YOUTH HOME

Dear Parent and/or Legal Guardian:

Thank you for your interest in Youth Home, Inc. We hope we can help your child and family through the difficult times you are experiencing.

Enclosed is some information for you. This includes criteria for admission into Youth Home, Inc.'s Intensive Residential or Community Residential Treatment programs and related financial information. There are also criteria for admission into our Day Treatment program for children referred by their home school district. If you have received this information packet through the mail, it may include a brochure that also provides information regarding our outpatient services (dba Behavioral Health Services of Arkansas).

Also enclosed is a form asking for some important information that we need. You may provide this information by phone if you prefer. Included as well is an authorization form for you to sign and an educational release form. The authorization will allow us to send to agencies for treatment records. The educational release is for us to send for school records and testing. These records should provide us with the necessary information for the screening process and for treatment of your child.

You may mail these forms back to us at the address below or FAX them to us at (501) 821-5582 or (501) 821-7709. You may also mail or fax copies of any records, which you may already have, which will enable us to review your case even faster. We will keep you regularly informed as to the status of your case and welcome your calls to check in with us as often as you like.

If you would like further information or have any questions, please feel free to call the Admissions Department at (501) 821-5500 or 1-800-728-6452. Thank you again for your consideration of Youth Home, Inc.

Sincerely,

Karen A. Cornwell, LCSW

Karen A. Cornwell, LCSW
Assessment & Referral Director

YOUTH HOME, INC.
20400 Colonel Glenn / Little Rock, AR 72210-5323
(P) 501.821.5500 / (F) 501.821.5580
info@youthhome.org / www.YouthHome.org

YOUTH HOME, INC. ADMISSION CRITERIA

INTENSIVE RESIDENTIAL TREATMENT PROGRAM

The Intensive Psychiatric Residential Treatment Program is located just west of Little Rock on our main campus of 50 acres.
Appropriate referrals will:

- **Be 12 to 18 years of age**
- **Have recent attempts at treatment in outpatient therapy and/or inpatient hospital**
- **Be intellectually capable of benefiting from the program (Full-Scale IQ = 70 or above)**
- **Have diagnosed emotional or psychiatric difficulties that require intensive treatment in a locked psychiatric facility**

Necessary Information for Screening Process

Most recent hospitalization records or outpatient therapy records on the child to include full DSM diagnosis and medications
Letter of recommendation from the current therapist with reasons residential treatment is needed
Specific recent behaviors/symptoms, particularly those which have occurred within the past month
Birth Certificate, Social Security card, Immunization Record, Medicaid number (if applicable)
Court Order (if applicable)
Medical History including any physical problems or limitation to full participation in the program

COMMUNITY RESIDENTIAL TREATMENT PROGRAM

The Community Based Residential Treatment Program is a therapeutic group home located in the community of Little Rock.
Appropriate referrals will:

- **Be female**
- **Be 12 to 18 years of age**
- **Be in DCFS Custody**
- **Be intellectually capable of benefiting from the program (Full-Scale IQ = 70 or above)**
- **Demonstrate only moderate behavioral and emotional problems**
- **Be able to live in the community without danger to self or others**
- **Be enrolled in an educational program (i.e. public school, day treatment, or vocational).**

Please keep in mind that this program is **NOT** an appropriate placement for girls that have demonstrated the following:

- Recent firesetting behavior
- Recent assaultive behavior
- Recent sexual acting out behavior
- History of sexual offending behavior
- Active drug or alcohol problems
- Chronic or recent runaway behaviors
- Recent suicide attempts
- Active psychosis
- Felony Conviction

Necessary Information for Screening Process

Primary Care Physician referral
DCFS intake summary and/or other records reflecting family history and child's behaviors
Placement History
Any recent treatment records
Medical history and any pertinent medical records
Birth Certificate, Social Security card, Immunization Record, Medicaid number, Medical Passport
School records, preferably all school transcripts but to include a minimum of a list of all previous schools attended and location

DAY TREATMENT PROGRAM

The Day Treatment Program is located on our main campus and requires referral from the public school district. It includes a full school day and individual, family, and group therapy as well as medication management/psychiatric evaluation if necessary. All occur in conjunction with the regular school calendar. **Appropriate referrals will:**

