CHILD & FAMILY SERVICES CAPITAL AREA
ANGEL HOUSE MOTHER & BABY PROGRAM
ADMISSION INFORMATION

Date: _____

Referring Agency: _____

Referring Agency Contact: _____

Phone: _____ E-mail: _____

Agency paying (if different): _____

Paying Agency Contact:_____

Phone:_____ E-mail: _____

Funding Source: ☐ Title IV-E ☐ CCCF ☐ Circuit Court ☐ Other _____

Client Information:

Name: _____ DOB: _____

Sex: _____ Height: _____ Weight: _____ Hair color:_____ Eye color: _____

Race: _____ Identifying marks: _____

Religion: _____

Current Address (if applicable): _____

Phone numbers: _____

Current Public Assistance: ☐ TANF ☐ WIC ☐ Housing ☐ Food Stamps ☐ Child Care

Other: _____

Health Insurance: ☐ Medicaid ☐ Other: (please specify)_____

Doctor: _____

Mothers Name: _____ ☐Married ☐Single ☐Divorced ☐Widowed

Mothers Address (if known): _____

Mothers Phone Number (if known): _____

Fathers Name: _____ ☐Married ☐Single ☐Divorced ☐Widowed

Fathers Address (if known): _____

Fathers Phone Number (if known): _____

Other agency involvement:

Agency	Contact Person	Phone Number/E-mail

Presenting Problem (from referring agency): _____

Previous Placements: _____

Other Services Received:

_____

History and Social Support:

Family Involvement: _____

Other Social Supports:_____

Delinquency Record: ☐ Yes ☐ No, If yes please explain:

_____

Is the applicant enrolled in school? ☐ Yes ☐ No, If yes complete school information:

Grade Level: _____ GPA: _____ Name of School: _____

Address of School: _____

School concerns: ☐ Yes ☐ No, If yes please explain:

_____

History of running away: ☐ Yes ☐ No, If yes please explain:

_____

History of mental illness: ☐ Yes ☐ No, If yes please explain:

_____

History of abuse or neglect experienced by applicant: ☐ Yes ☐ No, If yes please explain:

_____

History of domestic violence either personally or within family: ☐ Yes ☐ No, If yes please explain:_____

Suicide attempts or ideation: ☐ Yes ☐ No, If yes please explain:

_____

History of violence towards others: ☐ Yes ☐ No, If yes please explain:

_____

Physical or mental health concerns: ☐ Yes ☐ No, If yes please explain:

_____

Prescribed Medication

Medication/Dose	Instructions	Reason

Information on child accompanying mother (if any):

Child 1:

Name: _____ DOB: _____

Height: _____ Weight: _____ Hair color:_____ Eye color: _____

Race: _____ Identifying marks: _____

Religion: _____

Medical/Physical/Developmental/Mental Health concerns: _____

Medications: _____

Doctor: _____

Father's name: _____

Address: _____

Phone #'s: _____

Father's relationship with mother and child: _____

Any other additional concerns or information for Angel House staff:

_____

_____ _____

Signature of Applicant Date

_____ _____

Signature of person completing form Date

_____ _____

Angel House Staff Signature Date

Documents needed from applicant/guardian:

☐ Medical cards for applicant and child(ren)

☐ Photo ID (if applicable)

☐ Last ISP or USP (if applicable)

☐ Copy of immunizations for applicant and child(ren)

☐ Copy of last physical for mother

☐ Copy of last physical for child(ren) (if applicable)

☐ Copy of last dental for mother

☐ Copy of last dental for child(ren) (if applicable)

Forms to be completed by guardian:

☐ Application

☐ Agreement to pay

☐ Consent to Administer Medication

☐ Emergency Treatment Card

Forms to be completed by applicant once accepted (guardian should give input as well):

☐ Resident Questionnaire

☐ Safe sleep agreement

☐ Childcare agreement

☐ Photograph agreement

☐ Belonging agreement

☐ Receipt of rights signature page

☐ Receipt of privacy notice signature page

☐ Receipt of rules and expectations

☐ Goal Worksheet

☐ Schedule worksheet

☐ Vehicle agreement, insurance and registration (if applicable)

