Hibiscus Children's Center
Saving Children Since 1985

Village Group Living
Client Admission Information

Admission Date: _____ **Admission Time:** _____ **AM / PM**

Client Name:_____ **DOB:** _____

Gender: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Eye Color: _____ **Hair Color:** _____ **Race:** _____ **Ethnicity:** _____

State of birth: _____ **City of birth:** _____

Zip codes of last residence: _____

Scars/Marks/Tattoos:_____

Allergies: _____

Case Worker Name: _____

CW Office Number: _____ **Fax #:** _____

CW Cell Phone Number: _____ **Alternate #:** _____

CW e-mail: _____

Juvenile Probation Officer Name: _____

JPO Office Number: _____ **Fax #:**_____

JPO Cell Phone Number: _____

JPO e-mail: _____

CW Signature: _____ Date: _____

HCC Staff Signature: _____ Date: _____

Client admission Info revised 8/23/2013; 01/30/2014 mmm

Hibiscus Children's Center
Saving Children Since 1985

Child Green Book/Resource Record Checklist

Client Name:_____ DOB: _____ Date: _____

DCM/CPI: _____ Contact #: _____

DCM/CPI Supervisor: _____ Office #: _____

DCM Fax #: _____

Green Book Delivered? ☐ YES ☐ NO

All youth are to have a completed Green Book when admitted to the residential facility. The DCM/CPI will have a maximum of 72 hours to complete the record.

	Received ?	
Foster Care/Shelter order	☐ Yes	☐ No
Letter/Statement of Placement	☐ Yes	☐ No
Court order for Medications (if applicable)	☐ Yes	☐ No
Release of Information	☐ Yes	☐ No
Medicaid Number &/or Copy of card	☐ Yes	☐ No
Auth. For Consent to Medical Treatment	☐ Yes	☐ No
School Enrollment	☐ Yes	☐ No
Copy of Birth Certificate or birth verification	☐ Yes	☐ No
COMP Assessment or proof of referral	☐ Yes	☐ No
Social Security Number &/or copy of card	☐ Yes	☐ No
Other court orders/restrictions (if applicable)	☐ Yes	☐ No

Please Note:
– Any other pertinent information which can assist in providing services to the client should be provided at this time
– Items listed above marked "No" will not prevent admission of the youth but must be provided within 72 hours.
– If the client is on court ordered medications, the medications must be provided at admission as ordered in the original pharmacy containers with information concerning the diagnosis and side effects.

This form was reviewed at admission and it is understood that any required documentation will be provided as indicated within 72 hours.

DCM/CPI Signature:_____ Date : _____

HCC Staff Signature:_____ Date: _____

A copy of this form was provided to the DCM ☐

Date form was provided to DCM: _____

Date form was faxed to DCM: _____

Date missing items filed in folder: _____

A copy of this form was provided to the DCM or admitting CBC provider at time of admission. In addition, this form will be faxed within 24 hours of admission. Per contract, all missing documentation will be received by the residential facility within 72 hours of client's admission.

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE
GROUP LIVING SERVICES
PRE-ADMISSION SCREENING

1. DC&F/ CBC REFERRING _____ COUNTY:_____

   CASEWORKER:_____ TELEPHONE #_____

2. CLIENT'S NAME:_____ DOB_____ Age___ M__ F__ Race _____

3. SOCIAL SECURITY #_____ MEDICAID #_____

4. CURRENT ADDRESS:_____
   City & zip code

5. DATE CLIENT CAME INTO DC & F CUSTODY:_____ Number of Times in DCF Custody: _____

6. REASON FOR REFERRAL TO HIBISCUS VILLAGE program:
   _____

7. WHAT HAS HAPPENED TO CURRENT PLACEMENT (Briefly Explain):
   _____

8. IS THE CLIENT CUREENTLY OR PREVIOUSLY INVOLVED WITH DJJ OR HAVE AN ARREST HISTORY?
   ___Yes __ No If yes for what charges/
   _____
   _____
   _____

9. IS THE CLIENT CURRENTLY OR PREVIOUSLY receiving Mental Health Services? _____ _____ _____
   Unknown Yes No
   *If yes, where/why: _____
   _____

10. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? _____ _____ _____
    Unknown Yes No
    *If yes, where, when and why:
    _____

11. DOES THE CLIENT HAVE A HISTORY OF VIOLENT OR AGGRESSIVE BEHAVIORS EITHER AS AN
    __ ASSGRESSOR OR __VICTIM? _____ _____ _____
    Unknown Yes No

