Administrative Officer will serve as a back up to the Client Rights Representative. If after business hours, on-call will be notified by a pager at 303-851-0532 and on-call will speak to the client regarding the complaint. In the event that a grievance is filed and client is unidentified, on-call need to respond to the facility and review the grievance within 24 hours.
2. The Client Rights Representative will begin the investigation immediately upon receipt (verbal report) of the grievance.
  - All grievances will be investigated within 72 hours.
  - The Client Rights Representative will determine the course of the grievance investigation. If appropriate, the grievance will be given to the Program Coordinator/Supervisor on duty to resolve.
  - Written documentation will occur directly on the grievance form for investigation and resolution. If necessary, an additional sheet may be attached.
  - Once the grievance has been resolved, all parties will sign and date the grievance indicating resolution. Clients must write the word "**resolved**" next to their signature documenting the grievance has been resolved.
  - The Client Rights Representative will review the grievance to ensure the proper process has been followed and address any outstanding issues.

**Note: Should the grievance be filed against the Client Rights Representative, then the grievance will be presented to the supervisor for review and resolution.**
3. If the grievance is not resolved, the client can request a meeting with the Client Rights Representative, then the supervisor and then the CEO.
4. A copy of the grievance will then be issued to the CEO, the county worker and the client. The original grievance will be filed in the client's file and an additional copy will be submitted to the Director of Licensing and Operations to determine grievance patterns and statistics.

Staff may assist the client in understanding what a grievance is and how to have it resolved. The new client will then be asked to sign a *Client Agreement* form signifying that he understands the grievance procedure. A written grievance may be submitted directly to the Client Rights Representative. Staff may assist the client in writing and submitting the grievance.

### Clients Representatives

Residential Manager/Longmont Campus  
Residential Manager/Adams Campus  
Residential Manager/Littleton Campus  
Residential Supervisor/Sanctuary

### Complaints may also be filed with:

The Colorado Department of Human Services  
Division of Child Care  
1575 Sherman St.  
Education Director/Shiloh Academy  
Denver, CO 80203-1714  
303-866-5958

### Family Grievance Procedure

In the event of a family member grievance, the following procedure will be implemented:  
The family member will complete a grievance form and submit to the Director of Licensing.  
(303-932-9599 ext. 313)

The Director of Licensing will direct the complaint to the appropriate investigative personnel.

The grievance will be investigated and responded to within 3 business days from submission of complaint.

In the event the grievance is against one of the grievance representatives, the grievance will be submitted to the President/CEO.

Grievances against the CEO will be submitted to the Shiloh House Board of Directors for review and investigation.

By signing below, I acknowledge that I fully understand the **Parent Grievance Procedure** and the process of filing a grievance. Shiloh House staff has answered any questions I (we) had about the program/procedures.

By signing below, I acknowledge that I fully understand the **Client Grievance Procedure** and the process of filing a grievance. Shiloh House staff has answered any questions I had about the program/procedures

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



- A. Shiloh House ensures the availability of each of the following core rights for clients. Each client is advised, in writing, of these rights and a list of said rights is posted in each facility.

Every client has the right to enjoy freedom of thought, conscience, cultural and ethnic practice and religion.

Every client has the right to a reasonable degree of privacy.

Every client has the right to have his or her opinions heard and be included to the greatest extent possible, when any decisions are being made affecting his/her life.

Every client has the right to receive appropriate and reasonable adult guidance, support and supervision.

Every client has the right to be free from physical abuse or neglect and inhumane treatment. Every client has the right to be protected from all forms of sexual exploitation.

Every client has the right to receive adequate and appropriate medical and mental health and psychiatric care in the least restrictive setting possible, suited to meet individual needs.

Every client has the right to receive adequate and appropriate food, clothing and housing.

Every client has the right to live in clean, safe surroundings.

Every client has the right to participate in an educational program that will maximize his/her potential in accordance with existing law.

Every client has the right to communicate with "significant others" outside the facility, such as a parent or guardian, caseworker, attorney or guardian ad litem, current therapist, physician, religious advisor, and probation officer.

No foster child shall be fingerprinted unless required by law enforcement.

A client may be photographed upon admission for identification and administrative purposes of the facility pursuant to section 19-3-306, C.R.S. such photographs will be confidential and shall not be released by the facility except pursuant to court order. No other non-medical photographs or videotaping shall be taken or used without the written consent of the client's parent/legal guardian except in the case of a child abuse investigation.

