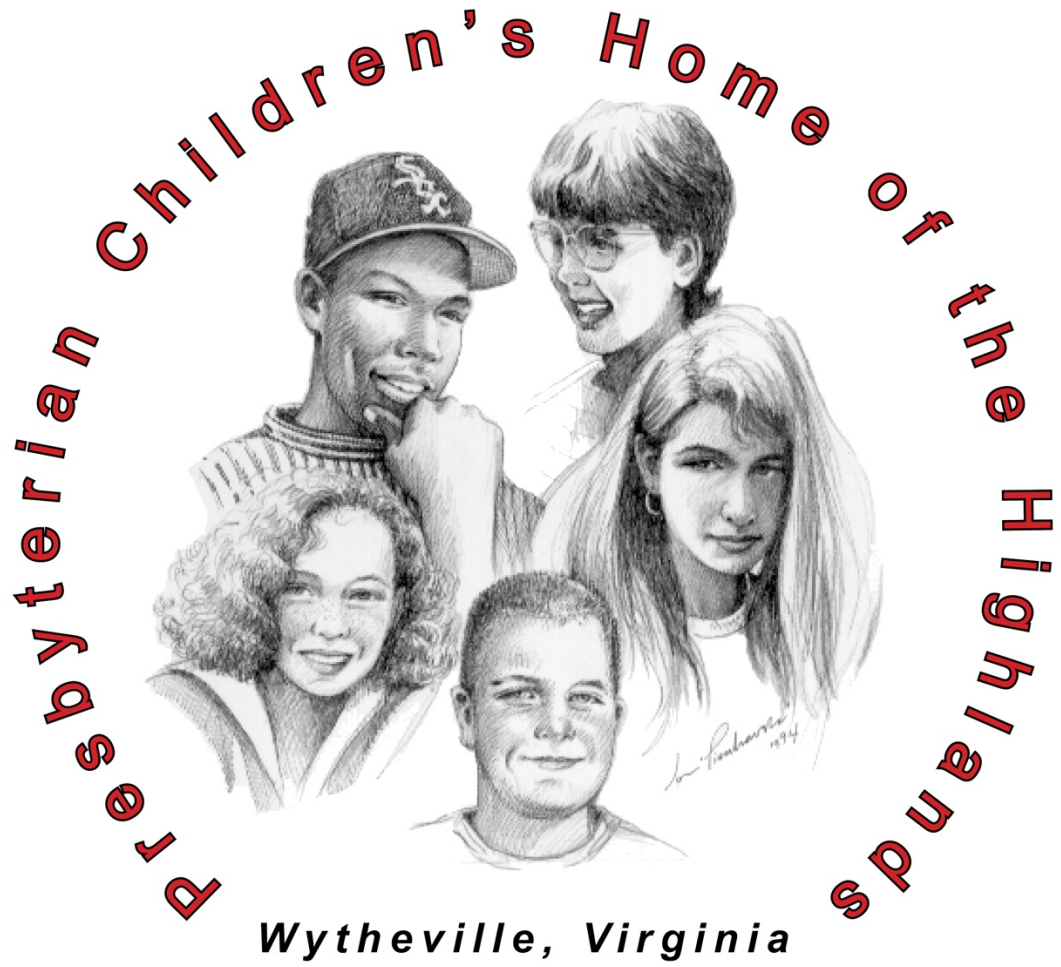


PCHH

Admission Packet

P.O. Box 545 • Wytheville, Virginia 24382 • 276.228.2861 • www.pchh.org

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

INTAKE CHECKLIST…

NOTE: We must have the following pages completed, initial request and application on file before application is considered complete.

APPLICATION: Agency application must be completed as completely as possible.

SCHOOL RECORDS: We need a copy of the last grading period report and IEP's if applicable.

MEDICAL & OTHER RECORDS: Please include a copy of:

- latest physical if done within 90 days prior to admission
- birth certificate
- immunization records
- discharge summaries from any previous placement. Please note, any discharge summaries from previous placements need to be included with the application.
- social security card
- previous psychological or other assessments
- court orders directing child into care or CHINS petition
- if on probation, "Terms of Probation"
- any "Protective Orders"

NOTE: If an emergency placement, placing agency has 30 days to submit the above named records.

TYPE OF CHILD/YOUTH ACCEPTED INTO CARE…

AGE REQUIREMENT: Residential Program: Ages 5 – 17
Independent Living Program: Ages 17-21
(regardless of race, color, religion, or national origin).

I.Q. REQUIREMENT: 70 or above. Children who have tested below 70 may be accepted if other factors indicate they are appropriate for our program. Documentation to substantiate IQ if available.

UNACCEPTABLE BEHAVIORS: A strong history of physical aggression in regards to pattern or duration, sexual predators, or fire starters cannot be accepted.

ACCEPTABLE PROBLEMS: Child/youth with a history of physical or sexual abuse issues.

Mild to moderate drug experimentation.

Mild to moderate behavioral and/or emotional disorders.

A child who has successfully completed a sexual offenders program.

THE ADMISSION PROCESS…

EMERGENCY ADMISSIONS: Our intake person will receive the preliminary information by phone regarding the child/youth and forward the Initial Request and Application (after the 8 pages are completed and submitted to the Program Director or his/her designee.

A decision will be made expediently (within the same day received) to determine acceptance of the child/youth into our program.

PLANNED ADMISSION: After application is completed and returned to PCHH, it is reviewed by the Coordinating Team to determine if the child/youth would benefit from the programs we offer. If the Coordinating Team feels the child/youth would be appropriate for our long-term residential program a notice will be provided to the referral agent if desired. An interview is then scheduled with the child/youth, parents, and/or legal guardians with the Coordinating Team or an admission date is set.

RATE & SERVICES INFORMATION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.

P. O. BOX 545
WYTHEVILLE, VIRGINIA 24382
(276) 228-2861
(276) 228-8154 (FAX)
http://pchh.org ● info@pchh.org

INDEPENDENT LIVING PROGRAM

$215.00 per day

LONG-TERM RESIDENTIAL PROGRAM

Residential Room and Board	$139.00	per day
Residential Case Management	$42.00	per day
Residential Daily Supervision	$34.00	per day
Total:	$215.00	per day

Rates for July 1, 2024 – June 30, 2025

DIRECTIONS: PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS

Giving Children Hope & Purpose For The Future

DIRECTIONS TO THE HOME: *If traveling I-81 North (from Bristol, Abingdon)...*

- ☐ take Exit #67 (first Wytheville exit)
- ☐ at end of exit ramp, turn left onto Hwy 11
- ☐ travel on Hwy 11 approximately 3 miles to Main Street
- ☐ turn right at traffic light # 1 (onto Main Street)
- ☐ Main Street turns into Hwy 21 South (bear left)
- ☐ proceed under railroad overpass (look for pond on right just past underpass)
- ☐ turn right onto paved campus road beside pond (campus road begins at Children's Home sign)
- ☐ travel up the hill to the administration building (behind the flag pole)

If traveling I-81 South...

- ☐ take Exit #73 (first of three Wytheville exit)
- ☐ travel on Main Street through downtown Wytheville (exit turns into Main Street)
- ☐ Main Street turns into Hwy 21 South (bear left)
- ☐ proceed under railroad overpass (look for pond on right just past underpass)
- ☐ turn right onto paved campus road beside pond (campus road begins at Children's Home sign)
- ☐ travel up the hill to the administration building (behind the flag pole)

If traveling I-77...

- ☐ take I-81 exit
- ☐ follow above I-81 South directions to the Home

FOR MORE INFORMATION:

- ➢ Billy Rice, Executive Director
- ➢ Wynette Yontz, Administrative Director
- ➢ Debbie Riggs, Program Director

P.O. Box 545
425 Grayson Road
Wytheville, VA 24382
(276) 228-2861
info@pchh.org
http://pchh.org

DISCHARGE POLICY

PHILOSOPHY

A successful discharge begins on the day of admission. It is our belief that many of the problems which young people have who come into residential care are a result of the lack of stability in many of their formative years. Because of this, we do not want a discharge to come as a surprise to a resident. We want it to be the result of good planning by all parties, including the resident.

