APPLICATION FOR ADMISSION

TO

RAINTREE VILLAGE CHILDREN AND FAMILY SERVICES

FOSTER CARE PROGRAM

Dear Custody Holder:

Please submit the following information when returning your application:

- ☐ County Placement Agreement
- ☐ Case Plan/WTLP
- ☐ Court Order
- ☐ Conditions of Placement (if DJJ involvement)
- ☐ Copy of Birth Certificate
- ☐ Current/Previous IEP's (if applicable)
- ☐ Dental and Medical Records
- ☐ Immunization Certificate
- ☐ Insurance Card
- ☐ Letter of Withdrawal from Previous School
- ☐ Medical Examination
- ☐ Psychological/Psychiatric Evaluation
- ☐ Recent Photo
- ☐ School Records
- ☐ Social Security Card
- ☐ Other Identifying Information

NOTE: ***If applying for more than one child, please complete a separate application for each child.***

CHILD'S INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
PREFERRED NAME:	SS#:	GA SHINES I.D #

DATE OF BIRTH:	SEX: ☐ Male ☐ Female	HEIGHT:	WEIGHT:
BIRTHPLACE:	CITY:	COUNTY:	STATE:
CURRENT ADDRESS:	CITY:	STATE:	ZIP:

THE CHILD LIVES WITH:

☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ Aunt ☐Uncle
☐ Friends ☐ Foster Home ☐ Group Home ☐ Male ☐

Other:_____

ETHNIC GROUP OF CHILD: (Check ✓ one)

☐ White ☐ Black ☐ American Indian ☐ Hispanic
☐ Oriental ☐ Bi-Racial ☐ Other:_____

RELIGION OF CHILD: (Check ✓ one)

☐ Protestant ☐ Catholic ☐ Jewish ☐ Don't Know
☐ Other: _____ ☐ Denomination:_____

LEGAL CUSTODIAN OF CHILD:

ADDRESS OF CUSTODIAN:

TELEPHONE:	FAX:	EMAIL:

HOW DID YOU LEARN OF OUR SERVICES? (Check ✓ one)

☐ Parent/Other Relative
☐ Private Therapist
☐ Minister
☐ DFACS or DYS Agency
☐ Community Mental Health Center
☐ School Counselor
☐ Placement Agency of Another State
☐ Public Psychiatric Hospital
☐ Private Psychiatric Hospital
☐ Court or Court Service Worker
☐ Other Residential Child Care Facility
☐ Other:

FINANCIAL SUPPORT FOR CHILD: (Check ✓ one and note amount for all sources)

☐ DFACS $Per Diem
☐ Family $_____
☐ Grant $_____
☐ Court Ordered Child Support $_____
☐ Mental Health/Retardation/ Substance Abuse $_____
☐ Dept. of Education $_____
☐ Other $_____
☐ Social Security $_____
☐ Veteran's Benefit $_____
☐ Youth Services/DYS $_____
☐ Insurance $_____
☐ SSI $_____
☐ Other Pension $_____
☐ Foundation $_____

REASONS FOR PLACEMENT

PRECIPITATING EVENTS REQUIRING PLACEMENT:_____

ARE THERE INDICATIONS THAT THIS CHILD HAS EXPERIENCED: (check ALL that apply)

☐ Sexual Abuse ☐ Physical Abuse ☐ Physical Neglect ☐ Other_____

☐ Incest ☐ Emotional Abuse ☐ Emotional Neglect

IF SO, HAS THE ABUSE/NEGLECT BEEN REPORTED TO THE AUTHORITIES? ☐ YES ☐ NO

WHAT PROBLEMS HAVE EXISTED IN THE THIS CHILD'S NATURAL OR SUBSTITUTE FAMILY?: (check ALL that apply)

☐ Alcohol or Drug Abuse ☐ Spouse Abuse ☐ Financial Stress

☐ Incest ☐ Other Family Violence ☐ Unemployment

☐ Child Abuse ☐ Court Involvement ☐ Parental Death

☐ Child Neglect ☐ Mental Illness ☐ Family Break-up

☐ Child Sexual Abuse ☐ Physical Illness ☐ Other_____

WHAT ARE THE REASON(S) FOR THE PLACEMENT OF THIS CHILD?

