ORCHARD PLACE CAMPUS ACCESS FORM

Please complete the following information to the best of your ability. This information is critical to the treatment that your child and family will receive. Full and accurate information is necessary. Please return this form to the Orchard Place admissions personnel at
925 SW Porter Ave, Des Moines, IA 50315 or Fax to 515-287-9695

Date Request Made: _____

Person Filling Out Form and Relationship to Child: _____

SECTION 1 - CHILD'S DEMOGRAPHIC INFORMATION

Full Name (First, Middle, Last): _____

Legal Name/Nickname:_____

SSN #: _____ Date of Birth: _____ Age: _____

City/State Born in: _____ Religious Preference: _____

Gender: ☐ Female ☐ Male ☐ Other/Non-Binary Legal Sex: ☐ Female ☐ Male

Pronouns: _____

CHILD's LEGAL HISTORY *(Check all that apply)*

☐ CINA ☐ Consent Decree ☐ Formal Probation ☐ Delinquent

☐ Informal Probation ☐ Other Police Involvement ☐ No Legal Involvement ☐ Unknown

☐ DHS Involvement If DHS involvement, please explain: _____

Is Child under Court Order? ☐ Yes ☐ No Date of Adjudication: _____

CLIENT RACE / ETHNICITY *(As identified by the client)*

ETHNICITY:

☐ Hispanic, Latino/a/x or Spanish origin (select all that apply)

☐ Cuban ☐ Honduran ☐ Mexican or Chicano/a/x
☐ Salvadoran ☐ Columbian ☐ Spaniard
☐ Puerto Rican ☐ Guatemalan ☐ Hispanic, Latino/a/x or Spanish origin self-identify: _____

☐ Not of Hispanic, Latino/a/x or Spanish origin

☐ Prefer not to answer

RACE: (select all that apply)

☐ Native/Indigenous American or Alaska Native (Nation/Tribe_____)
☐ Asian or Asian American
☐ Self-Identify:_____
☐ Prefer to not answer
☐ Black or African {American}
☐ Middle Eastern
☐ Native Hawaiian or Other Pacific Islander
☐ White

Client/family are refugees: ☐ Yes ☐ No

CULTURAL NEEDS: Is there anything we need to consider to meet you/your child's cultural needs? For example: Hair care products, hygiene products, holidays, roommate considerations, therapist considerations, language, etc.

SECTION 2 - SERVICES PROVIDERS/SUPPORTS

Indicate all services child is currently receiving or has received.

Provider Name/Agency/Phone Number

Primary Care Physician _____

Psychiatrist / Medication Prescriber_____

Therapist(s)_____

Behavioral Health Intervention Services (BHIS)_____

Integrated Health Program (IHP)_____

Substance Use Services_____

Psychological / IQ Testing_____

Hosptial Program (Inpatient/Outpatient)_____

Crisis Stabilization_____

PMIC / Residential Program_____

Shelter Stays_____

Juvenile Detention Placement_____

Juvenile Court Officer_____

DHS Worker_____

Guardian Ad Litem / Attorney_____

Other_____

SECTION 3 – FAMILY INFORMATION

Legal Custodian of Child: _____

Who Does Child Normally Live With: _____

Where is Child Living Now: _____

If Out of Home, List Date Placed at This Location: _____ Last Date Child Lived at Home: _____

Custody/Visitation Info:

_____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____
(if different from the child)

Telephone: Home #: _____

Highest Level of Education: _____

Occupation: _____

Work #: _____

Can we contact you at work? ☐ Yes ☐ No

Cell #: _____

Email Address: _____

Date of Birth: _____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____
(if different from the child)

Telephone: Home #: _____

Highest Level of Education: _____

Occupation: _____

Work #: _____

Can we contact you at work? ☐ Yes ☐ No

Cell #: _____

Email Address: _____

Date of Birth: _____

Military History / Service Record of the Parents: _____

Are There Other Caretakers for the Child: _____

Sibling Information

Sibling's Names (First and Last)	Live in Home? Y/N	Gender (F)emale (M)ale (O)ther	Date of Birth/Remarks
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____

Others in the Home

_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____

Is your child adopted? ☐ Yes ☐ No If Yes, at what age? _____

List important information about the birth family:

_____

Who in the child's/family's life is the child close to?