12. DOES THE CLIENT HAVE A HISTORY OF BEING A VICTIM OF SEXUAL ABUSE? _____ _____ _____
    Unknown Yes No
    *If yes, describe by whom, type of aggression and length of time of aggression. _____
    _____

13. DOES THE CLIENT HAVE A HISTORY OF SEXUAL AGGRESSION: _____ _____ _____
    Unknown Yes No
    *If yes, describe towards whom, type of aggression and length of time of aggression: _____
    _____

<u>IF THE ANSWER TO 12&/or 13 IS YES THE CLIENT MUST HAVE A SAFETY PLAN IN PLACE IN ORDER TO BE CONSIDERED FOR ADMISSION.</u>

IS THERE A SAFTEY PLAN IN PLACE? _____ _____
Yes No

Client Name: _____

14. DOES THE CLIENT HAVE ANY DISIBILITIES? _____ _____ _____
Unknown Yes No

15. DOES THIS CLIENT HAVE A HISTORY OF SUICIDAL &/OR HOMCICDAL IDEATIONS? _____ ___ ___
Unknown Yes No

16. IS THE CLIENT ON MEDICATION? _____ _____ _____
Unknown Yes No

PSYCHOTROPIC MEDICATION: _____ _____ _____
Unknown Yes No

LIST OF MEDICATIONS: _____

_____

** IF THE CLIENT IS ON PSYCHOTROPIC MEDICATION AUTHORIZATION FROM PARENT(S) OR COURT ORDER FOR HCC MUST ACCOMPANY THE YOUTH AT ADMISSION.

17. CLIENT'S CURRENT SCHOOL ENROLLMENT OR ALTERNATIVE EDUCATION PROGRAM.
NAME OF SCHOOL OR PROGRAM & GRADE: _____
PHONE #: _____

18. APPROXIMATE LENGTH OF STAY: _____

19. LONG-TERM PLAN: _____

20. The following DOCUMENTATION is required at admission.

*Copy of Birth Certificate or birth verification
*Copy of S/S card and Medicaid card
*Immunization Records/Current Physical
*Shelter/Detention Order
*Medications & Authorizations
*Copy of Safety Plan (if appropriate)
*Medical and/or psychological evaluations
*COMP Assessment or proof of referral

Referring DCM Signature & Credentials _____ Date: _____

HCC Reviewing Staff Signature _____ Date _____

Accepted for Admission on by _____ on _____
Authorized HCC staff, credentials & title Date

Additional comments/instructions: _____

_____

_____

_____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE

Group Living Program Permanent Register/Admission Assessment

Name of Case Manager: _____ **Telephone Number:** _____

Admission Date:_____ **Time:**_____ **AM / PM** **County:** _____

RESIDENT INFORMATION **HCC CASE#:**_____

Client's Name: _____ **DOB:**_____ **Age:**_____

Race:_____ **Ethnicity:**_____ **Birthplace:** _____ **Religion:** _____

S/S Number: _____ **Medicaid #**_____

Is this client eligible for public assistance: _____Yes ____ No **Medicaid** _____ **SSI/SSDI** _____
***If No, why?** _____

Current Address (Please include city and zip code): _____

Housing History for the past 5 years:_____
_____

Reason for Referral to HCC Village: _____
_____

Reason for disruption of current placement: _____
_____

Anticipated Length of Stay at HCC: _____ **Long Term Plan/Permanency Plan:**_____
Potential for Reunification:_____

Does this child have a Guardian Ad Litem (GAL) _____ **Yes** _____ **No**
If Yes .....Name:_____ **Phone #**_____

FAMILY INFORMATION (Biological/Foster)

Parents Name(s): Mother _____ **Father**_____
Address(s):_____
Contact Phone Number: _____
Substance Abuse in the home: _____
Domestic Violence in thehome:_____

Sibling Name(s)	DOB	Age	Race	Current whereabouts & Contact Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client's Name: _____

Grandparent(s): Grandmother: _____ Grandfather: _____
Address(s): _____
Contact phone number: _____

VISITATION APPROVAL:
On-campus visitation must be Pre-Approved and Pre-Arranged with the Program Director or designee and supervised by the case manager.