☐ Lack of Finances ☐ Legal Detainment of Child ☐ Family Break-up

☐ Child's Behavioral Problems ☐ Parental Drug Use ☐ Child Drug Use

☐ Death of a Parent ☐ Child's Sexual Acting Out ☐ Child's Emotional Problems

☐ Parental Alcohol Abuse ☐ Child Alcohol ☐ Child Law Violations

☐ Physical Abuse ☐ Emotional Abuse ☐ Runaway

☐ Need for Shelter (homelessness) ☐ Lack of Parenting Skills ☐ Parental Physical Illness

☐ Divorce/Separation ☐ Parental Imprisonment ☐ Sexual Abuse

☐ Physical/Mental Disabilities ☐ Parental Mental Illness ☐ Step-Parent Conflict

☐ Other_____

PLEASE LIST PRIMARY REASON:_____

WHICH OF THE FOLLOWING BEHAVIORS PERTAIN TO THIS CHILD'S PAST OR PRESENT?

☐ Runaway ☐ School Behavior Problems ☐ Other_____

☐ Destructive of Property ☐ Sexual Acting Out _____

☐ Violation of Curfews/Sneaking Out ☐ Alcohol or Drug Abuse _____

☐ Depression/Withdrawal ☐ Truancy _____

☐ Suicide Attempts or Threats ☐ Aerosol Sniffing _____

☐ Threats or Injury to Self ☐ Involvement in Satanism _____

☐ Threats or Attempts to Harm Others ☐ Fire setting (years ago) _____

☐ Stealing ☐ Harmful to Animals _____

EXPLANATION: (use additional pages if necessary)

PLEASE LIST SPECIFICS (i.e. drugs used, behavior problems, etc.)

FAMILY INFORMATION

FAMILY STATUS OF PARENTS (check ✓ the one that most closely describes the child's family):

☐ Married Parents	☐ Living Together	☐ Unmarried Parents
☐ Divorced Single Parent	☐ Separated Single Parent	☐ Unmarried Single Parent
☐ Widow(er)ed Parent	☐ Parent Deceased	☐ Unknown
☐ Biological Parent and Step-Parent	☐ Biological Parent and Partner	☐ Unspecified

FATHER'S INFORMATION

IS CURRENT FATHER ☐BIRTH FATHER ☐ADOPTIVE FATHER ☐STEP FATHER

FATHER'S FULL NAME: FIRST (Current)	MIDDLE	LAST

DATE OF BIRTH:	PLACE OF BIRTH:	SS #

☐LIVING ☐DECEASED ☐UNKNOWN ☐IF DEAD,	DATE	AGE	CAUSE

PRESENT MARITAL STATUS:

MARRIAGES:	DATE	PLACE
	DATE	PLACE
DIVORCES:	DATE	PLACE
	DATE	PLACE

PRESENT ADDRESS: STREET	CITY	STATE	ZIP

HOME TELEPHONE NUMBER: ( )	WORK TELEPHONE NUMBER: ( )

LENGTH OF RESIDENCY: COUNTY:	STATE:	NATIONALITY:

EDUCATION:	RELIGION/CHURCH MEMBERSHIP:

OCCUPATION:	INCOME (WK/MO/YR): $

EMPLOYEE NAME:	TELEPHONE #: ( )

ADDRESS: STREET	CITY	STATE	ZIP

MILITARY SERVICE BRANCH:	DATES:

PHYSICAL DISABILITIES:_____

MENTAL HEALTH/RETARDATION INSTITUTIONALIZATIONS:_____
(Name of Institution)

DATES/REASONS FOR INSTITUTIONALIZATION:

Date:	Reason:
Date:	Reason:
Date:	Reason:

MOTHER'S INFORMATION

IS CURRENT MOTHER ☐BIRTH MOTHER ☐ADOPTIVE MOTHER ☐STEP MOTHER			
MOTHER'S FULL NAME: (Current)	FIRST	MIDDLE	LAST
DATE OF BIRTH:	PLACE OF BIRTH:		SS #
☐LIVING ☐DECEASED ☐UNKNOWN ☐IF DEAD,	DATE	AGE	CAUSE
PRESENT MARITAL STATUS:			
MARRIAGES:	DATE	PLACE	
	DATE	PLACE	
DIVORCES:	DATE	PLACE	
	DATE	PLACE	
PRESENT ADDRESS: STREET	CITY	STATE	ZIP
HOME TELEPHONE NUMBER:	WORK TELEPHONE NUMBER: ( )		
LENGTH OF RESIDENCY: COUNTY:	STATE:	NATIONALITY:	
EDUCATION:	RELIGION/CHURCH MEMBERSHIP:		
OCCUPATION: Student	INCOME (WK/MO/YR): $		
EMPLOYEE NAME:	TELEPHONE #: ( )		
ADDRESS: STREET	CITY	STATE	ZIP
MILITARY SERVICE BRANCH:	DATES:		

PHYSICAL DISABILITIES:_____

MENTAL HEALTH/RETARDATION
INSTITUTIONALIZATIONS:_____
(Name of Institution)

DATES/REASONS FOR INSTITUTIONALIZATION:

Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:

CUSTODY HOLDER INFORMATION

CUSTODY HOLDER (circle one or, if joint, check ✓ ALL that apply):

☐ The Child ☐ Current Facility ☐ Natural Parents

☐ Adoptive Parents ☐ Non-Relative ☐ Natural Relative

☐ Step Parent ☐ DFCS ☐ DJJ Commitment

☐ Other_____

IF CUSTODY HOLDER IS BIOLOGICAL PARENT, SKIP TO BROTHERS AND SISTERS ON PAGE 7

IF DHS –PLEASE COMPLETE THE FOLLOWING:

NAME OF AGENCY:	TELEPHONE NUMBER:
ADDRESS: STREET / CITY / STATE / ZIP	
DATE CUSTODY GRANTED:	DATE CUSTODY TERMINATES:
NAME OF CONTACT PERSON:	TELEPHONE: / EMERGENCY #:
NAME OF BACK-UP PERSON:	TELEPHONE: / EMERGENCY #:
CUSTODY HOLDER'S FULL NAME: LAST / FIRST / MIDDLE	
DATE OF BIRTH:	Place of Birth: / SS #:
☐ Living ☐ Deceased ☐Unknown If Dead,	Date / Age / Cause

PRESENT MARITAL STATUS:

MARRIAGES:	Date:	Place:	Date:	Place:
DIVORCES:	Date:	Place:	Date:	Place:

PRESENT ADDRESS: STREET / CITY / STATE / ZIP	
HOME TELEPHONE NUMBER: ( )	WORK TELEPHONE NUMBER: ( )
LENGTH OF RESIDENCY: / COUNTY:	STATE: / NATIONALITY:
EDUCATION:	RELIGION/CHURCH MEMBERSHIP:
OCCUPATION:	WEEKLY INCOME: $
EMPLOYER NAME:	TELEPHONE NUMBER: ( )
ADDRESS: STREET / CITY / STATE / ZIP	
MILITARY SERVICE BRANCH:	Dates:

PHYSICAL DISABILITIES:_____

MENTAL HEALTH/RETARDATION

_____

INSTITUTIONALIZATIONS (Name of Institution)

DATES/REASON FOR INSTITUTIONALIZATION:

Date:	Reason:	Date:	Reason:

BROTHERS AND SISTERS

1. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP
2. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP
3. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP
4. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP
5. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP
6. NAME:	DATE OF BIRTH:	TELEPHONE:
ADDRESS: STREET	CITY	STATE ZIP

OTHER

1. NAME:	DATE OF BIRTH:	RELATIONSHIP:	TELEPHONE:
2. NAME:	DATE OF BIRTH:	RELATIONSHIP:	TELEPHONE:
3. NAME:	DATE OF BIRTH:	RELATIONSHIP:	TELEPHONE:
4. NAME:	DATE OF BIRTH:	RELATIONSHIP:	TELEPHONE:

INTERESTED RELATIVE, PERSON, AND AGENCIES APPROVED FOR CONTACT

1. NAME/RELATIONSHIP	ADDRESS:_____	TELEPHONE:
2. NAME/RELATIONSHIP	ADDRESS:_____	TELEPHONE:
3. NAME/RELATIONSHIP	ADDRESS:_____	TELEPHONE:
4. NAME/RELATIONSHIP	ADDRESS:_____	TELEPHONE:

INDIVIDUALS SPECIFICALLY NOT APPROVED FOR CONTACT

1. NAME: *The person whom she committed against. She stole their cell phone. She can't have any contact with them.*	RELATIONSHIP:	TELEPHONE:

2. NAME:	RELATIONSHIP:	TELEPHONE:
3. NAME:	RELATIONSHIP:	TELEPHONE:
4. NAME:	RELATIONSHIP:	TELEPHONE:

ADMISSION AND DISCHARGE INFORMATION

OTHER PLACEMENTS

INCLUDING CURRENT PLACEMENT, HOW MANY TIMES HAS THIS CHILD BEEN PLACED IN THE FOLLOWING ALTERNATIVES? ENTER THE NUMBER OF PLACEMENTS FOR EAC H APPLICABLE ALTERNATIVE. BEGIN COUNTING WITH THE FIRST SEPARATION FROM THE NATURAL FAMILY.

_____Biological Parent's Home	_____Relative's Home	_____Foster Home
_____Adoptive Home	_____Group Home	_____Emergency Shelter
_____Residential Child Care	_____State Detention Center	_____Regional YDC
_____Intermediate Care	_____Intensive Care	_____Juvenile Court Detention
_____M.R. Institution	_____Detox/Drug Treatment	_____Psychiatric Hospitalization
_____No Prior Placements	_____Other Alternative	

PLEASE LIST CURRENT/PRIOR PLACEMENTS/DATES INCLUDING HOSPITALIZATIONS

ADMISSION DATE/DISCHARGE DATE	NAME OF PLACEMENT	REASON FOR TERMINATION
1. From___/___/___ To ___/___/___		
2. From___/___/___ To ___/___/___		
3. From___/___/___ To ___/___/___		
4. From___/___/___ To ___/___/___		
5. From___/___/___ To ___/___/___		
6. From___/___/___ To ___/___/___		
7. From___/___/___ To ___/___/___		
8. From___/___/___ To ___/___/___		
9. From___/___/___ To ___/___/___		
10. From___/___/___ To ___/___/___		

THIS CHILD IS CURRENTLY LIVING:

☐ Biological Parent's Home	☐ Relative's Home	☐ Foster Home
☐ Adoptive Home	☐ Group Home	☐ Residential Child Care
☐ RYDC or ☐YDC	☐ Emergency Shelter	☐ Intermediate Care
☐ Intensive Care	☐ Psychiatric Hospital	☐ M.R. Institution
☐ Detox/Drug Treatment Program	☐ Other Alternative	

PLANNED PLACEMENT UPON DISCHARGE FROM THIS FACILITY (check one):

☐ Natural/Adoptive Parents	☐ Independent Living	☐ Semi-Independent Living
☐ Other Relative	☐ Foster Home	☐ Group Home
☐ State M. R. Institution	☐ Other Child Caring Institution	☐ _____

CURRENT EDUCATIONAL INFORMATION

CURRENT SCHOOL: | CURRENT GRADE:

IS THIS SCHOOL:

☐ Public Day School ☐ Private Day School ☐ Psycho-ed Center

☐ Vocational School ☐ Remedial Tutorial Program ☐ Residential Institution

☐ Other (please explain):_____

HAS THIS CHILD:

☐ Been retained in any grades, which ones: _____

☐ Failed any grades, which ones: _____

☐ Been suspended from school? Why? _____

☐ Been expelled from school? Why? _____

☐ Been evaluated for special education resources? _____

☐ Is this child failing now? ☐Yes ☐No

HAS THE DEPARTMENT OF EDUCATION IDENTIFIED SPECIAL NEED FOR THIS CHILD? ☐Yes ☐No

IF YES, INDICATE THE PRIMARY BASIS FOR THE SPECIAL NEED: (check one)

☐ Educable Mentally Handicapped ☐ Trainable Mentally Handicapped ☐ Learning Disorder

☐ Behavior disorder ☐ Academically Gifted ☐ Multiple handicapped

☐ Physically handicapped ☐ Other, Explain (Cerebral palsy)

DOES THE LOCAL SCHOOL SYSTEM RECOMMEND/SUPPORT AN EDUCATIONAL PROGRAM FOR THIS CHILD OUTSIDE OF THE LOCAL PUBLIC SCHOOLS? ☐Yes ☐No

HAS AN INDIVIDUALIZED EDUCATION PLAN (IEP) BEEN DEVELOPED FOR CHILD? ☐Yes ☐No

BY WHAT SCHOOL?