_____

Family Stressors and Mental Health History: *(select all the apply)*

☐ Abandonment
☐ Abuse
☐ Child abuse investigation current or previous
☐ Child custody/visitation dispute
☐ Citizenship
☐ Court involvement
☐ DHS involvement
☐ Death
☐ Disability
☐ Domestic violence
☐ Educational
☐ Employment
☐ Financial
☐ Illness
☐ Incarceration
☐ Mental health disorder
☐ Neighborhood
☐ Numerous moves
☐ Physical illness
☐ Racial trauma
☐ Separation/divorce
☐ Sibling rivalry/conflict
☐ Substance abuse
☐ Suicides attempts in the family
☐ Suicide completions in the family
☐ Transportation
☐ Other *(explain below)*

Describe Other Family Stressors or Mental Health History:

For each item identified, please describe:

If abuse, abuse investigation, suicide attempts or completions or family mental health issues, please indicate who and their relationship to the child.

SECTION 4 – DEVELOPMENTAL HISTORY

Prenatal Care (include feelings regarding pregnancy, mother's age, number of pregnancies, planned pregnancy, regular check- ups/prenatal care, other supports):

Complications during Pregnancy (include domestic violence/abuse, involved in accident, serious/viral illness):

Substance Used and/or Medications Prescribed During the Pregnancy: ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes: (*select all that apply)*

- ☐ Alcohol
- ☐ Cigarettes
- ☐ Prescription Drugs
- ☐ Street Drugs

Description of Substance Type and Frequency of Use:

Term and Delivery: *(Select appropriate)*

- ☐ C-Section
- ☐ Full Term
- ☐ Normal Delivery
- ☐ Premature
- ☐ Unknown

Complications During and/or Following Labor/Delivery (include anesthetic/medication(s) used, emotions of parents surrounding delivery, medical problems, oxygen used for baby following delivery, seizures):

Birth Weight: _____

Infant/Early Childhood Temperament: *(check all that apply)*

- ☐ Cuddly
- ☐ Easy to Comfort
- ☐ Irritable
- ☐Overactive
- ☐ Quiet/Aloof
- ☐Other (explain below)
- ☐ Unknown

_____

Description of Infant/Early Childhood Temperament:

Developmental Milestones

Sitting At (Months):_____ Crawling At (Months):_____ Walking At: _____

Saying Words At (Months): _____ Saying Sentences (Months): _____ Toilet Trained: _____

Developmental Concerns: *(Select all that apply)*

- ☐ Difficulty Separating from Parent
- ☐ Indiscriminate Interactions
- ☐ Speech Problems
- ☐ Suspicion of Autism
- ☐ Suspicion of Intellectual Disability
- ☐ Slower Development than Other Children
- ☐ Other (explain below) _____

Description of Developmental Milestones and/or Concerns (include if child nursed, used a pacifier, eating, fine/gross motor skills, hearing, how and where child sleeps):

SECTION 5 - TRAUMA HISTORY

History of Trauma: *(select all that apply and then describe below)*

- ☐ Accidents, e.g., care accidents
- ☐ Assault
- ☐ Attacked by an animal
- ☐ Care provider mental illness
- ☐ Community violence
- ☐ Contact with a sexual offender
- ☐ Death of someone important to child
- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Exploitation
- ☐ Illness
- ☐ Incarceration
- ☐ Mental health discrimination
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Physical abuser
- ☐ Racial language
- ☐ Racial trauma
- ☐ Rape
- ☐ Separation from caregiver/parent
- ☐ Sexual abuse - victim
- ☐ Sexual abuse - perpetrator
- ☐ Sexually Inappropriate with someone else
- ☐ Social trauma
- ☐ Suicide/ attempts
- ☐ Verbally abused, e.g., name calling, etc
- ☐ Witness to physical or sexual abuse
- ☐ Other (explain below)

Description of Trauma History and concerns *(please include age(s) of those involved)*:

If child has any physical, or sexual abuse, please indicate by whom abuse occurred.