	Name	Phone #	Relationship to youth
Off-Campus	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Supervised Phone Calls ____Yes ____ No

Name	Phone #	Relationship to youth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mail Censored _____Yes _____ No

EDUCATIONAL INFORMATION:

Client's Previous School or educational program: _____Grade:_____
Telephone #_____
Special Education Program: _____ Yes _____ No IEP Completed:_____

HEALTH INFORMATION:

Disabilities:_____ Yes _____ No If Yes, what:_____

Current Immunizations: _____Yes _____ No

Any Medical Hospitalizations: ____Yes ___ No If Yes, where and when:_____

Currently on Medications: ____Yes ____No If Yes, what:_____

Any known allergies: ____ Yes ____ No If Yes, what to: _____
_____

MENTAL HEALTH, DEVELOPMENTAL AND BEHAVIORAL INFORMATION:

Is the client currently receiving Mental Health Services: ____Yes _____No _____Unknown
If Yes, where and when_____
ICD9 Diagnosis: _____Source of Diagnosis:_____

Currently on Psychotropic Medications: _____Yes _____No If Yes, what:_____

Any previous Psychiatric Hospitalizations: _____Yes ____No _____ Unknown
If Yes, where and when_____

Does the client have Developmental Delays: _____Yes ____No ____ Unknown
If Yes, please explain_____

Client's Name: _____

MENTAL HEALTH, DEVELOPMENTAL AND BEHAVIORAL INFORMATION:

Is the client currently receiving Mental Health Services: ____Yes _____No _____Unknown
If Yes, where and when_____
ICD9 Diagnosis: _____Source of Diagnosis:_____

Currently on Psychotropic Medications: _____Yes _____No If Yes, what:_____

Any previous Psychiatric Hospitalizations: _____Yes ____No _____ Unknown
If Yes, where and when_____

Does the client have Developmental Delays: _____Yes ____No ____ Unknown
If Yes, please explain_____

Does the client have a History of Violent or Aggressive Behaviors: _____ Yes _____No _____Unknown
If Yes, where and when: _____
Does the client have a history of being a victim of violent &/or aggressive behavior? _____ _____ _____
Yes No Unknown
***If Yes, describe by whom, type of aggression and length_____**
_____

Does the client have a History of Suicidal/Homicidal Ideations:_____Yes ____No ____ Unknown
If Yes, please explain_____

Does the client have a history of being a Victim of Sexual Abuse:____Yes ____No ____ Unknown
If Yes, describe by whom, type and length of victimization_____
_____

Does the client have a History of Sexual Aggression: _____Yes _____No _____Unknown
If Yes, describe toward whom, type of aggression and length of time of aggression
_____

Client's Name: _____

PRESENTING ISSUES, STRENGTHS AND WEAKNESSES

Please check All Applicable Boxes

Physical aggression to others		School Suspensions		Anxiety	
Low Frustration Tolerance		Adult Conflict		Academic Problems	
Gender Identity Issues		Low Self-Esteem		Sexually Acting Out	
Verbal Aggression/Threatening		Depression		Panic Attacks	
Self-Injury		Runaway		Suicidal History	
Defiance/Non-compliance		Poor Anger Control		Obsessive/Compulsive	
Hyperactivity Problems		Bedwetting		Somatic Complaints	
Property Destruction		Peer Conflict		Tics/Stereotypic Movement	
Poor Impulse Control		Eating Problems		Sleep Disturbance	
Severe Tantrums		Adult Conflict		Attention Deficit	
Developmental Delay		Curses		Social Withdrawal	
Hallucinations		Support from Biological Parents		Peer Leadership	
Multiple Interest/Hobbies		Non-relative Support		Positive Peer Relations	
Support from Biological Relatives		Athletic		Good Verbal Skills	
Positive Academics		Energetic		Good Hygiene	
No DJJ Involvement		Shares Easily		Respectful	

Comments: _____

_____

_____ _____

Case Manager (name & signature) Date

_____ _____

HCC Staff Signature Date

Client Name: _____

Hibiscus Children's Center
Saving Children Since 1985

Residential Services

Statement of Eligibility & Authorization for Services

It is the policy of *Hibiscus Children's Center* that any person meeting program criteria be eligible to receive services, regardless of age, gender, race, ethnicity or religion. Discrimination of any kind, in any of these areas, will not be tolerated. If you believe that you were denied services on the basis of age, race, gender, ethnicity or religious affiliation, contact the Compliance Officer.

I understand all children entering the Hibiscus Residential Services may receive the following as indicated:

- Services and transportation for medical appointments, school and related educational activities and other professional services as defined under contract.

- Therapeutic services including individual and group therapy, psychiatric services and crisis intervention as defined through Behavioral Health Overlay Services (BHOS).

- Hibiscus Children's Center will not use or allow anyone else to use a child's photograph for the purpose of fundraising or public relations. School pictures will be taken and Hibiscus will make every effort to purchase them or provide the information to the parent/guardian.