SCHOOL ADDRESS:		TELEPHONE:
ACTUAL READING:	NAME OF TEST:	PSAT:
ACTUAL MATH GRADE LEVEL:	NAME OF TEST:	SAT:

RECOMMENDATIONS:

EDUCATIONAL HISTORY

GRADE	NAME AND LOCATION OF SCHOOL	STATUS (special, promoted, retained)
1.		
2.		
3.		
4.		

5.		
6.		

CURRENT EDUCATIONAL INFORMATION (CONTINUED)

IF NOT ENROLLED IN PUBLIC SCHOOL, STATE REASON:

☐ Severe Behavior Problem ☐ Mental retardation ☐ Physical Disability

☐ Facility Requires Private School Enrollment ☐ Performing Too Far Below Grade Level

IF NOT ENROLLED IN ANY SCHOOL, STATE REASON:

☐ Expelled ☐ Suspended ☐ Referred/Waiting for Special Placement ☐ Other _____

OTHER ASSESSMENTS

JUVENILE COURT INVOLVEMENT

No to juvenile because she is in an adult at the time. Judge allowed her to set her own consequences, She chose community service

HAS CHILD BEEN FOUND GUILTY OF STATUS OFFENSES? ☐ Yes ☐ No

☐ If yes , explain/dates: _____

HAS CHILD BEEN FOUND GUILTY OF DELINQUENT ACTS? ☐ Yes ☐ No

☐ If yes , explain/dates: _____

HAS THIS CHILD BEEN PLACED ON PROBATION? ☐ Yes ☐ No

☐ If yes , for what, and terms of Probation:

Is the child now on probation? ☐ Yes ☐ No

Has this child been committed to YDC? ☐ Yes ☐ No

Other court involvement? ☐ Yes ☐ No

IF YES TO ANY QUESTION ABOVE, NAME OF COURT, PROBATION OFFICES, SERVICE WORKER:

OFFICER:	WHAT COUNTY:	TELEPHONE:

MENTAL HEALTH HISTORY

HAS THIS CHILD EVER RECEIVED IN-PATIENT MENTAL HEALTH SERVICE? ☐ YES ☐ NO

If yes, were the services: ☐Public ☐ Private Provided by: BHS, three months ago

HAS THIS CHILD EVER RECEIVED OUT-PATIENT MENTAL HEALTH SERVICES? ☐ YES NO

If yes, were the services: ☐ Public ☐ Private Provided by: _____

HAS THIS CHILD EVER RECEIVED DRUG TREATMENT? ☐ YES ☐ NO

If yes, were the services: ☐ Public ☐ Private Provided by: _____

DID THE CHILD'S FAMILY PARTICIPATE IN THE TREATMENT? ☐ YES ☐ NO

HAS THIS CHILD EVER RECEIVED COMMUNITY MENTAL RETARDATION SERVICES? ☐ YES ☐ NO

If yes, were the services: ☐ Public ☐ Private Provided by: _____

IF YES TO ANY QUESTIONS ABOVE, COMPLETE THE FOLLOWING:

NAME OF AGENCY OR THERAPIST PROVIDING SERVICE:	TELEPHONE:
ADDRESS:	
DATES OF THERAPY: FROM: TO:	
PRESENTING PROBLEMS:	

GOALS:	REASON FOR TERMINATION:
DISCHARGE RECOMMENDATIONS:	

MEDICAL AND INSURANCE INFORMATION

MEDICAL INSURANCE POLICIES AND NUMBERS:	
INSURANCE COMPANY: Medicaid	Policy Holder:
CONTACT PERSON:	Telephone Number:

INDICATE WITH CHECK MARKS (✓) ANY OF THIS CHILD'S FUNCTIONAL IMPAIRMENTS OR MEDICAL PROBLEMS AND WHETHER OR NOT SPECIAL STAFFING OR SERVICE ARE REQUIRED BY THE FACILITY FOR THE IMPAIRMENT: (PLEASE EXPLAIN BELOW)