PROCEDURES

Planned Discharge

A planned discharge is one which comes about because of the successful completion of the goals and objectives set forth in the service plan. Normally, a discharge date is set, which allows the staff and resident to say goodbye to each other and plan for aftercare follow-up. It also allows the resident time to say goodbye to friends. A party is usually held by the cottage for the resident in recognition of completing a successful program.

Unplanned Discharge

An unplanned discharge may be at the request of the legal guardian or placing agency, at the request of Presbyterian Children's Home of the Highlands, Inc. , or at the request of the resident if the resident is 18 years of age or older.

Unplanned discharges at the request of Presbyterian Children's Home of the Highlands, Inc. may be initiated for the following reasons:

1. A resident becomes a threat to him/herself or to others.
2. A resident does not participate in any of the service plan components.
3. A resident runs away and is missing for a period of over three weeks.

Unplanned discharges at the request of the placing agency or legal guardian may at times occur because the resident has been removed to a detention facility, a drug rehab facility or a short term psychiatric facility. In such situations, the Home's staff will stay in close communication with the placing agency to determine if the best plan of care for the resident is to return to the Home.

Emergency Discharge

Emergency discharges are extremely rare. An emergency discharge requires the resident to be removed within 24 hours. This type of discharge may occur if the child becomes extremely violent or is seriously suicidal. In these types of situations, the discharge is in the best interest of the residents. Once they have been stabilized, the Home's staff will work with the placing agency's staff to determine if a return to the Home is the best plan for the resident.

FREQUENTLY ASKED QUESTIONS

Q. *If a resident runs away, does the Home take them back?*

A. Usually, yes. Each incident is different and is handled separately.

Q. *If a resident has charges filed against them, will he/she need to leave the Home?*

A. It depends. Each situation is reviewed separately to determine what is best for the resident. It may be determined that a short placement in detention is warranted.

Q. *If a resident refuses medical treatment, will he/she be discharged?*

A. Refusal of medical treatment which has been prescribed by a doctor is a serious problem. Each case will be judged on its own merits. However, in all cases where refusal to follow prescribed medicine or therapy may be life threatening, the resident will be discharged. For example: failure to take insulin.

Presbyterian Children's Home Of The Highlands, Inc.

ADMISSION PACKET

The Presbyterian Children's Home of the Highlands, Inc. is pleased to provide this Admission Packet. Please call (276) 228-2861 and ask for our Intake Worker or our Program Director if you have any questions.

This packet includes the following files:

01) **Admission Procedures/Criteria**
02) **Rate Sheet**
03) **Directions to PCHH**
04) **Discharge Policy**
05) **Listing of Forms**
06) **Initial Request for Placement**
07) **Application**
08) **Visitation Guidelines**
09) **Approved Visitors**
10) **Placement Agreement**
11) **Consent to Exchange Information**
12) **Consents**
13) **Emergency Contact Information**
14) **Statement for Public Schools**
14a) **Form A17 Notice and Request for Best Interest**
14b) **Form C17 Immediate Enrollment**
15) **Privacy Practices Statement**
16) **Acknowledgement of Privacy Practices**
17) **Behavior Assessment and Support Plan**
18) **Admission Census Information**
19) **Justification of Emergency Acceptance**
20) **Medical & Dental Appointment Report**
21) **Physical Exam Report**
22) **Release for Psychiatric Care**
23) **Info for Medication Order**
24) **Medical Standing Orders**
25) **Agreement for Pharmaceutical Services**
26) **Medication Inventory at Admission / Discharge**

You will receive prompt attention to your referral and you will be contacted by one of our Case Workers as soon as possible.

P.O. BOX 545 • WYTHEVILLE, VA 24382 • (276) 228-2861 • (276) 228-8154 fax • http://pchh.org

INITIAL REQUEST FOR PLACEMENT

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
PO BOX 545 • WYTHEVILLE, VA 24382 • · (276) 228-2861

DATE: _____/_____/_____ TIME: ____:____ am / pm COTTAGE: _____

PERSONAL INFORMATION…

CLIENT'S FULL NAME: _____ PERSON REQUESTING PLACEMENT: _____

E-MAIL ADDRESS: _____

AGENCY ADDRESS: _____

_____

AGENCY PHONE #: (_____) ____-_____ CUSTODY CURRENTLY HELD BY: _____

CUSTODIAN PHONE #: (_____) ____-_____

AGE: _____ HEIGHT: ____FT _____IN

DOB: _____/_____/_____ WEIGHT: _____LBS

SEX: ___ MALE ___ FEMALE EYE COLOR: _____

SSN: _____-____-_____ HAIR COLOR: _____

RACE: _____

IDENTIFYING MARKS: _____

EXHIBITING BEHAVIORS…

VERBALLY ABUSIVE: _____

PHYSICALLY ABUSIVE: ___ NO ___ YES AGAINST WHOM: _____

HOW: _____

* FIRESETTING: ___ NO ___ YES MOST RECENT FIRESETTING: _____

* RUNAWAY: _____ RUN FREQUENCY: _____

* SEXUAL BEHAVIOR: _____

CONCERNS: _____

SPECIFY: _____

FAMILY DISCORD: _____

_____

PREVIOUS PLACEMENTS…

DATE	FACILITY	TYPES
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____

PSYCHOLOGICAL / EMOTIONAL INFORMATION…

CURRENT COUNSELING: ___ YES ___ NO WITH WHOM: _____

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
PO BOX 545 • WYTHEVILLE, VA 24382 • · (276) 228-2861

PSYCHOLOGICAL ILLNESS / DIAGNOSIS: _____

_____ BY WHOM: _____

ADHD: ___ YES ___ NO DATE OF LAST APPOINTMENT: _____/_____/_____

SCHEDULED APPOINTMENTS…

_____/_____/_____ WITH WHOM: _____

ADDRESS: _____

PHONE NUMBER: (_____) _____-_____

_____/_____/_____ WITH WHOM: _____

ADDRESS: _____

PHONE NUMBER: (_____) _____-_____

PSYCHOLOGICAL NEEDS AT PRESENT…

_____

_____

SUBSTANCE USE: YES ___ NO ___

DRUG OF CHOICE: _____ OTHER: _____

CURRENT **NEEDS**: _____

_____

SCHOOL INFORMATION…

LAST SCHOOL ATTENDED: _____ GRADE: _____

CURRENT **NEEDS:** _____

SPECIAL ED: _____ TRUANCY: _____

BEHAVIOR IN SCHOOL: _____

RESPONSE TO AUTHORITY: _____

SUSPENDED: _____ EXPELLED: _____

SPECIFIC **SCHOOL NEEDS** AT PRESENT: _____

_____

HEALTH INFORMATION…

ALLERGIES: _____

_____

SPECIFIC **HEALTH NEEDS** AT THIS TIME: _____

CONDITIONS REQUIRING OBSERVATION / TREATMENT: _____

_____

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
PO BOX 545 • WYTHEVILLE, VA 24382 • · (276) 228-2861

SCHEDULED HEALTH CARE APPOINTMENTS:

_____/_____/_____ WITH WHOM: _____

ADDRESS: _____

PHONE NUMBER: (_____) _____-_____

Does this child need assistance with any self-care tasks such as dressing, grooming, hygiene, toileting or continence?

YES _____ NO _____ If yes, please explain the level of assistance needed in detail:

_____

_____

_____

CURRENT MEDICATIONS…

TYPE (NAME)	DOSE	REASON

METHOD of PAYMENT for MEDICAL BILLS…

INSURANCE: _____ NUMBER: _____

COMMENTS: _____

HISTORY WITH POLICE…

POLICE RECORD: _____

EXPLAIN: _____

PROBATION: _____

TERMS OF PROBATION: _____

SCHEDULED POLICE / COURT APPOINTMENTS:

_____/_____/_____ WITH WHOM: _____

ADDRESS: _____

PHONE NUMBER: (_____) _____-_____

PLEASE INCLUDE ANY DISCHARGE SUMMARIES FROM PREVIOUS PLACEMENTS.

WOULD THIS CHILD POSE ANY SIGNIFICATE RISK TO…

HIM / HER SELF: YES ___ NO ___ RESIDENTS: YES ___ NO ___ STAFF: YES ___ NO ___

IF SO, EXPLAIN: _____

This applicant… is ___ is not ___ …suitable for the PCHH program.