- Our contract manager with the contracted CBC Agencies has been given a copy of the Behavior Guidance Program used, including a copy of the Policies and Procedures.

_____ _____

DCM for CBC/Admitting Case Manager HCC Staff

_____

Date

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE

PLACEMENT LETTER

Client Name: _____

DOB: _____ Medicaid Number: _____

DCM Name: _____

DCM contact number: _____

Alternate DCM contact number: _____

The client is Florida Medicaid eligible and the number has been provided above. If the client does not currently have Medicaid, I understand that I must contact Hibiscus Children's Shelter to discuss payment or Medicaid application status. All medical charges should be billed to Medicaid. If you are a non Medicaid provider or an out-of-state provider, prior authorization for treatment must be obtained in order for payment to be made, except in cases of a medical emergency.

The above named client has been placed in the temporary custody and care of _____, a contractor of the Department of Children and Families for the provision of foster care and related services. This letter places the child in the physical care of Hibiscus Children's Center at the below referenced address:

Hibiscus Children's Village
1145 12th Street
Vero Beach, FL 32960

CPI/DCM Signature:_____ Date : _____

HCC Staff Signature:_____ Date: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER

PERMISSION TO CUT HAIR

Permission is granted

for_____
Name of Client

To have his/her hair cut for personal and/or hygiene purposes by Hibiscus Children's Center.

_____ Initial by guardian if permission is granted for hair dye or perm.

Parent/Legal Guardian Signature:_____

Date:_____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER

Permission for Out of District Travel & Water Activities

Client Name:_____ Client ID #:_____

Hibiscus Children's Center (HCC) is requesting permission for the above named client to participate in an out of district outing. HCC travels throughout Florida with the clients living in a Group Home during Summer Camps and other special events.

This permission will also include the client's ability to participate in water activities. All water activities will have lifeguards present. Please initial next to the approved water activities for this youth.

_____ Water Parks

_____ Beaches

_____ Pools

_____ Waterslides

_____ Other water related activities

- *This form needs to be signed by either the parent, guardian, or dependency case manager.*

_____ _____
DCM Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
HCC Staff Signature Date

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER
Teen Normalcy Plan

Youth Name:_____ Age:_____ DOB:_____

Florida law has maximized the authority of foster parents to approve participation in age-appropriate activities of teens by requiring a written plan for such activities. A plan is now required for all youth aged 13 to 17 in licensed care. The Teen Normalcy Plan (TNP) must be developed in collaboration with the dependency case manager, youth, and caregivers. The TNP is to describe the agreed upon responsibilities of the youth and the agreed upon activities the youth will be allowed to engage in.

Florida Statute 409.1451 (3) (a) 3 F.S. removes any responsibility for and prohibits the sanctioning of, a foster parent's license as a result of the actions of a child engaged in the activities specified in his or her written plan.

RESPONSIBILITIES OF YOUTH:

1. Clients need to attend school daily and tutoring as necessary.
2. Clients need to take care of personal care/hygiene daily.
3. Clients need to do assigned chores.
4. Clients are responsible for keeping rooms clean and bed made.
5. Clients are responsible for dressing appropriately.

ALL CLIENTS:

- Clients can participate in after school academic and sports programs.
- Clients can obtain employment.
- Clients can have a cell phone with contract.
- Clients can use the internet.
- Clients can have off campus visits with approved contacts thru DCM.

CLIENTS 15-17:

- Clients can participate in unsupervised activities with friends & peers (movies, shopping, and library, school) not to exceed 3 hours.
- Clients can ride public transportation.
- Clients can have overnight visits with approved friends from school, church or other social group.
- Clients can open a checking and savings account.
- Clients can obtain a Driver's License.

Youth Name: _____

CURFEWS:

1. Weekday Curfew: 7:00 PM
2. Weekend Curfew: 8:00 PM
3. Weekly Allowance: $10.00 - $15.00 Dollars depending of Level

ACKNOWLEDGEMENT:

In signing this Teen Normalcy Plan, I acknowledge:

- I have participated in the development of this Teen Normalcy Plan.
- I have received a copy of this Teen Normalcy Plan.

Signature of Youth Date

Signature of Caregiver Date

Signature of Dependency Case Manager Date

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER

Career Pathways to Independence
Referral/Consent Form

Among the many services being offered by Hibiscus Children's Center, youth 15-17 years old will be offered career training and employment opportunities. This program will also match youth with a mentor/life coach with similar career and personal interests.

