Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Intake Plan Of Care

Resident Name _____ Admission Date ____/____/____

Assessment: (will be addressed within the first 3 business days upon intake)

- ❑ Psychological Evaluation- to determine the level of intellectual functioning and achievement in order to rule out a disruptive disorder
- ❑ Initial Psycho-social
- ❑ Psychiatric/Medication Evaluation
- ❑ Substance Abuse Evaluation

Medical Needs: (will be addressed within the first 3 business days upon intake)

- ❑ EPSDT/well child exam- to ensure that preventative health care is received and identified health problems are diagnosed and treated
- ❑ Nursing Assessment
- ❑ Optical Exam
- ❑ Dental Exam
- ❑ Vaccines (Required by CDC only)
- ❑ Drug Screen
- ❑ Pregnancy Test
- ❑ STD Testing

Other (please explain)_____

Behavior Management:

- ❑ Counseling
- ❑ One on One

Other (please explain) _____

Continuation of Medications: will continue to administer on intake date

_____ is on the following medications and is to continue taking while at the shelter. Please list the current medications, dosage and reason that this medication (s) are being taken and are to continue until seen by a physician.

Medication _____ Dosage _____ Reason _____
Medication _____ Dosage _____ Reason _____
Medication _____ Dosage _____ Reason _____
Medication _____ Dosage _____ Reason _____
Medication _____ Dosage _____ Reason _____

_____ _____
Resident Signature Date Legal Guardian Signature Date

_____ _____
Care Coordinator Signature Date Registered Nurse Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Medication Packaging Release

Resident Name _____ Admission Date ____/____/____

Site: _____

Genesis Youth Crisis Center Inc. obtains all medications and supplies which require a prescription from Licensed Pharmacies. Medications that not packaged childproof containers are packaged using the "Docu-Dose" method for convenience and safety when dispensing the medication. Only AMAP trained Genesis staff, under the supervision of a registered nurse, LPN and RN, are authorized to handle and administer medications. All medications are kept locked for safety.

Please review the paragraph below and sign the prescription non-safety cap release form.

I understand that the Poison Prevention Packaging Act requires my pharmacist to dispense medication in childproof containers. However, for my personal convenience, I request that non-safety caps be used when filling my prescription. I further understand that in making this request I assume responsibility for the safety of persons whom may have access to this medication.

_____ _____

Resident Signature (14 years or older) Legal Guardian Signature

_____

Registered Nurse Signature

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Psychotropic Medication Consent

Resident's Name: _____ Date: _____

Prescribing Physician's Name: _____ Phone: _____

Reason for Authorization: ( ) Medication at admission ( ) New Medication
( ) Change in Dose ( ) Discontinued Medication

Name of Medication & Dosage:

_____

Specification of conditions the medication is to address (such as mood swings, irritability, etc):

_____

Efforts to address condition without medication:

_____

The expected length of time on medication:

_____

Is there necessary medical testing needed to determine proper usage of the medications: ( ) No ( ) Yes
If yes, please list: _____

How often symptoms will be evaluated to determine effectiveness of medication:

_____

Fully explain the benefits & possible side effects of the proposed medication: (except in cases of routine refill, changes with a class of medications or dosage change)

_____

_____

I have talked to the prescribing physician about the above-mentioned medication. I understand why I should take it, when I should take it and the possible side effects of the medication. I have been given the opportunity to ask questions about the medications. If I have more questions at a later time, I will ask the nurse. I have been given the opportunity for a copy of this form. I consent to take the medication listed above.

_____
Resident Signature Date

I, (Guardian, Parent, WV DHHR) consent for the resident to take the medication listed above.
Genesis Youth Crisis Center, Inc. will make every effort to notify you immediately after a medication has been prescribed, if this form is not signed and returned in 24 hours; the medication will be administered in regards to providing your client with the needed medical care as deemed necessary.

_____
Guardian, Parent, WV DHHR Signature Date

_____
Registered Nurse Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Admission Authorization for Release of Confidential Information

Resident Name:_____ Social Security #:_____

Date of Birth:_____ Parent/Legal Guardian:_____

I authorize Genesis Youth Crisis Center, Inc. to **obtain from**:

Name/Agency	Phone	Information to be shared	Purpose

I authorize Genesis Youth Crisis Center, Inc. to **release to:** *(initial all that apply)*

Initial	Name/Agency	Information to be shared	Purpose
	Bradley Gault, M.A. Licensed Psychologist	Relevant health, educational and case information	Psychological Evaluation/Case Consultation
	St. George Medical Clinical	Health and relevant case information	EPSDT, Dental Care, Urgent Care
	Dr. Dana Nugent	Relevant health, education and case information	Psychological Evaluation
	Family Eye Care Center- Dr. Hyre and Dr. Hyre	Health Information	Optical Care
	MedExpress Elkins, WV	Health Information	Urgent Care
	Davis Medical Center	Health Information	Urgent Care, Testing
	Tucker County Schools	Educational and relevant case information	Education
	Dr. Scott Gilchrist	Health Information and relevant case info	Psychiatric Care
	Wilson Martino	Health Information	Dental Care
	MDT, WVDHHR/West Virginia Treatment Initiative	Health and relevant Case information including Medication, Education, Mental Health, Assessments and Evaluations	For the Provision of Care Coordination

This authorization may be cancelled at any time by the resident or legal guardian; however cancellation will not rescind any action that has already occurred. This authorization shall remain in effect for a period of 1 year from the date of signatures.

I understand that any medical information released by Genesis Youth Crisis Center, Inc. pursuant to this authorization will be accompanied by the following language in accordance with federal laws:

"This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (42 C.F.R. Part 2). State law prohibits you form making any further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose".