Office Use Only:

Application reviewed by: _____

Interview Scheduled: ☐ yes, If yes complete information below. ☐ no, If no explain why:

_____

Interview Date:_____ Interview Time: _____

Staff to conduct interview: _____

Those attending interview: _____

Interview Outcome:

☐ Accepted ☐ Denied ☐ Waitlisted ☐ Applicant/agency denied admission

Reason for denial: _____

Waitlist Number: _____

Intake Date: _____ Intake Time: _____

Staff Conducting Intake: _____

J:\Angel House\Forms\Shelter Forms\Admission form-teen.doc

Child and Family Services
Angel House Mother & Baby Program
Resident Questionnaire

Name: _____ Date: _____

Education and Employment History:

1. Are you currently employed? ☐ Yes ☐ no
    a. If no do you plan on looking for employment? ☐ Yes ☐ no
    b. What type of employment are you currently doing or do you want to do?

        _____
2. Is there a specific career path you are interested in? ☐ Yes ☐ no, if yes what is it?

    _____

    _____
3. What type of educational program are you in?

    _____
    a. How are you doing in the program? Please give us an honest update:

        _____
    b. What is the highest grade you completed? _____
4. What are your plans for continuing your education?

    _____

Risk Behaviors:

1. Have you used substances? ☐ Yes ☐ no, if yes what kind?

    _____
2. Do you currently use any substances? ☐ Yes ☐ no
3. Does anyone in your family have a history of drug use? ☐ Yes ☐ no
4. Who did you or do you do drugs with? _____
5. Have you ever thought about or tried to commit suicide? ☐ Yes ☐ no, if yes please explain: _____

    _____
6. Are you involved or have you been involved with the court system? ☐ Yes ☐ no, if yes please explain all involvement:

    _____

    _____

    _____

7. Have you been or are you currently in a violent relationship with someone? ☐ Yes ☐ no, please explain:

   _____

   _____

8. How do you handle conflict?

   _____

   _____

Social Supports:

1. Who do you depend on most right now?

   _____

   _____

2. What kind of relationship do you have with your family?

   _____

   _____

3. What kind of relationship do you have with your child's father?

   _____

   _____

Treatment:

1. What are some things you want to work on/accomplish while you are here?

   _____

   _____

2. What are some concerns you have about being here?

   _____

   _____

3. What are some concerns you have about your child that you would like assistance with?

   _____

   _____

4. Where would you like to go once you leave here?

   _____

   _____

5. What needs to be in place in order to make that move happen?

   _____

   _____

6. Is there anything else you would like to tell or ask us?

   _____

   _____

   _____

   _____

   _____

   _____

_____ _____

Resident Signature Date

_____ _____

CCM Signature Date Reviewed

Child and Family Services, Capital Area
Angel House Mother/Baby Program

Belonging Agreement

I, _____ agree to abide by Angel House's Belongings Policy which states:

- All residents will be responsible for her own belongings
- Angel House is not responsible for lost, stolen, or damaged items.
- Personal storage is available for each resident.
- Residents will not share or lend their belongings to other residents.
- At admission residents belongings and person will be searched and inventoried.
- Anytime a resident enters back into the building a search and inventory is done of her person and belongings.
- All new items will be placed on the inventory.
- At discharge the inventory will be checked with the residents belongings to ensure they leave with all their items.
- Items not allowed on Angel House property will be discarded (e.g.drugs, alcohol, lighters, matches, etc).
- Items not allowed to be used at Angel House will be placed in personal storage until discharge.
- Money, bank cards, check books, etc will be kept in locked personal storage to be signed out as needed.

_____ _____
Resident Signature Date

_____ _____
Angel House Staff Signature Date

Child and Family Services
Angel House Mother & Baby Program

Safe Sleep Agreement

I, _____ agree to abide by Angel House's Safe Sleep Policy. For children under the age of 12 months I agree to:

- Place my child on his/her back when putting him/her to bed.
- Make sure my child only sleeps in a crib or playpen while at Angel House.
- Never put anything in my child's crib or playpen at any time.
- Keep my child's face uncovered while sleeping.
- Keep the crib sheet tight on the crib mattress.
- Use sleeper pajamas instead of blankets.
- Not allow anyone else to sleep with my baby.

