ADMISSIONS

PLEASE DO NOT UNSTAPLE PACKETS

THE FIRST PACKET IS TO BE FILLED OUT

COMPLETELY !!!!!!

BY WHOEVER IS ADMITTING THEM TO US.

IF INFORMATION IS UNKNOWN WRITE UNK

LET THEM KNOW THAT WE NEED THE

CLIENT'S BIRTH CERTIFICATE, SOCIAL AND

MEDICAID NUMBERS ASAP.

WE ALSO NEED THE COMPREHENSIVE

BEHAVIORIAL HEALTH ASSESSMENT INITIATED.

THE SECOND PACKET IS TO BE FILLED OUT BY

YOU OR THE STAFF YOU ASSIGN IT TO WITHIN

24 HOURS.

THANK YOU IN ADVANCE FOR YOUR

COOPERATION !!!!! JACQUELYN

HIBISCUS CHILDREN'S CENTER
INDEX – SHELTER RECORD

CLIENT NAME:_____ADMISSION DATE:_____

INDEX OF DOCUMENTATION *REQUIRED DOCUMENTATION	CHECK OFF	STAFF INITIALS
SECTION 1 – RESIDENT INFORMATION		
Shelter Discharge Summary (after discharge)*		
Green Book/Resource Book Sign-Off Form*		
Statement of Eligibility*		
Pre-Admission Checklist/Screening*		
Permanent Register*		
Personal Property Inventory*		
Welcome*		
Client Rights*		
Grievance Procedure*		
Reinforcer Survey*		
Copies of S/S and Medicaid*		
Copy of Birth Certificate*		
ISP*		
ISP Addendum		
SECTION 2 – RELEASE AND AUTHORIZATION		
Authorization for Medical Treatment*		
Permission to Cut Hair*		
Activities Consent Form*		
SECTION 3 – OFF CAMPUS RELEASE FORMS		
Child Release Verification		
SECTION 4 – CBC AGENCY - LEGAL		
Shelter Order*		
Case Plan*		
Permanency Plan*		
Placement Letter *		
GAL Appointment Letter		
SECTION 5 – CONTACT REPORTS		
All Reports of Contact / Visitation / Phone Logs		
SECTION 6 – EDUCATION		
Verification of School Enrollment*		
Report Cards, Interim Reports, Conduct Reports, IEP's,		
SECTION 7 – MEDICAL		
Admission Medical Data*		
EPSDT*		
Immunization Records*		
Medical Incident Reports / Medication Administration Records		
Authorization for Medication / Medical Records / History		

INDEX OF DOCUMENTATION (continued)	CHECK OFF	STAFF INITIALS
SECTION 8 – TREATMENT TEAM		
Treatment Team Notes		
SECTION 9 – BEHAVIOR REPORTS		
Behavior Incident Reports		
Comprehensive Behavioral Health Assessments*		
SECTION 10 - CLINICAL		
BHOS Referral Form		
BHOS Initial Screening		
BHOS Eligibility Certification (opening & every 6 months)		
Brief Face to Face Assessment		
Biopsychosocial/In-Depth Assessment		
CFARS		
MMPI		
Safety Plan		
Treatment Plan/Treatment Plan Reviews		
SECTION 11 - WEEKLIES		
BHOS Weeklies/Progress Note		

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 missing items filed in folder: _____

A copy of this form was provided to the DCM or admitting CBC provider at time of admission. All documentation will be faxed to the residential facility within 72 hours of client's admission.