Resident (age 14 and up):_____ Date:_____

Legal Guardian:_____ Date:_____

GYCC Staff:_____ Date:_____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Pesticide Application Notification

Genesis Youth Crisis Center, Inc. adheres to an Integrated Pest Management Plan in accordance with Title 61, Series 12j rules of the WV Department of Agriculture. Pests are controlled primarily through preventive measures. When pesticides are required, the least hazardous materials will be used.

Pesticides are classified as Level 1, Level 2, Level 3, and Level 4, depending upon the degree of hazard associated with their application.

Level 1—Non-chemical (preventive)
Level 2—Least hazardous (low toxicity, non-volatile baits or dusts)
Level 3—EPA Caution (limited volatility liquids)
Level 4—EPA Warning or Danger (broadcast and space treatments, spraying and fogging)

As a parent/legal guardian, you have the right to be notified if and when **Level** 3 **or Level** 4 pesticides are to be applied. Level 3 and Level 4 pesticides **will not** be applied when children are in the areas being treated.

( ) Please notify me if and when Level 3 or Level 4 pesticides will be used
(Notification will be made at least 24 hours prior to the use of these pesticides)

( ) It is not necessary to notify me if and when Level 3 or Level 4 pesticides will be used.

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Placement Agreement

Genesis Youth Crisis Center, Inc. (GYCC) is a private, non-profit organization, and is licensed by the WV Department of Health and Human Resources and the WV Office of Behavioral Health Services to provide Residential Crisis Support/Emergency Shelter Services. GYCC agrees to provide services in accordance with standards established by the Office of Social Services, Bureau of Medical Services, and all applicable regulatory agencies.

As a resident of this facility, he/she may participate in all planned educational, therapeutic, and recreational activities and field trips outlines in the program. This includes activities, which involve other GYCC facilities. Permission from the social worker/legal guardian will be obtained for any off campus activities in which GYCC staff will not be supervising the resident. Any stipulation or request, which may limit his/her ability to participate in the program, should be discussed at admission if possible. GYCC will make reasonable accommodations to comply with such requests, however reserves the right to deny such requests if the stipulation will cause disruption to the daily operations of the facility.

The resident will be assigned a case manager, and the treatment team will coordinate necessary services and develop a treatment plan to identify specific treatment goals for the resident. The social worker/legal guardian is expected to provide necessary information regarding the resident's case to the shelter and participate in the treatment planning process. The social worker/legal guardian shall also communicate with the resident and agency in accordance with DHHR Foster Care Policy. The case manager will provide a progress report every 30 days and assist, when appropriate, in making recommendations, submitting court reports, making referrals and arranging pre-placement interviews.

GYCC agrees to provide a safe, non-restrictive and supportive setting. Shelter staffs are responsible for knowing the whereabouts of residents at all times. GYCC shelters are staff secure, which means staffs have the ability to restrict or limit activities, but there are no construction fixtures designed to restrict or limit residential activities. The resident is considered to be "Away from Supervision" if he/she is absent from the supervision of staff without consent for more than 15 minutes. If the resident leaves the facility, staff will make a reasonable attempt to follow the resident, according to the AFS Training curriculum. If the resident runs away, shelter staff will immediately contact: local law enforcement, DHHR (hotline after hours), GYCC on call worker, the resident's family if appropriate, and the office of the circuit court judge involved in his/her placement. Shelter staff will make the same notifications when the resident is located or returned to the facility. GYCC will discharge the resident if not located or returned within 24 hours of the time of elopement.

Placement in emergency shelters is limited to 30 days. If the resident's stay is going to exceed this time limit, the social worker/legal guardian may request an extension from this facility for up to an additional 60 days if deemed necessary by the MDT and the appropriate re-authorization request has been approved by the Administrative Services Organization.

Should the resident display symptoms or functional impairment, which cannot be treated safely and effectively in this facility, GYCC will request the resident be discharged. Shelter staff will assist in making referrals and transporting the resident to an alternative placement as recommended and agreed upon by the MDT (if possible) or the social worker/legal guardian. One-on-one supervision may be provided in emergency situations for a period not to exceed 24 hours.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Medical Care and Treatment Authorization for Child in Residential Placement

Resident Name _____ Admission Date _____

The child named above has been placed with a facility of Genesis Youth Crisis Center, Inc. by the WV Department of Health and Human Resources. Having custody/guardianship of this child, DHHR hereby grants Genesis Youth Crisis Center, Inc. the right to sign for the following:

1. Emergency Medical Treatment;
2. Routine visits to EPSDT provider or other medical provider for necessary medical services;
3. Psychological assessment and/or counseling/therapy services deemed necessary for the child's treatment while in placement;
4. Immunizations recommended by WV DHHR or medical provider;
5. Hospitalization of the child for routine medical treatment as may be deemed necessary by the child's physician;
6. Release of medical and assessment information related to the child.

Genesis Youth Crisis Center, Inc. SHALL NOT sign for surgical procedures unless a life threatening emergency situation exists.

Genesis Youth Crisis Center, Inc. will notify the DHHR social worker immediately of any emergency, accident, serious illness, or hospitalization of the child.