If the child has contact with a person who is a sex offender please list person name.

SECTION 6 - REFERRAL INFORMATION/PRESENTING CONCERNS

Who is recommending Orchard Place Campus for your child?

_____

Reason for Referral: *(Select all that apply)*

- ☐ Addictive behaviors
- ☐ Aggression toward others
- ☐ Aggression with property
- ☐ Attempts to kill self
- ☐ Attempts to kill others
- ☐ Bouts of severe anxiety/panics
- ☐ Confused/inflexible thinking
- ☐ Confusion of fantasy and reality
- ☐ Cussing
- ☐ Depressive statements
- ☐ Disorientated
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Fire-setting
- ☐ Hearing voices or seeing vision
- ☐ Hurts animals or others
- ☐ Hyperactive
- ☐ Impulsive
- ☐ Inability to plan, organize, or sequence
- ☐ Inattentive
- ☐ Irritability/temper
- ☐ Language/speech problems
- ☐ Lying (other than minor ones)
- ☐ Outbursts
- ☐ Paranoid or unusual fears
- ☐ Picking at sores
- ☐ Plays with objects unusually
- ☐ Problem with authority
- ☐ Pulling out eyelashes
- ☐ Refuses to follow directions
- ☐ Repetitive behaviors
- ☐ Rocking/banging
- ☐ Running away
- ☐ Self-injury
- ☐ Short or long term memory problems
- ☐ Stealing
- ☐ Talks to self
- ☐ Throwing things
- ☐ Unusual thinking, e.g., odd or off-the-wall ideas
- ☐ Yelling
- ☐ Other *(explain below)*

_____

Description of Behavioral History and Concerns:

SECTION 7 - MEDICATIONS, DIAGNOSIS, AND USE OF HISTORY OF RESTRAINT OR SECLUSION

Please list your child's **current** psychiatric diagnosis:

_____

Please list your child's **previous** psychiatric diagnosis:

_____

Is child **currently** taking psychiatric medications? ☐ Yes ☐ No

List current psychiatric medication and response to the medication:

_____

Has your child taken psychiatric medications **previously**? ☐ Yes ☐ No

If **yes**, list previous psychiatric medication, response to the medication and reason for discontinuing:

_____

Has your child ever been restrained in a hospital, in a crisis stabilization unit, school at home or other setting?

☐ Yes ☐ No

If **yes**, indicate when, why and child's response.

_____

Are you aware of any medical conditions or any physical disabilities that may cause problems during a physical restraint

_____

Are there any nutritional concerns? If yes, please explain below: ☐ Yes ☐ No

_____

SECTION 8 - LIFE SKILLS AND BEHAVIORAL INFORMATION

Check all daily living activities your child can perform independently.

- ☐ Bathing
- ☐ Brushing Teeth
- ☐ Cleaning
- ☐ Cooking Simple Meals
- ☐ Doing Laundry
- ☐ Dressing Appropriately
- ☐ Driving
- ☐ Grooming Self
- ☐ Managing Medications
- ☐ Using the Phone
- ☐ Waking up on Own
- ☐ Washing Hair
- ☐ Other

Please list any concerns you have about your child's life skills or skills your child needs assistance with:

Any concerns with wetting or soiling self either during the day or at night? ☐ Yes ☐ No If **yes**, please describe:

Social/Recreational History

Relationship with Peers: *(Select all that apply)*

- ☐ Age-Appropriate Social Skills
- ☐ Fights
- ☐ Leader
- ☐ Poor Boundaries
- ☐ Bossy
- ☐ Follower
- ☐ Misuse of Social Media
- ☐ Problems with Peers
- ☐ Bullying
- ☐ Gang Involvement
- ☐ Outgoing
- ☐ Withdrawn
- ☐ Other (explain below)

Description of Relationship with Peers:

Interests/ Extracurricular Activities:

Any history that would indicate child needs a single room such as: sexual behavior, aggression, socialization issues?
(please note children needing single rooms may have to wait longer to be admitted)

What are the rules and consequences in your home?

