****

**KENNETH B. WALKER RESIDENITAL HOME, INC.**

KBW Home 1: 2305 Amos Street - Columbus GA 31903 | (706) 221-3380

KBW Home 2: 3108 11th Ave - Columbus GA | (706) 507-2317

KBW Home 3 Box Circle: - Columbus GA | Under Construction

KBW Home 4: 5790 Bunche St - Columbus, GA | (706) 940-0849

KBW Home 5: 3409 17th Ave- Columbus, GA | (706) 221-7332

Thank you for your interest in placing your child with Kenneth B. Walker Residential Home, Inc. Our mission is to provide the opportunity for each child to reach their fullest potential in a quality setting that encourages the pursuit of excellence and meet developmental needs. We believe in order to accomplish this mission, we need the increased involvement and support from families and our community. Our main goal is to keep our children safe and secure.

In this package we have included a placement authorization document providing you with pertinent information about our services our services and the current residents, ages, and behavior types that we serve.

Also, included is an admissions packet that should be completed prior to admission and a checklist of the necessary documents that will need to be included upon admission.

In the event you have or are in need of any additional information, please contact us directly at:

(706) 940-0478 Office | (706) 940-0479 Fax

Tim Crumbley

Tim Crumbley; Chief Executive Officer

(706) 681-1991

kbwhome@knology.net

Tasha Mahone

Tasha Mahone; Chief Operations Officer

(706) 358 - 9901

Tmahone97@hotmail.com

***PLACEMENT AUTHORIZATION***

KBW Residential Home provides room, board, watchful oversight, support, and guidance for youthful offenders and abused juveniles.

I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give Kenneth B. Walker Residential Home the authorization to place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the city of Columbus, Georgia and County of Muscogee. I/We understand the current number of residents at each facility and the types of behavior and/or diagnosis that may be present. I/We understand and am/are willing place this child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We understand the age range from \_\_\_\_\_\_ to \_\_\_\_\_\_.

KBW provides the following services:

1. Room and board, three nutritious meals daily, support and guidance toward independent

 growth. Staff persons present 24 hours, 7 days a week.

1. Assistance in planning and preparing nutritionally balanced meals in cooperation with other house residents. This includes special diets. Individual residents assume the major responsibility with support from staff and residents.
2. Support and guidance in the use of medication. In cooperation, with other house residents, the development of self care skills such as cooking, hygiene, house maintenance, and money management, along with behavioral modification skills.
3. Scheduled house meetings designed to facilitate group interaction and personal growth in a therapeutic environment.
4. Recreation consisting of outdoor and indoor activities and outings.
5. Counseling for residents and assistance in obtaining health, social, vocational and other services as needed
6. The home shall have the right to consult with resident's physician regarding medications and to assist in the supervision of such medications, if, in the opinion of the home administrator, it is necessary.
7. Will make routine physical/dental examination during the residents stay.

**Place an "X" next to the conditions that apply to youths already in placement. (KBW Staff ONLY)**

***The types of diagnosed children we currently have ranges from:***

\_\_\_\_\_\_\_\_\_\_ ADHD, ADD, Defiance Disorder, Bipolar Disorder, Conduct Disorder,

\_\_\_\_\_\_\_\_\_\_ Child molestation,

***The types of charges range from:***

\_\_\_\_\_\_\_\_\_\_ Run Away \_\_\_\_\_\_\_\_\_\_\_ Violation of Probation

\_\_\_\_\_\_\_\_\_\_ Simple Battery \_\_\_\_\_\_\_\_\_\_\_ Other

\_\_\_\_\_\_\_\_\_\_ Aggravated Assault

\_\_\_\_\_\_\_\_\_\_ Aggravated Battery

\_\_\_\_\_\_\_\_\_\_ Theft by Taking, Shoplifting

By signing the above placement agreement you give us at KBW permission to serve your child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party/Date

**Referral Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referral Source/Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Person Making the Referral**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anticipated Placement Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resident Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ **M \_**\_\_**F**

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E**thnicity**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral (Include pending charges or any court orders)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any conditions your child being placed may have, include any specialized services that are needed to provide the child with adequate room, board and watchful oversite.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Worker/Case Expeditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign)**

**KBW Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign)**

***Intake:***

Placing Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Identifying Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Name MI Last Name

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.N. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

Home Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Custodial Information:***

Current Custody Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Placement Information:***

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probation Officer/Case Manager/Case Expeditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Emergency Contact:***

In the event of an emergency, please provide two 24 hour emergency contact names and number.

