

YOUTH CARE & BEYOND, INC.

2819 S. 125th Avenue #276, Omaha, NE 68144



Admission Application

This application is to apply for: Youth Group Home A Program Adult DDS Supported Program

Applicant Information			
First Name	Last Name	Middle	
Date of Birth	Race	Master Case #	
Gender Female <input type="checkbox"/> Male <input type="checkbox"/>	Medicaid #	SSN	
IQ	Developmental Disability YES <input type="checkbox"/> NO <input type="checkbox"/> Type:		
Visible Scars/Tattoos			
Height/Weight	Eye Color	Hair Color	
Street Address		Apartment/Unit #	
City/State	ZIP	Phone	
Person Completing Paperwork			
Placing Agency	Address:		Email
	Phone:		
Chemical Use			
Does the applicant use alcohol?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Does the client smoke or chew tobacco? YES <input type="checkbox"/> NO <input type="checkbox"/>
Does the applicant use drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, type & frequency
Religion			
Denomination	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Does the applicant attend church? YES <input type="checkbox"/> NO <input type="checkbox"/>
Does the applicant attend youth group?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, name of church & frequency
Other			
Does the applicant wet the bed or have accidents?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so frequency
Does the applicant have a history of fire-setting?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, please describe the situation?
Does the applicant have history of cruelty to animals?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, please describe the situation?
Reason For Placement			
Please describe the circumstances for needing placement outside the home.			

Targeted Behaviors
Please describe the specific behaviors to be addressed before discharge.

Psychological Information

Date of most recent psychological evaluation		Name of person conducting evaluation	
Agency Address			
Counseling/Therapy	Does the applicant receive any counseling or therapy services YES <input type="checkbox"/> NO <input type="checkbox"/>		
Please complete the following	Name/Address of Professional and Reason		
Dates From: _____ To: _____	Therapy		
Dates From: _____ To: _____	Substance Abuse		
Dates From: _____ To: _____	Psychiatric		

Insurance
Please list any insurance that would cover the applicant

Policy Holder	Policy Holder's Date of Birth
Policy Holder's SSN	Policy Holder's Employer
Company Address	
Policy ID #	Group #

Medical Information

Allergies to medication		Food/Environmental Allergies	
List Physical/Mental Handicaps			
Please complete the following	Name/Address of Professional and Reason		
Date of last annual exam _____	Physical		F/up Needed YES <input type="checkbox"/> NO <input type="checkbox"/>
Date of last semi-annual exam _____	Dental		Braces YES <input type="checkbox"/> NO <input type="checkbox"/> F/up Needed YES <input type="checkbox"/> NO <input type="checkbox"/>
Date of last bi-annual exam _____	Eye		F/up Needed YES <input type="checkbox"/> NO <input type="checkbox"/>

School Information

Current School	Address		
Special Education Services	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Grade
If yes, Type			
How long have the services been provided?			
List any clubs, sports, activities, etc the applicant is involved in.			

Court Information

Name of County Court: _____ Judge: _____

Probation Officer		Phone
Probation YES <input type="checkbox"/> NO <input type="checkbox"/>	Dates From: _____ To: _____	Reason
Probation YES <input type="checkbox"/> NO <input type="checkbox"/>	Dates From: _____ To: _____	Reason

Previous Placements

Include all placements outside of the parental home.

Dates	Agency	Location	Reason for Discharge
From: _____ To: _____			
From: _____ To: _____			
From: _____ To: _____			
From: _____ To: _____			
From: _____ To: _____			

Relative History & Visitation

Please list all persons involved in the applicant's treatment including individuals who the applicant is likely to be discharged to

Full Name	Relationship
Approved for Contact YES <input type="checkbox"/> NO <input type="checkbox"/>	Phone ()
Type of Contact Phone <input type="checkbox"/> Day Pass <input type="checkbox"/> Overnight <input type="checkbox"/> Supervised <input type="checkbox"/>	
Address	
Full Name	Relationship
Approved for Contact YES <input type="checkbox"/> NO <input type="checkbox"/>	Phone ()
Type of Contact Phone <input type="checkbox"/> Day Pass <input type="checkbox"/> Overnight <input type="checkbox"/> Supervised <input type="checkbox"/>	
Address	
Full Name	Relationship
Approved for Contact YES <input type="checkbox"/> NO <input type="checkbox"/>	Phone ()
Type of Contact Phone <input type="checkbox"/> Day Pass <input type="checkbox"/> Overnight <input type="checkbox"/> Supervised <input type="checkbox"/>	
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Full Name	Relationship
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Address	
Full Name	Relationship
Approved for Contact YES <input type="checkbox"/> NO <input type="checkbox"/>	Phone ()
Type of Contact Phone <input type="checkbox"/> Day Pass <input type="checkbox"/> Overnight <input type="checkbox"/> Supervised <input type="checkbox"/>	
Address	



Individual Rights Form

While at Youth Care & Beyond, Inc., you will live in a family-style environment. For you to get better, it is essential that we help you develop many skills you will use throughout your life. We promise that we will keep Youth Care & Beyond, Inc., a safe place for you. Individual Rights are a condition of getting better.

You have the following Rights:

- To be respected for who you are such as cultural language, religion, family background, sexual orientation, and gender differences.
- To be heard- able to express your opinion when important decisions are being your treatment are made or to make a complaint by using our grievance procedure.
- To have a safe, healthy environment with good quality balanced meals, and age appropriate clothing.
- To have reasonable privacy includes:
 - Visit privately with family, unless a judge or social worker says otherwise.
 - Speak in privately with social worker or lawyer.
 - A place to keep your belongings and time to be alone.
 - Send or receive mail that has not been read by others, unless it may be harmful to your well being.
- To be treated respectfully and assured that staff will not hand on you unless you are in danger of harming yourself or others.
- To be informed of program rules; who the staff caring for you are; the benefits, risks and side effects of medication and special treatment procedures.
- To receive reasonable accommodations as required by the Americans with Disabilities Act, including Title II.

