Willow Creek Counseling Center, LLC 859-554-0740 1050 Chinoe Rd. Suite 203 Lexington, KY 40502

FOSTER CARE INTAKE FORM

CHILD GENERAL INFORMATION

Today's Date: _____
Child's First Name: _____ Middle Initial: ___ Child's Last Name: _____
Child's Nickname, if applicable:
Sex: M F
Child's SS#: _____
Date of Birth: _____ Age: ____

Foster Parent(s) Name: _____
Address: _____
City: _____ Zip Code: _____
Foster Parent Cell Phone: _____ Foster Parent Home Phone: _____

***Please provide a copy of court/custody paperwork

DCBS Worker's Name: _____
Phone _____ #: Ext: ____
Work Cell Phone #: _____
Email: _____

Please share the main reason/behavioral concerns for seeking counseling:
_____
_____
_____

Has the child had therapy previously? Y N
Previous Therapist: _____
Where: How Long:

CHILD TRAUMA/PLACEMENT HISTORY

When was the child removed from the biological family's care? _____
Why was the child removed from care?

_____
_____
_____

Is this the child's first foster placement? Y N
If not, type of previous placements/length:

_____
_____
_____

Is the child having difficulty finding pleasure in leisure activities lately? Y N
Has the child's appetite changed recently? Eating More Eating Less No Change
Has the child's sleep changed recently? Sleeping More Sleeping Less No Change
Nightmares? Y N
Sexualized Behaviors? Y N
Bedwetting? Y N
History of Physical Abuse: Y N
History of Sexual Abuse: Y N
History of Neglect: Y N
History of Psychological Abuse: Y N

CHILD HEALTH HISTORY FORM

Has the child been seen by a medical doctor in the past year? Y N
Current pediatrician: _____
Pediatrician's Office: _____
Would you like us to communicate and collaborate with the pediatrician? Y N
Has the child seen a dentist in the past 6 months? Y N
Please list any current medications and supplements the child is currently taking:

Medication	Dosage	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the child have any chronic illnesses? Asthma, diabetes, heart disease, etc Y N

If yes, please explain: _____

Does the child have any allergies? Y N
If yes, please list: _____

CHILD HEALTH HISTORY FORM

(continued)
Did the birth mother use drugs or alcohol while pregnant with this child? Y N

Any issues with pregnancy or delivery? Y N
If so, what: _____

Did the child have any developmental delays? Walking, talking? Y N
Any sensory issues? Sensitive to touch, loud noises, smells, bright lights:
_____

Are there any mental health issues that run in the child's biological family, such as depression, anxiety, ADHD, schizophrenia, etc? Y N
If yes, please explain who and which diagnosis: _____

Is there any history of substance abuse in the family? Y N
If yes, please explain who and what substances:_____

CONSENT AND PERMISSION FOR SERVICES/TREATMENT

I understand that Willow Creek Counseling Center, LLC is providing mental health assessment and treatment services to my child and family. I understand that there are no certain outcomes from these services and that individual experience with treatment may vary. In giving consent to Willow Creek Counseling Center, LLC to provide these services to me, I am aware that Willow Creek Counseling Center, LLC has a duty to protect my confidentiality except where the law requires disclosure of certain information. There are several situations in which Willow Creek Counseling Center, LLC cannot assure confidentiality including:

•Willow Creek Counseling Center, LLC has a duty to report the abuse or neglect of a dependent adult and/or domestic violence offenses to the Department for Community Based Services;
•Willow Creek Counseling Center, LLC has a duty to report any instance of child neglect, exploitation, or abuse to the Department for Community Based Services and/or the police;
•Willow Creek Counseling Center, LLC has a duty to report any threats against persons to the intended victim and to the police;

• Willow Creek Counseling Center, LLC has a duty to release information to agencies or persons with a need to know when a client is in need of hospitalization; and
• When a client introduces personal mental health or substance abuse issues in court proceedings then confidentiality is waived by the client.

[ ] Understanding all of the above possible waivers of confidentiality regarding information about my mental health and/or substance abuse condition and treatment, I give consent to Willow Creek Counseling Center, LLC and its therapists to provide assessment and treatment services to me.

Federal Rules prohibit any party from making further disclosure of this information "unless further disclosure is expressly permitted by the written consent of the person to whom it pertains" or is otherwise permitted by 42 CFR part 2.

[ ] I have been given a copy of the Notice of Privacy Practices. I have been allowed to ask any questions about this pamphlet and they have been answered for me.

Willow Creek Counseling Center, LLC can remind you of scheduled appointments the day before your appointment. This is offered as a service to you only with your permission, you may opt out of this service by selecting the appropriate box below.
[ ] I would like to have appointment reminders for the foster parent. I understand it is my responsibility to notify Willow Creek Counseling Center, LLC if their contact information changes.