- **Be 10 to 18 years of age**
- **Have evidence of behavioral and/or learning problems so severe that s/he cannot be served in a regular public school setting**
- **Have at least borderline to average or above average intelligence as measured by current individual intelligence testing**
- **Have Referral and Due Process procedures completed by the referring school district**

Necessary Information for Screening Process

Referral from home school district to our Educational Services Director
Primary Care Physician referral (Medicaid clients)
Any previous treatment records
Medical history and any pertinent medical records
Current achievement and intelligence testing
Medicaid number, insurance card, or arrangements made with our Business Office for private pay with use of a sliding scale
Birth Certificate, Social Security Card, and Immunization Record

EXPLANATIONS OF FEES

The fee for residential treatment is approximately $429 a day.

If you have private insurance, we will bill your insurance company. If your insurance company requires prior authorization, it must be obtained before admission. If you are in an HMO, you must obtain a referral from your Primary Care Physician prior to admission.

If your youth has a type of Medicaid which will cover our services, we will bill Medicaid. If you have both private insurance and Medicaid, we must bill your private insurance company first and Medicaid will pay any remaining balance.

You will be expected to pay:

a) $20 per month allowance - bring $20 with you the first visit
b) clothing
c) medical, pharmacy, and dental costs not covered by Medicaid or your private insurance

Please note regarding Medicaid coverage:

a) All income that is the youth's must be reported to Youth Home at the time of admission. If a youth has cash in the bank or has other property in his name, it could affect Medicaid eligibility.

b) Youth Home may decide that it is appropriate to apply to be representative payee for SSI or SSA payments. If so, the money will be applied toward Youth Home fees and used for the youth's personal needs, including the $20 allowance, clothes, and school supplies. Any funds left will be returned to SSA – no checks will be issued to patients or guardians.

Information Needed For Admission

Youth Home, Inc.
20400 Colonel Glenn Road - Little Rock, AR 72210-5323 -(501)821-5500 – FAX: (501)821-5582

YOUTH HOME

What program are you interested in: **Intensive Residential**___ **Community Residential**___ **Day Treatment**___

Youth Information (The following information is needed about the youth.) DATE COMPLETED:_____

Name:		
FIRST	MIDDLE	LAST

SS#:	DOB:	Race:	Sex: MALE / FEMALE

County:	School Enrolled In:	Grade:

Medicaid#:	Medicaid Tier:	Date Entered Foster Care:

Primary Care Physician:	PCP Phone#:

Is youth on probation? YES / NO Next Court date:	FINS? YES / NO Next Court Date:

Information needed regarding probation officer, or FINS officer:

NAME	ADDRESS	PHONE#	COUNTY

List all previous counseling services related to mental health history and/or out of home placements (include correctional, inpatient treatment, outpatient treatment, relatives, foster home, etc.):

DATES	SPECIFIC AGENCY NAME / ADDRESS ***Agency names must also be listed on Mandatory Attachment to Authorization*	CONTACT PERSON	PHONE#

List all current meds, with dosages, frequency (example: am & pm, or 3x daily), and at least estimated start date:

MEDICATION	DOSAGE	FREQUENCY (TIMES TAKEN)	Start Date	Compliant	Side Effects
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No

Legal Guardian Information (The following information is needed regarding the youth's legal guardian.)

NAME & RELATIONSHIP	COMPLETE MAILING ADDRESS	PHONE#	EMAIL

How did you hear about Youth Home, Inc. / Referral Source?_____

Authorization To Disclose Health Information

Patient's Full Name _____ Date of Birth _____ Social Security Number _____

I hereby authorize the persons or organizations listed on the attached page to disclose the following protected health information about the above named patient to **Youth Home, Inc.**

The following protected health information shall be disclosed pursuant to this Authorization. **A separate authorization is required for disclosure of psychotherapy notes**.

