VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

PROGRAMS TRANSFER OF PHYSICAL CUSTODY

INTAKE

Date: _________________

This is to certify that ____________________________________________

(Youth’s name)

From __________________________ County has been delivered into the physical custody of
VLPFS for admission.

Time of arrival: ____________________ a.m.  p.m.

_________________________________
Signature of Transporter

_________________________________
Signature of VLPFS Staff
INTAKE STUDY

ADMISSION INFORMATION VERIFICATION FORM

Youth Name: ____________________________  SSN: ____________________________

Admitting County: ______________________

The following information was requested from the youth’s caseworker or Guardian on ______

<table>
<thead>
<tr>
<th>Document</th>
<th>Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Passport</td>
<td>________</td>
</tr>
<tr>
<td>Birth certificate</td>
<td>________</td>
</tr>
<tr>
<td>Social Security Card</td>
<td>________</td>
</tr>
<tr>
<td>Immunization Record</td>
<td>________</td>
</tr>
<tr>
<td>Last Physical Exam</td>
<td>________</td>
</tr>
<tr>
<td>Medicaid PCP changed</td>
<td>________</td>
</tr>
<tr>
<td>(to Mainline Monticello)</td>
<td>________</td>
</tr>
<tr>
<td>School Records</td>
<td>________</td>
</tr>
<tr>
<td>Youth Case Plan</td>
<td>________</td>
</tr>
<tr>
<td>Psychological Reports</td>
<td>________</td>
</tr>
<tr>
<td>Social History</td>
<td>________</td>
</tr>
<tr>
<td>Discharge Summaries (if applicable)</td>
<td>________</td>
</tr>
<tr>
<td>Court Order/ Verification</td>
<td>________</td>
</tr>
<tr>
<td>of Placement Authority</td>
<td>________</td>
</tr>
<tr>
<td>Clothing Request (7 changes of clothing)</td>
<td>________</td>
</tr>
</tbody>
</table>

Intake Staff Signature  ____________________________  Date  __________

Caseworker/Parent/Guardian Signature  ____________________________  Date  __________

Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

INTAKE STUDY

Youth Name: ___________________________  SSN: ___________________________

Admission Date: ________  Admission Time: ________  Discharge Date: ________

Date of Birth: ________________________  Medicaid #/Insurance: ______________

Home Street Address: ____________________________  County: ______________

City, State, Zip: ____________________________

Race: ______  Sex: ______  Height: ______  Wgt: ______  Hair color: ______  Eye Color: ______

Legal Status/Custody: ____________________________

Intake Study Participants: ____________________________

Referral Source: ____________________________

Placing worker’s Name: ____________________________

Primary Worker’s Name: ____________________________

Address: ____________________________

City, State, Zip: ____________________________

Phone Number: ____________________________  Cell Number: ____________________________

Fax Number: ____________________________  On-Call Number or Emergency #: ____________________________

Attorney Ad Litem ____________________________  Phone #: ____________________________

Father’s Name: ____________________________

Address: ____________________________

Phone Number: ____________________________

Mother’s Name: ____________________________

Address: ____________________________

Phone Number: ____________________________

Number of days in any Emergency Shelter during the last six months: ____________________________
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

INTAKE STUDY

Youth Name: ___________________  SSN: ___________________

Schools Attended

________________________________________________________________________

Current Grade & Classroom Type: ___________________________

Educational Needs & Behavior

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Psychological History

Therapist/ Counselor: ___________________  Phone #: ___________________

Address: __________________________________________

List any Psychiatric Placements & reasons for Placement

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Current Psychiatric or Emotional Problems

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
<table>
<thead>
<tr>
<th>PRESENTING PROBLEM</th>
<th>IDENTIFIED</th>
<th>NOT A TREATMENT GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity/ Attention Deficit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Attempts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Threats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Assault toward Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Assault toward peers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbally Aggressive towards peers/adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Injurious Acts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-injurious threats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim of Sexual Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim of Physical Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate Boundaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate Behavior w/ Opposite Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate Behavior w/ Same Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Relationship Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School attendance Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School behavior Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Learning/ Academic Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language or Speech Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Delay</td>
<td></td>
<td></td>
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<tr>
<td>Mental Retardation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting Fires/Arson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possession of Weapon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vandalism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/Alcohol Abuse Substance Involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enuresis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysfunctional Parental Figure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to Thrive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to Follow Instruction of Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 7/14/16
CLIENT INTAKE INFORMATION

