INTAKE CHECKLIST

The following documents are required for Intake. If documents are missing, an explanation must be given, and date provided as to when documents should be available. Forms marked with an asterisk (*) are to be completed and signed by Case Manager or other authorized designee. The child cannot be admitted to the program unless all the required documents are signed.

Vital Statistics

- ☐ Birth Certificate (Copy or Original)
- ☐ Social Security Card (Copy or Original)

Admission Forms *(Must have signatures of Client, Case Manager (or designee), and FRIENDS Staff)*

- ☐ CMO Contact Sheet*
- ☐ Custody Letter*
- ☐ Consent for Participation*
- ☐ Consent for Medical & Dental Care*
- ☐ Release of Information*
- ☐ Medicaid Form*
- ☐ Initial Treatment Plan*
- ☐ Client Rights
- ☐ Client Grievance Policy
- ☐ Abuse Policy and Procedures*
- ☐ Notice of Information Practices (HIPPA)*
- ☐ Program Rules
- ☐ Health and Wellness Policy
- ☐ Clothing Inventory
- ☐ Room Checks*
- ☐ Placement Policy*
- ☐ Code of Ethics

Medical/Behavioral Health

- ☐ Medical & Dental Information Form*
- ☐ Physical (Most Recent)
- ☐ Immunization Record
- ☐ Medication Acknowledgement*
- ☐ Consent for Counseling*

Educational

- ☐ School Records
- ☐ Report Cards
- ☐ Individual Educational Plan (if applicable)

Legal

- ☐ Case Plan
- ☐ CBHA
- ☐ Judicial Review documents
- ☐ Original Order of Disposition
- ☐ Authorization for Phone Contact and Visitations
- ☐ Consent for Psychotropic Medication

Missing Documents

_____

CMO CONTACT SHEET

Contact information for _____
Client's Name

Family or Dependency Case Manager

Name:	
Office Phone:	
Cell Phone:	
Fax Number:	
Email Address:	

Family or Dependency Case Manager Supervisor

Name:	
Office Phone:	
Cell Phone:	
Fax Number:	
Email Address:	

Case Management Organization Information

Name:	
Mailing Address and Phone Number:	

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Custody Letter

_____ is in the custody of the Department of Children and Families and on_____was placed in a group home operated by:

FRIENDS OF CHILDREN &FAMILIES, INC
11875 High Tech Ave. Ste. 200
Orlando, Florida 32817
(407) 273-8444

and will be residing at the following address:

☐ 2436 Fawn Run
Oviedo, FL 332765
407-359-5162

☐ 10331 Lehman Road
Orlando, FL 32825
407-282-3015

☐ 1099 Fullers Cross Road
Winter Garden, FL 34787
407-877-7628

☐ 4495 Vancouver Avenue
Cocoa, FL 32926
321-208-7482

☐ 1311 Emerson Dr. N.E.
Palm Bay, FL 32907
321-914-3386

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Consent for Participation

As the undersigned guardian or custodian of:

_____ _____

NAME D.O.B.

Who is presently under the care of FRIENDS OF CHILDREN & FAMILIES, INC, I hereby consent that said child may attend: officially authorized school functions, school field trips or other planned school day activities, officially authorized FRIENDS program functions, field trips, or other planned day activities without any further consent from me, and that this consent shall be in force and effect unless cancelled by the undersigned in writing.

_____ _____

Dependency or Family Case Manager Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Consent for Medical and Dental Care

_____ _____
Name DOB

I,_____hereby give my consent for routine medical and dental care to the child listed below while under the care of FRIENDS OF CHILDREN & FAMILIES, INC, or any person or agency acting as the agent of FRIENDS OF CHILDREN & FAMILIES, INC.

This medical care may include physical examination, immunizations against communicable diseases and any tests which, in the opinion of the physician designated by the agency, are deemed necessary or advisable.

This DOES NOT include the right to perform surgical operations without any further consent, except in the case of an emergency, and when after an effort has been made to locate a representative from the Case Management Organization who is authorized to give consent.