Signed,

_____ _____

Legal Guardian Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Physical Admission Report

Resident Name _____ Admission Date ____/____/____

List any permanent markings (i.e. body piercings, tattoos, scars, birthmarks)

_____

_____

Physical Injury (i.e. bruises, cuts, bleeding, pain, swelling)

( ) No visible or reported injury
( ) Legal guardian-reported injury
( ) Self-reported injury
( ) Visible or suspected injury

Describe type of injury and explain when and how it occurred:

_____

_____

( ) Medical care is needed for reported injury
( ) Medical Care is not needed or has been provided

Physical Illness (i.e. cold, flu)

( ) No reported illness
( ) Legal guardian reported illness
( ) Self-reported illness
( ) Suspected illness

Describe the illness and if it is being treated:

_____

_____

( ) Medical care is needed for this illness
( ) Medical care is not needed or has been provided

Complete body chart on opposite page to indicate markings and/injuries. *(If necessary and appropriate, take photographs of physical injuries)*

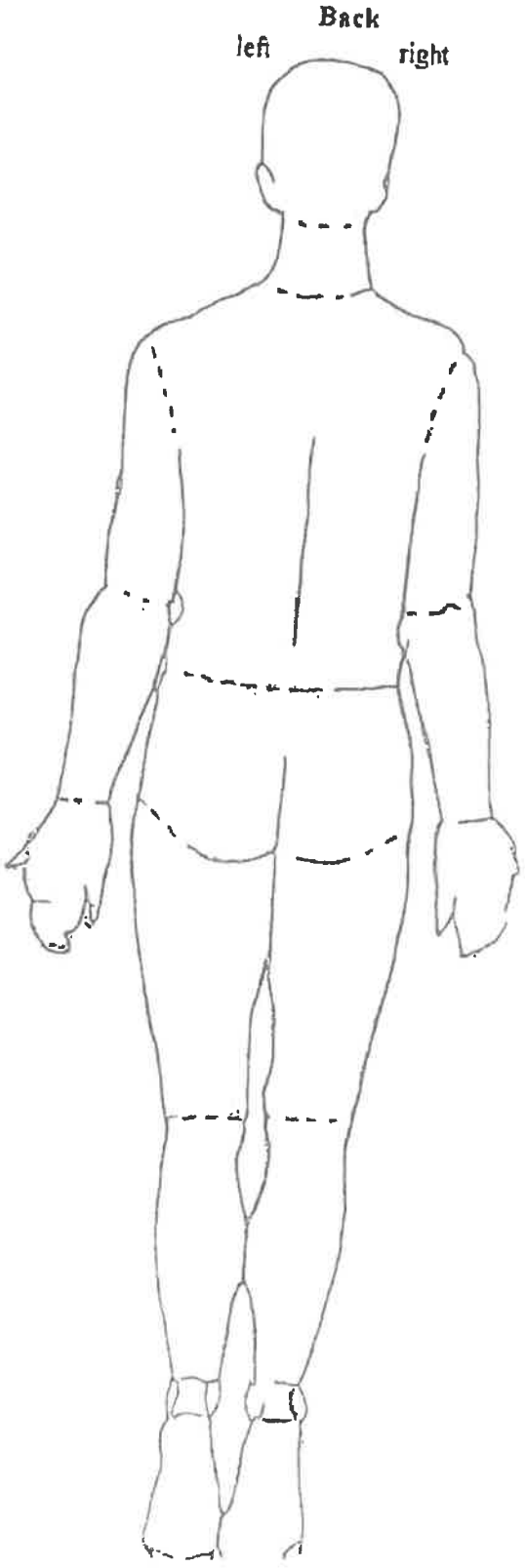
The above information was provided to GYCC staff by the resident, legal guardian or other source at the time of admission into the facility.

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

BODY CHART



Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Phone/Visitor Authorization

Resident Name: _____ Site: _____

It is the right of the resident to have private communication with others (family and friends) by mail, telephone or in person. Unless otherwise restricted, GYCC will allow the resident to have contact with friends and family by mail, telephone or in person, in accordance with GYCC phone and visitor policy. GYCC will provide monitoring of all phone calls and visits, but will provide direct supervision of phone calls and visits if requested. Mail, both incoming and outgoing, will not be opened of read by any staff. The resident will be required to open any packages or suspicious-looking mail in the presence of staff.

PHONE CALLS **( ) Supervision Required-call must be on speaker phone**
( ) Resident is permitted to make/receive telephone calls. Please list names and numbers of **APPROVED** contacts.

_____
_____
_____
_____
_____

( ) Restrictions-resident is **PROHIBITED** from having phone contact with the following people:

_____
_____

IN-HOUSE VISITS **( ) In room supervision required**
( ) Resident is permitted to have in-house visits. Please list names of **APPROVED** contacts.

_____
_____
_____
_____
_____

( ) Restrictions-resident is **PROHIBITED** from having phone contact with the following:

_____
_____

MAIL
( ) No Restrictions- resident may send and receive mail from family/friends of his/her choice.
( ) Restrictions-Please explain:

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Admission Report

Identification Information:

Resident Name_____ Admission Date___/___/___
Site _____ Medicaid #_____
County of Residence_____ Social Security #_____
D.O.B___/___/___ Age___ Sex: M F Race: ( ) White ( ) Black ( ) Hispanic
( ) Asian ( ) Other
Religion_____
Place of Birth_____

Legal Information:

Legal Custody Status_____ ( ) Temporary ( ) Permanent
DHHR Worker _____ Phone_____
Address_____ Email_____
-Supervisor Name, Phone and Email_____
-CSM Name, Phone and Email_____
Juvenile Probation Officer_____ Phone_____
Circuit Court Judge_____ Phone_____
Resident's Attorney_____ Phone_____

Presenting Problems (Identify *current* problems which led to placement):

( ) Physical Abuse ( ) Neglect ( ) Sexual Abuse ( ) Truancy ( )Incorrigibility
( ) Runaway ( ) Sex Offense ( ) Criminal Acts ( ) Behavioral ( ) Other
Explain Reason for shelter placement_____
Describe any behavioral problems_____
Pending Status Offense/Criminal Charges_____
Discharge
Plan_____

Family Information:

Name and Address of Mother_____ Marital Status_____
_____ Phone_____
Name of Step-Father (if living with mother or involved with child)_____

Name and Address of Father _____ Marital Status_____
_____ Phone_____
Name of Step-Mother (if living with father or involved with child)_____
Name and ages of Siblings (Also may identify other family members who are involved with child)
_____
_____