Youth Name: ______________________  SSN: ______________________

1. What was the client last placement and reason for being removed?
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

2. How many formal placements has client had?
   ___________________________________________________________

3. Within the past two years, how often has the client moved?
   ___________________________________________________________

4. Has the client been arrested? If yes, give date(s) and reason:
   ___________________________________________________________
   ___________________________________________________________

5. How has client relationship been with family members?
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

6. Any other information about the client and / or family members that we should know that is not listed above?
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

7. Visitation/contact plans: Phone only_____  Visit_______  Visit and phone_______

8. Persons allowed on visitation/contact list: ________________________________________
   ___________________________________________________________
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

HEALTH AND MEDICAL HISTORY

Youth Name: ___________________ DOB: ___________________ DATE: __________

Completed by: ___________________ Source(s) of information: ______________

Insurance Company/Medicaid Number: ______________________________________

<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>Date of Exam/Appt.</th>
<th>Name/ Address of Dr. /Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy or Counseling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please circle the following and give the approximate date/age youth had any of the following:

**Childhood Diseases**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Age/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medications:** ___________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Allergies (food, medication or any other substance):** ______________________

________________________________________________________________________

________________________________________________________________________

**Hospitalizations or Surgery (include type and date):** _____________________

________________________________________________________________________

________________________________________________________________________

Does youth wear Glasses? ________________________________________________
**VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.**

Other devises: __________________________________________

**HEALTH AND MEDICAL HISTORY**

Current Physical Symptoms (please check the appropriate box)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fainting</td>
<td></td>
<td></td>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td>Nervousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>Joint pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td>Nightmares</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Infections</td>
<td></td>
<td></td>
<td>Difficulty Sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td>Difficulty Relaxing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Aches</td>
<td></td>
<td></td>
<td>Temper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Problems</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes: Is there a medical plan ____Yes ____No

Comment __________________________________________

________________________________________

**Family History (who):**

Diabetes: __________________________________________

Tuberculosis: _______________________________________

Cancers: __________________________________________

High Blood Pressure: _________________________________

Kidney Disease: ____________________________________

Heart disease: _____________________________________

Allergies: _________________________________________

Mental Problems: ________________________________

Anemia: __________________________________________
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

DCFS PROGRAM INTAKE CONTRACT AND STATEMENT OF NEEDS

Youth Name: ___________________________ DOB: __________________ DATE: __________

Projected Discharge Date: ______________ Actual Discharge Date: ______________

(Maximum of 45 day stay under current contract-may be discharged with 10 day notice
from shelter placement and 30 days for residential if priority placement is requested. Priorities
are mandated through current contract.)

Alternatives/Options for placement upon discharge: __________________________________

Would you like the youth to be add to our long-term residential program waiting list? ______

Permanent Placement Plan: _______________________________________________________

The placement of the youth at Vera Lloyd Presbyterian is voluntary.

Early discharge can be requested by the placing agent, legal guardian of the youth or VLPFS
staff.

Youth: I agree to abide by program rules and expectation until I am discharged from the
program.

Caseworker/Parent/Guardian: I agree to participate in the placement program of my client by
maintaining weekly contact with the House Parents, following through with discharge planning,
and helping provide for the youth basic needs.

____________________________________  ______________________
Youth                                      Date

____________________________________  ______________________
Caseworker/Parent/Guardian                Date

____________________________________  ______________________
VLPFS Staff                                Date

Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

PCP CHANGE FORM

Date: ____________________________

Youth’s Name: ____________________________ County of Transfer: ________________

Caseworker or transfer Worker: _____________________________________________

Caseworker contact Number: ____________________________

Medicaid Number: _____________________________________________

Previous Dr. Name and PCP Number: _____________________________________________

County PCP will change from: _____________________________________________

I AGREE TO PROVIDE VLPFS WITH A CURRENT AND ACTIVE MEDICAID NUMBER AND NOTIFY
THE FACILITY WITHIN 24 HOURS OF ANY CHANGES REGARDING THE MEDICAID NUMBER.

