The Family Center of Hope (TFC, Inc.)
P.O. Box 752, Hayes, Virginia 23072
Phone: 804-684-2555 www.hope-tfc.org/placements.htm Fax: 804-642-6722

PLACEMENT DOCUMENT REQUIREMENTS

Client Name:____________________________Date of Birth:___________________SSN: ______________________

Placement Contract (signed by locality representative and TFC, Inc. authorized representative)

Foster Home Agreement (The Family Center of Hope provides)

ERO/Entrustment/Court Order /Non Custodial Agreement (authority to place)

*Medical Exam (current within 90 days). *(Child/youth in the continuous care of DSS - locality may submit a physical exam current within 10 months, together with a doctor's report of all interim medical care received since last exam).*

Immunization Report (current)

Visitation Authorization Schedule (FHA)

Treat & Transport Form (Authorization to receive medical, mental health, dental)

Medication Log (listing of all medications – prescribed and non prescribed)

Consent(s) to Release and Obtain Information (DSS, school, therapist, doctor, dentist, psychiatric)

Indian Child Welfare Act (ICWA) Acknowledgement

Expedited School Enrollment/Consent to Enroll

HIPAA agreement signed by legal guardian if client is under the age of 18

Most recent Foster Care Service Plan (if applicable)

Copy of Birth Certificate

Copy of Social Security Card

Copy of Medicaid Card or Other Insurance

Dental Exam (Current within one (1) year)

VEMAT

Social History Reports from locality

Placement History *(for all known out of home placements)*

Treatment Plans (Current service or treatment plan from all other treatment providers - including but not limited to other TFCs, In-Home, Family Support, mental health clinicians)

Discharge summaries from all previous placements (including group homes, residential facilities, detention center)

Psychological Reports

FAPT assessment or CPMT approval TFC placement – documenting the need for TFC Case Management

CANS assessment/current w/in 90 days

**22VAC40-131-10 (Emergency placement means placement of a child where the local DSS placing the child has within the past 72 hours removed the child from his own home or previous placement due to abuse or neglect or other emergency.*

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PO Box 752 - Hayes, Virginia 23072 (804) 684-2555 / Fax (804) 642-6722

REPORT OF PHYSICAL EXAMINATION

Full Name of child: ______________________ Birth date: ______________

PART I

Health and Developmental History

A. Significant events in the child's developmental history include:

1. ______
2. ______
3. ______

B. Serious illnesses, accidents, operations, nutritional, dental, mental, emotional Problems, or handicapping conditions include:

1. ______
2. ______
3. ______

PART II

(*To be completed by Physician)*

Documentation of Immunizations or record of immunizations since last physical exam or given during this visit:

Immunizations	Vaccine Doses Administered				
Diphtheria Tetanus Pertussis (DPT)	1./_ /____Mo Day Yr.	2./_ /_______ Mo Day Yr.	3.____/_____/ ___Mo Day Yr.	4.____/_____/ ___Mo Day Yr.	5./ /_____Mo Day Yr.
Diphtheria Tetanus (TD)	1./_ /____Mo Day Yr.	2./_ /____Mo Day Yr.	3./_ /____Mo Day Yr.	4./_ /____Mo Day Yr.	5./ /_____Mo Day Yr.
Poliomyelitis (OPV)	1./_ /____Mo Day Yr.	2./_ /____Mo Day Yr.	3./_ /____Mo Day Yr.	4.____/_ / Mo Day Yr.	5.____/_ / Mo Day Yr.
Measles	___/___/___Live Virus Vaccine? __________ Mo Day Yr. Yes No			Serological Confirmation of Immunity /Month ___/Day___/Yr.______	
Rubella	___/Month____/Day____/Yr.			Serological Confirmation of Immunity /Month ___/Day___/Yr.	
Mumps	___/Month____/Day____/Yr.				
Measles, Mumps Rubella (MMR)	___/Month____/Day____/Yr. ___/Month____/Day____/Yr.				

Additional immunization information: _

______

______

______

The medical examination report on each child shall include the following:

1. Child's Name: _ Date of Birth: _
2. Date of examination: _ Type of Exam: _
3. Current physical condition/illnesses: Blood Pressure: _ Hemoglobin: _ Urine: _

   Other: _
4. Growth and development: Height: _ Weight: _ Concerns: _
5. Visual Acuity: Left Eye: _ Right Eye: _
6. Auditory Acuity: Left Ear: _ Right Ear: _
7. Nutritional Status and Dietary Needs: _
8. Is child free from all communicable diseases including tuberculosis? _ (if no, list CD)

   ____
9. Tuberculosis assessment or PPD: _

   PPD administered: date given: _ date read: _ results: _
10. List all known allergies (food, medication and environmental allergies) _

