## INFORMATION REQUIRED FOR PLACEMENT CONSIDERATION

It is important for our pre-placement process that we receive pertinent required information from parents or the referring agency. It is essential that Connections has completed intake forms in order to meet licensing regulations and to find the best home for your child.

- **APPLICATION FOR ADMISSION:** Please complete the application for admission thoroughly.

- **MEDICAL CONSENT FORM:** During a youth's placement at Connections, it may be necessary for him/her to receive medical attention. Please provide the following applicable medical information:
  1. Physical or date of most recent physical if known.
  2. **Please furnish updated immunization records.**
  3. Medical consent form must be completed. If the youth is entitled to any medical assistance, include the appropriate Title XIX number for proper insurance information and forms.
  4. Please provide Connections with a copy of the youth's dental and eye examinations and current status of any medical, dental, or vision needs.

- **PUBLICATION CONSENT FORM:** Authorization for publications of youth

**ADDITIONAL INFORMATION NEEDED:**

- Report of psychological and/or psychiatric evaluation completed within the last twelve months

- Court order

- Detailed Social History

- Birth certificate

- Medicaid card

- Social security number

- Billing address and appropriate person to whom billing is submitted

- Complete school records including the IEP (if applicable)

- Pertinent records from past placements

- After hour contact information for placement worker or agency

- Any allergies, i.e., insect stings, medications, detergents, animals etc.

- Interstate compact with state of South Dakota (out-of-state placements)

CONNECTIONS
by Our Home, Inc.
103 W Maple Street
Parkston, SD 57366-2048
Phone: (605)-928-7907
Fax: (605)-928-7910

## REQUIRED INFORMATION FOR ADMISSION

**RETURN TO:** Desiree Gunnare, SW
TFC Case Manager
Connections
by Our Home, Inc.
103 W. Maple Street
Parkston, SD 57366
Office: 605-928-7907 Fax: 605-928-7910

**REFERRED BY:** Name_____

Agency_____

Address_____

Phone_____ Home Phone_____

**A. YOUTH**

Name_____
First Middle Last

Title XIX_____

Social Security_____ Sex_____

Race_____ Birthdate_____ Age_____

Present Address_____

Is youth living with parent (s) Yes_____ No_____

If not, where_____

_____

**B. CUSTODY**
Court Order (copy attached, **must** be forwarded prior to placement)

Social History (attached) or _____

_____

_____

**C. FAMILY**
Family Members Age Address

Father_____

Mother_____

Siblings Age Living in home or elsewhere

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**List those persons with whom contact might be detrimental to youth: _____**
_____
_____

Father's Occupation: _____

Mother's Occupation: _____

Home Telephone _____ Work Telephone_____

Parent's Marital Status: Married_____ Separated_____ Divorced _____ Widowed_____

Has either parent received any type of counseling? Yes_____ No_____

**D. HEALTH**

Is youth prescribed any medication at present? Yes_____ No_____

Name of medication_____

Prescribed by_____ Date_____

Name of youth's physician_____

Address_____ Phone_____

Date of last physical examination_____

Immunizations **(copy attached)**

Allergies_____

Name of youth's dentist_____

Address_____ Phone_____

Date of last dental examination_____

Name of youth's optometrist_____

Address_____Phone_____

Date of last eye examination_____

**E. MENTAL HEALTH**

Has the child received professional counseling, psychological, or psychiatric care?

Yes_____ No_____

By Whom _____

What were the goals of the services? _____

_____

**F. EDUCATION**

Complete transcript of grades (attached)

Last grade completed successfully_____ Date_____

Current grade placement_____ Last school attended_____

_____ Address_____

Is the youth presently in school? Yes_____ No_____ If not, why?_____

_____

Is the youth on an Individualized Education Plan (IEP)? (attached) Yes_____ No_____

**CHECKLIST OF POSITIVE PEER CULTURE PROBLEMS**
(Check those that apply to youth)

_____ 1) Low self-image: poor opinion of self; often feels put down or of little worth

_____ 2) Inconsiderate of others: does things that are damaging to others

_____ 3) Inconsiderate of self: does things that are damaging to self

_____ 4) Authority problem: does not want to be managed by anyone

_____ 5) Misleads others: draws others into negative behavior

_____ 6) Easily misled: is drawn into negative behavior by others

_____ 7) Aggravates others: treats people in negative, hostile ways

_____ 8) Easily angered: is often irritated or provoked or has tantrums

_____ 9) Stealing: takes things that belong to others

_____ 10) Alcohol or drugs: misuses substances that could hurt self

_____ 11) Lying: can not be trusted to tell the truth

_____ 12) Fronting: puts on an act rather than being real

**COMMENTS**:

**CONNECTIONS**
**FAMILY QUESTIONNAIRE**

Please provide the below requested information for your youth to be considered for placement in a Connections TFC home.