Every client has the right to the same consideration for care and treatment regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status or disability.

Every client has the right to be given the names and professional status of the staff members responsible for their care.

Every child has the right to receive assistance from the client representative in filing a grievance and to receive copies of the grievance procedure.

Every client fifteen (15) years of age and older has the right to request his own medical records, to see the records at reasonable times, and to be given written reasons if the request is denied.

Every client fifteen (15) years of age and older, who is NOT in the custody of Human Services, has the right to accept treatment of his own free will and may sign in as a voluntary client. The client has the right to refuse to sign the consent for voluntary treatment at the time of admission or may take back the consent at a later date pursuant to section 27-10-103, C.R.S.

- B. The following client's rights may be limited to reasonable periods during the day or restricted according to written policies of the facility to ensure the protection of the client, staff and program from unreasonable and unnecessary intrusions and disruptions and from health and safety hazards.
- Every client has the right to have access to letter-writing materials, including postage and to have staff members of Shiloh House assist the client if unable to write, prepare and mail correspondence.
- Every client has the right to have access to telephones to both make and receive call in privacy.
- Every client has the right to have convenient opportunities to meet with visitors.
- Every client has the right to wear his own clothes, keep and use his own personal possessions, and keep and be allowed to spend a reasonable sum of his own money.
- Every client has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, held or censored by the personnel of Shiloh House.

Plans for how and when telephone and written communications will take place.

Plans for regular visits of the client with relatives, friends, or others interested in the client's welfare, both within and outside of the facility, unless in the judgment of treatment staff and the placement agency visits would be detrimental to the client and/or family.

Plans for extenuating circumstances and emergency situations affecting the client and family.

The requirement that Shiloh House notify the client, if appropriate to the age of the client, and parents/guardians at the time of admission of any policy that would limit or restrict a client's rights. The notification must be communicated in a language or mode of communication the client can understand and, if possible be signed by the client and parents/guardian.

- C. If Shiloh House enforces any restrictions upon the client's rights as listed at 7.714.31B, Shiloh House will do the following:
- Inform the client and the client's family and custodian or legal guardian, in a language or mode of communication the client can understand, of the conditions of and reasons for restrictions or termination of the client's rights.
- Place a written report summarizing the conditions of and reasons for restriction, denial, or termination of the client's rights in that client's case record. Information pertaining to a restriction, denial, or termination of a client's rights contained in the client's case record must be made available, upon request, to the client or the client's parent/guardian.
- Any restriction of client rights will be reviewed every seven days and documented in the client's case record.



When a restriction of a client's rights affects another individual, the individual will be informed, in a language or mode of communication the individual can understand, of the conditions of and reasons for the action.

Within 24 hours of my admission to Shiloh House I received/reviewed the following:

Physical management procedures      Client rights and grievance procedures      Tour of the facility

Rules and regulations of the program      Review of emergency fire evacuation procedures

**By signing below, I acknowledge that I fully understand my rights as stated above. Shiloh House staff has answered any questions I had regarding my rights.**

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

\_\_\_\_\_  
Client Signature    Date

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

\_\_\_\_\_  
Staff Signature    Date

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### Client Questionnaire

What is your ethnic background?

What is your religious background?

What holidays do you practice cultural traditions?

How do you celebrate those holidays?

How do you think your cultural or religious beliefs can be incorporated to your treatment at Shiloh House?

What is something unique about your cultural background?

What is something about your background that you would want to teach to others?



### USE OF PHYSICAL MANAGEMENT

- Shiloh House uses physical management that is an age appropriate personal intervention by a staff member in an emergency situation to limit, restrict or control the dangerous behavior of a client by means of physical holding of a client. Physical holding of a client is the only method of physical management allowed. The use of mechanical restraints is prohibited. A physical management is used only during time of crisis or emergency for the client, when the client is a danger to himself or others and when all other means to control and de-escalate has failed. The management shall not impede or inhibit the client's ability to breathe, including placing excess pressure on the chest or back area. The management shall terminate when the client is calm, can respond to adult direction and is no longer a threat to self, others or property. **The management will be terminated immediately if the client exhibits adverse side effects such as, illness, severe emotional or personal injury.**
- Shiloh House will attempt all positive and constructive methods of dealing with a client prior to the use of physical management.
- Physical management will only be used in emergency situations after all de-escalation methods have been attempted.
- Physical management will never be used as a punitive form of discipline, treatment/therapy, a threat to control or gain compliance of a client's behavior.
- Physical managements will last no longer than 15 minutes, unless it is determined that for safety reasons, the restraint must be continued. Written justification is required in cases that management is longer than 15 minutes.