IMPAIRMENT	CHILD HAS THIS PROBLEM	SPECIAL STAFFING OR SERVICE REQUIRED
1. MOBILITY IMPAIRMENT	☐ YES ☐ NO	☐ YES ☐ NO
2. HEARING IMPAIRMENT	☐ YES ☐ NO	☐ YES ☐ NO
3. SPEECH IMPAIRMENT	☐ YES ☐ NO	☐ YES ☐ NO
4. SIGHT IMPAIRMENT	☐ YES ☐ NO	☐ YES ☐ NO
5. CURRENT PREGNANCY	☐ YES ☐ NO	☐ YES ☐ NO
6. PRIOR PREGNANCY	☐ YES ☐ NO	☐ YES ☐ NO
7. COMMUNICABLE DISEASE	☐ YES ☐ NO	☐ YES ☐ NO
8. VENEREAL DISEASE/STD	☐ YES ☐ NO	☐ YES ☐ NO
9. RESPIRATORY PROBLEM	☐ YES ☐ NO	☐ YES ☐ NO
10. CIRCULATORY/HEART PROBLEM	☐ YES ☐ NO	☐ YES ☐ NO
11. SEIZURE DISORDER	☐ YES ☐ NO	☐ YES ☐ NO
12. DIABETES	☐ YES ☐ NO	☐ YES ☐ NO
13. HYPERACTIVITY	☐ YES ☐ NO	☐ YES ☐ NO
14. SEVERE OVERWEIGHT	☐ YES ☐ NO	☐ YES ☐ NO
15. EATING DISORDER	☐ YES ☐ NO	☐ YES ☐ NO
16. TUBERCULOSIS	☐ YES ☐ NO	☐ YES ☐ NO
17. AIDS	☐ YES ☐ NO	☐ YES ☐ NO

PLEASE

EXPLAIN:_____

Who is responsible for Medical Bills:

MEDICAL AND INSURANCE INFORMATION (CONTINUED)

DOES THIS CHILD TAKE PRESCRIBED PSYCHOTROPIC MEDICATIONS? ☐ YES ☐ NO

If yes, what and why? _____

DOES THIS CHILD REGULARLY TAKE OTHER PRESCRIBED MEDICATIONS? ☐ YES ☐ NO

If yes, what and
why?_____

DOES THIS CHILD HAVE ANY KNOWN ALLERGIES? ☐ YES ☐ NO
If yes,what?_____

Present Treatment? _____

HAS A SPECIAL DIET BEEN PRESCRIBED FOR THIS CHILD? ☐ YES ☐ NO
If yes, what?_____

DATE OF THIS CHILD'S MOST RECENT PHYSICAL EXAM: _____

HAVE SEVERE MEDICAL PROBLEMS BEEN DIAGNOSED IN THIS CHILD THAT REQUIRE TREATMENT OR CHRONIC CONDITIONS?

☐ YES ☐ NO If Yes, what?

DATE OF THIS CHILD'S MOST RECENT DENTAL EXAM:

HAVE SEVERE DENTAL PROBLEMS BEEN DIAGNOSED IN THIS CHILD REQUIRING TREATMENT? ☐ YES ☐NO
If yes, what?

MUST SIGN BELOW BEFORE SUBMITTING APPLICATION

I HEREBY REQUEST CONSIDERATION FOR SERVICES FOR THE NAMED YOUTH DESCRIBED IN THIS APPLICATION AND HIS/HER FAMILY:

CUSTODY HOLDER OF CHILD: DATE:

NAME OF PERSON COMPLETING FORM:

RELATIONSHIP TO CHILD: DATE:

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Division of Family and Children Services
INSTITUTIONAL PLACEMENT AGREEMENT

Check One:
☐ Institutional Care
Family Foster Care
☐ (purchase from Institution or Private Agency)
☐ Group Home Care

Made this _____ Day of _____, 20____, between :
Raintree Village, Inc. and _____. County Department of Family and Children Services (both hereinafter referred to as "Institution" and "County Department") on behalf of _____born _____.
Child's: County Case Number_____; Social Security Number _____

Witnesseth, that the Institution and the County Department, in consideration of the following mutual obligations, agree as follows:

THE COUNTY DEPARTMENT AGREES:

1. To place the child in the Institution for care and services for a period up to one year at which time a joint conference will Be required to renew this contract for an extended time.