Medical/Treatment Information:

Does the child have any condition which requires special needs? ( ) No ( ) Yes
_____
Has the Child had an EPSDT? ( ) No, needs one ( ) Yes Date of Exam_____

(Please provide a copy of EPSDT report, if available)

Genesis Youth Crisis Center, Inc.
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Is the child on any medication at this time? ( ) No ( ) Yes
Were all medications/prescriptions brought with the child? ( ) No ( ) Yes
List all medications:

_____

_____

Other Medical Needs? ( ) Dental ( ) Optical ( ) Other
Has the child had a Psychological Evaluation? ( ) No, needs one ( ) Yes Date of eval/Availability____
Is the child currently attending Individual/Group/Family counseling ( ) No ( ) Yes
If yes, where/with whom_____ Is this to continue? ( ) No ( ) Yes
Other Psychological/Treatment needs?

_____

_____

Education:
Last school attended/County_____
Current Grade_____ ( ) Special Education ( ) L.D. ( ) B.D.

Child's History:

( ) Physical Abuse	( ) Neglect	( ) Sexual Abuse	( ) Truancy	( )Incorrigibility
( ) Runaway	( ) Sex Offence	( ) Criminal Acts	( ) Behavioral	( ) Other

Prior out of home placements (including name/type of placement and dates):

_____

_____

Prior Adjudications (indicate charge and date):

_____

_____

Please provide any additional information which may be helpful for the care and treatment of the child during this placement:

_____

_____

_____

_____ _____
Legal Guardian Signature Date

_____ _____
Care Coordinator Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Basic Rights

Resident Name _____ Admission Date ____/____/____

Protection of the civil rights of residents is very important. The agency makes every effort to ensure the residents' human and civil rights are exercised and protected. A resident, legal guardian, an employee, or any other individual may make a complaint to the agency regarding the violation of these basic rights.

- The right to all available services without discrimination because of race, religion, color, sex, sexual orientation, disability, age, national origin, or ability to pay.
- The right to treatment and services in the least restrictive, most appropriate, and most effective setting.
- The right to treatment and services that support your needs and that result in positive outcomes.
- The right to adequate food, clothing, and medical care.
- The right to be housed with other kids close to your age and needs.
- The right to speak to your legal guardian, attorney, or religious advisor at any time.
- The right to keep and use your personal things at all times, unless it is against the rules.
- The right to send and get mail, talk on the phone and visit with family and friends.
- The right to your own treatment plan to be done soon after you are here; treatment based on the plan, review and reassessment of your needs, and changes to the plan when necessary.
- The right to get help when you need it and have some say in the help you get; the right to refuse help, unless refusal will cause you to get hurt; the right to have someone speak for you if you cannot; the right to be free from involuntary experiment, and the right to be told of any changes in the help you will be getting.
- The right to be referred to other appropriate behavioral health services.
- The right to freedom from restraint or isolation. Passive physical restraint will only be used in a situation where there is danger to you or others and all other ways of helping you stay safe have been tried.
- The right to live in a place where you will be treated with kindness and respect and to have adults help you to feel good about yourself.
- The right to have information about you kept private.
- The right to see your file with permission from your case manager, in accordance with state and federal law.
- The right to be told in person about any fee for services.
- The right to practice your civil rights and to be able to talk to someone who can help you understand, protect, and exercise those rights.
- The right to be assessed and provided with appropriate auxiliary aids and/or services needed for effective communication when doing so would not constitute an undue burden to the agency.
- The right to be protected from all danger. You will not be harmed in any way, physically or verbally.
- The right to be free from unnecessary or too much medication; and to not be given medication as punishment, for the convenience of staff, or in amounts that will keep you from being able to do every day things.
- The right to not to do any work, except for basic housekeeping tasks, unless you get paid for it.
- The right to complain about your care, either by writing it down or telling someone; and the right to have your complaint investigated fairly and as soon as possible.
- The right to be told in person if a service authorization request is not approved and what is going to happen because it is not approved.

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

- The right to be told in person and in writing of the rights described above.
- Your rights may be limited or restricted by agency policies or because of treatment needs or other circumstances decided by the agency or your legal guardian. Any limitations or restrictions will be appropriate and clearly justified in writing.
- You will be told by staff any time any of your rights are limited or restricted. You will be told why and how long any rights are limited or restricted. Your legal guardian will also be informed any time the agency restricts or limits your rights.
- Only your legal guardian shall be the administrator of your rights, to the extent your legal guardian's acts are not hostile or in your best interest.
- Residents will receive assistance and training in personal care, hygiene and grooming appropriate to their age, sex, race, and culture.

**Signing below indicates you have been made aware of and fully understand these rights.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

EPSDT/HealthCheck Health History Form

7-20 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to child:** _____

Childhood

Has your child ever been treated for or diagnosed with:

- ☐ Asthma or wheezing _____
- ☐ Pneumonia _____
- ☐ Lung problems _____
- ☐ Heart murmur _____
- ☐ Anemia _____
- ☐ Recurrent ear infections _____
- ☐ Hearing problems _____
- ☐ Vision or eye problems _____
- ☐ Urinary tract infections _____
- ☐ Stomach or digestive problems _____
- ☐ Seasonal allergies or eczema _____
- ☐ Seizures _____
- ☐ Broken bone(s) _____
- ☐ Learning disability _____
- ☐ Other chronic medical problems _____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including counselors, your child is currently seeing and reason: _____

Developmental

Do you have concerns about any of the following:

- ☐ The way your child uses his/her arms, fingers or legs
- ☐ Speech problems
- ☐ Vision (Are you concerned about your child's vision?)
- ☐ Hearing (Are you concerned about your child's hearing?)