Other concerns or comments?

SECTION 9 - SEXUAL INFORMATION/HISTORY

Check all that apply and then describe below.

☐ Begun Dating
☐ Begun Puberty
☐ Birth Control
☐ Currently Pregnant
☐ Difficulties with Sexual Orientation
☐ Excessive Anxiety
☐ Excessive Flirting
☐ Gender Identity
☐ Previous Pregnancy
☐ Sexually Active
☐ Sexually Reactive Behavior
☐ Sexually Transmitted Disease
☐ Other (explain below)

Description of Sexual History/ Concerns:

_____

SECTION 10 - EDUCATIONAL HISTORY

Name of Current or Most Recent School: _____

Address: _____ Grade: _____

Current Individualized Education Plan (IEP)? ☐ Yes ☐ No Current 504 Plan? ☐ Yes ☐ No

Has your child been suspended from school? ☐ Yes ☐ No If **yes**, what grade(s)? _____

What behaviors led to being suspended?

_____

Schools Attended:	Grade	Problems? Yes/No	(Learning or Behavioral? When?) Comments
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____

Has your child ever been employed? ☐ Yes ☐ No

Trials/Career Interests:

_____

SECTION 11: CHILD'S SUBSTANCE USE HISTORY/EXPOSURE

Client has a History of Substance Use: ☐ Yes ☐ No ☐ Unknown

Early Childhood Exposure to Substance Use: ☐ Yes ☐ No ☐ Unknown

Previous Substance Abuse Services: ☐ Yes ☐ No ☐ Unknown

Substance Use: *(if indicated a history of substance use - check all that apply)*

☐ Alcohol
☐ Barbituates
☐ Benzodiazepines (Xanax, Klonopin)
☐ Caffeine
☐ Club Drugs/Hallucinogens
☐ Cocaine/Crack
☐ Heroin
☐ Inhalants
☐ Marijuana
☐ Methamphetamine
☐ Opiates
☐ Over the Counter
☐ Stimulants
☐ Synthetic Marijuana
☐ Tobacco/Nicotine
☐ Other (explain below)

_____

Description of Substance Use and/or Substance Abuse Services, including other involvement with drugs, dealing drugs *(please include age of use)*:

_____

Has your child experienced legal, behavioral or social consequences from the use of alcohol or drugs?

_____

SECTION 12 – FAMILY EXPECTATIONS AND PARTICIPATION REQUIREMENTS

What do you think your child's treatment goals should include?

_____

What are your child's strengths?

_____

What do you think the family treatment goals should include?

_____

Discharge Location and Plan:

_____

When one member of a family comes to Orchard Place Campus, the whole family shares concerns, worries, and the discomfort of separation. Regularly scheduled family therapy sessions and visitation will be planned by you and your family's therapist. Family sessions will be regularly scheduled and you may set up visits with your child through your family therapist.

Weekly family therapy sessions are required. At a minimum, twice per month in-person sessions are required with phone or telehealth sessions on the opposite weeks. Having all sessions in-person are preferred, when possible. Family therapy occurs between the hours of 8a—5p Monday-Friday.

Will you be able to participate weekly? ☐ Yes ☐ No

Preferred session day and time: _____

Do you have the capabilities for telehealth sessions? ☐ Yes ☐ No

Do you have means of getting to your appointments at the Orchard Place Campus? ☐ Yes ☐ No

Will you be able to visit your child regularly on campus? ☐ Yes ☐ No

When your child has progressed in treatment, will you be able to have your child come home for visits? ☐ Yes ☐ No

In addition to family therapy, we also ask out parents/guardians to attend scheduled Psychiatric Review/Treatment Planning Sessions, or staffings, as part of the treatment team. Staffings provide an opportunity to hear progress reports from the unit, school, therapist and psychiatrist as well as participate in treatment planning and review. These are held around 30 days after admission and every quarter thereafter. Staffings are held during normal business hours to accommodate the psychiatrist schedules and any other professionals involved in your child's treatment.

