UNK'S PLACE, INC.
120 W. 2nd St., Suite 425
Dayton, OH 45402
937-979-1699
www.unksplace.org

Youth Registration

OFFICE USE:	Admission Date:	Discharge Date:

TO BE COMPLETED BY THE REFERRING COUNTY:
Please complete all sections of this application. We are unable to accept incomplete applications. ***Thank You!***

Date	Name		Date of Birth
Age	Nickname		Social Security No
Height	Weight	Sex	Gender Identity
		❑ Male ❑ Female	
Hair Color	Eye Color	Religious Affiliation	County

Caseworker Name	Phone	Email
Supervisor Name	Phone	Email
Agency After Hours Number	Allergies	

Are there at least 30-days of prescription medications?		Are there refills?	
❑ Yes	❑ No: How many days?	❑ Yes	❑ No

Medication Names and Dosages				

Medicaid Number	Ohio Medicaid Type			
	❏ Molina ❏ CareSource ❏ Healthy Start	❏ Amerigroup ❏ Private Insurance Plan Name:		
SACWIS Case ID	Person ID	Last Physical	Last Dental	Last Vision
Last School Attended		School Contact Information		
Grade	Specify IEP and Any Learning Disabilities or Needs			
Visitation Schedule				
Additional Comments				

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Consent for Treatment

I understand that my family and I will be receiving services as a client of Unk's Place, Inc. I understand that the time will be set between the staff and me. As an Unk's Place, Inc. client, I commit to improve my behavior and to develop a responsible, healthy lifestyle. I agree, at a minimum, to the following:

- Giving the program a chance to help me
- Actively participating in treatment
- Following through on referrals
- Working on my educational/vocational plan
- Maintaining confidentiality of other clients
- Authorization for staff to transport myself or my family
- Recreational outings
- Vocational outings
- Following all program guidelines
- Maintaining weekly contact with treatment team
- Developing a crisis/safety plan
- Treating all staff and clients with respect
- Refraining from all aggressive, harmful, and illegal behaviors
- Following all probation guidelines
- Other activities as indicated in my child's treatment plan

Unk's Place, Inc. services includes assessment; therapy and/or Community Psychiatric Supportive Treatment (CPST) services, Therapeutic Behavioral Services (TBS); assistance with treatment goals; development of daily living and life skills; collaboration with referral source and other service providers; and referrals to community supports. These services are designed to help me achieve my goals and develop a healthy, responsible lifestyle.

Benefits of program participation may include improved functioning in home, school, and community; therapy for at risk youth and prevention of the disruption of placement while promoting the least restrictive level of care; as well as for youth who are transitioning from a residential setting or foster care to a natural family. Unk's Place, Inc. is tailored to meet the needs of individuals and families.

It has been explained to me that I am a full partner in the development of my family's/Individual Service Plan and that I will be participating in all team meetings. I understand that I can maintain my status in the program by participating in the offered services.

Records Policy

Your records or information regarding you and/or family may not be released to any other individual or agency without your written consent. Certain information, however, may be released without your authorization under the following legal circumstances:

- Upon receipt of a legitimate subpoena or court order.
- In the event of a medical emergency.
- Upon receipt of information that suggests that child/elder abuse or neglect has occurred. .
- If the worker believes that a member of the family is a danger to himself/herself or is a danger to others.
- In other circumstances as required/permitted by law.

My signature indicates that I have been informed of the risks and benefits of the services offered by the program as well as other services or alternatives that are available, and I consent to participate in the descriptions of services and mechanisms used to serve family and individuals. My signature also indicates that I have received copies of the Client Rights Statement and of the Unk's Place Inc. Grievance Procedures, and that these have been explained to me.

If Unk's Place, Inc. is unable to contact the legal guardian in the event of an emergency, I grant permission to contact the following individual.