Puberty

Concerns about:

- ☐ Body changes
- ☐ Sexual activity
- ☐ Sexually transmitted infection
- ☐ Discharge: vaginal or penis
- ☐ Contraception

For Girls:

Age of first menstrual period? _____

Social Emotional/Stress Indicators

Does your child have problems with:

- ☐ Depression/ anxiety _____
- ☐ ADD/ADHD _____
- ☐ School attendance
- ☐ Getting along with other children including siblings
- ☐ Getting along with parents or other adults
- ☐ Problems with sleeping or nightmares
- ☐ Bad temper/breath holding/jealousy
- ☐ Nail biting/thumb sucking
- ☐ Bedwetting (after 6 years)
- ☐ Threaten to harm self, others or animals
- ☐ Sexual acting out
- ☐ Destroying property
- ☐ Drug use, alcohol use or smoking

Exposure Risks

- ☐ Passive smoke ☐ Cigarettes ☐ E-Cigs ☐ Chew
- ☐ Alcohol ☐ Other drugs _____
- ☐ Access to weapons ☐ Has a weapon(s)
- ☐ Excessive television/video game/internet/cell phone use

Hours per day: _____ Who supervises usage? _____

Wears protective gear, including seat belts? ☐ Yes ☐ No

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Medications

Current medications and dose: _____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

Nutrition

☐ Has your child had any dietary problems? _____

- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Food allergies: _____

Dental

- ☐ Problems with teeth or gums
- ☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Drug and alchol use	☐	☐	☐	☐
Diagnosed Mental Condition	☐	☐	☐	☐

Other _____

Other Concerns/Issues:

Reviewed by: _____

Date: _____

Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. For assistance phone 844-HELP4WV (844-435-7498).

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Influenza Vaccine Consent

Resident Name _____ Site _____

The Center for Disease Control recommends that everyone over the age of 6 months old receive an influenza vaccine each year. Genesis Youth Crisis Center is committed to promoting the health of each of our residents. One of the ways we can help promote wellness is to provide the opportunity for each of our residents to receive the vaccines recommended by their physician and the CDC.

Resident Consent

_____ I wish to receive a flu vaccination

_____ I choose to decline a flu vaccination. By signing below, I understand that the flu vaccination is recommended by my doctor and agree that I will not hold staff or other residents responsible for my decision.

_____ I have already received a flu vaccination for this year

_____

Resident Signature

Guardian Consent

_____ I give consent for the above named resident to receive a flu vaccine

_____ I do not consent for the above named resident to receive a flu vaccine.

_____ Resident has already received a flu vaccination this year.

_____ _____

Legal Guardian Signature Date

_____ _____

Registered Nurse Signature Date

Genesis Youth Crisis Center, Inc.
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Educational/Recreational Outing(s) Permission

Resident Name: _____ Site: _____

During their stay at our facility, our residents have the opportunity to participate in a variety of educational and recreational activities. Some of these events take place in locations out of state, such as Pennsylvania and Ohio. By signing this permission slip, you are giving consent for your client to attend these outing. We will arrange for alternative options should your client not be permitted to attend these outings.

_____ Yes, my client may attend these outings.

_____ No, my client may not attend these outings.

( ) Check this box if you would like to be given advance notice of any out of state activities.

Special Instructions:

_____

_____

_____

_____

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Group Counseling Confidentiality and Consent Agreement

Genesis Youth Crisis Center Inc. provides some psychoeducational groups. These groups will be held on-site and will incorporate a variety of subject matter. Groups will be facilitated by professional staff from various disciplines.

Those residents who are currently in therapy will continue to see their therapist. These groups are not intended to replace any existing therapeutic services. Genesis Youth Crisis Center Inc. is requesting your permission to deliver these services to your client.

Participation in group counseling is encouraged and voluntary. No group member will be subject to intimidation, threats, undue group or peer pressure, or coercion. Any participant who fails to follow this rule will be asked to leave the session.

During therapeutic group sessions, some members may experience and express strong personal feelings and private information. Group members may "Pass" when asked to speak during group, but are encouraged to participate as fully as is comfortable in order to receive the most benefit from group sessions.

- All participants are expected to show respect for other's feelings.
- All participants are requested to maintain confidentiality of information shared in groups, but this cannot be guaranteed.
- All Group Facilitators will strictly adhere to the same confidentiality provisions as those of Individual Counseling sessions as agreed upon.

Subject materials covered in groups consist of the following:

Dealing with Anger	BAD Friendships	Making Good Choices Managing
Strong Emotions	Substance Use	Anxiety
Depression	Problem Solving	Social Success
Teen Pregnancy Prevention	STD's Just the Facts	Parent-Child Relational
Life Skills	Interviewing Skills	Nutrition and Healthy Living Teen
Issues	Teen Talk	Infectious Diseases

I have read and had explained this Agreement form and agree to its provisions.

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Individual Supportive Counseling
Confidentiality and Consent Agreement

I understand that information shared during Individual Supportive Therapeutic Counseling sessions will be kept confidential expect that I give my consent that information may be shared with:

1. Employees of Genesis Youth Crisis Center, Inc;
2. West Virginia Department of Health and Human Resources Social Worker, Juvenile Probation Officer, Child Protective Service Worker, or their supervisors;
3. Physician;
4. Scheduled correlative counselor;
5. Licensed Professional Counselor or Psychologist serving as supervisor for Counselor/Facilitator.

I understand that if I report any instances of child abuse or assault or intention to harm myself or another person, this information will not be held in confidentiality.

I have read and had this confidentiality form explained to me, and I understand and agree to its provisions.

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Haircut Release Form

Resident's Name:_____ Site: _____

I do authorize the staff of Genesis Youth Crisis Center, Inc. to administer basic haircuts and trims from a licensed Beautician, or Barber. A licensed beautician comes to the shelter monthly to administer the haircuts as needed. Please note that these haircuts and trims do not permit specialty cuts, designs, perms, dyes, or colorings.