    ____
11. List all known chronic conditions: _
12. List all known Disabilities; and _
13. Please attach a copy the record of immunizations the child has received since his last examination or list below:

    Normal Exam? _ if no, concerns and recommendations: _

    ____

Name and address of Medical Practice:

____

____

____

Printed signature of Licensed Physician

____

Signature of Licensed Physician

____

Date of Signature

The Family Center of Hope
PO Box 752, Hayes, VA 23072 804-684-2555 Fax 804-642-6722

TREAT AND TRANSPORT

Authorization to Receive Routine Medical/Dental/Mental Health Treatment and To Seek Emergency Medical Care

CLIENT IDENTIFYING INFORMATION:

Items	Information	
Child's Name		
Date of Birth:		
Social Security Number		
Medicaid or Other Insurance Number or Policy Number		
Allergies (medication, food seasonable, environmental):		
PERSON TO NOTIFY IN CASE OF AN EMERGENCY		
Locality		
Social Worker		
Address		
Phone Number		FAX Number:
MEDICAL/DENTAL INFORMATION		
Medical Illness/Problems		
Medication		
Medical Doctor and Contact Information		
Dentist and Contact Information		
MENTAL HEALTH INFORMATION		
DIAGNOSIS		
Medication for Diagnosis:		
Date of most recent Psy Eval		
Therapist		
Psychiatrist		

☐ *I authorize The Family Center of Hope staff and/or foster parents to assist the above named client in obtaining routine medical, dental and mental health care.*

*This authorization also includes transportation to a hospital or physician's office and treatment by emergency personnel or a physician other than the personalphysician when the **LEGAL GUARDIAN/CUSTODIAN AGENCY** listed above under **EMERGENCY CONTACT** is unable to be reached by emergency personnel or The Family Center of Hope.*

Initial guardian/custodial agency contact attempt shall be made immediately and prior to child receiving emergency care, surgical procedures or hospital admissions of any type. Foster parents shall verbally notify The Family Center of Hope, 7 days a week, 24-hours a day by calling 804-684-2555 to report all instances of illness, accidents, injuries, and other incidents. All incidents occurring or continuing after office hours must be reported to the agency's on-call service.

______________________________ ______________________
Client's Signature (child 18 & over) Date:

______________________________ ______________________
Legal Guardian (Minor under the age of 18 or custody of DSS) Date:

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Indian Child Welfare Act (ICWA)

Public Law 95-608,25 USC Chapter 21

Child:____________________________________DOB: ___________________________________

I,____________________________representative of the locality of legal guardianship ascertain that the above named child:

________is not of Native American, Alaskan or Aleut Heritage.

_________is of Native American, Alaskan or Aleut Heritage. I acknowledge that I have received a copy of the Indian Child Welfare Act and authorize TFC, Inc. to place the above named child in a non tribal foster .

____________________________ ______________________
Legal Guardian Representative Date

____________________________ ______________________
TFC, Inc. Representative Date

The Family Center of Hope
2902 George Washington Memorial Highway, Hayes, VA 23072
Phone: 804-684-2555; Fax: 804-642-6722

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Section A (Must be Completed In Full for All Authorizations)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations.

Patient Name ______________________________ **ID#** ____

Persons/Organizations Providing Information:

_____Department of Social Services
_____Physician
_____Therapist
______School/Daycare:
______Dentist
______Psychiatrist

Persons/Organization Authorized to Receive My Information:

The Family Center of Hope (TFC, Inc.)
P.O. Box 752, Hayes VA 23072
804-684-2555 FAX: 804-642-6722

Specific Description of My Information and Dates of Service To Be Released:

Coordination of services, care and case management
Information and documentation pertinent to the care of this client

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Section B (Completed Only If A Health Plan Or A Health Care Provider Has Requested the authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? ____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [ ] YES [X] NO

The patient or the patient's representatives must read and initial the following statements:

____I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

____I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Section C (Must be Completed In Full for All Authorizations)

The patient or patient representative must read and initial the following statements:

______I understand that this authorization will expire on my discharge from the agency's programs.
_____I understand that I may revoke this authorization at any time by notifying TFC, Inc. in writing and if I do revoke it, it won't have any affect on any actions they took before they received the revocation.