Would you be able to attend regularly scheduled staffings? ☐ Yes ☐ No

Would you be able to attend informational trainings/parenting classes/support groups? ☐ Yes ☐ No

Do any parents/guardians or therapy participants require accommodations such as language translator, wheelchair accessibility, hearing impaired services, etc. If yes, please list below.

_____

To my knowledge, the above information is complete and accurate. I understand that failure to provide information could result in unsuccessful treatment.

_____ _____

Signature ***Date***

Avatar ID: _____

Orchard Place
Client Health Screen

Client Name _____ Today's Date: _____

Has the client had the following examinations in the **PAST YEAR:**

Physical Exam? Yes ☐ No ☐ Date of Last Physical Exam _____

Dental Exam? Yes ☐ No ☐ Date of Last Dental Exam _____

Visual Exam? Yes ☐ No ☐ Date of Last Vision Exam _____

Residential/IHP Clients Only

Height: _____

Weight: _____

If a physical exam has **not** been completed within the **last year**, please make an appointment with a physician (excludes OP Campus). If you need assistance connecting with a doctor's office, please make the assigned staff aware of your need. We can provide resources.

Client Health Condition	Yes	No	Ukn	Explain	Client Health Condition	Yes	No	Ukn	Explain
Allergy to:									
Environment/Other	☐	☐	☐		Hearing Loss/Ear Problems…..	☐	☐	☐	
Food	☐	☐	☐		Heart Problems……	☐	☐	☐	
Medicine	☐	☐	☐		Migraines/ Chronic Headaches	☐	☐	☐	
Asthma	☐	☐	☐		Neurological Disorder	☐	☐	☐	
Bladder/ Urinary	☐	☐	☐		Reproductive Concerns	☐	☐	☐	
Cancer	☐	☐	☐		Respiratory Infections	☐	☐	☐	
Constipation/ Diarrhea	☐	☐	☐		Seizures	☐	☐	☐	
Dental Problems	☐	☐	☐		Sexually Transmitted Infection	☐	☐	☐	
Diabetes	☐	☐	☐		Sleep Problems	☐	☐	☐	
Vision Problems	☐	☐	☐		Sore Throats/Tonsillitis	☐	☐	☐	
Eczema/Skin Issues	☐	☐	☐		Stomach Aches	☐	☐	☐	
Epilepsy	☐	☐	☐		Unexplained Fever	☐	☐	☐	
Fainting	☐	☐	☐		Other	☐	☐	☐	
Head Injury	☐	☐	☐						

List significant injuries, hospitalizations or surgeries and dates. And, list any chronic medical conditions.

Has the client…

Experienced any unresolved physical pain or discomfort? Yes ☐ No ☐ _____

Had any infectious diseases such as MRSA, hepatitis, tuberculosis, meningitis, rubella, small pox, mumps, chicken pox, pneumonia, or any other? Yes ☐ No ☐ _____

Had exposure to second-hand smoke and/or nicotine vapor? Yes ☐ No ☐ _____

In last 3 months been exposed to lice, scabies and/or bed bugs? Yes ☐ No ☐ _____

In last 3 months had unprotected sex? Yes ☐ No ☐ _____

FOR STAFF USE ONLY

For any health condition and/or diseases still existing, is the client receiving medical treatment or follow-up? ☐ N/A ☐ Yes ☐ No

If **no**, please explain: _____

Staff Recommendations: Complete Yearly Physical Exam ☐ Follow-up with PCP ☐ Follow-up with Specialist ☐

Other (explain): ☐

Current Medications (including, Prescription, OTC, Supplements and Vitamins):

Medication	Dose	Prescriber	Usage (What it is for)

By signing, you are verifying the information above has been reviewed and any identified needs for medical follow up, including the need for a physical examination, have been discussed and reviewed with the client and/or parent/guardian.