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Expeditor/Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probation Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DJJ/DFCS Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DJJ/DFCS Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication Restrictions: (Please list any restrictions regarding communication or visitation with resident)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Consent for Treatment***

**Child's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent for treatment at Kenneth B Walker Residential Home (KBW) (to be filled out and signed by the legal guardian). It is the policy of KBW to provide routine medical and dental treatment for all clients.

**\*AUTHORIZATION FOR CARE**

I hereby authorize KBW and its duly appointed representative to act in my behalf in the care of the above noted child.

**\*AUTHORIZATION FOR EMERGENCY MEDICAL AND SURGICAL CARE**

KBW shall ensure that residents receive timely, qualified medical care in cases of medical emergencies (life threatening, limb threatening, or function threatening conditions). Residents of KBW will be treated for any emergency at a local authorized hospital in Muscogee County. All non emergency care will be provided by a licensed physician. I will be notified in advance of emergency care, if possible. Permission is also granted for KBW to keep required immunizations up to date. I also agree to inform KBW personnel in writing of any medications, including medications that may cause an allergic reaction, which may be administered.

**\*DENTAL INFORMATION**

My signature on this form authorizes release of any information relating to any dental care which may occur on the above noted child while being seen by a designated and licensed dentist.

\***MENTAL HEALTH CARE**

I hereby authorize KBW to conduct examinations, therapies, and treatments, including psychotropic medications. When such services are deemed necessary by a physician or other duly qualified personnel on the above noted child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KBW Staff/Date

**AUTHORIZATION FOR TRANSPORTATION**

The undersigned hereby authorizes and directs KBW, through its designee or representative to transport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the resident) to such locations as deemed necessary by staff of KBW. Further, it is understood by the undersigned that by execution of KBW Treatment Program Agreement, KBW, its agents, employees, officers, directors and staff are released from any and all liability and are fully indemnified and held harmless by the undersigned. For any loss or injury arising out of any transfer and/or any transportation provided by KBW or its representatives.

**Consent to be photographed**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent to be photographed for identification purposes only.

I understand that my picture will not be taken without my permission. I understand that my picture will not be displayed without my permission. I understand that I can withdraw my permission to be photographed at any time

I hereby consent to authorize the use and reproduction by the above named agency, or anyone authorized by the same, of any and all photographic images taken on above date negative or positive proofs, for any purpose whatsoever, without further consideration of compensation.

\_\_\_\_\_\_Agency does not give permission for youth to be photographed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Responsible Party/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KBW Staff/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Date

***Service Contract Agreement***

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree to participate in the residential treatment program offered by KBW at the KBW Home for males. I am aware that this program will provide the following services:

1. Room and board, three nutritious meals daily, support and guidance toward independent growth. Staff persons present 24 hours, 7 days a week.
2. Assistance in planning and preparing nutritionally balanced meals in cooperation with other house residents. This includes special diets. Individual residents assume the major responsibility with support from staff and residents.
3. Support and guidance in the use of medication. In cooperation, with other house residents, the development of self care skills such as cooking, hygiene, house maintenance, and money management, along with behavioral modification skills.
4. Scheduled house meetings designed to facilitate group interaction and personal growth in a therapeutic environment.
5. Recreation consisting of outdoor and indoor activities and outings.
6. Counseling for residents and assistance in obtaining health, social, vocational and other services as needed
7. The home shall have the right to consult with resident's physician regarding medications and to assist in the supervision of such medications, if, in the opinion of the home administrator, it is necessary.
8. Will make routine physical/dental examination during the residents stay.