Name of Youth: _____ DOB: _____
Age: _____ SS#: _____
Current/Most Recent Grade: _____
Anticipated Length of Stay: _____

Case Manager Name: _____
Case Manager Phone Number: _____
Case Manager Email: _____

Does this youth currently have a mentor/life coach: ☐ YES ☐ NO
If so, Name and Contact Information: _____

Is this youth currently employed: ☐ YES ☐ NO
If so, where and for how long: _____

What are your career interests?

_____

By signing this form I am providing consent for the above named youth to participate in this program. I understand the youth will be matched with a mentor, receive on-going career training and support, will be placed in a work experience or internship (on the HCC property or with a community business) and will take part in research (where non-identifying information will be gathered) about their experience in the program. I also understand that after the appropriate background checks are completed, the mentor may transport the above youth to Indian River State College or other educational programs, work sites of interest, and/or job fairs. I have read the above information and was allowed to ask questions.

Youth's Signature: _____ Date: _____
Case Manager Name: _____
Case Manager Signature: _____ Date: _____
HCC Staff Signature: _____ Date: _____

***Please place this form in Cyntheria's Mailbox
***External referrals should be emailed to ccollier@hcc4kids.org or faxed to 772-299-6012

Hibiscus Children's Center
Saving Children Since 1985

Hibiscus Childrens Center
MEDIPASS PCP CHANGE REQUEST

Patient Name (print): _____

Medicaid ID #: _____

Date of Birth: _____

Indian River County Health Department Providers

[x]	Indian River County Health Department 1900 27th Street Vero Beach, FL 32960 (772) 794-7400 Medipass #: 0279412-91
[ ]	Gifford Health Center 4675 28th Court Vero Beach, FL 32967 (772) 770-5151 Medipass #: 0279412-96

I understand I will be assigned to the provider I have selected above, if available, for my MediPass Provider. If the provider I have chosen is not available a MediPass representative will contact me for another choice.

_____ _____
Patient Name/DCM Name | Agency & Representative Name (print)

_____ _____
DCM signature and phone number | Representative Signature

1145 12th St. _____
Address

Vero Beach, FL 34960 _____
City, State, Zip Code

772-299-7293 x325 _____
Phone | Date

Fax: (561) 616-1547

Hibiscus Children's Center
Saving Children Since 1985

CONSENT FOR MEDICAL TREATMENT

Client Name:_____ Date of Birth:_____

I hereby authorize any physician, hospital or dentist to provide for the above named minor ordinary and necessary medical and dental examination and treatment to include those laboratory tests recommended by the Early Periodic Screening, Diagnosis and Treatment testing and any blood testing deemed necessary by documented history or symptomatology but shall exclude any test for which separate court order or informed consent is required by law. Ordinary and necessary medical and dental care shall also consist of preventive and prophylactic care, to include immunizations, tuberculin testing and well child care, but shall not include surgery, general anesthesia or other extraordinary procedures for which separate court order or informed consent is required by law. I further authorize any physician, dentist, hospital or clinic to furnish the Department of Children and Families, or its authorized agent, any verbal or written information pertaining to the present or past state of health and medical treatment given to my child. I/we also agree to be financially responsible for the care of any pre-existing medical conditions and/or any self-inflicted injuries while in the custody of the Department and give permission for the hospital/physician to file a direct claim to the insurance company or Medicaid on my behalf. I authorize that a photocopy of this release may be considered as valid as the original.

_____	_____	_____
Parent/Guardian Signature	Date	Relationship to Minor
_____	_____	_____
Witness Signature	Date	Address
_____		_____
Telephone Number		Medical Insurance
_____		_____
Policy Number		Medicaid Number

Pre-existing medical condition:_____

_____

Medication:_____

_____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER
Admission Medical Data

Name:_____Date:_____Time:_____Shelter:_____Village _____

DOB:_____ Age:_____ Hair: ___ Clean ___ Dirty ___ Matted ___ Nits/Lice

Allergies: No___Yes___list:_____

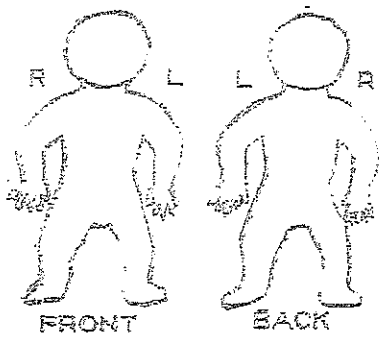
Medications

Date of Rx	Name of medication	Dose	Amount in container	Date/Time of Last Dose

Baby Information: Formula:__No__Yes: Type& Amt._____
& Time of Feedings:_____
Table Food:__No__Yes:__Reg. or __Soft