Emergency Contact Name	Email	Telephone
Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date

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HIPAA Notice

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient/client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient/client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient/client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient/client in order to defend myself.
- If a patient/client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient/client's employer, the insurance carrier, or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

In some situations, I am legally obligated to take actions I believe are necessary to attempt to protect others from harm. I may have to reveal some information about a patient/client's treatment:

- If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with Montgomery County Children's Services Department at 937-224-KIDS Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe there is a clear and immediate probability of physical harm to the patient/client, other individuals, or society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient/client.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's/Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is reasonable, and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of OHIO Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date

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HIPAA NPP Acknowledgement of Receipt

Today's Date: _____

I acknowledge that I was provided with a copy of the Unk's Place, Inc. HIPAA Notice of Privacy Practices.

Client Name (Print) _____

Client Signature _____

If completed by a client's personal representative, please print and sign your name in the space below:

Personal Representative Name (Print) _____

Personal Representative's Signature _____

Relationship to Client _____

For Unk's Place, Inc. office use only:

Complete this section if this form is not signed and dated by the client or client's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Unk's Place' Notice of Privacy Practices but was unable to for the following reason:

□ Client refused to sign
□ Client unable to sign
□ Other _____

Employee Name (Print) _____

Employee Signature Date

This form must be placed in the client's record.

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Client's Rights and Responsibilities Acknowledgement

Client Name:_____

Every program participant at Unk's Place, Inc. has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. Unk's Place, Inc. is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons; and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

As a participant in programming of Unk's Place, Inc., you have the right to:

- Be fully informed about the course of your care and decisions that may affect your treatment
- Revoke your consent for treatment at any time
- Receive timely and accurate information to assist you in making sound decisions about your treatment
- Be fully involved as an active participant in decisions pertaining to your treatment
- Have an individual identified in writing that will direct and coordinate your treatment
- Request a change in individual directing and coordinating our treatment, if you so desire
- Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
- Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
- File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
- Have family members, friends or others involved in your treatment with your consent and approval
- Receive services that comply with all applicable federal and state laws, rules and regulations
- File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit

- To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences
- You may also have additional rights afforded to you based on federal, state, and local regulations; your service coordinator will advise you of any additional rights that you may have

As a program participant in services of Unk's Place, Inc., you have the responsibility to:

- Refrain from all forms of physical violence or abuse toward other program participants, staff, or visitors
- Refrain from abusive language, disruptive behavior or overt sexual conduct
- Refrain from loitering outside the organization's facilities
- Refrain from bringing any type of weapon into the organization's facilities or property
- Refrain from bringing any illicit (illegal) drug or alcohol onto the organization's property
- Refrain from using illicit drugs or alcohol while participating in services provided by the organization
- Refrain from all tobacco use, including any type of vapes and/or electronic cigarettes
- Attend all services required by the organization to meet agreed upon goals
- Notify any outside treatment provider (physician, case worker, counselor, etc.) of participation in services, should your treatment impact, or compromise, the provision of those services
- Treat other program participants, staff, and visitors in a respectable manner

By my signature below, I acknowledge that I have read and understand my rights and responsibilities as a participant in services of Unk's Place, Inc.

Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date

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Grievance Policy and Reporting Form

It is the policy of Unk's Place, Inc. to treat all clients with fairness and professionalism and to strive for excellence in providing services to clients. Unk's Place, Inc.'s policy provides clients and their families or legal guardians with the opportunity to express a problem or grievance related to the quality of services. If you feel you have been treated unfairly or unprofessionally, or feel that your rights have been breached, the following procedure should be used.

Unk's Place, Inc.'s grievance procedure is designed to provide a means for those applying for Unk's Place, Inc.'s services and clients receiving services to bring a grievance to the attention of Unk's Place, Inc. and to reach a speedy resolution. Unk's Place, Inc. has a strict policy prohibiting retaliation in any form against anyone who files a grievance.