2. To arrange for preplacement visit(s) of the child and, if possible, his parents or other responsible persons before his admission.

3. To pay to the Institution the per diem rate of $_____for the care of the child.

4. To supply an adequate basic wardrobe on admission or to authorize up to a maximum of $_____to purchase a suitable basic initial wardrobe.

5. To provide written proof of the child's health examination, which includes eye, dental, hemoglobin or hematacrit, and urinalysis screenings, current to within sixty days of admission

6. To authorize the Institution to consent for routine medical and dental care and for unusual medical care, including emergency surgery, when a representative of the County Department is not available.

7. To Cooperate with the Institution in arranging with parents, relative, or other interested persons for visits of the child in the community or for visits with the child in the Institution.

8. To be involved in the remedy of problems in the child's home and community which relate to the child's placement outside his home, based on a mutually agreed upon plan between the County Department and the Institution which delineates the roles o feach. Written reports will be provided at six months intervals and more often as needed.

9. To visit the Institution and the child as often as is needed and upon request, but at a minimum of once a year, and to communicate by telephone or correspondence at a minimum of every three months.

10. To be involved in the assessment of the child's progress and need for change in the plan of care as often as is needed but at least every six months.

11. To assume primary responsibility for after care plans when the child is to leave the Institution—involving the child, his parents, and institutional personnel as much as possible and as early as possible.

12. To assist in the preparation of the child for changes in his situation when he is to leave the Institution.

13. To provide a follow-up report about the child and his progress six months following his release from the institution if requested and if the case remains active with the County Department.

14. To provide additional services, or services with modification of the above conditions, as listed on the following page.

(OVER)

THE INSTITUTION AGREES:

1. To accept the child for a per diem rate of $_____to be paid promptly by the County Department following receipt of a monthly invoice from the Institution.

2. To provide the County Department with written progress reports at least every six months, to include:

   A report of dental and physical examinations and treatment. Such examinations will be provided on at least annual basis and will include a urinalysis and hemoglobin or hematacrit check, and eye examination, and any recommended treatment or corrective procedures for any physical and dental needs. The immunization status and illnesses during the period will also be included in the progress report.

   Pertinent psychological and psychiatric evaluations and treatment summaries made available to the Institution during the period of review.

   A report of school progress.

   A summary of significant relationships, including family contacts.

3. To immediately advise the County Department of serious illnesses, accidents, or need for hospitalization or surgery.

4. To involve the County Department in planning for any visits of three days or more from the Institution and for <u>all</u> trips or visits <u>out of state.</u>

5. To promptly refer to the County Department any person who expresses an interest in the adoption of this child or in providing a family foster home.

6. To obtain through the County Department parental or court permission to use pictures, including photographs, slides and films of the child.

7. To give the County Department reasonable time, at least four weeks if possible, to make plans for the child when he is to leave the Institution.

8. To give the child all of his personal clothing and other personal belongings when he is removed from the institution.

Date _____	Signed _____, Director
	_____County Department of Family and Children Services
Date _____	Signed _____, Director
	_____(Name of Institution)

(REVERSE SIDE)

Raintree Village
3757 Johnston Road
Valdosta, GA 31601

Phone: 229-559-5944
Fax: 229-559-7760

www.raintreevillage.org

Raintree Village
CHILDREN AND FAMILY SERVICES

MEDICAL EMERGENCY CONSENT FORM

As the legal guardian or as one of the parents of the following child:

_____

I hereby give my consent for the representatives of Raintree Village, including the Executive Director, the Programs Director, the Case Worker, and/or Child Care Supervisors to provide medical and emergency care for said child as deemed appropriate by their judgments.