General Appearance:__Clean__Neat__Dirty__Unkempt
__Sad__Crying__Quiet__Happy
__Talkative__Shy__Excited__Laughing

Other information/comments:



BI-BITES C-CUT B - BRUISES
A - ABRASIONS R - RASH
SC - SCARS SR-SCRATCH
BM - BIRTHMARK S -SORES

_____ Date:_____ Time:_____
ICC Staff Signature

_____ Date:_____ Time:_____
DCM Signature

Revised 8/23/13 mmm

Hibiscus Children's Center
Saving Children Since 1985

Hibiscus Children's Village

INDIVIDUAL SERVICE PLAN (ISP)

Client's Name: _____ Date of ISP: _____

Admission Date: _____

DOB: _____ Gender: _____ Race: _____

Person Performing the Interview: _____ Title: _____

Client's Strengths: _____

_____

Client's Long-Term Goal(s): _____

_____

_____

_____

Client's Short-Term Goal(s): _____

_____

_____

_____

Behavioral Concerns: _____

_____

_____

_____

Is Reunification the goal at this time? YES or NO

Other Information

_____

_____

_____

_____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE
Personal Property Inventory

Client's Name: _____ Admission Date: _____

DCM Name & County: _____ Telephone #: _____

Upon admission all belongings need to be itemized, boxed, labeled with the Client's Name Inventories are to be conducted upon the client's receipt of new items.

ITEM	QUANTITY	DESCRIPTION
Clothing:		
Underwear		
Socks/Stockings		
Pants/Jeans		
Shirts		
Blouses		
T Shirts		
Coats/Jackets		
Sweaters		
Jackets		
Shorts		
Dresses		
Skirts		
PJ's/Robe		
Bathing Suit		
Baby outfits		
Shoes		
Sneakers		
Jewelry		
Games/Toys		
Other		
Other		

Staff Signature: _____ Date: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE
CHILDREN'S REINFORCER SURVEY

Client's Name:_____ Age: _____ Date:_____

Attempt to elicit from the client, in a conversational style, as many of the actual and potential reinforcing events as possible.

Some things I like to do:

_____Go to the park
_____Ride my bike
_____Stay up late
_____Hike
_____Have a picnic (eat outside)
_____Watch TV/movies
_____Play with pets
_____Watch a movie
_____Be alone in my room
_____Play music
_____Do crafts
_____Bake goodies
_____Do crafts

_____Get a job
_____Listen to the radio
_____Play a game
_____Go fishing
_____Have a party
_____Go swimming
_____Go on an outing
_____Go to the beach
_____Go out to dinner
_____Talk on the telephone
_____Read books
_____Cook dinner
_____Just hang out

If you were planning a birthday dinner, what would you have for dinner (pick 2). What desserts would you choose?

_____

_____

If you could have anything you want for a snack, what would it be?

_____

What sports do you like to play? _____

What sports do you like to watch? _____

If you had $10.00 to spend anywhere, to which store would you prefer and what would you buy?

_____

What do you like to do in your spare time? _____

_____

Staff: Describe any other reinforcers or comments not mentioned above.

_____

_____

Client Signature: _____ Date: _____

HCC Staff Signature: _____ Date: _____

Client Name: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER

Career Pathways to Independence and Employment
Research Informed Consent

Description of Research: You are invited to participate in a study regarding programs designed for youths' residing at Hibiscus Children Center (HCC). Hibiscus, partnering with eight community agencies and businesses created a model program to support youths' transition to adulthood/emancipation and the ending of state custody. The program promotes continuing education, career pathways, gaining a high school diploma and the acquisition of independent living and social/emotional skills. This program may include work internships, part time employment and job shadowing. Furthermore, the program will provide career testing, support for staying in school, adult mentoring, self sufficiency seminars, focus groups and interactive situations designed to develop intelligent decision making and problem solving skills. The research will focus on whether this program is successful in meeting its stated goals and objectives and an analysis of the program's challenges and successes from varying perspectives (i.e. administrators, counselors, mentors, employers and participating youths.)

(Please check what is applicable for participant – see below)

- *Youths* –Youths will be asked to communicate (or rate) work experiences and attitudes about work; educational plans and attitudes about education/training; acquisition of independent living skills, social/emotional skills and problem solving skills; ideas regarding the skills/knowledge needed for adulthood/emancipation, school experiences, reasons for completing high school and short and long term goals for completing high school .