### PHYSICAL MANAGEMENT POLICY

- Shiloh House uses CPI a Non-Violent Crisis Intervention. It is a safe non-harmful behavior management system designed to aid in the management of disruptive and assaultive clients. A Behavior Management Progression is used as a preventive, de-escalating method prior to personal management.
- All staff members will be trained in CPI. This training is initially 8 hours followed by a 4-hour refresher course every 6 months. Staff who are not current in their CPI training are restricted from using this intervention on the clients. This will be documented in the employee's personnel file. The Behavior Management Progression is used as a preventive, de-escalation method prior personal management. Shiloh House utilizes a modified behavioral system that emphasizes positive behavioral responses rather than attention for inappropriate behavior. The behavior management progression is a three-step process.

Shiloh House utilizes a modified behavioral system that emphasizes positive behavioral responses rather than attention for inappropriate behavior. The behavior management progression is a three-step process.

**1<sup>st</sup> Step:** Self Time-Out  
The client is cued by staff to take a self time out. The client will stop on the spot and think about his choices. The client raises his hand when ready to rejoin the program.

**2<sup>nd</sup> Step:** Away Time-Out  
The client is asked to take seclusion in a designated area in the room. The client completes a STOP, THINK, and CHOOSE assignment. The client verbally acknowledges the problem and new choices.

**3<sup>rd</sup> Step:** Bench Time  
The client is asked to leave the room and sit in a designated area. The client completes a treatment assignment and a GOAL, PLAN, DO, CHECK assignment. The client verbalizes to staff his GOAL and PLAN and then returns to the program. The client reports DO and CHECK to staff following the activity.

Shiloh utilizes the CPI method of physical management.

- Physical management will be reviewed regularly (please refer to *Review* section of policy). Physical managements are documented on an *Incident Report* form by the staff member who led the management. The content of the debriefing will also be documented.
- Staff will not manage a client in any areas of the facility that may pose a threat to the health and safety of the client.
- Physical management methodology will be reviewed with the client and parent/legal guardian at intake.
- The client will be checked by staff during the management noting any difficulty in breathing, pulse rate, color or signs of choking or respiratory distress. If a staff and/or a client is injured during a management, they will receive immediate first aid, Shiloh medical coordinator and/or on-call staff will be notified and when required injured person will be transported for medical care. Any bruising, injuries or death that occurs as a result of a physical management will be reported to Jefferson County Protective Services, Adams County Protective Services or Weld County Protective Services.

### REVIEW

Each physical management will be reviewed by a supervisor, member of the Safety Risk Committee or an on-call representative within 24 hours of the management.

The entire client's treatment plan must be reviewed if any of the following occur:  
If it appears that the client is being managed an excessive number of times.  
Frequency in a short period of time.  
Frequency by the same staff member.

If any de-escalation techniques appear to be causing an escalation in the behavior of the client or a group of clients, the use of the technique will be evaluated for its effectiveness. De-escalation techniques that are not effective or are counter-productive must be terminated at the earliest opportunity.

If either the client or staff member was seriously injured or died during a management, a thorough review of the management and injuries will be instituted immediately.

Staff that appears to be involved in a larger number of management than other staff members, Shiloh will conduct a thorough review of the staff member's interactions with clients.



Dear Parents,

Welcome to Shiloh House! This packet of information is offered to assist you and your child in understanding the treatment program provided at Shiloh House.

It is the mission of Shiloh House to create a therapeutic environment for youth by providing nurturing adult guidance both from the staff and you. Shiloh was founded in January 1985 by Steven and Vicki Ramirez. Presently, there is approximately 180 staff that work together and are available to provide the best services possible to youth and families.

### **ADMISSION:**

Admission to Shiloh Treatment programs can be made twenty-four hours per day, seven days per week. Shiloh House serves males/females ages 5 -17. The programs address youth with a variety of mental health issues. All youth must speak English.

Once an admission date is established you will be asked to complete paperwork that allows your child to participate in Shiloh's therapy program.

Admission paperwork is very important and needs to be filled out completely with as much information as possible. The different forms and releases give Shiloh House permission to provide care for your child and to begin to learn more about your child. This begins the process of putting together an individualized treatment plan for you and your child.