Further, I want to alert them to the following special medical/health conditions of the said child that may require special attention. (If there are no special health conditions, please write "NONE" in the space below):

_____

_____

_____

_____

_____

Legal Guardian's Signature: _____ Date: _____

Youth's Signature: _____ Date: _____

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MEDICAL/HEALTH CARE RELEASE

Name of Child:_____

Social Security Number:_____

Insurance/Medicaid Number:_____

The child named above is legally in the care of:

_____

As the legal guardian I, _____,

I agree to authorize Raintree Village to render medical services and treatments, including surgery, as may be deemed necessary by duly licensed physicians in the best interest of the child, with or without notice to or further comment of the undersigned.

Authorized agents shall be persons in possession of this release.

Legal Guardian's Signature: _____ Date: _____

Youth's Signature: _____ Date: _____

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Raintree Village
CHILDREN AND FAMILY SERVICES

CONSENT OF GUARDIAN TO MENTAL HEALTH TREATMENT

As the legal custodian/guardian of _____, a minor whose birth date is _____, I am authorized to act on behalf of the individual minor in making health care decisions, and I hereby consent to the following mental health treatment (excluding inpatient psychiatric hospitalizations and psychotropic medications) for the individual minor:

- ☐ Therapy
- ☐ Psychological Assessment
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Counseling
- ☐ Medication Monitoring
- ☐ EEG's and EKG's
- ☐ Blood Level Check

It is understood that that such treatment will take place at:

_____
(Name, Address, and Telephone Number)

The above consent is valid until_____ and is subject to the following special conditions:

_____

_____

_____

I retain the right to revoke this authorization with written notice to the above-named provider prior to the expiration date.

Legal Guardian's Signature: _____Date: _____

Youth's Signature: _____Date: _____

Family Involvement Form

Child's Name: **Date of Provider/DFCS Case Plan Consultation:**

DFCS Contact Information

Agency Name:		
Caseworker:	Telephone:	Email:
Address	City, State:	Zip Code:

Sibling Placements

Does the youth have any siblings in DFCS custody?			
Is the youth currently placed in the same foster home or CCI facility as all siblings who are in DFCS custody?			
List Each Sibling Separately			
Name	Age	Sex	Contact Info., Address, Contact #
What is plan to ensure a reasonable and practical method for assisting the youth with maintaining the contact?			

Parent Visits

Is there a parent, relative or other potential permanency placement adult with whom the youth needs to maintain contact?
What is plan to ensure a reasonable and practical method for assisting the youth with maintaining the contact?

In accordance with FY 2017 Room, Board and Watchful Oversight Minimum Standards for Child Placing Agencies and Child Caring Institutions, "Providers must have contact with the child's birth parents, guardian or other permanency person (EPEM—Every Parent Every Month) in order to support the DFCS case plan unless, in accordance with the DFCS case manager, the provider is not expected to conduct EPEM contacts. The frequency, type, mode and purpose of the contacts must be negotiated with the DFCS case manager. Within the first 30 days of placement, providers must communicate with DFCS to understand each individual child's permanency plan, the DFCS EPEM plan and to establish the provider's EPEM plan. The provider's EPEM plan should be updated when the ISP is updated, when the DFCS case plan or EPEM plan is changed or when events dictate. If in accordance with the DFCS CM, the provider is not required to conduct EPEM contacts, this must be documented in the child's case record."

Will Raintree Village expected to conduct EPEM contacts?		
If yes,		
Frequency:		
Type:		
Mode:		
Purpose:		
List Each Parent, Relative, and/or Potential Permanency Placement Separately		
Name	Relationship to Child	Contact Info., Address, Contact #

Visitation Plan:

- ☐ Level 1: Monitor in room with family at all times
- ☐ Level 2: Monitor outside/nearby room checking in every 10 minutes
- ☐ Level 3: Monitor outside/nearby room checking in every 30 minutes
- ☐ Level 4: Monitor outside/nearby room, available if needed
- ☐ Level 5: Unsupervised visitations

Frequency of visits:	Duration of each visit: ☐ 1 hour ☐ 2 hour ☐ other:	Date visits to commence:

Other Contacts (Supportive Adults, Children, Relatives, Etc.)

Name	Relationship to Child	Contact Info., Address, Contact #	Visitation Plan

Are there any persons with whom contact is not allowed?

Name	Relationship to Child	Contact Info., Address, Contact #	Visitation Plan

DFCS's Case Manager: _____ Signature: _____ Date: _____

RTV Foster Care Staff: _____ Signature: _____ Date: _____