  Some *youths* will also be chosen to be interviewed about their experiences in the foster care system, self sufficiency preparation and attitudes, social/emotional and critical thinking skills, current and future education and educational/training plans, current and future social supports, plans for the future, experiences/attitudes regarding this program, analysis of skills needed for adulthood/emancipation and recommendations for program's improvement.
- *Program Administrators/Staff* – Maybe be asked in interviews regarding their thoughts about programs, programs' challenges, favorite activities, least successful activities, youths' struggles, ideas for improvement, how these programs have affected them and their jobs etc.

Client Name: _____

Possible Risks: Risks are no different than you would encounter participating in a classroom activity or going to an interactive lecture or workshop.

Possible Benefits: The research data will be used to improve the program and inform others about this program. Data can show that this multi faceted transitional program can be copied and/or expanded. Data can be used to ask for funding to continue and/or expand the program. This program can give youths the opportunity to become productive citizens and brake the vicious cycle of abuse and neglect.

Confidentiality: Your identity in this study will be treated confidentially. The results of this study may be published in journals or articles, used for academic study/papers, conferences and presented in meetings. The data will not contain identifiable references to anyone. All data will be coded and kept inaccessible. However, data can be inspected by Hibiscus or any other relevant agency that Hibiscus feels requires access. The data will be kept private in so far as permitted by law and legitimate review.

Available Sources of Information Regarding Study: Any further questions, comments or concerns about this research can be answered by:
Dr. Trudy Sack – 774-238-8713

AUTHORIZATION

I have read the consent form. I had time to ask questions and the consent form has been explained to me. I understand the consent form and I volunteer to participate in this research study. ***I received a copy of this signed and dated form.***

My signature means I agree to participate in this study.

PARTICIPANT PRINTED NAME _____

PARTICIPANT SIGNATURE _____

DATE _____

HCC STAFF SIGNATURE _____

DATE _____

*****Please place this form in Pathways Coordinator's Possession*****

Allowance Policy

The goal of the Behavioral Guidance Plan is to provide positive reinforcement for appropriate behaviors. Currently, all youth in our program have been eligible to receive $10.00 allowance per week regardless of what Level they were on. If a youth was on Level 1 Status, their allowance would be held until they achieved Level 2 Status. As we move forward, we will no longer hold a client's allowance.

In order to encourage youth to maintain Level 2 Status and to promote positive behaviors, we are changing the way that allowances will be calculated and dispersed to the youth.

To receive $10.00 per week, a youth must be on Level 2 Status for the entire week. If at any time during the course of the week, a youth drops to Level 1 Status, they will receive $2.50 for that week.

Examples

1. **If you have maintained Level 2 Status for Saturday, Sunday, Monday, Tuesday, Wednesday, Thursday and Friday, then you will receive $10.00 allowance on Friday**
2. **If you were on Level 2 Status for Saturday, Sunday, Monday and Tuesday but received a Major Infraction that dropped you to Level 1 Status on Wednesday, you will receive $2.50 allowance on Friday.**
3. **If you remain on Level 1 Status, you will receive $2.50 allowance for that week.**

The change in the allowance structure is to promote positive behaviors and to encourage youth to work towards achieving and maintaining Level 2 Status.

_____ _____

Client's Name **Date**

_____ _____

Hibiscus Staff **Date**

Client Name: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER

GRIEVANCE PROCEDURE FOR CHILDREN

Any client having any kind of problem while at Hibiscus Children's Center is able to speak to a Childcare worker, Supervisor, Program Manager, Director of Operations, or Therapist and/or file a grievance without fear of being punished for discussing his/her problem.

Every attempt will be made to resolve the client's problem and meet his/her individual needs when possible. The steps for following a grievance procedure are as follows:

*Fill out a Grievance form – obtain from staff member
*Put completed form in the Grievance Box – in the main area
*Program Manager will pull the Grievance and meet with the client to resolve.

Client Signature: _____

Admission Date: _____

HCC Staff Signature: _____

Client Name: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S CENTER
CLIENT RIGHTS

As a client of the Hibiscus Children's Center organization, you have the following rights:

- You have the right to respect and dignity at all times
- You have the right to communicate anything which is discussed during your sessions
- You have the right to confidentiality (anything which is talked about in your session will be kept in the sessions by your therapist unless it relates to abuse, homicidal and/or suicidal thoughts/plan)
- You have the right to quality services
- You have the right to refuse any service or treatment and be informed of the consequences of such refusal
- You have the right to participate in the development of your treatment plan
- You have the right to know about progress toward the completion of your treatment plan on a routine and ongoing basis
- You have the right to be informed of any research activities and have the right to refuse involvement in research activities other than routine and normal program evaluation
- You have the right to review your records with Hibiscus staff
- You have the right to call the Department of Children and Families at any time to report abuse
- You have the right to be treated equally regardless of financial status (the amount of money your family has)
- You have the right to take any legal action you feel is justified
- You have the right to be treated without discrimination due to differences in religion, race, ethnicity, age or sexual orientation.