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Release of Information

Client _____ Date _____

I authorize FRIENDS OF CHILDREN AND FAMILIES to exchange, release, or obtain the following information that may be required for services (Check all that apply)

- ☐ School Records
- ☐ Medical Records
- ☐ Legal Documents
- ☐ Other (Must Specify) _____

☐ I understand this release can be revoked at any time by providing written notice

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

Friends of Children and Families
11875 High Tech Avenue, Suite 200
Orlando, FL 32817
407-273-8444 (Office)
407-273-9344 (Fax)

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Medicaid Form

Please provide Friends of Children and Families with a **copy** of the child's ten-digit **Medicaid Card**. If the number is not currently active, please make a formal request to Medicaid to have the number reactivated, so that we can provide required medical care. We also require a **copy** of the child's **Social Security Card**.

_____
Child's name

10 digit number
_____
Medicaid Number

_____
Social Security Number

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Initial Treatment Plan

RE:_____ D.O.B._____

Upon placement with the FRIENDS program, an initial treatment plan is developed to facilitate care in the home and from educational, medical, dental, psychiatric and psychological service providers.

Immediate goals include:

- ☐ Obtain all necessary medical, legal, and educational documents
- ☐ Orientation to the FRIENDS home, to the house parents, peers, and to the immediate area
- ☐ Enroll the Client in the appropriate school
- ☐ Obtain medical, dental, psychological, or psychiatric evaluations
- ☐ Establish a schedule of family visitation (if applicable)
- ☐ Complete a detailed placement evaluation, and complete an individualized treatment plan
- ☐ Develop Discharge/Aftercare Plan

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

CLIENT RIGHTS

The Resident Rights were created for Clients within Friends of Children and Families. The rights will describe both the limits and privileges available to a Client within our care.

1. Under Florida Law, no client will be left out, denied benefits, or be treated unfairly because of their age, race, gender or sexual orientation

2. Each Client has the right:
    - To be able to receive care and treatment that is appropriate to their individual needs, characteristics, and abilities
    - To proper medical treatment
    - To safe and clean housing
    - To attend religious services
    - To receive needed services in a timely manner
    - To be treated with respect
    - To not be abused or neglected
    - To not suffer retaliations
    - To not be exploited
    - To have access to counseling services
    - To a nutritious and well balanced diet
    - To file a grievance if they feel their rights have been violated
    - To receive an allowance for personal use
    - To wear personal clothing and use personal belongings, as long as they are within guidelines of program rules
    - To have contact with people on their approved contact list
    - To use the telephone during assigned times
    - To review their Case files under the supervision and discretion of administrative staff

3. Each Client is made aware of abuse reporting procedures

4. The Client Rights will be posted in the common area of each home.

_____ _____

Client Signature Date

_____ _____

Friends of Children and Families Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

CLIENT GRIEVANCE POLICY

A Grievance Policy was developed to make sure that all Residents are treated fairly. A Grievance Policy gives a resident the right to make a complaint about any problem that they have, including any problem or complaints that may involve a FRIENDS staff member. Any client may make a complaint and will not be punished or denied services for reporting a complaint or grievance. If a client is having problems with any Staff Member at FRIENDS, the following steps should be taken:

1. Talk with the staff person that you are having a problem with to discuss your complaint.
2. If you do not feel comfortable talking to the staff person, complete a grievance form and give it to a staff member to take to the office. This can be your House Parent, Case Manager, Therapist, or any other staff that you have a good relationship with.
3. Within three business days, if you feel like your complaint has not been resolved, request to speak with a supervisor.
4. Within seven business days, if you still feel that your issue has not been resolved, your grievance will be sent to the Grievance Committee.
5. The FRIENDS Grievance Committee will then review the problem.
6. The Committee will make suggestions to the Executive Director
7. The Executive Director will make a final decision based on the advice given by the Grievance Committee.
8. The Grievance Committee will give you an answer in written form within two business days of receiving the complaint.
9. A copy of the Grievance and its outcome will be filed in a Grievance Folder, after you have been informed of the outcome.

I am aware of the Client Grievance Policy at FRIENDS. I understand my rights and steps to follow in filing a grievance. I have been given a copy of the policy and procedures form.