_________________________________________  ___________
Caseworker/Parent/Guardian Date

I have changed _________________________’s PCP number to Mainline Health Systems
Effective for date of intake.

_________________________________________  ___________
Caseworker/Parent/Guardian Date

_________________________________________  ___________
VLPFS Staff Date

Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

MEDICAL CONSENT

I, the Caseworker/Parents/Guardian of ________________________________,
do hereby give consent to VLPFS, or its duly appointed representative for my child to receive
such medical/dental services which may be recommended by a duly licensed medical doctor or
dentist, and which is considered necessary for my child by VLPFS staff.

In the event surgery is needed, I hereby reserve the right to give consent at the time surgery is
necessary, UNLESS 1) said surgery is an emergency where delay might endanger the life of the
child or possibly cause permanent damage to the child’s health, 2) it is virtually impossible to
reach child’s Caseworker/Parents/Guardian to give consent. In this event, I give consent for
surgery which is recommended by VLPFS staff and licensed medical doctor. Furthermore, in the
event emergency surgery is required I am to be notified at the earliest possible opportunity.

I also accept the responsibility for all the medical and dental bills incurred by my child while he
or she is placed at VLPFS. I authorize the medical or dental provider to send all bills to the DCFS
office. I further acknowledge that VLPFS is in NO way liable for any medical or dental billing
incurred by my child.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

Caseworker/Parent/guardian                        Date

Witness                                                Date

Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
PURSUANT TO HIPAA

Child's Full Legal Name: _______________________________ DOB: ___________

Parent/Legal Guardian: ________________________________

I, am the legal custodian(s) of the aforementioned child, so hereby request the health
information regarding the care and treatment of my minor child to be released as set forth on
this form:

In accordance with the Arkansas State Law and Privacy Rule of the Health Insurance Portability and
Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information related to ALCOHOL AND DRUG ABUSE,
MENTAL HEALTH TREATMENT, except psychotherapy notes, and other health information
regarding my minor child.
2. If I am authorizing the release of alcohol and drug treatment, or mental health treatment
information, VLPFS is prohibited from disclosing such information without my authorization
unless permitted to do so under federal and state law.
3. I have the right to revoke this authorization at any time by writing to the health care provider
listed below. I understand that I may revoke this authorization except to the extent that action
has already been taken based on the authorization.
4. I understand that signing this authorization is voluntary.
5. THIS AUTHORIZATION IS LIMITED TO THE RELEASE OF INFORMATION TO VERA LLOYD
PRESBYTERIAN FAMILY SERVICE, INC. AND ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF
MY CHILD FROM SERVICES.

6. Name and address of health provider or entity to release this information:

7. Specific Information to be released: (include by initialing)

_________ Medical Records for (insert date) ________ to (insert date) ________
_________ Alcohol/Drug Treatment
_________ Mental Health Treatment
_________ Psychiatric/Psychological testing and Evaluation Records
_________ Social /Behavior Management Progress Reports

8. Authorization to Discuss Health Information

By initialing here ___________ I authorize ___________ (Initials) (Name of health care provider)
To discuss the health information of my child with agents of the Vera Lloyd Presbyterian
Family Service, Inc.

All items on this form has been completed and my questions about this form have been answered. In
addition, I have been provided a copy of this form.

Signature of Caseworker/Parent/Guardian __________________________ Date ___________

VLPFS Staff __________________________ Date ___________

Revised 7/14/16
Recreation Consent form

Name: _________________________________ Date: ____________

I, the legal custodian of aforementioned child, do hereby give permission for him/her to participate in recreational or athletic activities. If the child is not able to participate I will provide a signed document from a qualified medical professional stating that the resident is physically incapable of participating.