Staff Signature: _____ **Date Reviewed:** _____

ORCHARD PLACE
FINANCIAL AGREEMENT

ALL DIVISIONS

Name of Person Receiving Services: _____ SSN: _____

For the services provided by Orchard Place, I understand and agree that I and/or my insurance carrier will be billed. My insurance carrier will be billed at full fee. I understand that Medicaid is always the payer of last resort. **I agree to notify Orchard Place if there is a change in my insurance coverage and understand I may be responsible for all charges if I do not do so.** I understand I am responsible for payment of my fee regardless of insurance coverage and agree to pay my portion of the fee as the service is provided. I understand my payment will be used to cover my co-payment and any charges deemed uncovered by my insurance carrier. I understand that if my account is not paid in a timely manner, the balance may be turned over to a collection agency and court action may be pursued. I understand that payment beyond the full service charge will be returned to me.
I authorize the release of any medical or other information necessary to process insurance claims. I authorize insurance payment of medical benefits and major medical benefits to Orchard Place. I also request payment of government benefits to the party who accepts assignment. A photocopy of this assignment is considered as valid as an original. In addition, if the insurance company issues a check directly to you for services provided by Orchard Place, our psychiatric consultant or pharmacy, this check must be forwarded to our business office to be credited to your account.

FOR UPDATES ONLY: Please provide a copy of your insurance card. Also, indicate whether your insurance has changed. ☐ Yes ☐ No

SLIDING FEE ELIGIBLE CLIENTS ONLY

If I am receiving services at Orchard Place, I understand I may be eligible for a sliding fee based on my county of residence, my income, and the size of my family. I understand I will not qualify for sliding fee and may be charged full fee if I do not provide legal settlement information which includes the client's social security number and that my fee may be waived based on the program and services received.

County of Residence: _____ Gross Annual Income: _____

Size of Family Supported by Income: _____ My Fee is _____ % of Full Fee

CAMPUS CLIENTS ONLY

The Department of Human Services will make a determination as to how much of the income from sources such as child support, Supplementary/Social Security or subsidized adoption proceeds is to be paid towards the treatment expenses of the child. Orchard Place/Campus will be notified of the amount and will send the parent/guardian a statement for the monthly amount due. To estimate the amount of client participation you will owe each month, please provide the following information:

Does this child receive Social Security or Supplemental Security? ☐ Yes ☐ No If **yes**, how much per month? _____

Does this child receive any child support or subsidized adoption? ☐ Yes ☐ No If **yes**, how much per month? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Your signature indicates that you have read and understand the above and agree to pay Orchard Place the amount of client participation and insurance co-pay if either should be assessed to you.

Signature: _____ Date: _____

Name: _____

Street Address: _____

City: _____ Zip Code: _____

WITNESS SIGNATURE

For verbal consent only: I have reviewed information and verified understanding with the above signed.

Signature: _____ Date: _____

ORCHARD PLACE
INSURANCE INFORMATION

FOR PERSON RECEIVING SERVICES

Last Name: _____ First Name: _____

Date of Birth: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

TERTIARY INSURANCE INFORMATION

Tertiary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

CAMPUS CLIENTS ONLY

Name of Dental Insurance: _____

Please provide a copy of your insurance card for our records.

At Orchard Place we are driven by our mission to develop stronger futures for every child that is admitted. A child's caregivers are absolutely essential to positive treatment outcomes during and after treatment. Therefore, we require caregivers to participate fully in the treatment process, which includes the following expectations. Please initial on the line after each item to indicate that you have read, understand and agree to each expectation.