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
PO BOX 545 • WYTHEVILLE, VA 24382 • · (276) 228-2861

— Check to make sure there are NO lines blank anywhere in this form! —

INFORMATION TAKEN BY: _____ _____/_____/_____ TIME: _____:_____ AM / PM

INFORMATION RECEIVED BY CASE MANAGER: _____/_____/_____ TIME: _____:_____ AM / PM

ACCEPTED ___ DENIED ___ COTTAGE ASSIGNED: _____

APPLICATION FOR ADMISSION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

CLIENT'S FULL NAME: _____

PERSONAL INFORMATION…

Place of Birth: _____

Religious Preference: _____

Last Known 911 Address: _____

_____

Is this a parental placement? YES ____ NO ____

Why is this child in need of this residential placement:

_____

_____

LEGAL INFORMATION…

◊◊◊ COPY OF **SOCIAL SECURITY CARD** AND **BIRTH CERTIFICATE** ARE **REQUIRED** ◊◊◊

List Court, Police Record, Foster Care, Previous Group Home Placements, Psychiatric Hospitalizations:

Out-of-Home Placements	Dates	Reasons for Discharge

PARENTAL INFORMATION…

Parental Rights Terminated: Yes ____ No _____

Father: _____

:

Address: _____

_____

Phone Number: (_____) _____-_____ SSN: _____-____-_____

Employer: _____

Work Phone: (_____) _____-_____

Father's Involvement With Child: _____

_____

Mother: _____ Maiden Name: _____

Address: _____

_____

Phone Number: (_____) _____-_____ SSN: _____-____-_____

Employer: _____

Work Phone: (_____) _____-_____

Mother's Involvement With Child: _____

_____

FAMILY HISTORY…

Siblings	Ages	History of abuse, if yes, describe

Step-Parents, if any: _____

If the child is not a parental placement, does the legal guardian want the family involved in the resident's service plan? YES _____ NO _____

MEDICAL INFORMATION…

Assessment of current Health status

Allergies (medication or environmental): _____

_____

Illness/injuries: _____

Communicable diseases: _____

Current **Medical/Physical Needs**: _____

Current **Dental Needs**: _____

Was medication **BROUGHT** with the resident on date of admission: YES ___ NO ___

If so, what: _____

Immunizations Needed: _____

◊◊◊◊◊ **PLEASE PROVIDE A COPY OF IMMUNIZATION RECORD** ◊◊◊◊

Physician Last Seen: _____

Phone Number: (____) ____-_____

Address: _____

_____

Dentist Last Seen: _____

Phone Number: (____) ____-_____

Address: _____

_____

Medicaid #:	VA. Medicaid	Policy #:
Medical:	*Forest Family Care, Inc.* **Dr. Susan Griffin**, MD **Jill Snider**, FNP & **Susan Moore** FNP 1785 West Lee Highway, Wytheville, VA 24382	Phone: 276-228-6499 Fax: 276-228-6145
Medical:	*Wythe Bland Pediatrics* **Kasey Stanper**, MP • **Matthew Aney**, MD 590 West Ridge Road, Wytheville, VA 24382	Phone: 276-228-2405 Fax: 276-228-4573
Dental:	*Bland Family Denistry* **Dr. Lambert** 537 Main Street, Bland, Virginia 24315	Phone: 276-688-3667
Psychiatric:	*Healing Waters* Erin Crane, PMHNP-BC 510 W. Main, Wytheville, VA. 24382	Phone #: (276) 227-8201 (276) 963-0111
Emergency:	***Wythe County Hospital*** 6000 West Ridge Road Wytheville, VA. 24382	Phone #: (276) 228-0200

SOCIAL HISTORY…

History of Child:

Significant Developmental Delays: Yes _____ No _____

If yes, explain:_____

_____

Describe Social/Recreation/Religious Interest:

_____

List any Current **Mental Health Needs**: (Include drug/alcohol use)

_____

List recent Psychological, Personality, IQ, Achievement Test, etc. (Attach copies)

_____

_____

_____

Describe below Current Behavioral Problems:
(Include strengths, talents, and problems)

_____

_____

_____

Protection Needs: _____

_____

SCHOOL INFORMATION…

LAST SCHOOL ATTENDED: _____ GRADE: _____

CURRENT **NEEDS:** _____

SPECIAL ED: _____ TRUANCY: _____

BEHAVIOR IN SCHOOL: _____

RESPONSE TO AUTHORITY: _____

SUSPENDED: _____ EXPELLED: _____

SPECIFIC **SCHOOL NEEDS** AT PRESENT: _____

_____

All Scheduled Appointments (use back if necessary):

With Whom	Date	Time	Place / Address / Phone Number	Reason
_____	____/____/____	_____	_____	_____
_____	____/____/____	_____	_____	_____
_____	____/____/____	_____	_____	_____
_____	____/____/____	_____	_____	_____

Application Completed by:

_____
Placing Agency & Representative

_____
PCHH Representative Accepting Application

_____/_____/_____
Date

VISITATION GUIDELINES

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

Presbyterian Children's Home of the Highlands, Inc. encourages appropriate and positive contact between a resident and his/her family. The placing agency or legal guardian shall provide a list of approved visitors. This list may be updated as needed.

The frequency and length of visits will be determined by the cottage team and placing agency's staff or legal guardian. The service plan shall reflect any goals and objectives pertaining to visitation as it relates to family reunification or relationship building.

For an approved visitor to arrange a visit, he/she needs to call the resident's social worker and make the appropriate arrangements. Unapproved visitors must first seek the permission of the placing agency or legal guardian. The Home's staff cannot give permission to unapproved visitors.

For visits by approved visitors:

1. Arrive on time or call if you are going to be late.
2. Don't bring other visitors unless they are also approved.
3. Don't give money to a resident unless it is approved.
4. No alcohol or drugs are allowed on campus. Our staff is required to report any violations.
5. Visitors are asked to cooperate with staff. If problems exist, please let us know.
6. Visitors may not invite other residents to go with them unless it has been approved in advance.
7. Weekend or overnight visits must be approved in advance by social workers.
8. If the resident is on any medication, the person responsible for supervising the home visit must ensure the medication is given properly and accounted for. Failure to do this may result in a CPS complaint being filed.
9. Do not return from a visit early unless you call in advance. Often, the cottages are locked due to other staff and residents being off campus. You may not leave a resident at the Home unless the cottage is open and staff present.
10. Don't bring cell phones into the cottage. Please secure it in your vehicle.

We/I have read and understand each of the above guidelines. We/I understand that frequent or severe violations may result in suspension of visitation at the Presbyterian Children's Home of the Highlands, Inc.

Resident also certifies that they have received a copy of the PCHH Resident Handbook.

_____	____ /_____/_____	_____	_____/_____/_____
Resident	Date	PCHH Representative	Date
_____	____ /_____/_____	_____	_____/_____/_____
Parent	Date	Placing Agency Representative	Date

APPROVED VISITORS

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

Resident's Name: _____

Consent granted by: _____ Date: _____/_____/_____

Approved Visitors

Name	Relationship	On Campus	Off Campus	Overnight	Phone Number

Restricted Visits / Contacts

Name	Relationship	Comments

PLACEMENT AGREEMENT

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

In consideration of acceptance of _____ into care of the Presbyterian Children's Home of the Highlands, Inc. (hereafter referred to as the Children's Home), Wytheville, Virginia, I/we, the undersigned legal guardian of this child, do hereby agree and promise:

1. To grant the Children's Home the right of returning this child to me at any time that it appears to be in the best interest of the child or the Children's Home that this child be discharged.

2. *To obligate myself to pay for fees as scheduled in the accompanying Rate Sheet for the Residential program and/or the Independent Living Program.

3. To grant the Children's Home complete authority to authorize routine medical, psychological and dental treatment and to secure educational services and immunizations deemed necessary for the care of this child. The Children's Home further agrees to contact the legal guardian if (non-billable) major or surgical treatment is needed for the child.

   Every reasonable effort will be made to contact the legal guardian if emergency medical / dental treatment has to be given to a child. If there is insufficient time to contact the legal guardian to obtain their consent, the Children's Home is hereby authorized to grant approval for all necessary emergency procedures and the guardian will be contacted as soon as possible thereafter.