____
Printed Name of Patient or Patient Representation (If representative - relationship)

Signature ____ Date: ____________________

REPORT OF DENTAL EXAMINATION ___

Full Name of Child:____ Date of Birth: ____________________

Foster parents are responsible for submitting this report to the agency immediately after child receives care.
Please provide results of dental examination for above listed person to:

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This is to certify that the above listed child had a dental examination on: ____________________________________

Dental work performed, included:

Recommendations, include:

Next scheduled exam date and time___

Signature: ____
(Dentist or Dentist Designee)

Date: ____________________________________

Printed or stamped name and contact information for dental practice:

____

____

____

Enrollment of Child Placed in Foster Care

(Child school placement changing upon entering or changing foster care placement)

State Law (Ref. *Code of Virginia* 22.1-289 and 63.2-900) requires that within 72 hours of placing a child in foster care, the agency making such placement shall, in writing, notify the appropriate principal and superintendent of the placement and inform the principal of the status of the child's parental rights. Children placed in foster care shall be immediately enrolled in school subject to the requirements of § 22.1-3.4 of the *Code of Virginia.*

This child is being enrolled by the agency having legal custody or its representative:

____Local Department of Social Services

____Licensed Child Placing Agency

Name of School: ____

Student's Name: ____

Students Date of Birth:____/ /____Sex:__________State or Country of Birth ______________

Foster Parent Name:______________________Tel: ______________________

Foster Parent Address: ____

Department of Social Services or Licensed Child Placing Agency contact information:

Agency Name: ____

Contact Name:____________________Phone:____________Fax: ____________

Custody of this student was placed with the above named agency on: ______________________

Date

Information on status of Parental Rights:

____

____

Student's School Status Affirmation:

To the best of my knowledge,______________________has____has not been expelled from school attendance at a private school or in a public school division of the Commonwealth or in another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.

To the best of my knowledge,______________________has____has not been found guilty or adjudicated delinquent for any offense listed in subsection G of § 16.1-260 of the Code of Virginia or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.

To the best of my knowledge,______________________is in good health and is free from communicable or contagious disease. If documentation of a physical exam, birth certificate, social security number, and/or immunization record is unavailable at the time of enrollment, they must be provided to the school within 30 days of enrollment.

____

Representative of Custodial Agency

____

Date

NOTICE OF STUDENT RECEIVING FOSTER CARE SERVICES

Out of Zone School Placement

ATTENTION: PRINCIPAL AND SUPERINTENDENT OF SCHOOLS OR THE DESIGNEE FOR:____SCHOOL

State Law (Ref. Code of Virginia 22-I-289 and 63.2-900) requires that within 72 hours of placing a child in foster care, the agency making such placement shall, in writing, notify the appropriate principal and superintendent of the placement and inform principal of the status of the child's parental rights. Children placed in foster care shall be immediately enrolled in school subject to the requirements of §22.11-3,4 of the Code of Virginia)

Student name:____________________________DOB:___________Age: _______

Social Worker/Case Manager: ____

Telephone Number: ____

Foster Parent Name: ____

Telephone Number: ____

Custody of this student was placed with______________________Department of Human Services/Licensed

Child-Placing Agency on__________________(date).

_________Court Order/Other restrictions related to status of parental rights are attached

_________Child's foster care placement is outside this school district, but it is in the child's best interest to attend the school she/he was enrolled in prior to placement in foster care as determined by the social worker and school officials, taking into consideration all relevant factors.

__________________________ ________________

Representative of Custodial Agency Date

CLIENT VISITATION AUTHORIZATION

(FHA addendum) 22VAC40-131C8/330A

Client Name:_______________ Date of Birth:__________________ Last 4 SSN: ________

Locality:___________________________ Social Worker: ____________________________________

I,_____________________________________ attest that I am the social worker or person authorized by the locality to approve and arrangement visits for the client listed above.

Client is **not allowed** to have visitation with biological family members for the following reason:

Client is **allowed** to have visitation or contact with the following family members (Full Names and relationship to the client):

Full Name of Family Member	Relationship	Type of Visit or Contact Permitted (if supervised - who will supervise)	How often is visit to occur?	Where will visits occur?	Have all involved family members been advised on this arrangement?

The social worker agrees to provide the agency with updated information as visit schedule changes. The agency and foster parents will support the visitation schedule as listed above and will provide progress to social worker on agency progress reports.

Social Worker:___________________________________ Date: _________________________

Foster Parent:___________________________________ Date: _________________________

Agency Representative:___________________________ Date: _________________________

CLIENT MEDICATIONS

Client Name: ____

Today's Date: ____

Social Worker/Representative: ____________________________________

I,_______________________________, authorize that the aforementioned client has been prescribed the following medications *(Please list the medication, the dosage, the reason for the med, the frequency):*

List of Medications: **Side Effects Noted:**

Please list the name and address of prescribing physician in the box below:

______________________________ Social Worker/Guardian Name/Date

______________________________ TFC, Inc. Representative/Date

______________________________ Foster Parent Name & Date

Detailed Client Placement History

Name: ________________________________

Location: StartDate: End Date: Why did this placement end?
Location: Start Date: End Date: Why did this placement end?
Location: Start Date: End Date: Why did this placement end?
Location: Start Date: End Date: Why did this placement end?

****NOTE: If you have a prepared agency document detailing client's placement history, please forward and disregard this form.*