Shiloh House is not responsible in any way for the replacement of personal belongings that are lost, stolen, broken, etc. If a youth damages property, he will be assessed a reasonable monetary fee and/or community service to cover the cost of damages.

Youth are not permitted to possess any entertainment electronic devices while in placement at Shiloh. Shiloh House has entertainment electronic devices that may be used by youth who earn this privilege. The following items are not permitted; cell phone, CD players, radios, hand held games, IPOD'S, clock radios, and items of value over \$ 50.00.

### **MEDICAL:**

For medical needs, you continue to be responsible for providing the updated insurance information and we ask that you stay as involved as possible. Our Medical Department will coordinate having your child's medical needs met. Please feel free to call them directly at 303-932-9599 EXT 350 should you have any medical issues or concerns.

Youth are monitored by a psychiatrist under contract with Shiloh House and parent participation is encouraged. At discharge, we provide medication or a prescription for 30 days. After discharge we cannot provide any additional medications or prescriptions.

All special needs or emergency health requirements for youth will be taken care of immediately and reported to the Clinician and/or On-Call Representative. Parents/guardians will be notified.

### **TREATMENT:**

All youth are assigned a clinician that will both coordinate and provide the individual, family, group therapy and case management services for your child. When possible, your child's clinician will be available during the admission process.

The **Portland Program** provides services to 16 youth who present with a wide range of behavior and emotional disorders, usually resulting in involvement with the juvenile court system. A structured therapeutic program is provided that emphasizes safety and personal responsibility.

The **Yarrow/Estes Program** specializes in offense specific treatment. Shiloh's therapeutic program for sexually abusive youth emphasizes community safety. Shiloh assumes a victim-centered approach in working with these youth. Being accountable for one's sexually abusive behavior, learning the triggers that lead to sexually acting-out and developing "tools" so that personal safety can be maintained are the centerpieces of Shiloh's program.

The **Adams Program**. The Adams program serves the younger youth (age 6 -13) who require intensive support and intervention and cannot function in less restrictive community settings. The youth live in a home like environment provides structure and support. Healthy and adaptive ways of coping are reinforced. Positive relationships with staff and peers are encouraged.

The **Longmont Program** provides residential services to youth (ages 11-18) that present with a wide range of emotional/behavior disorders and sexual offense-specific treatment.

The **Sanctuary Program** a multi-agency, multi-purpose center that provides shelter, education, and treatment services for youth ages 5-18.

### **EDUCATION:**

Shiloh House has an on-grounds school that provides educational services to both regular and special education students. Shiloh Academy is endorsed by the Colorado Department of Education. Credits earned by students at Shiloh Academy will transfer to the youth's home school when he leaves Shiloh House. Shiloh Academy is staffed with qualified educators. The school follows the same school calendar as Jefferson County Schools.

### **RECREATION:**

Recreation is a vital part of the treatment program. Indoor and outdoor recreational and leisure activities are regularly scheduled. Recreational outings require staff supervision and all activities are reviewed on a monthly to ensure safety for all involved.

### **DAY TREATMENT:**

Shiloh House's day treatment program is available year-round. It is often used as a step-down program for youth discharge from our residential program. Shiloh's day treatment program provides a structured school environment, as well as individual, group and family therapy. Youth attend the program during the day (8:00 am to 3:15 pm). Transportation to and from the program is offered. Day Treatment services are offered in Littleton, Thornton, Longmont and Adams.

### **FAMILY THERAPY AND VISITATION:**

You are an important component of your child's treatment program. Ongoing contact with your child, through letters, telephone calls and personal visits, regular contact with your child's clinician and participation in family therapy is critical to your child benefiting from the services available at Shiloh House.

Once your child has demonstrated safety in the program, family visits are encouraged. Visitation is scheduled weekly by calling your child's clinician by Tuesday at 5PM. Visits with your child at Shiloh House on Saturdays between the hours of 10-2 PM and Sundays between the hours of 2 - 6 PM are encouraged so long as your child is demonstrating safe behavior (visits are scheduled for 2 hour increments). Parents bringing siblings along for visits need to keep their children with them at all times. Parents will be given a reminder if a child accompanying them for a visit leaves their parent's side. If this occurs a second time, the visit will be terminated. Future visits will need to be coordinated with the client's clinician to ensure that necessary supervision is provided at all times. When the client and the family demonstrate progress in the therapy program, passes away from Shiloh House may be approved. The duration of these passes will be decided between you and your child's containment team.