_____ _____
Resident Signature Date

_____ _____
Angel House Staff Signature Date

Child Care Agreement

I, _____ agree to arrange for my own child care while living at Angel House and I will not leave my child with other residents. I will not leave my child with Angel House staff without prior authorization from my case manager.

_____ _____
Resident Signature Date

_____ _____
Angel House Staff Signature Date

CHILD & FAMILY SERVICES, CAPITAL AREA

Angel house

CONSUMER RIGHTS AND RESPONSIBILITIES

AND

HOW TO MAKE A COMPLAINT

Child & Family Services, Capital Area

Child & Family Services, Capital Area, is a non-sectarian, not-for-profit agency, serving residents of Clinton, Eaton, Ingham and Shiawassee counties. We are dedicated to serving all segments of our community. Our programs include Counseling, Adolescent Substance Abuse Treatment Services, Foster Care and Adoption. Some of our programs are funded by the Capital Area United Way.

COMPLAINTS

Consumers have the right to address complaints verbally or in writing to the staff of the program from which they receive services, the program director, and/or the Agency's Recipient's Rights Advisor. Clients also have the right to receive a copy of this brochure at the time the complaint is made.

HOW TO MAKE A COMPLAINT

1. First, discuss the issue with the staff person you regularly see. If you are not satisfied, contact:
   a. The program director of the agency program from which you receive services. If you are not satisfied, contact:
   b. The Recipient Rights Advisor of Child & Family Services, Capital Area.

Staff of Child & Family Services, Capital Area, shall receive, investigate and respond to your complaint in writing, within ten (10) working days and shall notify the immediate program director of the complaint and any action taken.

Consumers who receive services from Child & Family Services, Capital Area, as a result of contracts with the State of Michigan Family Independence Agency (FIA), Community Mental Health, or Mid-South Substance Abuse Commission, also have access to the recipient rights offices of these agencies:

- Foster Care, Adoptions, In-Home Counseling you may contact: Family Independence Agency/Ingham County at (517) 887-9400
- Mid-South Substance Abuse Commission at (517) 337-4406
- Maternal & Infant Support Services (Clinton County) at (517) 224-0958

Child & Family Services, Capital Area
4287 Five Oaks Drive
Lansing, MI 48911
Phone: 517-882-4000
FAX: 517-882-3506

YOUR RESPONSIBILITIES

You have certain rights and responsibilities. You are responsible:

- To keep appointments and arrive on time. If you are unable to keep the appointed time, please call in advance. Also, let the staff know of any change in your address or phone number so that your record is kept current.

- For providing clear and accurate information about yourself and for following your treatment plan.

- Other clients and staff also have the right to the same respect, privacy and confidentiality. In fact, you are expected to maintain the confidentiality of others while you are receiving treatment.

- Like other expenses, such as rent or groceries, you are also responsible for treatment costs in your fee contract. This amount may be part of or all of the costs, depending on the coverage of your health insurance or other benefit providers. Please discuss the manner of payment with your social worker or a member of the business office staff.

- As an agency, we have the right to expect that our clients will conduct themselves in a manner that does not pose a danger to themselves or others. Dangerous or unpleasant behavior or substance abuse may result in a request to leave the agency. Both staff and clients are expected to use courtesy in their relationships.

- We have the right to terminate treatment if agreement on goals and methods to attain those goals cannot be reached.

YOUR RIGHTS

You have the right:

- To have information about you or your family kept confidential unless you have given your written consent or unless otherwise required by law. You must sign a release of information if you wish your therapist or caseworker to talk to or send a report to someone else. Current law allows information about you to be released if you pose a danger to yourself or others and requires the reporting of suspected child abuse and neglect.

- To review your case record in the presence of your counselor unless the Executive Director decides it is in your own or another's best interest not to do so.

- To appeal any decisions made by professional staff of the agency regarding services provided.

- To a clear explanation of any treatment or services used or recommended, including any medication and its side effects.

- To refuse services, treatment, or medication.

- To review the agency fee schedule and receive an explanation of your bill upon request.