Green Book revised 10/25/2013 mmm

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

ALL ABOUT ME

(BIOGRAPHICAL INFORMATION)

FULL NAME: _____

DATE OF BIRTH: _____

MEDICAID NUMBER: _____

SOCIAL SECURITY #: _____

DEP. CASE MANAGER NAME: _____

DEP. CASE MANAGER PHONE #: _____

DCM SUPERVISOR NAME: _____

DCM SUPERVISOR PHONE #: _____

EMERGENCY ON-CALL PHONE #: _____

SCHOOL & GRADE: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS EMERGENCY SHELTER SERVICES
PRE-ADMISSION SCREENING

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

   CASEWORKER:_____ TELEPHONE #_____

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

3. SOCIAL SECURITY #_____ MEDICAID #_____

4. CURRENT ADDRESS:_____
   City & zip code

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

6. REASON FOR REFERRAL TO HIBISCUS Emergency Shelter program:
   _____

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

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

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

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

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

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

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

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

Client Name: _____

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

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

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

PSYCHOTROPIC MEDICATION: _____ _____ _____
Unknown Yes No

LIST OF MEDICATIONS: _____

_____

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

17. CHILD'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 CENTER

Emergency Shelter Services Permanent Register/Admission Assessment

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

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

RESIDENT INFORMATION **HCC CASE#:** _____

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

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

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

Is this child 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 Emergency Shelter: _____
_____

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): _____
_____

Substance Abuse in the home: _____
Domestic Violence in thehome: _____

Sibling Name(s)	DOB	Age	Race	Current whereabouts
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child'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 Manager 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:

Child'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 child 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 child have Developmental Delays: _____Yes ____No ____ Unknown
If Yes, please explain_____

Client Name: _____

Does the child have a History of Violent or Aggressive Behaviors: _____ Yes _____No _____Unknown
If Yes, where and when: _____

Does the child have a history of being a victim of violent &/or aggressive behavior? _____ _____ _____
Unknown Yes No

*If Yes, describe by whom, type of aggression and length _____

Does the child have a History of Suicidal/Homicidal Ideations: _____Yes ____No ____ Unknown
If Yes, please explain _____

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

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 Manage (name & signature) Date

_____ _____
HCC Staff Signature Date

Hibiscus Children's Center
Saving Children Since 1985

Hibiscus Children's Shelter

INDIVIDUAL SERVICE PLAN (ISP)

Child's Name: _____ **Date of ISP:** _____

Admission Date: _____

DOB: _____ **Gender:** _____ **Race:** _____

Person Performing the Interview: _____ **Title:** _____

Child's Strengths: _____

_____

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

_____

_____

_____

Child'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 SHELTER

Child's Name: _____ **Date of Initial ISP:** _____

BEHAVIOR/ SERVICE	ACTION PLAN	PERSON(S) RESPONSIBLE	GOAL	DATE BEGAN	DATE DONE
Personal Safety	Provide child with a safe environment.	All HCC Staff	Ensure safety for the child.		
Medical	Obtain a nursing assessment within 24 hours of admission and an EPSDT within 72 hours of admission. Follow up with necessary medical care including dental services.	Nursing Staff/ Guardian	Ensure all medical needs are met for the child.		
Educational	Enroll the child in school or daycare within 7 days of admission.	Education Coordinator	Provide the child with an educational experience and assist with future goals.		
Adapt to Shelter Life	Orient child to the Shelter rules, procedures, and structure of the program. Review child handbook and behavioral guidance program.	Mental Health Technicians/MHT Supervisors	Aid the child in becoming comfortable in their new living situation.		
Mental Health	Complete all additional and appropriate assessments.	Clinical Staff	Determine the child's Mental Health needs.		
Parental Involvement/ Visitation	Encourage parental involvement based on DCF's determination of visitation rights of the parent/guardian.	All HCC Staff	Include the parent/guardian to be an active participant in the life of the child, to identify visitation opportunities, to involve the parent in the child's treatment, and to encourage a positive parenting approach as allowed by CBC & legal entities.		
Staffing	Treatment team staffing within 14 days of admission	All HCC Staff	Determine all needs of the child and complete a service summary.		

Child's Name:_____ **Date of Initial ISP:** _____

BEHAVIOR/ SERVICE	ACTION PLAN	PERSON(S) RESPONSIBLE?	GOAL	DATE BEGAN	DATE DONE
Other (if applicable)					

This ISP will remain active and reviewed bi-weekly until or unless BHOS services are delivered, in which the Treatment Plan would prevail.