4. Placing agencies will inform this facility of long term goals for resident. They will also participate in the discharge planning for each youth.

5. Residents may have visits on and off campus by permission of the legal guardian. All home visits will require approval by the resident's legal guardian. Residents will be allowed to participate in off campus activities under the supervision of facility staff. If activities occur outside of the state, permission will be gained by the legal guardian prior to the activity.

6. In the event a child leaves campus and is reported as a runaway, PCHH will hold their place and will bill for the days they are absent until notified by the placing agency of the resident's discharge.

7. The Guardian accepts PCHH's audio/video policy of video monitoring in common areas, such as the living rooms, hallways, and offices of the cottages and the central dining hall. Video monitoring is prohibited in the bedroom and bathroom areas.

Presbyterian Children's Home of the Highlands, Inc. agrees to provide each resident with residential services, case management, Christian education, recreation, socialization, a variety of independent living skills, transportation, and behavioral management. Educational programming on campus, in the Wythe County Public School System or the community college is provided and will be billed separately as needed.

❑ Public School: _____

❑ On-campus School: Minnick Education Center ❑ Community College

Student will be enrolled by _____ who will also obtain needed educational information.

These additional services may be provided as needed: counseling for resident and family, tutoring, and life skills.

Date: _____/_____/_____

Legal Guardian: _____

PCHH Representative: _____

** If party responsible for payment is other than the legal guardian, signature of responsible party is required below.*

Name: _____

Agency: _____

CONSENT TO EXCHANGE INFORMATION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide these services or benefits.

I, _____, am signing this form for
(full printed name of consenting person or persons)

Client's Name: _____

Client's birth Date: _____/_____/_____

Client's SSN: _____-____-_____

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

YES	NO		YES	NO		YES	NO	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits / Services Needed Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

Other information (write in):

I want The Presbyterian Children's Home

_____
(name and address of referring agency and staff contact person)

as well as the following other agencies to be able to exchange this information:

Minnick Education/Wythe County Schools/Mt. Rogers Mental Health ____
FAPT & CMPT ____ Family Resource Center ____

_____

_____

I want this information to be exchanged ONLY for the following purpose(s):

- ☐ Service Coordination and Treatment Planning
- ☐ Eligibility Determination.
- ☐ Other _____

I want information to be shared (check all that apply):

☐ Written Information ☐ In Meetings or by Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: Yes ☐ No ☐

This consent is good until the completion of services. Yes ☐ No ☐

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s) Consenting Person(s): _____

Date: _____/_____/_____

Person Explaining Form: _____

Title: _____

Phone Number: (_____) _____-_____

Witness (if required) Signature: _____

Address: _____

Phone Number: (_____) _____-_____

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

	NO	YES	ONLY WITH SPECIFIC APPROVAL
1. Photographs *	_____	_____	_____
2. Transport for activities outside VA (Day activities ONLY — does not apply to overnight travel)	_____	_____	_____
3. Participate in chapel services	_____	_____	_____
4. Drug testing (Drug testing is administered on campus by PCHH Staff)	_____	_____	_____
5. HIV testing (HIV testing is administered by professional medical labs)	_____	_____	_____
6. Participate in fund raising activities	_____	_____	_____
7. Participate in horseback riding	_____	_____	_____
8. Participate in the PCHH Giving Back Volunteer Program	_____	_____	_____

NOTE:
The Presbyterian Children's Home of the Highlands believes it is important to not only provide all the material, emotional and spiritual support for each resident but to offer ways to positively build their self-esteem. Photographs of residents used in a positive manner in our newsletter, display and informational materials are one avenue we use to accomplish this. Of course we make sure each resident has personal copies of photographs that help him/her retain good memories. Our selection and use of photographs are done with great care and determination in order to ensure a positive Impression. We appreciate your understanding and cooperation with this matter.

Guardian's Signature: _____

Date: _____/_____/_____

EMERGENCY CONTACT INFORMATION

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.

NAME:	COTTAGE:
BIRTHDAY:	SSN:

Medical:	*Forest Family Care, Inc.* **Dr. Susan Griffin**, MD **Jill Snider**, FNP & **Susan Moore** FNP 1785 West Lee Highway, Wytheville, VA 24382	Phone: 276-228-6499 Fax: 276-228-6145
Medical:	*Wythe Bland Pediatrics* **James Scott**, MD **Matthew Aney**, MD 590 West Ridge Road, Wytheville, VA 24382	Phone: 276-228-2405 Fax: 276-228-4573
	Wythe Rapid Care 155 North Street, Suite 502	Phone: 276-6227-0775
Dental:	*Bland Family Denistry* **Dr. Lambert** 537 Main Street, Bland, Virginia 24315	Phone: 276-688-3667
Psychiatric:	*Healing Waters Counseling Center, LLC* **Erin Crank**, PMHNP-BC 510 West Main St., Wytheville, VA. 24382	Phone : (276) 227-8201
Emergency:	***Wythe County Hospital*** 600 West Ridge Road Wytheville, VA. 24382	Phone #: (276) 228-0200

LEGAL GUARDIAN:

PHONE #:

LIST ANY SIGNIFICANT CURRENT MEDICAL PROBLEMS, TREATMENTS, ETC.:

LIST ANY SIGNIFICANT PAST MEDICAL PROBLEMS, TREATMENTS, ETC.:

LIST ANY ***ALLERGIES*** TO MEDICATIONS:

LIST ANY ***OTHER TYPES OF ALLERGIES***:

CURRENT MEDICATIONS (see current MAR's):

DESCRIBE ANY KNOWN HISTORY OF SUBSTANCE **USE**:

INSURANCE INFORMATION…

COMPANY:

ID NUMBERS:

SECONDARY INSURANCE (if applicable):

PRESCRIPTION DRUG CARD INFORMATION (if applicable):

PO Box 545 · Wytheville, VA 24382 • (276) 228-2861 • http://pchh.org • info@pchh.org

VIRGINIA DEPARTMENT OF EDUCATION

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF STUDENT RECEIVING FOSTER CARE SERVICES & REQUEST FOR BEST INTEREST DETERMINATION PARTICIPATION FORM

Date of Notice: (select date)	☐ **Foster Care Liaison for Division of School of Origin** (notification, request for records, and participation)	☐ **Foster Care Liaison for School Division of New Residency** (notification and request for participation)

School of Origin Information		
School Division/School: (select division) (enter school name)		
Superintendent: (enter name)	**E-mail:** (enter email)	**Phone:** (___) ___-____
Principal: (enter name)	**E-mail:** (enter email)	**Phone:** (___) ___-____
Foster Care Liaison: (enter name)	**E-mail:** (enter email)	**Phone:** (___) ___-____

School Division of New Residency Information		
School Division: (select division)		
Superintendent: (enter name)	**E-mail:** (enter email)	**Phone:** (___) ___-____
Foster Care Liaison: (enter name)	**E-mail:** (enter email)	**Phone:** (___) ___-____

Student Information			
Student Name: (first, middle, last)	**DOB:** (MM/DD/YYYY)	**Age:** (age)	**Grade:** (grade)
504 Plan: ☐YES ☐NO	**Special Education (IEP):** ☐YES ☐NO		

Student's New Placement Information	
Type of Placement: select placement type	**Date of Placement:** (select date)
Address: (street, city, state, zip)	**Phone:** (___) ___-____
Contact: (enter full name of placement contact person)	**E-mail:** (enter email)
Licensed Child Placing Agency (LCPA): (enter agency/case manager-if applicable)	**Phone:** (___) ___-____

Local Department of Social Services (LDSS) Agency Information		
Custodial Department of Social Services: (select local social services agency)		**Removal Date:** (select date)
LDSS Case Worker: (enter case worker's name)	**Phone:** (___) ___-____	**E-mail:** (enter email)
LDSS Educational Stability Liaison: (enter liaison's name)		**E-mail:** (enter email)

Parent Information	
Are parental rights terminated (TPR)? ☐ **YES** ☐ **NO** (If yes, move to next section)	
Mother's Name: (enter full name)	**E-mail:** (enter email)
Address: (street, city, state, zip)	**Phone:** (___) ___-____
Father's Name: (enter full name)	**E-mail:** (enter email)
Address: (street, city, state, zip)	**Phone:** (___) ___-____

Best Interest Determination (BID) Information
☐ **NO BID is needed.** The student's new placement is: select a rationale. Please notify transportation of address change.

