

ADMISSIONS AGREEMENT

_____, a licensed child placement agency, does hereby request the Robert J. Kinsey Youth Center to receive care for _____.

I believe that this child poses a threat to self or others only as described below.

I further believe that this child is under the influence of drugs or non-prescription drugs only as described below. I agree if the Robert J. Kinsey Youth Center accepts this child for care that:

1. Said child shall remain in the care of the Robert J. Kinsey Youth Center for the time designated by the court.
2. Said child may be visited by approved visitors as stipulated below and under conditions stipulated by the Robert J. Kinsey Youth Center.
3. We, the undersigned, will be available for conferences regarding said child as requested by the Robert J. Kinsey Youth Center.
4. We, the undersigned, agree to provide written documentation of said child as requested by the Robert J. Kinsey Youth Center.
5. Any placing agency outside Howard County agrees to immediately remove any child whose removal is deemed appropriate and/or necessary by the Robert J. Kinsey Youth Center.
6. We, the undersigned, agree to make monthly payments, as billed, at the per diem rate for:

Emergency Shelter Care _____ Secure Detention _____

PER DIEM:

Shelter Care: DCS contracted rate paid by DCS

Secure Detention: \$175.00

7. We, the Placing Agency agree to assume responsibility for all medical, dental, and psychiatric cost, when insurance/Medicaid information is not provided by the Placing Agency.

I believe this child to be a threat to self or others: ____Yes ____No

WE MUST REQUIRE THAT YOU PROVIDE A TELEPHONE NUMBER AND PERSON WHO CAN BE CONTACTED ON A 24-OUR BASIS

Name _____

Title _____

Mobile/Telephone Number (24/hr.) _____

Email Address _____

Date _____
Placement Agency Staff Signature

Date _____
Kinsey Youth Center Staff Signature

Robert J. Kinsey Youth Center

Admissions Packet

Child's Information				
First and Last Name:				
Date of birth:		Age:		Sex:
Current address:				
City:		State:	ZIP Code:	Phone:
Height:	Weight:	Race:	SSN:	
Place of birth:				
Family Background Mother				
First and Last Name:				
Date of birth:		Age:		SSN:
Current Address:				Marital Status:
City:		State:	Zip Code:	Phone:
Employer:				
City:		State:	Zip Code:	
Work Hours:		Allowed to visit?		
Family Background Father				
First and Last Name:				
Date of birth:		Age:		SSN:
Current Address:				Marital Status:
City:		State:	Zip Code:	Phone:
Employer:				
City:		State:		Zip Code:
Work Hours:		Allowed to visit?		
Current Allegations				
Date:	Time:	Offense:		
Date:	Time:	Offense:		
Date:	Time:	Offense:		
Previous Referrals				
Date:	Charge:	Detention:	Disposition:	
Date:	Charge:	Detention:	Disposition:	
Date:	Charge:	Detention:	Disposition:	
Health and Medical List All Prescribed Medications				
Medication:		Reason:		
Medication:		Reason:		
Medication:		Reason:		
Has the child been exposed to any communicable diseases: Which ones: Any other medical concern, allergies, etc.?				
Insurance Carrier:			Other:	
Medicaid:				

Authorization Form

Name of child: _____ Date: _____

Child's Signature: _____

Parent/Legal Guardian Signature: _____ Relationship: _____

Staff Signature Witness: _____ Date: _____

Consent for Medical Treatment

I, _____ parent or legal guardian of the minor, _____

do hereby give permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MEDICAL HEALTH treatment and sign an authorization on my behalf for any MEDICAL HEALTH treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

Parent of Guardian Signature

Date:

Consent for Mental Health Treatment

I, _____ parent or legal guardian of the minor, _____

_____, do hereby give permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MENTAL HEALTH treatment and sign an authorization on my behalf for any MENTAL HEALTH treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

Parent of Guardian Signature

Date:

**ROBERT J. KINSEY YOUTH CENTER
AUTHORIZATION FORM**

Name of Child : _____

Date: _____

I authorize the Kinsey Youth Center staff to release or receive educational, medical, social and psychological information when the staff feels it serves the best interests of the above-mentioned child.

Child's Signature

Parent/Legal Guardian Signature

Relationship to Child

Staff Signature/Witness

Date

CONSENT FOR MEDICAL AND MENTAL HEALTH TREATMENT

I, _____, parent or legal guardian of the minor,
_____, do hereby give my permission for the personnel of the
Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that
person to give consent for MEDICAL and MENTAL HEALTH treatment and sign an authorization on
my behalf for any treatment or procedure deemed necessary by the attending physician. I further accept
all financial responsibility for costs incurred for treatment.

Parent or Guardian Signature

Date

APPROVED FAMILY CONTACT

Phone:

Name/s

Phone number

Name/s

Phone number

Visitation:

Name/s

Relationship

Name/s

Relationship