All of my Questions about this form have been answered. In addition, I have been offered a copy of this form.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

_________________________________________ Date
Signature of Caseworker/Parent/Guardian

_________________________________________ Date
Youth Signature

_________________________________________ Date
VLPFS Staff Signature

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Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Photograph Consent form

Name: ___________________________ Date: __________

I understand that:

1. Signing this consent is voluntary.
2. Without my consent Vera Lloyd is prohibited from disclosing this information unless permitted to do so under federal and state law.
3. I have the right to revoke this consent at any time.
4. The recording, photograph, film will not be publicized outside of the Vera Lloyd Presbyterian organization.

All of my Questions about this form have been answered. In addition, I have been offered a copy of this form.

________________ I, the legal custodian of aforementioned child, do hereby give permission for VLPFS to record, photograph and/or film the child.

________________ I, the legal custodian of aforementioned child, do not give permission for VLPFS to recorded, or film. Photographs are only allowed for the purpose of his/her file.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

________________ Signature of Parent/Guardian Date ___________________________

________________ Youth Signature Date ___________________________

________________ VLPF Staff Signature Date ___________________________

14 Revised 7/14/10
COUNSELING SERVICES
CONSENT FOR TREATMENT

Name: ________________________________

Date of Birth: _______________________

I, the legal custodian of aforementioned child, do hereby give permission for VLPFS to provide counseling services for the above named youth for whom I am parent or legal guardian.

_______ Individual Therapy

_______ Group Therapy

_______ Family Therapy

I understand VLPFS counseling service are contracted with an outside provider. It is further understood that all records are to be kept confidential and will not be released to other persons or agencies without my permission.

THIS AUTHORIZATION ENDS AFTER ONE YEAR OR UPON THE DISCHARGE OF MY CHILD FROM SERVICES.

________________________________________  ________________________
Signature of Caseworker/Parent/Guardian              Date

________________________________________  ________________________
Witness                                              Date

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Revised 7/14/16
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Youth Questionnaire – To be filled out with Intake Packet by youth

Name: ___________________________ Age: ___________________________

Birthday: _______________________ Grade in School: _______________________

Favorite Color: ___________________________

Most Important Person in your life: ___________________________

Favorite Shampoo/Soap/hygiene product: ___________________________

Favorite outside Activity: ___________________________

Favorite inside Activity: ___________________________

Favorite Subject in School: ___________________________

Least Favorite Subject in School: ___________________________

Current Strength: ___________________________

Special Interest: ___________________________

Special Skills: ___________________________

What are some areas in your life you need to work on? (examples – getting along with others, making decisions, getting better grades)

________________________________________________________________________

If you could have any job in the world, what would it be? ___________________________

If you could choose where you would live, where would it be and with whom?

________________________________________________________________________

What is a vacation you would like to go on? ___________________________

What is something you have always wanted to do but have not been able to do it?

________________________________________________________________________

What are the main things you want Vera Lloyd to help you with while you stay with us?

________________________________________________________________________
VERA LLOYD PRESBYTERIAN FAMILY SERVICES, INC.

Youth Questionnaire – To be filled out with Intake Packet by youth (p. 2)

Name: ________________________________________________________________

How is your physical health today?  (Circle One) Excellent  Good  Fair  Poor

If you chose fair or poor, please explain:
____________________________________________________________________

____________________________________________________________________

Does any part of your body currently hurt?  If so, please describe and explain: ______________
____________________________________________________________________

____________________________________________________________________

Do you need to go to the doctor or dentist for any reason? __________________________
____________________________________________________________________

Who did you live with before coming here?  Describe the dwelling you lived in.
____________________________________________________________________

____________________________________________________________________

Have you ever been homeless? _____________________________________________
____________________________________________________________________

Have you ever been physically or sexually abused?  If so, by whom? __________________
____________________________________________________________________

Did you feel safe when you were at home?
____________________________________________________________________

What was your address and phone number? _________________________________
____________________________________________________________________

Is there anything else you think we need to know about you to provide the best possible care

for you during your stay with us?
____________________________________________________________________

____________________________________________________________________