- To be treated with dignity and respect during your treatment. No research photographs or video tapes will be done without your written consent. Once treatment is completed, all photos or videotapes to which you consented will be given to you, or otherwise disposed of as specified in the consent form.

- Not to be discriminated against on the basis of color, race, sex, age, martial status, sexual preference, or handicaps.

ANGEL HOUSE
CONSENT TO TREAT &
ACKNOWLEDGEMENT OF RECEIPT OF RIGHTS AND PROGRAM INFORMATION

I, _____, agree to participate in the services and programming provided by the Angel House Mother & Baby Program. Services may include individual, group, and family therapy. The development of my treatment plan will be a collaborative process involving my case manager, myself, and as indicated, my family or other support system, and/or other professionals involved in my care. I understand that consent may be withdrawn at any time.

(Please initial the boxes)

☐ **CONSENT FOR EVALUATION AND TREATMENT**

I acknowledge that I am voluntarily authorizing treatment at Child & Family Services - Capital Area/Angel House, for myself, and/or for my dependent(s)

_____

I agree to follow the treatment plan as discussed with my case manager. I recognize that my treatment may be discontinued by the Agency if I do not comply with the treatment plan. Other treatment alternatives may be offered if I do not agree with the treatment plan.

☐ ***ACKNOWLEDGEMENT OF RECEIPT OF: CONSUMER RIGHTS/RESPONSIBILITIES***

I have received a copy of the Child & Family Services, Capital Area, Consumer Rights and Responsibilities Brochure. I understand that if I wish to make a complaint about Child & Family Services, I can follow the steps listed in the brochure. These rights and confidentiality have been explained and all my questions have been fully explained to my satisfaction.

☐ ***ACKNOWLEDGEMENT OF RECEIPT OF: PROGRAM INFORMATION BROCHURE***

I have received a copy of the Angel House Division Program Information Brochure.

_____ _____

Client Signature Date

_____ _____

Case Worker Signature Date

_____ _____

Witness Signature Date

Child and Family Services, Capital Area
Angel House Mother Baby Program
Discipline and Behavior Management Policy

Policy:

1) This policy will be made available to each resident along with his/her guardian at admission.
2) Staff will use behavior management techniques, which are non-invasive and promote positive behavior and self-responsibility.

2) The following types of behavior management are prohibited at Angel House:
- *Use of physical discipline such as spanking, pinching, shaking, hitting, biting*
- *Use of seclusion*
- *Use of physical restraint in non-emergency situations*
- *Use of verbal abuse, ridicule or humiliation*
- *Denial of essential program services*
- *Denial of meals, communications with family, and opportunity for 8 hours of sleep within a 24-hour timeframe, clothing, or other personal needs*
- *Use of chemical restraint*
- *Using other children to discipline a child unless that child doing the discipline is the parent of the child being disciplined.*

Procedure:

1) Staff will use the following child-handling techniques when intervening with a child:
   a) Redirecting negative attention getting behaviors.
   b) Talking with the child about his/her behavior.
   c) Ignoring minor negative attention seeking behaviors.
   d) Modeling positive behaviors.
   e) Praise for appropriate behaviors.
   f) Rewards for appropriate behaviors.
   g) Self or staff mandated time out.

2) Staff will receive training in child development and verbal de-escalation techniques.

3) Staff who observe the use of prohibited techniques will report the incident to the Director. Staff may also be required to report the incident to Child Protective Services.

4) Staff will advise children to use self regulated time outs in which a child is asked to take some time out in his/her room and exit when he/she is ready to do so. Or staff may mandate a time out in order to separate the child from the stimuli that is causing negative behavior by use of a time out chair or in the child's room with a staff member sitting with the child to coach him or her on new behaviors.

5) Staff will back away from children who are becoming violent in order to give the child space and keep staff safe.

Reference: R 400.4137 Licensing Rule for Child Care Institutions
Revised September 11, 2008

Child & Family Services, Capital Area

PRIVACY NOTICE

This notice describes how health and other personal information about you may be used and disclosed, your access to this information, and our obligation to keep information private and confidential.