☐	Facesheet	☒	Progress Notes
☒	Summary of Initial Assessment	☐	Birth Certificate
☒	Psychiatric Evaluation	☐	Social Security Card
☒	Psychosocial Assessment	☐	Immunization Record
☐	Treatment Plan	☐	Case Management Plan
☒	Treatment Plan Reviews/Case Reviews	☒	Neurological Consultations/Testing
☒	History & Physical/Physical Exam	☒	Laboratory Reports
☒	Psychological/Psychoeducational Evaluation/s	☐	Radiology Reports/EEG
		☒	Discharge Summary/Discharge Note
☐	Speech/Language/Hearing Assessment	☐	Other (Specify):
☒	Other Educational Testing/School Records		_____

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm. Reasonable copying costs may be assessed.

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: Certain information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be disclosed from the persons or organizations on the attached page for the following reasons:

☒	Assessment & Evaluation	☐	School Placement
☐	Treatment Planning/Continuity of Treatment	☐	Legal Reasons
☐	Coordination of Community Services/Discharge Planning	☐	PATIENT'S REQUEST
☐	Other (Specify):		

This authorization will expire: ☒ 90 days from the date of the signature,
☐ 90 days following date of discharge of patient from Youth Home, Inc.,
Or ☐ other: _____

This Authorization may be revoked by notifying Youth Home, Inc. in writing addressed to:
Attention: Privacy Officer
Youth Home, Inc.
20400 Colonel Glenn Road
Little Rock, Arkansas 72210
Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Youth Home, Inc.

I also authorize release of information regarding:
☒ Alcohol and/or Substance Abuse ☒ HIV/AIDS or other communicable diseases

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR SUBSTANCE ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Personal Representative's Signature (generally parent/guardian) _____ Date _____ Relationship/Authority _____

Patient Signature _____ Date _____

This Authorization is voluntary. A refusal to sign will **not** affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits. A photocopy or fax of this Authorization shall be as valid as the original.

Mandatory Attachment to Authorization

Persons or Organizations Authorized To Disclose/Receive Health Information*

Patient's Full Name _____ Date of Birth _____ Social Security Number _____

Please include the name of professionals or organizations, the city, and telephone number including area code.

This should include all previous and current inpatient and outpatient treatment facilities, primary care physicians, and other doctors or therapists that have provided treatment to the patient.

NAME OF PROFESSIONAL / ORGANIZATION / CITY / PHONE / DATES:

Treatment within the past two years:

1. _____
2. _____
3. _____
4. _____
5. _____

Treatment over two years ago:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

* Persons listed on this page are authorized to disclose information as indicated on the attached page 1 of the authorization. When the full 2-page authorization is sent to the persons listed above, portions of the list may be blocked for patient privacy purposes.

Youth Home, Inc./20400 Colonel Glenn Road, Little Rock, Arkansas 72210/ (501) 821-5500

RELEASE OF EDUCATIONAL INFORMATION/PSYCHOLOGICAL TESTING

TO: All Applicable Schools/Districts

in the State of Arkansas

RE: _____

DOB: _____

FROM: Youth Home, Inc.
ATTN: Admissions
20400 Colonel Glenn Road
Little Rock, AR 72210

The above named student has been referred to Youth Home, Inc. Please send the following school records if completed to **Youth Home, Inc., ATTN: Admissions:**

1. Wechsler Intelligence Scale for Children (WISC III)
2. Wechsler Individual Achievement Test (WIAT)
3. Developmental Test of Visual-Motor Integration (VMI)
4. Auditory perception testing (Wepman)
5. Classification: Regular, Special Educ., Resource Classes
6. Transcript of Academic Record
7. Immunization Record
8. Health Records
9. Testing Record
10. Grades as of withdrawal
11. Woodcock-Johnson Psychoeducational Battery
12. Bender-Gestalt Visual Motor Test
13. Language testing (CELF)
14. All other Educational and Psychological Testing
15. Due Process information if classification is Special Education
    Please include all of the following:
    - referral for placement in Special Education
    - referral conference decision
    - parent consent for initial placement
    - evaluation/programming conference decision
    - current IEP
    - annual review
    - evaluation results

This release is effective for the period the undersigned is receiving services from Youth Home, Inc.

Authorization to release this information is given by:

_____
Parent/Guardian or Legal Custodian

_____
Date