_____ _____

Client Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

ABUSE POLICY AND PROCEDURE ACKNOWLEDGEMENT

Chapter 39 of the Florida Statutes (F.S.) mandates that any person who knows, or has reasonable cause to suspect, that a child is abused, neglected, or abandoned by a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall immediately report such knowledge or suspicion to the Florida Abuse Hotline of the Department of Children and Families.

All employees of Friends of Children and Families are Professionally Mandated Reporters, and are required to report any known or suspected abuse, neglect, and/or exploitation.

The following policies and procedures are to be followed by all employees of Friends of Children and Families:

1. All employees are to receive Mandated Reporter Training regarding the signs and symptoms of abuse, neglect, and exploitation.

2. In such cases where abuse, neglect, and/or exploitation is known or suspected, Friends of Children and Families employees are required to contact the Florida Abuse Hotline at 1-800-962-2873 (1-800-96-ABUSE).

3. The Friends of Children and Families Employee will provide the Florida Abuse Hotline with all available information required to determine the presence of potential danger or harm to the child.

4. Friends of Children and Families will provide the Case Management Organization and the Community Based Care Organization with written documentation of the report made to the Abuse Hotline.

I,_____, have read and fully understand the Reporting Abuse, Neglect, and/or Exploitation Policy and Procedure. I understand that all Friends of Children and Families Employees are Professionally Mandated Reporters, and are required to report suspected or known abuse, neglect, or exploitation.

_____ _____

Client Signature Date

_____ _____

Dependency or Family Case Manager Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

Notice of Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULL Y.

NOTICE OF PRIVACY POLICY FOR FRIENDS OFCHILDREN & FAMILIES, INC
EFFECTIVE JULY 1, 2008

1.Who is Subject to This Notice

FRIENDS OFCHILDREN & FAMILIES, INC

2. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care.

3 .Contact Information

After reviewing this information if you have any questions please contact:

Compliance Officer
11875 High Tech Ave. #200
Orlando Fl. 32817
Phone: (407) 273-8444

4. Uses and Disclosures of Information

Under federal and state law, we are permitted to use and disclose personal health information under certain conditions. Listed below are conditions under which we may disclose information without prior authorization:

~

- Any organization that is working in conjunction with FCF to provide treatment services for clients;
- Any organization that reimburses FCF for services provided;
- Any health care organization that provides medical treatment for clients
- Reports of abuse and/or neglect
- Uses about decedents
- Disclosures to avert a serious threat to health or safety, there is a court order, national security, or crime at the program against personnel; or any other disclosures specifically required by law

5. Psychotherapy Notes

Psychotherapy notes may be disclosed by a therapist only after the Caseworker for the client has given written authorization to do so. Under limited exceptions such as to prevent harm to our self or others this requirement may be waived. Also, psychotherapy notes cannot be reviewed by the client unless prior permission from the psychotherapist and caseworker is given.

6. Your Health Information Rights

Under the law, you have certain rights regarding the health information we maintain and collect about you. This includes the right to

Request we restrict uses and disclosures of your information. We however are not obliged to abide by the request.

Request that we communicate with your through alternative means. We will accommodate any reasonable request for means of communication.

Request to review or receive a copy of your health information

Request that we amend the health information we have about you. Your request must be in writing and explain why data is wrong. If we deny the request for amending data we will explain why in writing and tell you how you can appeal such a decision. You may write a statement of rebuttal for the denial and it will be kept in your file

Request a list of disclosures of your data. This list details who your information was disclosed to and when. This disclosure will not convey information pertaining treatment, payment or health care operations.

Request a copy of this notice.

7. For more information or to file a complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it, or delivering it to our contact person. You may file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington DC 200201 or by calling 1-800-368-1019 or emailing ocrprivacy@hhs.gov. You will not be penalized or waive your right to make a complaint.

8. Revision to this Notice

We reserve the right to amend the terms of this Notice. The rules of the new notice will apply to all past, present and future information we collect or obtain about you. If revisions are made, a new Notice will be distributed to all clients and posted in public areas.