**ABOUT MY CHILD:**

1. My child's likes/dislikes (foods, activities, etc.)_____

_____

_____

2. My child's daily schedule during the school year and in the summer:_____

_____

_____

3. Personality traits (shy, outgoing, loud, quiet, sarcastic, homebody, etc.)_____

_____

_____

4. Does your child have any fears? (animals, situations, people, places, etc.)_____

_____

_____

5. Are there any specific triggers that your child has?_____

_____

_____

6. What discipline methods have been tried? What has worked and not worked? _____

_____

_____

7. What would you want us to know about your child to assist us in finding the best foster parent match for them? _____

_____

_____

**SUBSTANCE USE:**

1. Describe to the best of your ability the substance (including alcohol) you know your child has used and how long the child has/had been using:_____

_____

_____

2. Has your child ever missed or have difficulties at school or work (if applicable) due to substance use? Yes_____ No_____

Describe incidents: _____

_____

_____

3. Describe all legal problems that your child has had as a result of/or involving drugs and alcohol use: _____

_____

_____

4. Describe any family arguments or difficulties the family has had with the child because of substance use:_____

_____

_____

**EDUCATION**

1. Describe your child's attitude and performance in school:_____

_____

_____

**FINANCES**

1. Describe how your child gets money and how much he/she is accustomed to having in an average week:_____

_____

_____

**RELATIONSHIPS**

1. Describe how your child gets along with his/her peers:_____

_____

_____

2. Describe how your child interacts with adult authority figures (parents, etc.):_____

_____

_____

**FAMILY**

1. Describe any family problems affecting the child:_____

_____

_____

2. Describe how the child gets along with his/her siblings:_____

_____

_____

3. Does the child have visits with his or her siblings or parents and what does that look like?_____

_____

_____

4. Do any other members of the child's family have a history of substance abuse/dependence?
   Yes_____ No_____

Describe:

_____

_____

_____

**RELIGION**

1. What is your family's religious denomination? _____

2. Does religion play a large_____ average_____ small_____ part in your family's life?

**CONNECTIONS**

1. Please list any connections your child has that are important to the child or for the child to maintain:_____

_____

_____

2. Are there any people in your child's life that he/she should re-connect with and why would this be beneficial to your child?_____

_____

_____

3. What cultural connections does your child/family have? Please explain some practices/traditions that your family has ie holidays, cultural events, foods, etc._____

_____

_____

CONNECTIONS
by Our Home, Inc.
103 W Maple Street
Parkston, SD 57366-2048
Phone: (605)-928-7907
Fax: (605)-928-7910

**TO**: Referral agencies of youth placed at Connections

**FROM**: Desiree Gunnare
TFC Case Manager

**RE**: School Records/Medical Records

It is imperative that we receive current school records, current Individualized Education Plan (IEP) (if applicable) and a list of all schools child has attended prior to placement at Our Home, Inc.

It is also imperative that we receive any medical, dental and optometry records that the youth has incurred before being placed at Connections, along with the youth's Medicaid card.

If you have any questions, please contact me @ (605) 928-7908.

**CONNECTIONS**
**MEDICAL CARE POLICIES AND PROCEDURES**

Please acknowledge the following policies and procedures pertaining to the medical care of youth in the Connections TFC program. It is imperative that you provide documented consent authorizing Connections to secure emergency medical care so that we can assure for the safety of your child. Connections wants to acknowledge "your need to know" in regard to matters involving the medical care. Therefore, the following policies are maintained:

1. Consent for the purpose of securing Emergency Medical Care **must** be signed and provided to the Connections program prior to or at the time of admission. This consent form must be signed by an individual that holds parental/guardian/custodian rights.