- **Family Sessions: Family sessions are required to take place one time a week. These sessions can take place virtually on a bi- weekly basis if needed, but two in person session must occur every month.** Face to face sessions are the preferred modality. **Sessions are scheduled to take place Monday through Friday between the hours of 8am and 5pm.** Therefore, you will need to arrange your schedule as needed in order to meet within those time frames. Furthermore, it is expected that you show up on time for your sessions as our therapists are unlikely to be able to accommodate for last minute adjustments to their schedules._____

- **Visits: In person visits with your child need to take place at least one time a week**. Visits typically start on campus but then transition to off campus visits and visits in the home per the recommendation of your child's treatment team. _____

- **Phone contact:** Your child will be assigned two phone call days a week in which they will be given an opportunity to contact you. However, **it is recommended that caregivers also call their child at least 3 to 5 times a week** or as recommended by your child's treatment team. _____

- **Openness to change: As your child is working on making their own changes, there will also be changes that you will need to make as their caregiver to support them along their journey both during and after treatment.** Your therapist, along with other members of the treatment team, will be providing various recommendations, which may include needed changes to the home environment and approaches to parenting. **It is essential for you to be open to making changes and accepting that areas of needed growth exist within the entire family unit.** _____

- **Discharge Plans- Discharge planning starts from day one, with the expectation that your child will return to your care upon the completion of their treatment.** The treatment team will provide various recommendations and support in securing services for after discharge, but **it is the caregiver's responsibility to get all aftercare appointments scheduled prior to discharge**._____

- **Communication- We expect open, respectful and non-violent communication with all members of our treatment team, regardless of their role in your child's treatment.** If you have concerns, we want to know about them, but they need to be shared respectfully so that we can

continue to work together to ensure your child's needs are being met throughout their treatment stay. **_____**

- **Sanctuary Commitments:** Orchard Place is a Certified Sanctuary Institute. Sanctuary is a trauma informed care approach which includes an agency wide adherence to following 7 commitments: Non-violence, Open Communication, Democracy, Growth and Change, Emotional Intelligence, Social Responsibility and Social Learning. **We ask that staff, parents and clients be mindful of these commitments in their interactions with each other and within the treatment environment.** _____

- **Diversity, Equity and Inclusion:** Orchard Place is additionally committed to providing an inclusive and non-discriminatory environment for all clients, families and staff. **Engagement in statements or behaviors that target a specific group of people will be addressed promptly and be accompanied by any needed education and/or restrictions as appropriate to the situation.** _____

- **Approach to treatment: This is team based care, meaning every member of the team, regardless of their role plays an equally important part in the treatment process. Treatment decisions are made as a team, which includes collaboration with caregivers and clients.** Additionally, members of our treatment teams are trained to use strategies from a variety of different evidenced based treatment modalities. All staff are trained on Sanctuary and Trust Based Relational Interventions. **As caregivers, we ask that you be open to our approaches to treatment and with the understanding that progress looks different for every client. Your child will leave treatment and need ongoing services to help them continue on their journey towards healing and achieving their goals.** _____

By signing below I am acknowledging that I have read, understand and agree to follow through on the above expectations for treatment. Furthermore, I understand that failure to do so may result in poor treatment outcomes and/or discharge from treatment due to lack of parent engagement.

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

Suicide prevention "FACTS"

Warning Signs to look for:

Developing Strong Futures
Orchard Place

Feelings

- Hopelessness, Helplessness, or fear of losing control
- Worthlessness, Shame, Guilt, or extreme loneliness
- Self hate, Anger, or Worry

Actions

- Substance Abuse
- Reckless behavior
- Aggression
- Talking or writing about destruction or death

Changes

- Personality
- Behavior
- Sleep
- Sudden improvement
- Loss of interest

Threats

- "How long does it take to bleed to death?"
- "I won't be around much longer."

Signs

- Trouble at school, home, or with the law
- Recent loss through death, relationships ending, loss of opportunity, self-esteem
- Overwhelming life changes
- Exposure to suicide or death of a peer

If you notice any of these warning signs

1. Express your concern about what you are observing in their behavior

2. Ask directly about suicide

3. Encourage them to call 988, the Suicide and Crisis lifeline

4. Involve an adult they trust

If you have IMMEDIATE safety concerns call 911 right away!

988 SUICIDE & CRISIS LIFELINE

Source: 2011 Hazeldon Foundation & Society for the prevention of Teen Suicide.

spts society for the prevention of teen suicide