VIRGINIA DEPARTMENT OF EDUCATION

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF STUDENT RECEIVING FOSTER CARE SERVICES &
REQUEST FOR BEST INTEREST DETERMINATION PARTICIPATION FORM

☐ **YES, BID is needed.** The student's new placement is outside of the school of origin's geographic zone; therefore, a BID is necessary to address educational stability.

☐Please provide your availability (at least 3 dates/times) via e-mail to the LDSS Case Worker **within 2 business days** of the date of this notice.

☐A BID meeting for this student has been scheduled on (date) / (time) , at (location) and you, or a designee, are invited to attend. If attendance in person is not possible, participation via phone is most welcomed. Please call (___) ___-____ to participate in the meeting telephonically.

If you are a school of origin, information regarding the student's current academic placement, including grades/transcript, attendance, discipline, and IEP/504 is requested to inform the BID decision making process. If the student is a special education student, a representative who is knowledgeable of the student's educational needs is requested to participate.

****Additionally, you (or your designee) will be asked to provide information regarding transportation options which may be available**.

General Instructions:

Whenever a student enters foster care or has a change in placement, please be sure to complete all sections as thoroughly as possible. Field information can be entered by clicking in the area enclosed in parentheses which will yield a text, calendar, or drop-down field.

Section Specific Instructions:

Although most sections of this document are self-explanatory, below is some section-specific guidance which may assist in the form's completion.

Date of Notice Information:

In this section, select the date that the form is being sent to the school division and which school division the form is going to. BEST PRACTICE: If across school division lines, notification should be sent to the foster care liaisons in BOTH school divisions.

The School of Origin is the school that the youth is currently attending when entering foster care or experiencing a placement change.

School of Origin/School Division Information:

Most school divisions have a "school finder" feature on their website which will locate a school building for an address. The Virginia Department of Education maintains a listing of Virginia Public School Division information by region at http://www.doe.virginia.gov/directories/schools/school_info_by_regions.shtml. By selecting the school division link, you can find information such as the name and contact information for the superintendent and local school building administration. A listing of school division Foster Care Liaisons, with contact information, can be found at http://www.doe.virginia.gov/support/student_family/foster_care_students/fostering_connection_liaisons.pdf

Student Information:

Please be sure to indicate if a child has a 504 plan or an IEP. This information is important and impacts the BID process.

Student's New Placement Information:

Along with the type, address, and date of the placement, please be sure to provide a contact name with phone number in this section. If the placement is a foster home, this would be the foster parent and their direct contact information. If the placement is a group home placement, the "contact" should be the person who will be attending the BID meeting. This is not a treatment foster care case manager; that information would be placed on the line below entitled Licensed Child Placing Agency (LCPA).

Agency Information:

This section is where the Local Department of Social Services contact information is entered.

Parent Information:

This is where information on the **Biological Parents** is entered. If there is a termination of parental rights (TPR), move to the next section. If there is NOT a TPR, please complete this section with the most accurate information available.

NOTICE OF STUDENT RECEIVING FOSTER CARE SERVICES &
REQUEST FOR BEST INTEREST DETERMINATION PARTICIPATION FORM

Unless there is a TPR, biological parents retain their educational rights, and therefore, should be considered active participants of this process as well as all other educational processes, such as 504 plans and IEP meetings.

Best Interest Determination (BID) Information:

If the new residence is zoned for the current school; the distance between the school of origin and receiving school is greater than 100 miles; the placement is a Level C residential treatment facility; or the student is returning from a residential treatment facility or detention to the same foster care placement, then there is no need for a BID meeting to take place and the "NO" box should be checked. In such cases, this form serves as notification of the move so that school databases can be amended to reflect the new address and contact information.

If one of the criteria above is not met, a BID meeting to address educational stability is necessary and the "YES" box should be checked.

- If a meeting has not been scheduled and school division staff availability is being requested, select the first check box.
- If a meeting has already been scheduled, please include the time, date, and location of the meeting as well as a phone number to allow for participation via phone.

NOTE: Documents should be password protected prior to sending electronically. Instructions on password protecting a word document can be found at https://support.office.com/en-us/article/Password-protect-a-document-8f4afc43-62f9-4a3a-bbe1-45477d99fa68. You will need to share the document password telephonically or in a separate email.

VIRGINIA DEPARTMENT OF EDUCATION

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

IMMEDIATE ENROLLMENT OF STUDENT IN FOSTER CARE FORM

Date Student Presented for Enrollment: (select date)		**Date of Enrollment:** (Recorded by School)	
Best Interest Determination (BID) Process Information			
BID Completion Date: (Select date the BID process was completed) (Documentation must be attached)			
Student Information			
****Student Name:** (first, middle, last)	**DOB:** (MM/DD/YYYY)	****Age:** (age)	**Gender:** (M/F)
Current Grade: (grade)	**504 Plan:** (Y/N) (if yes, attach)	**Special Education (IEP):** (Y/N) (if yes, attach)	
Student's New Placement Information			
Type of Placement: select placement type		**Date of Placement:** (select date)	
****Address:** (street, city, state, zip)		**Phone:** (___) ___-____	
Contact: (enter full name of foster parent(s) or group home contact)		**Email:** (enter email)	
Licensed Child Placing Agency (LCPA): (enter agency/case manager-if applicable)		**Phone:** (___) ___-____	
Local Department of Social Services (LDSS) Agency Information			
Custodial Department of Social Services: (select local social services agency)		**Removal Date:** (select date)	
LDSS Case Worker: (enter LDSS case worker's name)		**Phone:** (___) ___-____	
LDSS Educational Stability Liaison: (enter liaison's name)		**Phone:** (___) ___-____	
School/Division of Origin Information (last school attended)			
School Division/School: (select division) (enter school name)		**School Phone:** (___) ___-____	
Foster Care Liaison: (enter name)	**Email:** (enter email)	**Phone:** (___) ___-____	
Parent Information			
Are parental rights terminated (TPR)? ☐ **YES** ☐ **NO** (If yes, move to next section)			
Mother's Name: (enter full name)		**Email:** (enter email)	
Address: (street, city, state, zip)		**Phone:** (___) ___-____	
Father's Name: (enter full name)		**Email:** (enter email)	
Address: (street, city, state, zip)		**Phone:** (___) ___-____	

VIRGINIA DEPARTMENT OF EDUCATION

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

IMMEDIATE ENROLLMENT OF STUDENT IN FOSTER CARE FORM

The local department of social services (LDSS) shall coordinate with the school division representative to ensure that the child in foster care is immediately and appropriately enrolled with all educational records provided to the new school (Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351); Social Security Act, Title IV, § 475 (1) (G) [42 USC 675]); Every Student Succeeds Act of 2015 (P.L. 114-95). The sending and receiving school divisions shall expedite the transfer of the student's record (§ 22.1-289 of the Code of Virginia).

This document provides all information required for the LDSS to notify the school principal and school division superintendent and for the school to immediately enroll the child in compliance with §§ 63.2-900.D and 22.1-3.4 of the Code of Virginia. The three asterisked (**) areas meet these minimal requirements of enrollment. All other information helps to ensure a smooth transition for the child and school.

"Immediate" means no later than the beginning of the next school day after the presentation for enrollment. **Presentment"** means the person enrolling the child has appeared at the school and presented all required information and certifications. **"Enrollment"** means the child is attending classes and participating fully in school activities. If, despite all reasonable efforts, school officials are unable to enroll the child by the beginning of the next school day following presentment for enrollment, the student shall be enrolled no later than the second school day following presentment.

If enrollment is delayed until the second school day after presentment, school officials shall document reasons for the delay and attach these reasons to this form.

(Please complete page 2) **(Print on yellow paper for easy identification)**

**Enrollment Certifications

I am a representative of the agency to whom the court has committed or the parent has entrusted the child's care through a voluntary entrustment or noncustodial agreement of the above-named child. This child meets the definition of a child placed in foster care in § 22.1-3.4 of the Code of Virginia; therefore, I am certifying that the child is eligible for *immediate* enrollment.