2. "Financial Responsibility for Medical Costs" form must also be provided prior to or at the time of admission. It is Connections' program policy **that all medial costs are the responsibility of the parent/guardians/ or custodian.** This policy applies to Admission Physical Examination costs as well as those medical and medication costs incurred during the treatment process. All youth must have an admission physical by the Our Home, Inc. Medical Director as mandated by rules.

3. Connections recognizes that there will be situations wherein there is a potential for third party pay in regard to medical costs. If you wish the attending physician to bill the insurance company for any medical costs, it is **your responsibility to inform our Office Manager and furnish her with ALL necessary information.** Another option would be to have the attending physician send you the itemized bill, which you can send along with your insurance form to the insurance company.

4. Connections will make and document reasonable efforts to contact parents/guardians or third party pay if necessary in any event of a medical emergency. This is done to assure that significant others are advised of the emergency situation and to advise such party that it was necessary to incur an unexpected medical expense.

5. Connections will not obtain any routine medical care or incur any medical expense for ordinary care without the prior authorization from the parent/guardian.

**CONNECTIONS**
**FINANCIAL RESPONSIBILITY FOR MEDICAL COSTS**

As a parent/guardian/custodian of a youth in foster care placed in the Connections program, I acknowledge that I have been provided with a copy of the Connections Medical Care Policies and Procedures. I acknowledge that the costs of medical care are my responsibility as a parent or guardian.

If a third party is to be used for expense incurred, please identify below with the information needed:

_____ Title 19 # _____

_____ Indian Health Services
Location _____

Address and Phone # _____

_____ Private Health Insurance
Insurance Company Name _____

Company Address _____

Insurance Company Telephone # _____

Policy # _____ Employer _____

Policy Holder Name _____

Policy Holder Social Security # _____

**MEDICAL CONSENT**

As a parent/guardian/custodian of _____, I authorize Connections to procure **EMERGENCY MEDICAL TREATMENT, SURGERY, HOSPITALIZATION** and other medical care determined to be necessary in the care of the child identified.

I acknowledge that this authorization is given even though circumstances may not allow for proper notification, to you as parent or guardian, of the need for the procurement of emergency medical care.

Signed this _____ day of _____, 20_____.

_____ _____
Parent/Guardian Signature Please Print Parent/Guardian Name

_____
Referral Agent Signature

**IHS MEDICAL INFORMATION**

Client's Name: _____

Date of Birth: _____

Degree of Blood: _____

Tribe Enrolled With: _____

Enrollment Number: _____

Mother's Name (Maiden): _____

Mother's Place of Birth: _____

Father's Name: _____

Father's Place of Birth: _____

# Parkston School District #33-3

102C South Chapman Drive
Parkston, South Dakota 57366-2017
TELEPHONE: (605) 928-3368
FAX: (605) 928-7284

SUPERINTENDENT: SHAYNE MCINTOSH PRINCIPAL: ERIC NORDEN
BUSINESS MANAGER: CRAIG BRUENING


## CONSENT FOR MEDICAL TREATMENT

I am the _____ (Mother, Father, Legal Guardian) of

_____ who participates in extra-curricular activities for

Parkston High School. I hereby consent to any medical services that

may be required while said child is under the supervision of an employee of

Parkston School District while on a school-sponsored activity and hereby

appoint said employee to act on behalf in securing necessary medical services from any duly

licensed medical provider.

Dated this _____ day of _____, 20__ .

_____
Parent's Signature

## CONSENT OF CHILD

I, _____, have read the above Consent form signed by

my _____ (Mother, Father, Legal Guardian) and join with

_____ (him, her) in the consent.

Dated this _____ day of _____, 20__.

_____
Student's Signature

**CONSENT**

I (We) being the parent(s)/legal guardian/custodian of:

_____

(Name of Youth in Full)

and being resident of the city of _____

in the state of _____. Do hereby give my (our) permission and consent to Connections, to use, for the purpose of publication thereof, information relating to the residency and activities of said youth, at Connections, which permission and consent includes, but is not limited to the use of said youth's full name and photograph and stories concerning his/her residency and activities at Connections.

Signed this_____ day of_____, 20_____

_____

Parent/Guardian

_____

Referral Agency Representative