A grievance is defined as any situation or condition that a client thinks is unfair, unjust or inequitable. In addition, if a client merely states they want to file a grievance, a grievance should be completed. Under this Client Grievance Procedure, you should submit a grievance in the following sequence:

- Step 1: A discussion between the resident/client or family member and the Youth Worker (Aunt/Uncle) member involved may resolve the situation responsibly and reasonably. If the resident/client or family member feels that the complaint is not resolved to his or her satisfaction, he or she may proceed to Step 2.

- Step 2: Submit a complaint in writing to the Case Manager (after completing Step 1). Within five working days, the Case Manager will review it and interview the individuals involved. If a resolution is determined, a written report of the complaint and the resolution will be compiled, and a copy placed in the resident/client's record. If the resident/client or family member feels that the complaint is not resolved to his or her satisfaction, the resident/client or family member may proceed to Step 3.

- Step 3: Submit the complaint to the Executive Director (or designee). Within five working days the Executive Director will review the complaint and interview the individuals involved. In any event, resolved or unresolved, a written report of the complaint and the resolution or reason for lack of resolution will be compiled and a copy placed in the resident/client's record.

- Step 4: If the grievance is against the executive director, a resident/client or family member may submit his or her complaint in writing to the President of the Board. Within 10 working days after receipt of the complaint, the President of the Board will review the information and call a meeting of all concerned to resolve the complaint. In any event, resolved or unresolved, a written report of the complaint and the resolution or reason for lack of resolution will be compiled and a copy placed in the resident/client's record.

If you have a grievance, the concern can be discussed with an Unk's Place, Inc. staff member. If you decide to speak to an Unk's Place, Inc. staff member and an agreement cannot be reached, you should proceed to the next step of this grievance procedure. You can also file a grievance without any discussion and proceed to the next step. Grievance forms can be found at the following:

1. Attached to this document

2. The lobby of any Unk's Place, Inc. site

3. By request the from any Unk's Place, Inc. staff member

3. By calling 937-979-1699 to request a form

If the matter has not been resolved to your satisfaction, you may choose to discuss your concerns with any supervisor.

Once notified in writing, Unk's Place, Inc. will initiate an investigation within two business days and provide an acknowledgment to you within 7 business days.

If for any reason you are unsatisfied with the results, you may contact the Executive Director to further discuss the matter. The Executive Director will conduct a review of the matter and will respond to you in writing within 10 business days. The Executive Director’s decision and recommendations will be final.

Grievance Reporting and Procedure Form

This form is to be completed if you wish to make or file a grievance or complaint. You may also ask someone else who is acting with your knowledge and consent to write or express the grievance. (You may file this report anonymously, without your name; however, it may make it more difficult for Unk's Place, Inc. to address the matter.)

Date of Report * _____

Client Name: (Last, First)* _____

Client Address* _____

Client Phone* _____

Program or Location* _____

When did the event or incident happen?

Specific Date(s)* _____

Time(s) if known* _____

List the name or names of all persons involved in the event or incident *

_____

_____

_____

_____

State the event or incident that prompted this complaint or grievance (Include all relevant details that will help in following up on this issue) *

_____

_____

_____

_____

_____

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Grievance Policy and Receipt

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If for any reason you are unsatisfied with the results, you may contact the Executive Director to further discuss the matter. The Executive Director will conduct a review of the matter and will respond to you in writing within 10 business days. The Executive Director's decision and recommendations will be final.

By my signature below, I acknowledge that I have read and understand Unk's Place, Inc. Grievance Policy & Procedure.

Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date

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Release of Information Authorization

I hereby authorize Unk's Place, Inc. to use and share protected health information about:

Client name: _____ D.O.B.: _____

Name of Parent/Guardian (If applicable): _____

Relationship to Client: _____

Person or Entity information may be shared with:_____

Address: _____

Phone: _____ Fax: _____ Email: _____

Specific protected health information to be used and shared includes: Identifying information; medical and social history; treatment and service history; educational and legal history; information concerning AIDS/AIDS-related conditions, HIV/HIV-related conditions, AIDS/HIV testing; drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

*If exceptions, note here:*_____

I understand that this information will be used for assessment, service planning service coordination and service delivery.