To the best of my knowledge, (first, middle, last) ☐ **has** ☐ **has not** been expelled from school attendance at a private or public school division of the Commonwealth of Virginia, or in any other state, for an offense in violation of the school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.

To the best of my knowledge, (first, middle, last) ☐ **has** ☐ **has not** been found guilty of or adjudicated delinquent of any offense listed in § 16.1-260.G of the Code of Virginia or any substantially similar offense under the laws of any other state, the District of Columbia, or the United States or its territories.

To the best of my knowledge, (first, middle, last) is in good health and is free from communicable or contagious disease. If documentation of a physical exam, birth certificate, social security number, and/or immunization record is unavailable at the time of enrollment, they must be provided to the school within 30 days of enrollment.

_____

_

LDSS Case Worker Signature ***Date***

IMMEDIATE ENROLLMENT OF STUDENT IN FOSTER CARE FORM

Release of Information
I, (LDSS Case Worker) , as legal custodian/guardian of (first, middle, last) , hereby authorize schools, their agents and employees in possession of this student's educational records to release such information as necessary for the purposes of his/her educational enrollment at (receiving school) . _____ _ ***Legal Custodian/Guardian Signature*** ***Date***

Direct Questions To:

VDOE: Office of Student Services: (804) 225-2071

VDSS: Division of Family Services: (804) 726-7944 or (804) 726-7423

REQUIRED STATEMENT FOR STUDENTS ENTERING PUBLIC SCHOOL

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.
"Giving Children Hope and Purpose For The Future"

Virginia law requires that, prior to admission to any public school of the Commonwealth of Virginia, a school board shall require the parent, guardian, or other person having control or charge of a child of school age to provide, upon registration, a sworn statement or affirmation indicating whether the student has been expelled from school attendance at a private school or in a public school division of the Commonwealth or in another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful inflection of injury to another person. Any person making a materially false statement or affirmation shall be guilty upon conviction of a Class 3 misdemeanor. The registration document shall be maintained as a part of the student's scholastic record. (Code of Virginia 22.1-3.2)

Please complete and sign the applicable statement below…

I, _____, affirm that _____ has not been expelled from school attendance at a private school or public school in Virginia or another state for an offense in violation of school board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

Parent, Guardian, or Person Having Control Or Charge Of Child: _____

Date: ____/____/____

I, _____, affirm that _____ has been expelled from school attendance at a private school or public school in Virginia or another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.

Parent, Guardian, or Person Having Control Or Charge Of Child: _____

Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issue a new notice.

Our commitment to your privacy. We are responsible for the information that we collect about you, and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information. We understand how important it is to protect your privacy and we will continue to make this a priority.

Our legal duties. We are required by applicable federal and state laws to keep certain information about you private. An example of this is your medical information. We treat your medical and demographic information that we collect as part of providing counseling and psychological services, as "Protected Information." It is our policy to maintain the privacy of Protected Information in accordance with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. Any terms not defined in this Notice will have the same meaning as they have in the HIPAA privacy regulation.

The HIPAA Privacy Regulations generally do not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard that we are required to follow. For example, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, HIV or AIDS, etc.

We reserve the right to change the terms of this notice. We may make the new notice provisions effective for all the Protected Information that we maintain. This includes information that we created or received before we made the changes. Any revised notice will be provided to you by mail or in person at your next appointment in our office.

Anyone may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us as specified at the end of this notice.

Our primary uses and disclosures of your Protected Information. We may use and disclose your Protected Information without your specific authorization for the purposes of treatment, payment, and health care operations. To illustrate:

- Treatment activities are activities performed by a health care provider related to the provision, coordination or management of health care provided to you. An example of this would be telling your insurance company how many office visits and what type of office visits you have had to date.
- Payment activities are activities undertaken to obtain reimbursement for services, confirm health care coverage, bill for services rendered, perform collecting activities, and perform utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations activities include the business aspects of running our practice, such as business planning and development, quality assessment and improvement, submission of claims, obtaining legal and auditing services, and cost-management analysis. We may also use your Protected Information to give you information about treatment alternatives or other health-related services that may interest you.

When using and disclosing your Protected Information in our health care and billing operation activities, we may only request, use, and disclose the minimum amount of your Protected Information necessary to complete the activity.

We may contract with others to assist us with treatment, billing or health care operation activities that involve the use of your Protected Information. Such third parties are referred to as our business associates. We require business associates to agree, in writing, to contract terms. These terms are specifically designed to safeguard Protected Information before it is shared with them. We may also have business associates assist in the activities described in the following section that involves permitted uses and disclosures.

Other uses and disclosures of your Protected Information. We must disclose your Protected Information to you. This is described in the Individual Rights section of this notice below. You may also give us written authorization to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or disclose your Protected Information without your specific written authorization.

Family and friends. If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Research, death, organ donation. We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIP~ privacy regulations. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public health and safety. We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious imminent threat to your health or safety or the health and safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contracts, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, domestic violence or other crimes.

Required by law. We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected Information to comply with workers' compensation or similar laws.

Legal process and proceedings. We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.

Law enforcement. We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escap3d from lawful custody.

Military and national security. We may disclose to military authorities the Protected Information of Armed Forces personnel under ce4rtain circumstances specified by the HIPAA privacy regulation. We may also disclose to authorized federal officials Protected Information required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

Access. You have the right to inspect and obtain copies of your Protected Information for as long as your information is maintained in our designated record set. Our designated record set includes records from our billing, claims, treatment planning, and medical management and treatment systems, as well as any other records we maintain in order to make decisions about providing health care services. Your right of access to Protected Information does not extend to certain information. This includes information contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative proceeding. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We reserve the right to charge a reasonable fee for copies of Protected Information that we provide. Any request to exercise your individual right of access to your Protected Information must be in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will respond to your request within 30 days of receiving the request. If all or any part of your request is denied, our response will detail any appeal rights you may have with respect to that decision. Notwithstanding the formal process for your right of access, certain information related to claims processing may be available to you by contacting us as part of our normal insurance billing business procedures.

Amendment. You have the right to request that we amend your Protected Information that we keep in our designated record set if you believe it is incorrect. A request that your Protected Information be amended must be done in writing. You may obtain a form to request amendment by using the contact information listed at the end of this notice. We will respond to your request for amendment within 30 days of receiving the request. If we accept your request to amend the information, we will notify you. We will make reasonable efforts to inform other person, including those identified by you as having any future disclosure of that information. If we deny your request for reasons permitted by the HIPAA privacy regulation, our notice to you will explain any appeal right you may have with respect to that decision. Notwithstanding the formal process for your right of amendment, certain information related to claims processing may be corrected by contacting us as part of our normal insurance billing business procedures.

Disclosure accounting. You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures. The most significant types include: any disclosures made prior to April 14, 2003; disclosures for treatment, payment or health care operations activities; disclosures to you or pursuant to your authorization; disclosures to persons involved in your car; disclosures for disaster relief, national security or intelligence purposes; disclosures that are incidental to a permitted use or disclosure. To request an accounting of disclosures, you must submit the written request by using the contact information listed at the end of this notice. You may request one such accounting at no charge every 12 months. You

may request that the accounting cover up to 6-year period of reportable disclosures from the date of your request. We will respond within 60 days of your request. We reserve the right to impose a reasonable charge for requests made more than once per year.

Confidential communications. You may believe that you will be in danger if we communicate Protected Information to you at your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by an alternate form of communication. We will make reasonable efforts to accommodate your request if you specify an alternate address. To request a confidential communication, you must direct your request to the contact office listed at the end of this notice.

Restriction request. You have the right to request that we restrict the use or disclosure of your Protected Information for treatment, payment or health care operation activities. You also have the right to request that we restrict disclosures to relatives, friends, or other individuals that may be involved in your care or payment for your health care. We are not required to agree to such a request for restriction. To request a restriction, you must direct your request to the contact office listed at the end of this notice.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We maintain and enforce a policy of non-retaliation against individuals who bring breaches, or potential breaches, of this notice to the attention of our privacy officer or the U.S. Department of Health and Human Services.