****** Signatures to be obtained within 30 days of admission:***

Program Director	Date	Child Signature	Date
Parent/Legal Guardian Signature	Date	DCM Signature	Date
BHOS Therapist Signature	Date	Nurse Signature	Date

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

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 Shelter

Activities Consent Form

All children residing at Hibiscus Children's Center may be given the opportunity to participate in the following activities as part of the normalcy plan for the children in our care:

- **Water activities**- swimming, beaches, pools, water slides, water parks and other water related activities. Lifeguards will be present during all off campus water activities.
- **Sports**-Football, soccer, baseball, basket ball, karate, gymnastics, dance, or bowling.

Occasionally, these activities require travel to other counties throughout the state of Florida.

By signing this form you are giving permission for _____
(Child's name)

To participate in the activities listed above, and acknowledge these activities will , at times, require travel outside of the tri-county(Martin, St Lucie, Okeechobee) area.

_____ _____
DCM/Legal Guardian Signature Date

_____ _____
HCC Staff Signature Date

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S SHELTER

PLACEMENT LETTER

Child's Name: _____

DOB: _____ **Medicaid Number:** _____

DCM Name: _____

DCM contact number: _____

Alternate DCM contact number: _____

The child is Florida Medicaid eligible and the number has been provided above. If the child 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 child 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 Shelter
4001 Savannah Road
Jensen Beach, FL 34997

CPI/DCM Signature:_____ Date : _____

HCC Staff Signature:_____ Date: _____

Form #76
Rev. 7/24/13

THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

STUDENT ENROLLMENT FORM

School_____ Grade Entering_____ Date of Birth _____ Age_____ Today's Date_____

Student's Legal Name: Last First MI (Alias/AKA) Social Security# (optional) ___/___/___ Sex: M ☐ F ☐

4001 SAVANNAH RD JENSEN BEACH 34957 MAR (772) 334-0701

Residence Address Street Number & Name Apt. # City Zip County Home Phone

Mailing Address (if different) Street Number & Name/PO Box City Zip County Birthplace City, State/Country

* Name of Parent/Legal Guardian Relationship Name other individual living in the home

* Name of other family members living in the home Name of other individual living in the home

* Name of other family members living in the home Name of other individual living in the home

Student lives with ☐Father ☐Stepfather ☐Mother ☐Stepmother ☒Other, Explain HIBISCUS CHILDRENS CENTER

* Who has legal custody of the student?_____ Are there custody conditions that may affect the school? _____(attach papers)

* Name of last school attended Address City State Zip County Date(s) attended

* Name of previous Florida school attended County Date(s) attended

Has the family moved across state or county lines within the last three (3) years seeking employment in agriculture or fishing? (circle) YES NO

Date of entry into the United States (If applicable) _____

Date the student originally entered a United States school: _____

Ethnicity Are you of Hispanic or Latino ethnicity? YES ☐ NO ☐

* **Race** (check all that apply)

White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐

* **Pre-Kindergarten** Information

☐ Headstart ☐ ESE/Disabilities ☐ Private (Paid by family) ☐ Student did not attend Pre-K

☐ Migrant Pre-K ☐ Early Intervention ☐ Subsidized (Paid by agency) ☐ VPK

* **Special Needs** Information

☐Y ☐N Is the student homeless? ☐Y ☐N Is the nighttime residence temporary or inadequate?

☐Y ☐N Has the student ever been enrolled in a Special Education Program (ASD, EBD, Gifted, InD, LI, Speech, OHI, SLD (circle all that apply)

☐Y ☐N Has the student ever had a 504 plan?

☐Y ☐N Does the student require any assistive equipment? (glasses, hearing aid, wheelchair, other)?_____

☐Y ☐N Does the student have an ongoing medical problem (diabetes, asthma, seizures, other)? _____

☐Y ☐N Is the student Medicaid eligible? If yes, Medicaid number _____

* **Student Services** Information

☐Y ☐N Has the student ever been expelled from school?