Client Signature	Date
Dependency or Family Case Manager Signature	Date
Friends of Children and Families Staff Signature	Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

The Program Rules Include:

1. For legal, safety and health reasons, no smoking or possession of tobacco or related materials. This includes e-cigarettes.

2. Alcohol and/or illegal or unauthorized drugs, medicines, or dangerous weapons are not allowed.

3. No physical or verbal abuse of other children or staff. Respectful language is requested. Please avoid using profanity when talking to others.

4. Cell phones are permitted if approved by Case Manager. If in possessive of a cell phone, the phone must be used appropriately, or it will be confiscated.

5. Enrollment in school, a vocational program, or employment is required for all children.

6. Personal items should not be exchanged with other residents without permission from staff.

7. Must remain within designated/approved boundaries on the property, children are not allowed to leave the house without permission from staff. Children who are at least 13 are allowed to go on Normalcy after being in the program for 2 weeks, if they have displayed appropriate behavior, and have approval from Case Manager

8. Food must be eaten in the dining area; no eating in the living area or bedrooms. Food is not to be stored in any bedrooms. Food and drink should not be eaten in the house van.

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

9. Chores will be assigned on a weekly basis, and need to be completed before privileges such as normalcy can be utilized.

10. Clothing must be appropriate, and should not be sexually provocative or have references to gangs or drugs. Acceptable clothing should be worn at all times, walking around the home in underclothes is not permitted.

11. Basic hygiene should be followed in regards to self and surroundings. Rooms should be kept clean at all times, and bathing or showering should occur on a daily basis.

12. Only one child is allowed in the bathroom at a time and the door must be fully closed.

13. If a Safety Plan is in place, all of the requirements most be followed. The requirements of the plan must be followed until amended by child's Dependency or Family Case Manager.

Client Signature _____ Date _____

Friends of Children and Families Staff Signature _____ Date _____

Health and Wellness Policy

Friends of Children and Families is committed to providing a safe environment that protects and promotes children's health and well-being.

- Children will be provided with access to medical, dental, and psychiatric services.
- Information on daily living activities such as cooking, nutrition, money management, hygiene and healthy lifestyles will be provided to all children in a format that is appropriate to the age and level of understanding of the child.
- Children will be provided with the opportunity to participate in recreational activities that promote physical fitness
- Children who are 12 and older will receive information regarding tobacco and substance use, healthy relationships, reproductive health (including HIV/AIDS), and other subjects related to issues related to developmental changes that occur during adolescence.

I have read and understand the policy concerning HIV/AIDS education. My signature below indicates that I have received informational literature on the subject of HIV/AIDS.

_____ _____

Client Signature Date

_____ _____

Dependency or Case Manager Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

CLOTHING/PERSONAL ITEMS INVENTORY CHECK LIST

(Please write number of items available)

Item	Amount	Item	Amount
Socks		Bras	
Panties		Briefs	
Shirts		Pants	
Shorts		Dresses/Skirts	
Sleep Wear		Eyeglasses	
Shoes		Computer	
Jacket		Cell Phone	
Sweaters		Watch	

Please list any additional items (jewelry, electronic equipment, cell phone)

1._____

2._____

3._____

4._____

The inventory Checklist should be completed upon admission, every six months, and whenever the Client receives a new item. The completed Inventory should be placed in Client's Case File.

_____ _____

Client Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Room Checks

The FRIENDS OF CHILDREN & FAMILIES conducts regular, random room checks on all clients taken into the program. We have found this necessary in order to ensure the safety and well-being of clients and staff as well as promoting basic living skills. Your belongings will be treated with respect, and will be disturbed as little as possible. However if you have items that are not allowed under the program rules, the items will be confiscated.

Please sign below to indicate that you understand and are willing to comply.

_____ _____

Client Signature Date

_____ _____

Dependency or Family Case Manager Signature Date

_____ _____

Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Placement and Operational Policy:

Friends maintains all its group homes in the community in residential neighborhoods. Continuous supervision is provided by House Parents. The Oviedo and Brevard group homes operate on a 24 hour awake supervision format with Support Staff that work in shifts.