A child may be discharged from the program if the judgment of the house staff and residents' representative find that it is no longer appropriate for said child to be at the KBW Home... A resident will be given a notice of his discharge plan available within a week period in writing unless the discharge is for disciplinary reasons (i.e. if youth engages in behavior which is clearly a threat to the safety of any person in the home or property), or unless child is hospitalized without expectation of their return.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

***NOTICE***

* KBW gives services to male/female youths without regard to race, color, creed, sexual orientation or national origin.
* KBW will not accept private referrals from individual families.
* Fees for all services shall be based on the per diem/level of care received from the placement agency.
* Referral agents and/or parents or guardian are responsible for all damages their resident renders during their stay. All damages will be paid in full within 48 hours of incident.
* The KBW Home will not be responsible for any money, valuables or personal effects brought into the home.
* Notice of any changes in the conditions of this contract will be given 30 days prior to change.

This form also serves as placement agreement and authorization for residential childcare between KBW and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to render services for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resident/Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party/Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KBW Staff/Date**

**KENNETH B. WALKER RESIDENITAL HOME, INC.**

**Authorization For The Release Of Confidential Information**

|  |
| --- |
| *Section 1:* |
| **Name of Client:** |  |  **Date of Birth:**  |  |
| **Name of Person and / or Program Exchanging Information:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address of Person and / or Program Exchanging Information:** |  |
| **Name of Person and / or Program Exchanging Information:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address of Person and / or Program Exchanging Information:** |  |

|  |
| --- |
| **Purpose For Which Information Is Being Released:** |
| **Continuity of Care** |  L**egal Matter** |  Ed**ucational/Vocational Planning** |
| **Personal** |  |  |
| **Other (Specify)** |  |

|  |
| --- |
| **The Information Is To Be:** |
| **Mailed** |  **Faxed** |  **E-Mailed** |
| **Picked Up** |  **Delivered Face To Face** |  **Verbal** |
| **Other (Specify)** |  |

|  |  |
| --- | --- |
| **Information To Be Released: Time Frame Service Occurred** |  |
| **Service/Treatment Plan** | **Progress Reports** | **Medication E.** |
| **Medication Prescribed** | **Psychiatric Update** | **Diagnosis** |
| **Psychological Assess**. | **Psychological Testing** | **Therapy Update** |
| **IEP/MFE** | **Education Testing** | **Grade Reports** |
| **Behavior Reports** | **Court Documents** | **History** |
| **Medical Records** | **Discharge Summary** |  |
| **Other (Specify):** |  |

|  |
| --- |
| **Recipients of this information are forbidden from re-disclosure without my specific further authorization as cited by Federal Regulations Section 2.31 of PI.L 93-282 42 part 2. I understand that this authorization may be withdrawn at any time in writing, except to the extent that the agency or the person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for a maximum of**  **90 days after I sign and date the form below, unless the purpose of this authorization is to maintain ongoing communication in order to enhance continuity of care, in which case it will expire** X **1 year from the date signed. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signature of Parent/Guardian** |  |  | **Date:** |  |
| **Signature of Client (If Applicable):** |  |  | **Date:** |  |
| **Witness:** |  |  | **Date:** |  |

**PLACEMENT AGREEMENT**

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Placing Agency Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the placing agency, I agree to the following:

1. To provide KBW with complete and accurate information to the best of my knowledge
2. To assist in arranging visits with the biological family as needed and to provide biological family with necessary information concerning placement.
3. To delegate to KBW the authority to authorize routine medical, dental, educational and psychiatric procedures as well as emergency procedures. KBW will notify the placing agency in the event of an emergency or accident.
4. To supply KBW with adequate medical/dental coverage, proof of Medicaid or private insurance coverage.
5. To maintain regular communication with resident and KBW staff
6. To provide input to treatment planning. KBW agrees to provide service/treatment plans to the placing agency as well.
7. To assist in discharge planning and arrange post KBW placement.
8. The legal guardian is responsible for securing all personal items belonging to the client post discharge. KBW is not responsible for any unclaimed items 30 days past discharge date.
9. To inform KBW of commitment order deadlines, as well as court dates and other relevant dates.