How to contact us:

Presbyterian Children's Home of the Highlands, Inc.
P.O. Box 545
Wytheville, VA 24382
Attention: Billy Rice
(276) 228 - 2861 ext. 101

For more **information about HIPAA** or **to file a complaint:**

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(877) 696 – 6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Presbyterian Children's Home of the Highlands, Inc.
P. O. Box 545
Wytheville, VA 24382
(276) 228-2861

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (Protected Information). I understand that this Protected Information can and will be used to perform:

- **Treatment activities** are activities performed by a health care provider related to the provision, coordination or management of health care provided to you. An example of this would be telling your insurance company how many office visits and what type of office visits you have had to date.

- **Payment activities** are activities undertaken to obtain reimbursement for services, confirmed health care coverage, bill for services rendered, performed collecting activities, and performed utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations activities** include the business aspects of running our practice, such as business planning and development, quality assessment and Improvement, submission of claims, obtaining legal and auditing services, and cost-management analysis. We may also use your Protected Information to give you information about treatment alternatives or other health-related services that might interest you.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my Protected Information. I understand that you have the right to change the Notice of Privacy Practices from time to time and that I may contact your office at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____/_____/_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: _____/_____/_____ INITIALS: _____ REASON: _____

Presbyterian Children's Home of the Highlands, Inc.
Wytheville, VA

Resident's Name: _____

Admission Date: ____/____/____

1. Give some examples of your positive behaviors.

2. Give examples of your problem behaviors.

3. What might trigger a problem behavior?

4. What interventions have proven to be successful for you in the past?

5. What would make these behaviors worse?

6. What makes you angry?

7. What techniques have you used to manage your anger?

8. What should residents and staff need to be aware of or careful not to do when you are angry?

9. What can residents and/or staff do to help you when you are angry?

10. What makes you nervous or anxious?

11. What techniques have you used to manage anxiety in the past?

12. What should residents and staff need to be aware of or careful not to do when you are anxious?

13. What can we do to help you when you are anxious?

14. Is there anything else staff or residents need to know about you in order to assist you in managing your behavior?

NOTE: This Behavior Assessment Plan may be reviewed and updated as the residents' needs change.

Presbyterian Children's Home of the Highlands, Inc.
Wytheville, VA

RE: Resident: _____

Admission Date: _____/_____/_____

Participating Signatures…

Resident:	_____	Date: _____/_____/_____
Legal Guardian:	_____	_____/_____/_____
Resident's Parents:	_____	_____/_____/_____
(If applicable)	_____	_____/_____/_____
Program Director:	_____	_____/_____/_____
Placing Agency Staff:	_____	_____/_____/_____
Therapist:	_____	_____/_____/_____
Case Manager:	_____	_____/_____/_____
Former Care Givers:	_____	_____/_____/_____
	_____	_____/_____/_____

I have read and understand what this resident has written:

Houseparent:	_____	_____/_____/_____
Houseparent:	_____	_____/_____/_____
Houseparent:	_____	_____/_____/_____
Houseparent:	_____	_____/_____/_____
Evening Supervisor:	_____	_____/_____/_____
Evening Supervisor:	_____	_____/_____/_____

PCHH CENSUS INFORMATION

— ADMISSION —

REQUIRED WITHIN 24 HOURS

Resident's Name: _____

D.O.B.: _____/_____/_____ Race: _____ Sex: M____ F____

Admitted To: Buchanan ____ Gilmer ____ Webb ____

Type of Admission: Planned ____ Emergency ____

Is this a parental placement?

Date of Admission: _____/_____/_____

Placing Agency: _____

Agency Caseworker: _____

Photo Release Approved: Yes ___ NO ___ With specific consent only ___

Date Submitted: _____/_____/_____ By: _____

Allergies:

_____

_____

_____

_____

_____

This form must be submitted to the Program Director and Executive Director on ALL residents **within 24 hours** of admission.

Check all of the following circumstances that apply for: _____.

____ Legal guardian requested immediate placement

____ There was insufficient time to complete a planned admission

____ While there was enough information to make a decision on placement, additional information is needed to complete the application packet

____ Based on available information, immediate placement is in the best interest of the child

____ Has been staffed and determined that this child meets PCHH criteria for admission

Brief narrative regarding circumstances of this admission:

_____

_____

_____

_____

_____

_____

Signature of PCHH Staff: _____

Date: ____/____/____

MEDICAL & DENTAL APPOINTMENT REPORT

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS, INC.

Resident's Name: _____ Appointment Date: _____/_____/_____

DOB: _____/_____/_____ Medicaid #: _____

Doctor's Name: _____ Appointment Time: _____:_____ am / pm

Reason for appointment: _____

_____

_____

_____

_____

Allergies: _____

_____

_____

TO BE COMPLETED BY HEALTH CARE PROVIDER…

Diagnosis: _____

Treatment Provided / Ordered: _____

_____

_____

Medication Prescribed: ___ No ___ Yes (see information below)

Drug Name: _____ Strength: _____

Schedule for administration: _____ Route: _____

Instructions for missed dosage (Physician Standing Orders) _____

_____

Follow-up Appointment: ___ No ___ Yes _____/_____/_____ _____:_____ am / pm

Signature of Care Provider: _____

PHYSICAL EXAM REPORT

PRESBYTERIAN CHILDREN'S HOME OF THE HIGHLANDS

Child's Name _____ **Date of Examination** _____/_____/_____

DOB: _____/_____/_____ Medicaid#: _____

IMMUNIZATIONS ADMINISTERED THIS DATE: _____ or **NONE**

_____ **(please provide a response)**

TUBERCULIN TESTS: Mantoux skin test in accordance with Virginia Dept. of Health procedures:

Date Tested _____/_____/_____ Date Test Read _____/_____/_____ Result _____

Is it inadvisable for this individual to have a chest X-Ray? Yes _____ No _____

Chest X-Ray (if applicable) _____ Findings: Positive _____ Negative _____

COMMUNICABLE DISEASE Does this child appear to be **free from communicable disease**? **Yes___ No___**

ALLERGIES: _____

HANDICAPS; _____

CHRONIC CONDITIONS: _____

NUTRITIONAL REQUIREMENTS / SPECIAL DIET:_____

RESTRICTIONS ON ACTIVITIES: _____

HEARING Right_____ Left_____

VISION w/o glasses: R-_____ L-_____ w/glasses: R-_____ L-_____

Color Discrimination: _____

GENERAL PHYSICAL CONDITION: _____

HEIGHT: _____ **WEIGHT: _____**

RECOMMENDATIONS: _____

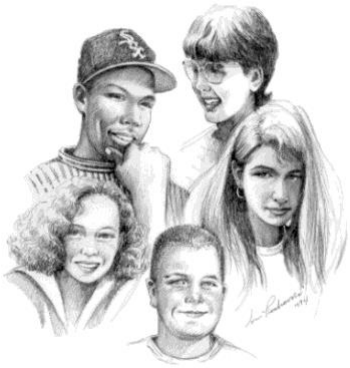
THIS AGENCY TRAINS ITS STAFF TO PHYSICALLY RESTRAIN A RESIDENT WHEN APPROPRIATE TO PROTECT HIM/HERSELF OR OTHERS FROM DANGER. THIS RESIDENT IS
___ DEEMED ___ IS NOT DEEMED
TO GENERALLY BE IN GOOD PHYSICAL CONDITION AND SHOULD NOT BE ADVERSELY AFFECTED BY PHYSICAL RESTRAINT IF NECESSARY.

FOLLOW-UP APPT. DATE (complete only if needed): _____

PHYSICIAN'S SIGNATURE _____

With _____ Medical Practice

PHONE : (_____) _____-_____



"Giving Children Hope & Purpose For The Future"

Release for Psychiatric Care

for

_____

☐ Being a ward and in the custody of _____ DSS

☐ Being a parental placement, and a _____ County resident has my permission for the Presbyterian Children's Home of the Highlands to seek all psychiatric service s including psychiatric evaluations, psychiatric medications, substance abuse, sexual issues and any other areas Therapist / Counselor / Doctor deems necessary. This also includes any medical tests and or procedures required to treat psychiatric issues, as long as they are covered by Medicaid.