Friends of children and Families does not encourage arbitrary movements or relocations of any child from home to home, even within the Friends of Children and Families group homes. Therefore, most children will remain in the group home in which they were originally admitted. However, Friends of Children and Families reserves the right to change the child's placement based on the child's overall behavior. This will be done in circumstances where the Staff determines the safety of that child and other children may be at risk, or the child's behavior has improved to the point that they require less supervision.

Client Signature _____ Date _____

Dependency or Family Case Manager Signature _____ Date _____

Friends of Children and Families Staff Signature _____ Date _____

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

CODE OF ETHICS

The goal of Friends of Children and Families is to maintain a safe and stable environment for children who have been entrusted to our care. We have established the following code of ethics to guide the behavior of all of our employees.

1. Demonstrates professional and courteous behavior toward residents, their family members, guardians, and others involved in the child's case.

2. Obtains training, education, supervision, and experience to provide competent services.

3. Respects the privacy of residents and holds in confidence information obtained in the course of providing services.

4. The staff will report, as the law requires, any suspected abuse incidents to the Department of Children and Families.

5. Does not participate in practices that are disrespectful, degrading, dangerous, exploitive, or psychologically or physically harmful to the child.

6. Ensures that services are sensitive to and non-discriminatory, regardless of race, color, ethnicity, age, gender, religion, sexual orientation, or mental or physical condition.

7. Complies with any required federal, state, or local law ordinances.

I have read and understand the Friends of Children and Families Code of Ethics

Client Signature _____ Date _____

Friends of Children and Families Staff Signature _____ Date _____

Intake Information Sheet

Date of Placement: _____ Name of Child: _____ Age: _____

Last Placement: _____

Reason for Removal: _____

Education:

Last School Attended: _____ County: _____ Grade: _____

Child has IEP? ❑ YES ❑ NO ❑ Unknown

DJJ History:

❑Child is on probation Name of JPO: _____ County: _____

❑Child is not on probation

Services (Please check list of services that child is currently receiving)

❑ Therapy Name of provider: _____ Agency/Phone number: _____

❑ Mentoring Name of provider: _____ Agency/Phone number: _____

❑ Tutoring Name of provider: _____ Agency/Phone number: _____

❑ Other: _____ Contact Information: _____

Physical Health History

Date of Last Physical: _____ Name of Doctor: _____Phone: _____

Date of Last Dental: _____ Name of Doctor: _____ Phone: _____

Date of Last Vision: _____ Name of Doctor: _____ Phone: _____

❑ Allergies List: _____

Is Child on Birth Control? ❑ YES-takes Pills ❑ YES-takes shots ❑ NO-Child is not currently on Birth control

Please document any additional health information that FRIENDS should be aware of:

MEDICATION ACKNOWLEDGEMENT

Client's Name:_____

Please check ONE of the following:

☐ To the best of my knowledge, the above-named child is not currently taking any prescribed medications

☐ The above named child has been prescribed the following medication(s)

_____

_____

☐ These medications HAVE been transported with the child

☐ These medications have NOT been transported with the child, and will be available at this time:_____

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

Consent for Counseling

Client Name: _____

Date of Birth: _____

☐ I give CONSENT for the Client listed above to receive counseling services from therapists employed by Friends of Children and Families.

☐ I DO NOT give consent for the Client listed above to receive counseling services from therapist employed by Friends of Children and Families

_____ _____
Dependency or Family Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

This Consent is valid for one year, and can be revoked at any time in writing.

FRIENDS
OF CHILDREN & FAMILIES
TURNING HURTING INTO HEALING

AUTHORIZATION FOR PHONE CONTACT & VISITATIONS

Phone Contact Permitted With:

Name	Relation	Phone #	Supervised?

Visitations Permitted With:

Name	Relation	Phone #	Overnight?

_____ _____
Family or Dependency Case Manager Signature Date

_____ _____
Friends of Children and Families Staff Signature Date

A new form must be completed and signed by the Dependency or Family Case Manager if there are any additions or deletions to the Contact and Visitation List