KBW agrees to provide as much advance notice as possible in the event of placement termination.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Placing Agency Representative Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**KBW Staff Date**

**RIGHTS AFFORDED TO YOUTH IN KBW HOME**

Individuals receiving services have:

* The right to sufficient clothing, food, shelter, and recreation to ensure proper development
* The right to be treated with dignity and respect
* The right to be free from physical, psychological, sexual, verbal abuse, humiliation and neglect
* The right to privacy and freedom from intrusion
* The right to communicate with family, peers, and members of the community through visitation, telephone contact unless otherwise indicated.
* The right to practice or not to practice a religion of my choice
* The right to an education
* The right to professional, age appropriate services and treatment
* The right to informed consent/refusal/expression of choice in the composition of my service delivery team, concurrent services and research projects.
* The right to be free from physical and emotional punishment
* The right to have a competent guardian if my biological parents are unable or unwilling to assume the role.
* The right to file complaints and grievances and to receive responses to such grievances, free from interferences, retaliation, coercion, or discrimination.
* The right to be free from financial or other exploitation for financial gain and free from exploitation in employment related training or gainful employment
* If participating in research, the right to adhere to research guidelines and ethics
* The right to be involved in the service planning process and to express opinions on issues concerning services to be provided.
* The right to access information in sufficient time to aide in making decisions about my services.
* The right to an investigation and resolution if I feel my rights have been violated.
* The right to confidential treatment of my personal information and records and to know who has access to my records.
* The right to have access to my records in accordance with KBW policy.
* The right to access and/or referral to representation for legal, self-help and or/or advocacy assistance.

I have read and had explained to me the above description of my individual Rights.

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 Youth Signature/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature/Date

***KBW Home***

***Grievance Procedure***

In the event of a questionable act performed by a staff member, a resident has a right to file a grievance against an individual, staff or the organization.

Place your grievance in writing and turn it in to your HSP. Please ensure that you sign and date it.

Director will review and address the compliant with the Chief Operations Officer and Chief Compliance Officer. If the complaint is with the HSP please turn in the written complaint directly to the Chief Operations Officer and Chief Compliance Officer.

You will be provided with a response within three days of when the complaint was turned in.

If you disagree you can appeal with the Chief Executive Officer within 48 hours who will give a response to you within 72 hours. Please note that the Chief Executive Officer will make the final decision.

Please note that KBW does not tolerate any form of retaliation in regards to the compliant

Chief Operations Officer Tasha Mahone | 706-358 - 9901

Corporate Compliance Officer (Agency Ombudsman) Sebrina Porter | 706-940-0478

I have read and understood the grievance policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Resident Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 KBW Staff Date

**CHECK LIST**

Here is a list of the needed documents that should be accompany the admission packet prior to admission.

\_\_\_\_ BIRTH CERTIFICATE

\_\_\_\_ SOCIAL SECURITY CARD

\_\_\_\_ IMMUNIZATION RECORD

\_\_\_\_ INSURANCE CARD/MEDICAID CARD

\_\_\_\_ PHYSICAL/DENTAL WITHIN THE LAST YEAR

\_\_\_\_ COURT ORDER

\_\_\_\_ WAIVER OR FUNDING LETTER

\_\_\_\_ CONDITIONS OF PLACEMENT IF APPLICABLE

\_\_\_\_ RBWO PLAN OF CARE/CASE PLAN

\_\_\_\_ SCHOOL RECORDS

\_\_\_\_ SOCIAL HISTORY

\_\_\_\_ STATEMENT ON YOUR AGENCY LETTERHEAD, WITH SIGNAUTRES GIVING

 KBW AUTHORIZATION FOR CARE