You have the following responsibilities:

- Keep in touch with your worker or placing agency
- Go to school when you should and do homework as required
- Show up for your appointments
- Respect other people, neighbors, and property
- Respect other people's differences in gender, ability, race, color, culture, religion, gender identification, and sexual orientation
- To take responsibility of yourself and your actions
- Give accurate information about your behaviors, mental health, and substance use issues as well as other circumstances which might impact your treatment.
- Assist by making and keeping a safe environment.
- Work with staff in planning, reviewing and changing your individual service plans; and
- Inform staff immediately if you have any concerns or problems with the service provided.

_____ I understand my rights and responsibilities.

_____ I have been informed that my individual service plan will be developed.

_____ I have received a copy of the *Consumer Grievance Process* form.

_____ The information contained in the form has been explained to me.

Client Signature date

Placing Agency Signature date

Youth Care and Beyond Signature date



Client Placement Agreement

Date of Admission: _____

This agreement is made between:

The Referring Agency

Referring Agency Location

and Youth Care & Beyond, Inc for the placement of:

Client's Name

Date of Birth

Master Case Number

The Youth Care & Beyond, Inc.'s program is tailored to meet the individual needs of the child and family. During the child's placement at Youth Care, Inc, the following conditions are established by this agreement:

- I understand that Youth Care & Beyond is an integral part of the client's treatment. The client's family, my agency staff and other involved persons will be asked to communicate important information for the client's placement to be successful.
Residential staff are prohibited from using safety holds or manual guidance except under emergency conditions where there is a clear and imminent threat to the physical safety of the client or others. Only the minimal therapeutic holding necessary shall be used. Staff are trained to the least restrictive and safest methods to deescalate behavior to use in these emergency situations.
If Youth Care & Beyond is unable to meet the treatment needs of the client, Youth Care & Beyond will notify the referring agency and give proper notice according to our contract with the referring agency.
During placement at Youth Care & Beyond, Inc your client may receive routine medical, dental, and optometry services. Additionally, your child may receive pharmacy, psychiatric and therapeutic services. In the event these additional services are needed you will be notified in a timely fashion. The financial responsibility will be retained by the placing parent/guardian or placing agency. If applicable, the parent is required to maintain health insurance and is responsible for payment of all services.



Standing Order Medication Consent Form

Client's Name _____ Program _____

Drug Name	Route	Dosage	Time
Acetaminophen Tablets (Tylenol)	Oral	Per label instructions by height and weight	Every 4 hours as needed for pain or fever >100.4F
BISMUTH SUBSALICYLATE Tablets	Oral	1 -2 Tablets every 1/2 to 1 hour as needed	Follow dosage to relieve the symptoms of an upset stomach, such as heartburn, indigestion, and nausea in adults and teenagers
Clotrimazole topical Cream	Topical	Apply a small amount of the cream (usually twice daily) for 2 to 4 weeks	Follow dosage instructions for relief of athletes' foot, jock itch, and ringworm
Diphenhydramine Tablets (Benadryl)	Oral	Per label instructions by height and weight	Every 4-6 hr as needed for temporarily allergic reactions, sneezing; runny nose; itching, watery eyes; hives; rashes; itching; and other symptoms of allergies and the common cold
Halls Naturals Cough Drops	Oral	Dissolve 2 drops (one at a time) slowly in the mouth. Repeat every 2 hours as needed.	Follow dosage to relieve cough due to a cold , occasional minor irritation or sore throat
Ibuprofen Tablets	Oral	Per label instructions by height and weight	Every 4-6 hours as needed for pain or fever >100.4F
Loperamide Tablets Imodium AD	Oral	2 caplets after the first loose stool; 1 caplet after each subsequent loose stool; but no more than 4 caplets in 24 hours	Follow dosage to relieve diarrhea
Premysyn PMS Midol (teens) Pamperin	Oral	Per label instructions by height and weight	relief not just of pain and cramps, but of other, associated PMS symptoms including tension, irritability, bloating, fluid retention and weight gain

I consent to the use of these over-the-counter medications for the youth in my care. They will only be administered as needed. Dosing may not exceed the manufacturer's recommended dose. I have reviewed the medications and have crossed out any medications that I do not want my child to receive. Medication administration will be documented on the medication administration record.

Print Legal Guardian Name(s) _____ Signature of Person placing the client _____ Date _____

Street Address _____ City _____ State _____ Zip _____



2819 S. 125th Avenue, Omaha, NE 68144
Phone: 402-991-9709 Fax: 402-898-1147

AUTHORIZATION TO RELEASE EDUCATIONAL & TREATMENT INFORMATION

Client's Name: _____ Date of Birth: _____

I hereby, as legal guardian give my consent to _____
Agency Name

Address/Location

To release the following information of the client named above to:

Youth Care & Beyond, Inc.
2819 S. 125th Avenue, Omaha, NE 68144
Phone: 402-991-9709 Fax: 402-898-1147

- Psychological evaluations
- Treatment information (treatment plan, progress notes, discharge summary)
- Scholastic/educational testing/school transcripts
- Most recent Special Education Information
- Other:

Legal Guardian
Signature: _____ Date Signed: _____

Address _____ Phone: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.