If you feel any of the rights listed above have been violated, you may submit a written grievance to your treating therapist or to the Chief Operating Officer. You will receive a written response to your grievance within five (5) working days.

ABUSE HOTLINE 1-772-398-0845

The client rights have been explained to me and I was provided a copy upon request.

Client Signature: _____ Date : _____

Parent/Guardian Signature: _____ Date: _____

HCC Staff Signature: _____ Date: _____

Revised 3/12/07 kmg; revised 8/23/2013 mmm

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S VILLAGE
GROUP HOMES
WELCOME

Client Name: _____ Age: _____

1. Client has had a tour of the Village
2. Client has been given the fire evacuation route and procedure
3. Client has been assigned to an appropriate house, room and supplies
4. Client has had the Behavior Guidance Program explained
5. Client has been given a Client Handbook which includes HIPAA policy and the Grievance Procedure
6. Rules were explained to the client and understood:
   *Shower/bath each day and be well-groomed
   *Walk and use indoor voices in the House
   *Make their bed and keep their room clean
   *Personal belongings that are not kept neat will be put in storage
   *Treat staff and other children as they would like to be treated – no cursing, no hitting, no teasing, no biting
   *Do not take or borrow anyone else's belongings without permission from the owner
   *Leave bedroom doors open when inside their room and doors remain closed when children are not in their rooms
   *Children are not allowed outside with permission from a houseparent/team parent
   *Children are not allowed in the group home office without permission
   *Children can only eat in the dining area, main area and outside
   *All school age children will attend school
   *All children will be expected to do chores while they live here
   *Boys and girls may not enter each others rooms
   *Do not answer the telephone or the door
   *Go to bed when asked

BEDTIMES

BEDTIME	AGE GROUP
9:00pm – Go to room 9:30pm – Lights out	Ages 12 – 16 years
9:30 pm – Go to room 10:00pm – Light out	Age 17 years

I understand that by not following the rules, I will have a consequence. I am not allowed to damage property or hurt others.

Client Signature:_____ Date : _____

HCC Staff Signature:_____ Date: _____

Hibiscus Children's Center
Saving Children Since 1985

Cell Phone Contract

Client Name:_____ Date: _____

Serial Number: _____

Make: _____ Model: _____

Telephone number: _____

Password: _____

I agree to abide by the following rules in order to have a call phone at Hibiscus Children's Center. Hibiscus will not be held liable for broken or stolen cell phones.

Rule #1: Client will turn in cell phone nightly by 9:00 PM for charging and overnight care. Phones will be returned by staff at 6:00 AM.

Rule #2: Any misuse such as calling non-approved persons on your contact list or sending inappropriate texts or photographs will result in confiscation of the cell phone.

Rule #3: Staff may request your cell phone at anytime to check incoming and outgoing calls.

Rule #4: Client will be responsible for paying the cell phone bill and taking care of it.

Rule #5: Cell phones will not be used to contact staff under any circumstances.

Client Signature:_____ Date : _____

HCC Staff Signature: _____ Date: _____

Hibiscus Children's Center
Saving Children Since 1985

BHOS Referral Form

Client name _____

Birthday _____

Social security _____

Race _____

Gender _____

Medicaid # _____

Location: **Village - Vero Beach**

1145 12th Street
Vero Beach, FL 32960

772-299-6011
772-260-1917, fax

DCM _____

DCM contact # _____

Staff completing referral _____

Date of referral _____

Hibiscus Children's Center
Saving Children Since 1985

Psychiatric Referral Form

Client Name:_____ Client #: _____ Date:_____

Legal Guardian: _____ Contact # : _____

Guardian Relationship: _____

Village Shelter Mental Health Outpatient

Reason for referral: _____

_____

_____

Is the client currently taking medication? YES NO

If yes, what type of medication(s): _____

Reason for current medication(s): _____

Prescribing doctor & phone number (if known):_____

Referring HCC staff (print name): _____

Signature of referring staff: _____ Date: _____

Date referral form was submitted: _____

Submitted to: Village medical staff

Shelter medical staff

Mental health Outpatient