Within the first 10 days, a staffing is held (usually this is scheduled during the intake) with the MDT in order to develop the service plan. Then, staffings are scheduled on the average of once per month to review progress and discuss issues. There is a written report completed by the clinician, and based on the service plan, sent to treatment team members.





### GRIEVANCE PROCEDURE:

Providing quality services to our clients is the number one priority at Shiloh House. Therefore, if there are any concerns or questions we ask you to call us immediately at 303-932-9599. The procedure is to try to work the problem out directly with the clinician or the staff. If this does not work you may file a written grievance. This grievance will be submitted to The Client's Rights Representative and a plan to resolve the grievance will also be documented. If this is not worked out, the Executive Director may be approached in another attempt to resolve the issue. Most of the time we find that communication or a lack of clear understanding of how things work at Shiloh is the reason for the problem. Again, we welcome any comments or concerns. Additionally, we send out questionnaires, which elicit information about how we are doing. We read each and every one of them and respond with changes, which seem appropriate to our treatment philosophy.

Complaints may also be filed with:

The Colorado Department of Human Services  
Division of Child Care  
1575 Sherman St.  
Denver, CO 80203-1714  
303-866-5958

Division of Behavioral Health  
3824 W. Princeton Circle  
Denver, CO 80236  
303-866-7408

Shiloh House utilizes a "Containment Treatment" approach. This philosophy holds that some of the most crucial factors in the successful treatment of the high-risk youth is supervision, support and guidance with a team approach, as well as, clear and frequent communication among all the many people involved with each client. Accountability from the youth and establishment of community safety is priority. Treatment focuses on the effective and balanced use of structure, nurturance and respect for authority. This philosophy is taught to all involved staff and professionals. It focuses on giving credit to the youth for his success, as well as holding the youth responsible for behaviors that do not meet expectations.

Shiloh uses CPI, a Non-Violent Crisis Intervention that is an age appropriate physical intervention by a staff member in an emergency situation to limit, restrict or control dangerous behavior of a youth by means of physical holding. A physical management is used only during times of crisis or emergency for the youth when he is a danger to himself or others and when all other means to control and de-escalate has failed. All physical managements are reviewed within 24 hours.

The youth will successfully attain established goal relating to presenting problems prior to discharge. Any dangerous and/or illegal behavior/action to include: harmful behavior toward self, suicidal ideation, assaulting others, intentionally destroying property, sexually acting out toward others, running away or refusing to participate in the treatment program may result in termination from Shiloh.

**Shiloh House is not responsible in any way for the replacement of a client's personal belongings that are lost, stolen, broken, etc. If a client damages property, he/she will be assessed a reasonable monetary fee and/or community service to cover the cost of the damages.**

**Clients are not allowed to possess any entertainment electronic devices (cell phone, CD players, radios, electronic hand held games etc.) while in placement at Shiloh House. Shiloh House has entertainment electronic devices that may be used by clients who earn this privilege.**

**The following prohibited items include but is not limited to the following:**

- Cell phones
- CD players
- Radios
- Electronic hand held games
- IPOD'S
- Clock radios

I understand the expectations regarding the Shiloh House personal items policy as well as the consequences of damaging Shiloh House property.

We hope that this information is helpful. Please do not hesitate to ask questions, and let us know how we can successfully work with you and your child.

Program: \_\_\_\_\_

Address: \_\_\_\_\_

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

Assigned Clinician \_\_\_\_\_

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



### Consent Form for Animal Assisted Therapy (AAT) and Animal Assisted Activities (AAA)

AAT is a goal directed intervention, in which an animal that meets specific criteria is an integral part of the treatment process. This intervention will include a professional working within their scope of competency. The animal participating will be assessed by a neutral party through Professional Therapy Dogs of Colorado (PTDC).

This process will be documented and evaluated. According to Delta Society "AAT is designed to promote improvement in human physical, social, emotional, behavioral and cognitive functioning".

AAA's provide opportunities for motivational, educational, recreational and therapeutic benefits to enhance quality of life. They are delivered in a variety of environments in association with animals that meet specific criteria.