Effective April 14, 2003

Introduction

The Federal Government passed legislation in 1996 called the **Health Insurance Portability and Accountability Act (HIPAA)**. One of the provisions of the act emphasizes our legal obligation to protect information about you, the consumer of our services. This information includes your name, address, social security number, date of birth, health insurance, physical and mental health condition, treatments and prior services you may have received, diagnosis, plan of care, and the observations of others. These examples of consumer information are known as **Protected Health Information (PHI)** and are used for a number of purposes that are explained in this Notice. Attached to this notice is a document requesting your signature as acknowledgement that you are aware of our obligation to protect your privacy and information about you. This is part of our overall commitment to provide services of the highest quality.

Child & Family Services, Capital Area is required by HIPPA to follow the terms of this Notice. We will not use or disclose Protected Health Information (PHI) about you without your written authorization, except as described in this Notice.

How We May Use And Disclose Protected Health Information

We may use and disclose your Protected Health Information in various ways, including:

Uses for Service Delivery, Payment, and Quality Improvement:

- **Treatment:** We may use and disclose your PHI to provide, coordinate, or manage your care and related services. This includes the coordination or management of your care with another person such as a doctor, therapist, caseworker, or family member, as appropriate and necessary.
- **Payment:** We may use and disclose PHI about you so that services you receive at Child & Family Services may be billed and paid for. Examples include health insurance companies as well as county, state, and federal funding sources.
- **Quality Improvement:** We may use or disclose your PHI for internal purposes in order to maintain or improve program services. This can include quality assessment; accreditation, licensing or business management; and general administrative activities. These uses and disclosures are necessary to make sure that all of our clients receive the highest quality of services.
- **Education:** Information about you may be shared during the training of our professional staff and student interns, as well as case consultation and clinical supervision meetings.
- **Service Alternatives:** We may use and disclose PHI in helping you to arrange for other services.
- **Research:** Under certain circumstances, we may use and disclose PHI about you for research purposes. Before PHI is used or disclosed, the research project must comply with Federal and State law.
- **If we disclose your PHI to another person or entity, we must do so consistent with Federal and State law and regulation (for substance abuse, 42 CFR Part 2). In many instances, this requires you to sign an authorization allowing us to provide that information to the other party. If you do not sign an authorization, there are circumstances where we may not be able to provide services to you.**

Uses and Disclosure Without Your Authorization:

- **Health Risk or Death:** To prevent, control or report disease, injury, disability or death.
- **Abuse, Neglect or Domestic Violence Reporting:** To alert State or local authorities if we know or suspect someone is a victim of child abuse, neglect, or domestic violence.
- **Duty to Warn:** To alert authorities or medical personnel if we believe someone is at risk of injury by means of violence.
- **Health Oversight:** Your PHI may be provided to oversight and regulatory agencies for audits, civil or administrative reviews, proceedings, inspections, and licensing activities.
- **Legal Proceedings:** If you are involved in a legal action, we may disclose your PHI in response to a court order.
- **Law Enforcement:** Your PHI may be given to law enforcement in response to a court order or to report a crime.

Your Rights Regarding Personal Health Information

We may only use and disclose PHI as generally described in this Notice or according to laws that apply to us. You have the following rights regarding your PHI:

- ✓ **Right to Inspect and Copy.** You have the right to inspect and copy PHI that we maintain. If you request a copy of the information we may charge a copying fee. We may deny your request to review and copy in a few limited circumstances. If your request is denied, you may ask that the denial be reviewed by contacting Child & Family Services' Privacy Officer.
- ✓ **Right to Amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend your PHI. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, the current information is accurate and complete, or if we did not create the information.
- ✓ **Right to an Accounting of Disclosures.** You have the right to request a list of our disclosures for purposes other than your care or treatment, payment or health care operations, disclosures made to you or your representative, authorized by you, or made to law enforcement personnel.
- ✓ **Right to Request Confidential Communications.** You have the right to make a reasonable request that we communicate PHI to you in a certain way or at a certain address. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.
- ✓ **Uses Requiring Patient Authorization.** There are some uses of your PHI that require client authorization. If your health information is requested for a use that requires your approval or authorization, you will be told why your information is requested, who is asking for the information and what information is requested. You will also be told how you may revoke your authorization.