If a resident has been placed into a shelter with an un-natural hair color and causes school enrollment issues (or self-esteem issues), the resident will be taken to a local, licensed beautician/barber to have the color turned back to a natural color. If this needs to occur the case manager will attempt to contact you or a supervisor prior to the appointment.

If a resident needs any type of special hair treatment (weaves, perms, shavings, colorings) outside of a basic haircut, the DHHR will be contacted and requests will be discussed.

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Management of Inappropriate Behavior

When a child is acting out or demonstrating inappropriate behavior, the child should be taken aside and the behavior discussed. Staff will ensure the child understands why the behavior is not acceptable and the consequence for continuing the inappropriate behavior. The consequence must be clearly understandable and enforceable; involve the supervisor when staff need help handling severe behavior problems or simply need to discuss suggestions or process experiences. Staffs who are aware of any incident(s) involving the following should report the incident to the supervisor immediately.

- Corporal Punishment (physical hitting, or verbal threats)
- Physical exercise such as running laps or pushups used solely as punishment
- Requiring a child to take an uncomfortable position for an extended period of time
- The use of aversive conditioning (sound, heat, cold, light, water, noise, hot pepper, etc)
- Interventions that withhold nutrition, sleep or hydration
- Punitive work assignments
- Sanctioning by peers
- Punishment of the group for an individual child's behavior except as it involves a brief delay
- Punishment with includes verbal abuse, ridicule or humiliation
- Excessive denial of on-grounds program services
- Denial of visiting or communication privileges with family
- Enforced silence for long periods of time
- Exclusion of the child from entry to the residence

A child who exhibits extremely inappropriate or dangerous behavior while receive more intensive services from the staff through the modification of the child's individualized plan of care. The plan will address specific service issues on which the child and staff will work. The need to use time out or other service interventions will be clearly stated in the service plan and approved by the treatment team or MDT. If at any time the behavior intervention appears to be causing any adverse effects such as illness, severe emotional or physical stress, or physical damage the behavior intervention will be discontinued.

Only trained staff shall use the Therapeutic Crisis Intervention passive physical restraint techniques. Genesis Youth Crisis Center, Inc. does not authorize the use of isolation, mechanical or chemical restraint or locked seclusion.

_____ _____

Resident Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Procedure on Passive Physical Restraint

Only staff that have been trained and certified in Therapeutic Crisis Intervention may use passive physical restraint. Passive physical restraint is utilized in the proportion necessary to:

1. End a disturbance that threatens the safety of the acting out youth
2. End a disturbance that threats the safety of others

Passive physical restrain requires a crisis management plan(s) once the child is evaluated; that plan will be shared with the treatment team/MDT and must be documented in the service plan.

Passive physical restraint is to be implemented only after all other less intrusive interventions have been exhausted. It should be time limited with a maximum of 15 minutes per episode for client's age 9 and under and 30 minutes per episode for clients age 10 and older. Time frames may be extended for chronic, self-harming behavior on a case by case basis. All such instances must be approved by appropriately trained and certified personnel. Youth who are being physically restrained are monitored continuously and assessed at least every 15 minutes for any harmful health or psychological reactions. If at any time the physical restraint appears to be causing any adverse effects such as illness, severe emotional or physical stress, or physical damage the restraint should be immediately discontinued.

When passive physical restraint has been utilized the event should be processed with the client and appropriate personnel as soon as possible following the event and within a maximum of 24 hours. The parent or guardian will be notified and debriefed within 24 hours when possible. The staff involved in the passive physical restraint must complete a passive physical restraint form. The form must be signed by the staff participating in the restraint and reviewed and signed by a Director and TCI trainer.
Only trained staff shall use the Therapeutic Crisis Intervention passive physical restraint techniques. Genesis Youth Crisis Center, Inc. does not authorize the use of isolation, mechanical or chemical restraint or locked seclusion.

When following a resident during an away from supervision "restraint techniques are only used when a child presents himself/herself to be in danger or self-harm and/or poses a legitimate danger to others-not to simply prevent elopement". Danger and risk to the resident and staff are increased. The public may be confused about the events that are occurring. The lack of immediate support and potential for injury are significantly increased. Restraint should be considered only as a last alternative to risk of life.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Search of Resident and Shelter Property

Genesis Youth Crisis Center, Inc.'s intention is to provide for the safety, security and general well-being of residents and staff. This procedure is intended to define the methods of searching the resident's property and shelter common areas, and the procedures to be utilized in finding and disposing of unauthorized property.

1. Authorized property is limited by restrictions imposed by the resident handbook, state and local regulations and may also be limited by other sources such as a probation officer, etc. Property is screened at a resident's intake. Searches of a resident's property should be differentiated from searches of the resident.
   - Property belonging to the shelter, i.e. rooms, closets, dresser, etc. may be searched by staff when a probable cause exists for such action and periodically for maintenance routine. Any property placed in such areas by a resident that a resident is not permitted to possess will be removed by staff and given to an on duty supervisor. In the case of property, which is an obvious danger to persons in the opinion of the supervisor, it will be placed under lock and key, and removed from the shelter as soon as possible and given to the parent or guardian or law enforcement, as appropriate.
   - Property, which a resident could legally own but which is forbidden by shelter regulations, will be returned to them or their guardian upon their discharge if it can be safety arranged. This will only be done if it is feasible and the shelter makes no guarantees that property, which is taken, will be returned. Also cigarettes are specifically excluded from this provision, as their return would constitute a violation of state law.
   - In the event that contraband of any type or unauthorized items; are found a reprimand will follow.
2. In searching a resident's property (2) staff members should be present if possible; staff will attempt to return the area to the condition in which it was found. While some disruption is inevitable, resident's property will be respected and any damage will be reported to a supervisor. If property is discovered which is unauthorized, it will be reported to a supervisor immediately. The resident will be informed that the property was discovered in their area and of the options available to them if any. Staff will document any searches and/or contraband that was found at this time.