☐Y ☐N Has the student ever been suspended out of school for more than three (3) days

☐Y ☐N Has the student ever had any arrest which resulted in a charge?

☐Y ☐N Has the student ever had any action taken against him/her by Juvenile Justice?

Parent/Legal Guardian Signature *_____

For Office Use: ——SSN Verification ——Pre-K ——Immunization ——Residence Verification
——Birth Verification ——Geo Code ——Exemption(s) ——ESE Verification
——Custody ——Out-of-Zone ——Physical

An Equal Opportunity Agency

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:_____

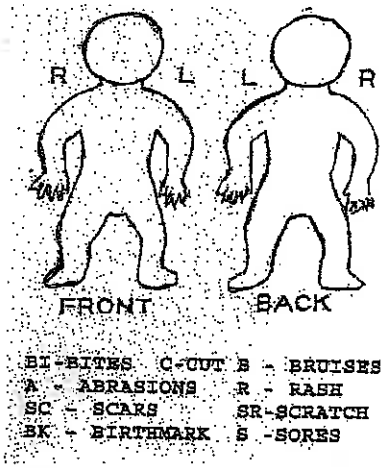
Medications

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:



_____ Date:_____ Time:_____
HCC Staff Signature

_____ Date:_____ Time:_____
DCM Signature

Revised 8/23/13 mmm

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S SHELTER
Personal Property Inventory

Child's Name: _____ **Admission Date:** _____

DCM Name & County: _____ **Telephone #:** _____

Upon admission all belongings need to be itemized, boxed, labeled with the Child's Name Inventories are to be conducted upon the child'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		

HCC Staff Signature: _____ **Date:** _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S SHELTER
WELCOME

Child's name: _____ Child's age: _____

1. Child has been given a tour of the Shelter
2. Child has been given the fire evacuation route and procedure
3. Child has been assigned appropriate room and supplies
4. Child has had the Behavior Guidance Program explained
5. Rules were explained and understood by the child
   - 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.
   - Do not go outside without permission from a staff member
   - Do not go in the staff office without permission
   - Eat in the dining area, main area and designated areas only
   - Attend school daily
   - Do chores
   - Do not enter either wing without permission from a staff member
   - Do not answer the telephone or the door
   - Go to bed when asked

BEDTIMES

Age Group	Bedtimes
Ages 0— 5 years	7:30pm — Go to room 8:00pm –Lights out
Ages 6— 8 years	8:00pm — Go to room 8:30pm — Lights out
Ages 9— 10 years	8:30pm — Go to room 9:00pm — Lights out
Ages 11- 12 years	9:00pm — Go to room 9:30pm — Lights out

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

Child Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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

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: _____

Hibiscus Children's Center
Saving Children Since 1985

HIBISCUS CHILDREN'S SHELTER
CHILDREN'S REINFORCER SURVEY

Child's Name:_____ **Age:** _____ **Date:**_____

Attempt to elicit from the child, 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
_____Play with pets
_____Watch a movie
_____Be alone in my room
_____Play music
_____Build models
_____Bake goodies
_____Do crafts
_____
_____

_____Have a book read to me
_____Listen to the radio
_____Play a game
_____Go fishing
_____Have a party
_____Go swimming
_____Go on an outing
_____Read comics
_____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 (get answers for 2 or 3 dinners)
What desserts would you choose?

_____ _____
_____ _____
_____ _____

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

_____ _____

What are your favorite toys or games? _____
_____ _____

What sports do you like to play? _____

What sports do you like to watch? _____

If you had $5.00 to spend anywhere, to which store would you go?

_____

What would you buy?_____

Child's Name: _____

Page 2 – REINFORCER SURVEY

If you had 3 wishes, what would you wish?

_____
_____
_____

If you could change anything about Hibiscus Children's Shelter, what would it be?

_____
_____

What do you like to do in your spare time?

_____
_____
_____

If you could do an activity with staff, what would you want to do?

_____
_____
_____

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

_____
_____
_____
_____

Child Signature: _____ **Date:** _____

HCC Staff Signature: _____ **Date:** _____