Although every individual is different, some people who have participated in AAT have experienced the following benefits:

- Animals help improve motivation and engagement in therapy
- Animals help build trust and provide a sense of security
- Animals offer unconditional acceptance
- Animals can act as symbols and metaphors in the client's life
- Animals help in the areas of focus and attention
- Animals act as agents of de-arousal as the help clients learn soothing and calming skills
- Animals can be a source of social and emotional support
- Animals can act as objects of attachment
- Animals can be instruments of learning
- Clients may project their own problems onto the animal
- Animals offer humor and fun in the session as the help facilitate play

Although AAT comes with many benefits, it also comes with inherent risks. When working with animals we cannot be 100% sure that their behavior will always be predictable. We will follow PTDC's standards of practice as well as their policy and procedures in regards to animal participation. The companion animals participating have been medically screened and they have passed an evaluation through PTDC. Knowing this, I, and anyone who might claim on my behalf, release Shiloh Home and PTDC and its staff from liability of any kind arising out of personal injury, and property damage resulting from participation in AAT/AAA at Shiloh Home.

I assume all the foregoing risks and accept personal responsibility for all expenses, medical or otherwise, following any such damages or injuries, which may in any way be associated with participation in AAT/AAA at Shiloh Home. This may include but not be limited to injuries that therapy animal.

Any known aversions to animals or acts of animal abuse and/or neglect? Please explain: \_\_\_\_\_

\_\_\_\_\_

Any known allergies: \_\_\_\_\_

### Client Participation Contract for Animal Assisted Interventions

I agree to try my hardest while working with any therapy animals at Shiloh House. This includes following safety protocol for meeting a canine for the first time. The protocol is to ask for verbal permission from the handler, if granted, allow the dog to smell the top of your hands, and then pet him/her on the neck or an area where the dog can see your hand.

When you are meeting a dog for the first time, never stare directly into his eyes as dogs read this body language as a challenge.

Remain calm while in the animal's presence.

Always follow adult directions while with the animal.

Always wash hands or use hand sanitizer after having contact with the animal.

Never give the animal something to eat without permission from the adult.

When giving a dog a treat, use the open hand method.

If you are not following directions or are being unsafe with the animal, you may be asked to leave group, or end the session.

If you have a question, please ask

If you are uncomfortable in a situation, use your voice to express this.

Clients will always be accompanied by an adult while with an animal.

I will be aware of what the animal needs by listening, observing, and learning about the animal.

If I become angry or frustrated I will verbalize this to my therapist and ask for what I need

Participation with the animal is always a choice.

It is okay to take a time out. Please make this request if needed.

Please ask for help when needed.

Have fun and stay safe!

**I have read the following contract with a Shiloh House staff member and agree to follow these expectations.**

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date



Client Name: \_\_\_\_\_ Is this an emergency placement: Yes  No

Date of Admission: \_\_\_\_\_ Date of ITP: \_\_\_\_\_

Program Admitted to: \_\_\_\_\_

### I. Treatment Team Members

Clinician: \_\_\_\_\_

Residential Manager: \_\_\_\_\_

Assistant Principal: \_\_\_\_\_

Program Coordinator: \_\_\_\_\_

II. Medications at Admission: \_\_\_\_\_

III. Presenting Problems/Reason for Admission: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IV. What is the Plan for Parent/Guardian Involvement: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

V. What is the discharge plan for this client: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Client's Strengths/Limitations: \_\_\_\_\_

Strengths

Limitations

- |    |       |       |
|----|-------|-------|
| 1) | _____ | _____ |
| 2) | _____ | _____ |
| 3) | _____ | _____ |
| 4) | _____ | _____ |



### VII. Treatment Goals

Goal: Orientation/Learn Rules of The Program Objective:

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### VIII. Type Of Behaviors At Risk For:

1. \_\_\_\_\_

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2. \_\_\_\_\_

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3. \_\_\_\_\_

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### Triggers:

1. \_\_\_\_\_

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2. \_\_\_\_\_

---

### Intervention Do's

1. \_\_\_\_\_

---

2. \_\_\_\_\_

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### Intervention Don'ts

1. \_\_\_\_\_

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2. \_\_\_\_\_

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Identify which of the following treatment modalities the client will receive, person/agency responsible and frequency.

Treatment Interventions	RCCF	Day Treatment
Individual Therapy		
Group Therapy		
Crisis Management Therapy		
Family Therapy		
Psychiatric Services		
Other		

Comments:

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Additional Comments/Information: \_\_\_\_\_

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\_\_\_\_\_  
**Clinician Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Supervisor Signature**

\_\_\_\_\_  
**Date**

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

\_\_\_\_\_  
**Date**