_____ _____

Resident Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Visual and Pat Down Search

Safety is the primary issue of Search Policies: safety of the child, safety of the staff and the other residents in the agency. When probable cause exists to conduct a search, it is imperative that the Search Procedures are carried out in a standardized manner with each resident. A Pat-Down Search is conducted when a child returns from a runaway and based on physical factors such as evidence of bulges, etc, in plain sight, a resident's condition, other evidence such as smell of smoke, alcohol or reliable report that the resident has unauthorized property.

Visual Search

1. A visual search is conducted when staff have established that probable cause exists for the visual search.
2. Procedure:
    a. Residents are to be asked to give staff anything they are not permitted to have.
    b. Expose all pockets
    c. Have the resident remove multiple layers of clothing for staff to check
    d. Have resident remove and staff check shoes and socks
    e. Search through bag, items, etc.

Note: When the resident is not at the shelter, **DO NOT** transport the resident or permit reintegration into the program until a visual search is completed.

Pat-Down Search:

1. A Pat-Down Search is conducted when staff have established that probable cause exists for the pat-down search. Residents are searched upon admission and any other time they return from an outing or pass when they were not supervised by staff. Searches may also be done if staff suspects a resident may have contraband in their possession.

2. Procedure:
    f. Conduct a-e steps of visual search
    g. Have two (2) staff present
    h. Contact will only be made by staff of same gender
    i. A resident's continued refusal results in Law Enforcement intervention.

Note: If there is reasonable suspicion the Pat-Down Search is indicated, **DO NOT** transport the resident or permit reintegration into the program until Pat-Down Search is completed.

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

I have read and had this procedure explained to me and had the opportunity to ask questions regarding it by signing this I understand that I am giving consent.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Consent to Photograph Form

Resident's Name:_____ Site:_____

Photographs of residents may be taken at the shelter for a variety of reasons including but not limited to: resident identification, to document an illness or injury, and/or during agency sanctioned events and holiday parties. Additionally, the shelters are equipped with a video monitoring system. Cameras are located in common living areas. Photographs and video monitoring are for internal agency use only and will not be released, unless legally bound, without formal written consent.

**Please initial below indicating your consent for the use of the video monitoring system and any internal photographs as indicated above.

_____ I have been informed and consent to the use of video monitoring and internal photographs.

Special Instructions:

_____

_____

Additionally, residents who attend public school may have their full name and/or likeness used in school approved publications, webpages, printed materials, audio, visual or electronic means. This may include but not be limited to yearbook photos, classroom community apps, etc.

**Please initial below indicating your consent for the use of the resident's full name and/or likens to be used by the public school system as indicated above.

_____ Yes, I consent to the public school system's use of full name and/or likeness.

_____ No, I do not consent to the public school system's use of full name and/or likeness.

Special Instructions:

_____

_____

_____ _____
Resident Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
GYCC Staff Signature Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Grievance Procedure

Your rights will be explained to you at intake. If at any time you feel your rights have been violated, you may file an oral or written grievance with any staff member. Your grievance will be reviewed by the Director or designee.

The grievance procedure should NOT be used as a way to complain about staff or the shelter rules. If you have a problem with a staff member or another resident, you should try to work it out appropriately before filing a grievance.

If you still want to file a grievance, ask any staff member for a grievance form or use the form in your Resident Handbook. When you have completed your grievance, please place it in the designated lock box. If you need help writing your grievance, staff will assist you.

The Director or designee will meet with you within 3 working days of filing your grievance. All outcomes of the grievance will be put in writing and placed in your file upon discharge.

You may appeal any decision made to the Director or the Chief Executive Officer. If you still are not satisfied with the outcome, you may make an appeal externally to the Board of Directors and/or the Federal Office of Civil Rights.

If at any time you have been physically, sexually, or emotionally abused by staff or another resident, report it to any staff member immediately.

If any parent has a complaint regarding the care of their child during their stay, please contact a member of Administration listed on page 2 of the Resident/Parent handbook.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Consent for OTC Medication

Name: _____ Admission Date: _____

Allergies: _____

Each occurrence of the use of over the counter medication(s) and treatment of injury is monitored by the Registered Nurse. If symptoms worsen in 24 hours; a follow up will be scheduled with health care provider.

Please check the appropriate box to agree or disagree with each the over the counter medications that we use at the Genesis Youth Crisis Center, Inc. shelters.

( ) Agree ( )Disagree **Acetaminophen** (Tylenol): **500mg Tablet (or liquid Tylenol 120ml)**

Indications: Headache, , Muscular Aches, Minor Pain of arthritis, toothache, backache, the common cold, menstrual cramps, Fever reducer, Swelling

Take 2 caplets (500mg each) every 6 hours while symptoms last, DO NOT EXCEED more than 6 caplets (3000mg) in 24 hours (liquid form 5ml follow weight/age chart and may give every 4 hours; DO NOT EXCEED more than 5 times in 24 hours.

( ) Agree ( ) Disagree **Ibuprofen** (Motrin): **200mg tablet (or liquid Ibuprofen 5ml)**

Indications: Headache, , Muscular Aches, Minor Pain of arthritis, toothache, backache, the common cold, menstrual cramps, Fever reducer, Swelling

Take 1-2 tablets (200mg each) every 4-6 hours while symptoms persist; DO NOT EXCEED more than 6 tablets (1200mg) in 24 hours (liquid form 5ml follow weight/age chart and may give every 6-8 hours; DO NOT EXCEED more than 4 times in 24 hours.