All requests involving these rights must be made in writing to Child & Family Services - Capital Area, Attention Privacy Officer.

Complaints

If you believe your privacy rights have been violated, you may file a complaint by submitting in writing a statement to the agency Privacy Officer:

Liz Gonzalez
Child & Family Services, Capital Area
4287 Five Oaks Drive
Lansing, MI 48911
(517) 882.4000 ext. 124
liz@childandfamily.org

You may also contact the U.S. Department of Health and Human Services, 201 Independence Avenue SW, Washington DC, 20201 or by calling HHS at 1-877-696-6775.

CHILD & FAMILY SERVICES, CAPITAL AREA
ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Child & Family Services, Capital Area's **Notice of Privacy Practices**.

_____
Printed Name of Client

_____
Signature of Client Date

_____
Signature of Guardian Date

_____
Signature of Witness Date

If the client does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

- Client given a copy of the Notice but refused to sign form.
- Client unable to sign acknowledgement related to:
  ___ Mentally Incompetent
  ___ Language Barrier
  ___ Minor Child
  ___ Other
- Other Explanation:

_____
Signature of Provider Employee Date

J:common/HIPAA acknowledgement of policy

Child and Family Services, Capital Area
Angel House Mother Baby Program
PHYSICAL RESTRAINT POLICY

Policy

1) At admission residents and their guardians will be made aware of and given copies of the programs physical management policies.
2) Residents will be assessed throughout his or her stay at the shelter to determine if he/she can be physical restrained if this type of intervention becomes necessary.
3) Staff will consult with the Angel House director or a Clinical Case Manager prior to using physical restraint except in cases of emergency. Standing orders for the use of physical restraint is not permitted.
4) The use of physical restraint at Angel House may be used only to prevent a child from harming themselves or others.
3) The use of physical restraint regarding property is limited to instances in which the child is presenting a danger to themselves or others.
4) The use of seclusion is strictly prohibited at Angel House.
5) Physical restraint shall not be used as a means of coercion, discipline, convenience or retaliation by staff.
6) Staff will demonstrate competencies in the use of physical restraint on a semi-annual basis.
7) Residents will be assessed throughout the restraint by staff to ensure he/she is physically and mentally safe and his/her nutritional and hydration needs are met.
8) Physical restraints are limited to the following maximum time limits:
    a) Fifteen minutes for children nine and under.
    b) Thirty minutes for children ten and older.
9) If a restraint lasts longer than the maximum time frames a master's level clinician will need to assess the resident in order for the restraint to be reauthorized.
10) Medical attention will be sought for residents whose restraints last more than fifteen minutes.
11) Any physical restraint situation which results in serious injury is required to be reported to the State licensing agency.
12) Angel House will maintain a record of the incidences of physical restraint used. The record will include:
    a) Staff initiating the process.
    b) Duration of the personal restraint.
    c) Date, time and day of week.
    d) Whether injuries were sustained by the minor child or staff.
    e) Age and gender of the minor child.
13) Staff and residents involved in physical restraints will be debriefed within twenty-four hours of the incident.
14) Guardian's of residents who require physical restraint will be notified of all incidents of physical restraint within twenty four hours of the incident.
15) All physical management reports/incidents will be reviewed by the director within the next business day.