I understand that this consent to disclose may be revoked by me at any time by written notice to Unk's Place, Inc., effective upon receipt of notice. If I do this, it will prevent any releases after the date it is received but cannot be the fact that some of the information may have been sent or shared before that date.

This consent will expire upon exit from the program, or one year from today's date, or on the following condition:

_____

I understand that I do not have to sign this authorization, and that my refusal to sign will not affect my abilities to obtain services from Unk's Place, Inc., nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

Release of Information Authorization

By signing below, I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. I understand that I may receive a copy of this completed form upon request.

The witness, an Unk's Place, Inc. employee, has discussed the issues above with the client and/or parent/guardian. The witness has observed no behaviors or responses that would lead to the belief that the signer is not fully competent to give informed and willing consent.

Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date

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Transportation and Emergency Medical Authorization

TRANSPORTATION AUTHORIZATION

As part of the services provided by Unk's Place, Inc., I understand that there may be occasions when Unk's Place, Inc. will be providing transportation to participate in educational, cultural, therapeutic and/or recreational activities. Please indicate one of the following by initialing on the line to the left and signing below:

_____ **I authorize** Unk's Place, Inc. staff and/or volunteers to provide transportation for (client name)

_____, and understand that Unk's Place, Inc. is exempt from any

liability.

_____ **I DO NOT authorize** Unk's Place, Inc. to provide transportation.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Staff: _____ Date: _____

.....

MEDICAL EMERGENCY AUTHORIZATION—CHILD ONLY

I understand that Unk's Place, Inc. will make every effort to inform me, as soon as possible, of a medical emergency. I acknowledge that Unk's Place, Inc. assumes no financial responsibility for the cost of medical care. Please indicate one of the following by initialing on the line to the left and signing below:

_____If emergency medical attention is needed for my child, **I authorize** Unk's Place, Inc. to obtain the necessary emergency medical attention for this child and to have the condition evaluated and treated until I can be reached.

_____If emergency medical attention is needed for my child, **I DO NOT authorize** Unk's Place, Inc. to obtain the necessary emergency medical attention for this child and to have the condition evaluated and treated. Unk's Place, Inc. should make reasonable efforts to contact me *prior to* obtaining necessary emergency medical attention for my child.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Staff: _____ Date: _____

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Statement on Normalcy in Foster Care

According to federal and state laws (ACYF-CB-IM-14-03, 2014; ORC 5103.162, 2014), youth in foster care settings should have the opportunities and advantages of participation in age or developmentally appropriate extracurricular, enrichment, cultural, and social activities. Unk's Place, Inc. is dedicated to ensuring the youth in our care have the best possible experience while they are in our home.

Unk's Place, Inc. works with the youth, custodial guardians, family members, and other stakeholders to develop each individual service plan, which is followed throughout the youth's time in our home and our program. All Unk's Place, Inc. staff and interns complete training in understanding and applying the Reasonable and Prudent Parent Standard (RPPS) within each individual service plan.

Within the youth's service plan and through the Unk's Place RISE Program, we provide for and promote appropriate activities for youth who are able to have such privileges, taking into consideration:

- The youth's age, maturity and developmental level
- Potential risk factors
- The best interest of the youth
- Emotional and developmental growth
- Family-like living experience
- The youth's behavioral history

We also follow the guidelines provided by our stakeholders and custodial agencies in interpreting the RPPS and applying it to the individual youth's service plan and program in areas such as:

- Spending the night with friends and family
- Use and ownership of electronics
- Social media use
- Curfew and free time
- Clothing and personal item purchases
- Participation in community-based activities
- Participation in afterschool extracurricular activities and sports
- Obtaining driving privileges
- Obtaining jobs and volunteering opportunities
- Etc.

By signing below, I affirm that I understand the Unk's Place Statement on Normalcy in Foster Care.

Client Name (Print)	Client Signature	Date
Guardian Name (Print)	Guardian Signature	Date
Staff/Witness Name (Print)	Staff/Witness Signature	Date