Preferred appointment reminder contact:
Cell / Text _____
Home Phone _____
Foster Parent Email Address _____

[ ] I would like to have appointment reminders for myself as well. I understand it is my responsibility to notify Willow Creek Counseling Center, LLC if my contact information changes. Please note, the appointment reminder contact method will need to be the same as for the foster parent. For example, if you select sending a text message to foster parents, then you must select text message for yourself.
Preferred appointment reminder contact:
Cell / Text _____
Home Phone _____
Email _____

[ ] I DO NOT wish to have appointment reminders at this time.

Child's Name:_____

Printed DCBS Worker's Name: _____

DCBS Worker's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Finally, I understand that Willow Creek Counseling Center, LLC and their therapists do not and will not express opinions for custody and/or visitation at any time. The therapists' role is to strictly provide therapy and they do not participate in reunification. I agree not to subpoena any staff at Harmony Farm for court proceedings to testify for custody and/or visitation hearings.

As the clinician for this client I have explained this form to the guardian and foster parent and answered his/her questions. In my professional judgment the guardian is capable of making and has made an informed decision to accept treatment services.

_____ _____
Signature of Clinician with Credential Date

FINANCIAL RESPONSIBILITY STATEMENT

Today's Date: _____
Child's Name: _____
Insurance/MCO: _____
Insurance ID#: _____
Medicaid ID#: _____

I,_____, agree that DCBS is fiscally responsible for services rendered by Willow Creek Counseling Center. I give permission to Willow Creek Counseling Center, LLC to submit a claim to the child's insurance.

_____ _____
DCBS Worker's Signature Date

_____ _____
Witness Date

Authorization to Disclose Health Information to PCP

Today's Date: _____
Child's Name: _____

1. I authorize the use or disclosure of the above named individual's health information as described below for use by Willow Creek Counseling Center, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Willow Creek Counseling Center, LLC to communicate relevant information obtained over the course of treatment to the individual, entity, and/or facility listed below.

2. Name of the individual, entities, or facilities authorized to make the disclosure:

Primary Care Physician: _____

Address: _____

Phone Number: _____

3. The type and amount of information to be used or disclosed is as follows:

✓ All medical records

✓ All diagnostic and assessment information including psychological or psychiatric reports and evaluations ✓ Results of Drug & Alcohol Testing

✓ Laboratory results

✓ Other: verbal and written collaboration

4. I understand that the information in the child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I will initial here _____ if I wish to include this information. Signature of Minor, granting permission, if applicable:

_____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Willow Creek Counseling Center. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
TERMINATION OF TREATMENT_____.

6. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

DCBS Worker/Guardian _____
Signature of Client or Legal Representative If Signed by Legal Representative,

_____

Date_____
Relationship to Patient _____
Witness _____
Date_____

Authorization to Disclose Health Information to Foster Parents

Today's Date: _____
Child's Name: _____
1. I authorize the use or disclosure of the above named individual's health information as described below for use by Willow Creek Counseling Center, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Willow Creek Counseling Center, LLC to communicate relevant information obtained over the course of treatment to the individual, entity, and/or facility listed below.

2. Name of the individual, entities, or facilities authorized to make the disclosure:
Foster Parent(s): _____
Address: _____
Phone Number: _____

3. The type and amount of information to be used or disclosed is as follows:

✓ All diagnostic and assessment information including psychological or psychiatric reports and evaluations ✓ Other: verbal and written collaboration

4. I understand that the information in the child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I will initial here _____ if I wish to include this information.
Signature of Minor, granting permission, if applicable:
_____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Willow Creek Counseling Center. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
TERMINATION OF TREATMENT_____.

6. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

7. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

DCBS Worker/Guardian _____
Signature of Client or Legal Representative If Signed by Legal Representative,
_____ Date_____
Relationship to Patient _____
Witness _____
Date_____

Authorization to Disclose Health Information to School

Today's Date: _____
Child's Name: _____

1. I authorize the use or disclosure of the above named individual's health information as described below for use by Willow Creek Counseling Center, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Willow Creek Counseling Center, LLC to communicate relevant information obtained over the course of treatment to the individual, entity, and/or facility listed below.

2. Name of the individual, entities, or facilities authorized to make the disclosure:
_____
_____
School System: _____
Address: _____
Phone Number: _____

3. The type and amount of information to be used or disclosed is as follows:

✓ All school records

✓ All special education records such as IEP or 504 plan

✓ All diagnostic and assessment information including psychological or psychiatric reports and evaluations ✓ Other: verbal and written collaboration

4. I understand that the information in the child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I will initial here _____ if I wish to include this information. Signature of Minor, granting permission, if applicable:
_____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Willow Creek Counseling Center, LLC. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ TERMINATION OF TREATMENT_____.

6. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

DCBS Worker/Guardian _____
Signature of Client or Legal Representative If Signed by Legal Representative,
_____ Date_____
Relationship to Patient _____
Witness _____Date_____