Procedure

1) During the admission process the resident will be given Angel House's Physical Restraint and Behavior Management policy. This policy will also be made available to the residents guardian. Both the resident and the guardian will sign that they were offered copies of these policies.
2) At admission it will be determined by staff and the guardian whether the resident being admitted can be physically restrained if such an intervention becomes necessary. Staff will assess this based on information from the guardian that specifies the residents physical ailment/handicaps, illness, medication, and abuse history. If no history is available staff will assess the child based on sight and information gained from the resident.
3) The Clinical Case Manager will complete a Mental Health Status Exam within three days of admission to determine whether the resident is physically and emotionally capable of being physically restrained.
4) All residents will be re-assessed on an on-going basis to determine if the status of restraint use on that resident needs to be changed or adjusted.
5) Only Therapeutic Crisis Intervention (TCI) trained Angel House staff may use physical restraint on a child.
6) Only the techniques trained in the Angel House TCI training can be used unless an emergency requires staff to physically block or escort residents by placing his or her hands on the residents shoulders to move the resident without the use of force.
7) Solo restraints may be used only when no other staff are available and in circumstances to prevent the child from further harming themselves or another individual.
8) When a physical restraint is being used, all other children must be removed from the area where the restraint is necessary.
9) An on-call worker must be notified immediately. The on-call worker will be at the scene of the incident to observe that the resident is physically and mentally safe and ensure his/her nutritional and hydration needs are met.
10) The on-call worker will keep track of the time frame and call a master's level clinician if one is not already on the scene to reauthorize the restraint. If the restraint needs to end the on-call worker will indicate this to the staff performing the restraint so they can initiate the letting go process.
11) If a physical restraint lasts more than fifteen minutes staff will transport the resident to Urgent Care when it is safe to do so. If the resident continues to be unsafe staff will be advised by the on-call worker to notify Emergency Services and have an ambulance transport the resident to be assessed for hospitalization. Staff will accompany the resident to Emergency Services.
12) Staff will document any incident of physical restraint; using a physical restraint report form.
13) Staff will include in the documentation, the name of the on-call person contacted, date and time called, the type of physical restraint used including the length of time.
14) If a child is injured during a restraint the child must receive medical care immediately.
15) If a child requires physical restraint more than one time in a 24 hour timeframe, staff will contact the Director of Angel House to consult about the appropriateness of placement.
16) The child's parent or legal guardian will be notified by the on-call worker within twenty-four hours of the incident.
17) The next business day following the incident, a debriefing will be held between staff in[48] in the intervention and the minor child. The child's parent or legal guardian may participate also if deemed appropriate by the child caring institution. The intent is to review the circumstances resulting in the use of personal restraint and to identify strategies that could prevent the future use of personal restraint.
18) The next business day following the incident, all staff involved in the intervention along with the appropriate supervisory staff will conduct a debriefing session which include:
    a) Review of the circumstances and precipitating factors that led up to the situation.
    b) Alternative techniques that might have prevented the use of personal restraint.
    c) Procedures if any, that staff are to implement to prevent a reoccurrence of the use of personal restraint.
    d) The outcome of the physical restraint intervention including any injury that may have resulted from the use of personal restraint.
19) Staff will document in the child's file that both debriefing sessions occurred along with the identification of staff present, staff excused and any changes in the child's plan of service that result from the debriefing.
20) During the next business day the director will review all reports and documentation of the incident to determine follow-up or corrective action.

Reference: R400.4137 Licensing Rules for Child Care Institutions
Public Act No 116 of 1973 722.112c & d
COA BSM 1-6 Revised: March 11, 2010

Child & Family Services, Capital Area
Angel House Program

Consent to Photograph

I, _____, authorize Angel House
(name of guardian)

staff to photograph _____ for safety and security
(name of client)
purposes.

I understand that photographs will be used for safety reasons only and will not be viewed by anyone other than staff at Angel House, you, or emergency personnel.

I understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it. Unless sooner revoked, this consent expires:

One year from the date of signature: specify month/day/year _____ OR

Specify date, event or condition _____.

I understand that the above stated client can still receive services from Angel House if I refuse to consent.

_____ _____
(signature of client) (date)

_____ _____
(signature of guardian) (date)

_____ _____
(staff/witness signature) (date)

Child and Family Services, Capital Area
Angel House

Consent for Medication Administration

Name_____ DOB_____ Admission Date_____

Please list all medications prescribed and over the counter as well as dosage, frequency, number of pills, and next refill date.

Name of Medication	Dose	Frequency Taken	Number of pills at admission	Next refill date

Purpose of Medication: _____

_____

Allergies: _____

Name and # of Prescribing Physician:

_____

I hereby give permission to Angel House staff to administer the above listed medications as well as any medication that is prescribed on an emergency basis while my child is at Angel House. Staff will notify me In the event that medication is prescribed to my child while he/she is at Angel House.

_____

Signature of Parent/Guardian **Date**

_____

Signature of Witness **Date**