Name: _____ Date: _____

Position: _____

Presbyterian Children's Home of the Highlands, Inc.
P. O. Box 545 ▪ 425 Grayson Road ▪ Wytheville, VA 24382
(276) 228-2861 • info@pchh.org

Presbyterian Children's Home of the Highland, Inc.

P. O. Box 545
Wytheville, VA 24382

276.228.2861 phone
276.228.8154 fax

http:/pchh.org

INFO FOR MEDICATION ORDER

Resident's Name: _____

Medicaid Number: _____

Birthday: _____/_____/_____

Social Security Number: ---------- _____

Allergies: _____

_____

_____

Presbyterian Children's Home of the Highland, Inc.

P. O. Box 545
Wytheville, VA 24382

276.228.2861 phone
276.228.8154 fax

http:/pchh.org

INFO FOR MEDICATION ORDER

Resident's Name: _____

Medicaid Number: _____

Birthday: _____/_____/_____

Social Security Number: ---------- _____

Allergies: _____

_____

_____

Name: _____ ***DOB:*** _____/_____/_____ ***Cottage:*** _____

PROBLEM	MEDICATION	OK	DOSAGE	COMMENTS
ALLERGY	***Diphenhydramin Hydrochloride***	☐	25 mg (1 Tablet) every 6 hours PRN for itching, watery eyes, sneezing, runny nose or rash	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
CONSTIPATION	***Polyethylene Glycol (peg) 3350***	☐	***10-16 yrs old:*** 1/2 capful with (8.5 gms) by mouth mixed with 8 oz water daily PRN until stool becomes regular.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
		☐	***17 yrs old & older:*** 1 capful (17 gms) by mouth mixed with 8 oz water daily PRN until stool becomes regular.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
COUGH / SCRATCHY THROAT / CONGESTION	***cough drop***	☐	One cough drop by mouth every 2 hrs PRN for cough, scratchy throat or congestion.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
COUGH / COLD	***cough syrup***	☐	***6 yr old & older:*** 2 tsp. every 6 hrs PRN for cough / cold symptoms not to exceed 4 doses daily.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
CUTS / SCRAPES	***Triple Antobiotic First Aid Ointment***	☐	Apply thin coat to affected area twice a day PRN. Cover with bandaid as needed.	Notify doctor for signs and symptoms of infection… to include redness, fever, swelling, or increased wound drainage.
DIARRHEA	***Anti-diarrhea Tablets***	☐	***12 yr olds & older***: 2 tablets after 1st loose stool, then 1 tablet after each loose stool not to exceed 4 per day PRN.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
EYE IRRITATION	***Eye Wash***	☐	Flush eye for 3-5 minutes with eye wash solution. Seek medical attention ASAP if no relief.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs

Use only meds approved by the physician (indicted by OK boxes beside each approved med). After administrating medications check and document the results within 45 minutes to 1 hour. Document results on PRN-MAR.

Name: _____ ***DOB:*** _____/_____/_____ ***Cottage:*** _____

PROBLEM	MEDICATION	OK ▼	DOSAGE	COMMENTS
HEADACHE / PAIN / SORE THROAT / FEVER (100+ degrees F or above)	***Ibuprofen Liquid***	☐	***9-11 yr olds***: 2 1/2 teaspoons by mouth every 6 hrs PRN for headache, pain, sore throat or fever (100+). If younger than 9 yrs old, contact MD for dosage.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
	Ibuprofen Tablets	☐	***12 yrs & older:*** 2 tablets (200mg) by mouth every 6 hrs PRN for headache, pain, sore throat or fever (100+).	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
	Acetaminaphen Tablets	☐	***9-11 yr olds***: 1 tablet (325mg) by mouth every 4 hrs PRN for headache, pain, sore throat or fever (100+).	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
		☐	***12 yrs & older:*** 2 tablets (325mg) by mouth every 4 hrs PRN for headache, pain, sore throat or fever (100+).	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
INDIGESTION / NAUSEA / VOMITING	***Bismuth Subsalicylate Chewable Tablet***	☐	***6--11 yr olds:*** 2 tabs every 6 hrs, not more than 6 tabs daily PRN not to exceed 6 tablets in 24 hrs.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
	Bismuth Subsalicylate Liquid	☐	***12 yrs & older:*** 15 cc by mouth every 6 hrs PRN for indigestion or stomach ache.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
INSECT BITES	***1% Hydrocortisone anti-itch cream***	☐	One application to the affected area every 2 hrs PRN.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
POISON IVY / OAK	***Calamine Lotion***	☐	One application to affected area every 2 hrs PRN.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
SORE THROAT	***Lozenge***	☐	***6 yrs & older:*** 1 lozenge by mouth every 2 hrs PRN.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
SUNBURN PREVENTION	***SPF 30 waterproof sun screen***	☐	Apply 15 minutes before sun exposure to all bare skin areas. Reapply every 2 hrs PRN	Notify Medical Services Coordinator / doctor if continues more than 24 hrs
TOOTHACHE	***Oral Anesthetic Gel***	☐	Apply to affected area & gums 4 times daily PRN.	Notify Medical Services Coordinator / doctor if continues more than 24 hrs

Allergies:

Approved by: _____

_____

_____

_____ _____/_____/_____

signature of physician date signed

Southern PHARMACY SERVICES

Pharmacy Admission Agreement

Please forward to pharmacy when completed and upon discharge.

Facility Name: _____ Date: _____

Resident Name: _____

All accounts are due and payable by the 25th of each month. All payments are to be made directly. Should the account be referred to collection, the undersigned agrees to pay reasonable costs in such a collection effort. Southern Pharmacy Services reserves the right to discontinue providing services for those accounts that are in excess of 90 days delinquent.

I understand that the use of Southern Pharmacy Services as a provider of pharmaceuticals and other necessities is optional. I also understand that Patient Inserts are available upon request.

I agree to the following for all purchases:

1. I will pay the entire amount within 30 days of the statement date.
2. I will pay for any purchases not payable by Insurance, Medicaid or Medicare.
3. I agree in order for the account to remain active, the account must remain current.
4. I authorized nursing home personnel to make purchases on this account on behalf of the named resident.
5. I understand that this document is to be submitted to the pharmacy before any resident's medications and/or supply orders.
6. I understand that Southern Pharmacy Services will request personal patient information from time to time, and that the pharmacy does this in compliance with HIPPA regulations.

_____ _____
Signature of resident/Responsible Party Date

_____ _____
Street Address Phone Number

_____ _____ _____
City State Zip Code

_____ _____
Medicare Number Medicare exhausted date

_____ _____
Medicaid Number Third Party prescription coverage

- ☐ Private
- ☐ VA Contract
- ☐ Other, Please specify _____

4459 Tar Heel Drive
Pink Hill, NC 28572
866.768.8479

1031 E. Mountain St. #319
Kernersville, NC 27284
866.768.8479

185 Stafford Umberger Dr.
Wytheville, VA 24382
800.220.9292

Fax: 866.928.3983

www.southrx.com

185 Stafford Umberger Dr.
Wytheville, Virginia

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FORM

Revised 8/21/2006

Southern Pharmacy Services, is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to send out a Notice of Privacy Practices to our customers and to obtain a signed acknowledgement that the customer has received and read the notice.

After reading the enclosed Notice of Privacy Practices, please sign this form and return to:

Renae Cregger, Privacy Officer
Southern Pharmacy Services
185 Stafford Umberger Drive
Wytheville, VA 24382

I, the Undersigned, have read the Notice of Privacy Practices obtained from Southern Pharmacy Services, and understand my rights as a patient.

Print Patient Name_____

Signed _____ _____
Patient **Date**

Signed _____ _____
Patient Representative Date

MEDICATION INVENTORY at ADMISSION or DISCHARGE

Resident: _____ DATE: _____/_____/_____

MEDICATION	AMOUNT PCHH RECEIVED	AMOUNT LEAVING PCHH	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	PCHH ON CALL WORKER / STAFF	HOUSEPARENT	CARE GIVER / FAMILY MEMBER / SOCIAL WORKER

For Admissions…

I _____ (social worker or person admitting resident) give PCHH permission for _____ (resident's name) to be given his/her medications brought with them until they can be evaluated by facility doctor.