( ) Agree ( ) Disagree **Tums Antacid (1000mg)/ Mylanta Liquid** (Regular Strength may substitute Maalox) 10-20 ml/

Indications: Heartburn, Acid Indigestion, Sour Stomach, pressure & bloating

Chew 2-3 tablets (2000-3000mg) DO NOT EXCEED 7 tablets (7000mg) in 24hours.

Take 2-4 teaspoonfuls 2 times per day; DO NOT EXCEED 8 teaspoonfuls in 24 hours.

( ) Agree ( ) Disagree **Chloraseptic Sore Throat Spray**: (1-2 sprays) and/or **halls cough drops**

Indications: temporary relief of occasional minor irritation, pain, sore mouth and sore throat.

Take 1 application to affected area (5 sprays) (1 cough drop); can use every 2 hours as needed; DO NOT EXCEED more than 2 days.

( ) Agree ( ) Disagree **Anti-Diarrheal: (2mg tablet)**

Indications: controls symptom of diarrhea.

Take 2 caplets (4mg) after the first loose stool; 1 caplet (2mg) after each subsequent loose stool; but DO NOT EXCEED more than 4 caplets (8mg) in 24 hours

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

( ) Agree ( ) Disagree **Allergy Relief** (Diphenhydramine HCl, **25 mg Antihistamine)**

Indications: Sneezing, itchy, watery eyes, running nose, itchy throat

Take 1-2 capsule (25/50mg) every 4 -6 hours, DO NOT EXCEED more than 6 capsules (150mg) in 24 hours.

( ) Agree ( ) Disagree **Triple Antibiotic Ointment (Neosporin)**

Indications: to treat cuts, scrapes

Apply a small amount to affected area 1-3 times daily, may bandage; DO NOT EXCEED usage for more than 1 week

( ) Agree ( ) Disagree **Hydrocortisone 1% Cream**

Indications: to treat allergic reactions, insect bites, eczema & psoriasis

Apply to affected area 3-4 times daily; DO NOT EXCEED usage for more than 1 week.

All residents are given a multi-vitamin daily as a proactive approach.

( ) Agree ( ) Disagree **Multi-vitamin** (Gummy): (1) gummy chewable

Indications: As a dietary supplement to provide vitamin, Vitamin B-6 &B-12, Vitamin C, Vitamin D and Vitamin E.

Take 1 gummy bear daily, DO NOT EXCEED more than 2 gummy bears in 24 hours.

I understand at times I will need to take over the counter medications, and can ask questions about when I should take it and the possible side effects of the medication. If I have more questions at a later time, I will ask the nurse. I consent to take the medication(s) marked as listed above as needed.

Resident Signature _____ Date _____

Legal Guardian Signature _____ Date _____

GYCC Staff Signature _____ Date _____

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Consent for Prescribed Medication

Resident's Name: _____ Date: _____

Physician's Name: _____ Phone: _____

Medication and Dosage:

_____

_____

Administration Instructions:

_____

_____

Route: _____

Reason Prescribed:

_____

_____

Describe the possible side effects of the medication:

_____

_____

I have talked to the prescribing physician/nurse about the above-mentioned medication. I understand why I should take it, when I should take it and the possible side effects of the medication. I have been given the opportunity to ask questions about the medications. If I have more questions at a later time, I will ask the nurse. I have been given the option for a copy of this form. I consent to take the medication listed above.

_____

Resident Signature Date

I, (Guardian, Parent, WV DHHR) consent for the resident to take the medication listed above. Genesis Youth Crisis Center, Inc. will make every effort to notify you immediately after a medication has been prescribed, if this form is not signed and returned in 24 hours; the medication will be administered in regards to providing your client with the needed medical care as deemed necessary.

_____

Guardian, Parent, WV DHHR Signature Date

_____

Registered Nurse Signature Date

MEDICAID TARGETED CASE MANAGEMENT
MEMBER ENROLLMENT FORM

PROVIDER AGENCY:

Client Name: _____ County: _____

Date of Birth: _____ SS#: _____

Medicaid Number: _____ Effective Date of Enrollment: _____

Previous Agency of Record: _____

- I (and/or my legal representative) have been informed of my rights to Targeted Case Management Services including the right to appeal my individual service plan.
- I (and/or my legal representative) understand that my use of these services is voluntary and services may be withdrawn or ended at my request.
- I (and/or my legal representative) understand that I may choose to receive Targeted Case Management Services from any available qualified provider, and I have the right to change my case management provider if I feel services are not appropriate or sufficient to meet my needs.
- I (and/or my legal representative) understand that I may not enroll with another provider until the first day of the new calendar month.
- I (and/or my legal representative) have been informed of the definition of Targeted Case Management Services, and I understand that receiving these services does not guarantee the receipt of other services or treatments, but it is a process to help me get necessary services and/or treatment based on my individual needs.
- I (and/or my legal representative) have been informed of other case management providers available in my county.

☐ I choose to receive Targeted Case Management Services.

☐ I choose **NOT** to receive Targeted Case Management Services.

_____ _____

Member/Legal Representative Date

_____ _____

Provider Representative Date

Genesis Youth Crisis Center, Inc.
Emergency Shelter Care

Parental Involvement Consent

Resident Name _____ Admission Date ____/____/____

Per licensing requirements, the organization is required to notify parents and/or other caregivers of treatment activities, unless participation is not clinically or legally appropriate for the resident.

Is there a parent/caregiver(s) that will be involved in the resident's treatment? ☐ **Yes** ☐ **No**

If so, please provide contact information in order for the parent/caregiver(s) to be notified of treatment meetings.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Mailing Address: _____ Mailing Address: _____

_____ _____

_____
Resident Signature Date

_____
Legal Guardian Signature Date

_____
Care Coordinator Signature Date