Date: ______________________________________

Youth's Name: ______________________________________

Youth's Date of Birth: ______________________________

Medicaid Number: ___________________________________

To Whom It May Concern:

The above named child is currently in the temporary care, custody, and control of the Department of Children and Families of the State of Florida. This child has been placed in the care of **VISIONQUEST**, a licensed facility, and facility representatives have permission to have this child seen by medical personnel and treated by same.

The authority of the facility to consent to treatment for this child is limited to consent for ordinary and necessary medical and dental examination and treatment, including immunizations, tuberculin testing, and well-child care, but does not include consent for surgery, general anesthesia, provision of psychotropic medications, or other extraordinary procedures for which a separate order or informed consent as provided by law is required.

When treatment is provided pursuant to this authorization, the requirements of Section 743.0645(4), Florida Statutes that notice of the treatment be given to the legal custodian of the child shall be satisfied by notification to the following:

Agency Name: ______________________________________

Agency Address: ____________________________________

____

Agency Phone: _____________________________________

Agency Fax: _______________________________________

Thank you,

___________________________________ ___________________________

Authorized Case Manager Signature Case Manager Printed Name

To the DCM:

VisionQuest is willing to grant the children time in the community to give them a sense of normalcy and to prove themselves as responsible young ladies. The youth will have to specify where they are going and check in with the staff every 30 minutes. Their level of supervision while out there will be determined by you, the DCM. Please indicate below the level of supervision you are willing to approve for your youth who is placed at VisionQuest:

__________ No community time (Youth can only leave with staff)

__________ Limited community time (Only allow the youth ______ hours in the community)

__________ Full community time (Youth is allowed to sign out and can be trusted to return at curfew)

The level of supervision can be reevaluated based on the child's behavior. Please indicate below any other stipulations of the youth's community time:

____

____

____

____

Youth Name ________________________ DOB:_______________

____________________________________ ____________________________________
DCM Printed Name DCM Signature

Date: ______________________________

VisionQuest – Palm Beach Shelter
8641 Sunset Dr. • Palm Beach Gardens, FL 33410 • 561.691.8995
www.vq.com

VISIONQUEST DCF PLACEMENT APPLICATION

GENERAL INFORMATION

Child Information

Name of Child:	Date of Birth:
Medicaid ID#:	Gender:
SS #:	Race/Ethnicity:

Placement Agency

Agency Name:	Placement Representative:
Phone:	Email:
Date of Referral:	**Date Placement Needed:**

Family Services Counselor

DCM Name:	Mailing Address:
Agency:	
Phone:	
Pager/Cell Phone:	
Fax:	
Email:	County:
DCM Supervisor Name:	Supervisor Phone:
Supervisor Cell Phone:	Supervisor Email:

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Palm Beach Gardens, FL 33410

Guardian ad Litem ☐ **Not Applicable**

Name: Phone: Pager/Cell Phone: Email:	Mailing Address:

Child's Current Living Arrangement

Name of Current Caregiver:	Street Address:
Relationship to Child/Placement Type:	
Daytime Phone:	
Evening Phone:	

Reason for removal from most current living situation

FAMILY INFORMATION

Parent Information

Mother's Name:	Father's Name:
Mother's Address:	Father's Address
Mother's Phone:	Father's Phone:
Parental Rights Terminated? Yes No	Parental Rights Terminated? Yes No

What is the youth's involvement with his/her family? What effect does this have on him or her?

LEGAL-DELINQUENCY ISSUES

Does the youth have a history of arrests? YES NO

If yes, please complete the following section. An UP TO DATE DJJ face sheet can substitute for writing the information.

Please list all arrests including approximate dates of arrest.

Is the youth currently on probation? YES NO

List all current court ordered sanctions

Department of Juvenile Justice Probation Officer ☐ Not Applicable

Name:	Mailing Address:
Phone:	
Pager/Cell Phone:	
Email:	

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BEHAVIORAL/PHYSICAL HEALTH INFORMATION

Has a CBHA been completed on this youth? YES NO

If yes, please provide this with the referral packet. If not, please provide a recent psychological evaluation.

List current and past counseling received including issues addressed in therapy.

List counseling it is believe youth will need if placed at.

Do you feel this youth displays self-control in most situations? Please comment on his or her reliability, maturity, judgment abilities, emotional state, etc.

List the youth's strengths and needs/weaknesses.

Has the youth exhibited any of the behaviors listed below? (Please circle "C" if this is a current behavior and "P" if the behavior was present in the past.)

Behavior			**Behavior**		
Bedwetting (Enuresis)	C	P	Lying	C	P
Soiling (Encopresis)	C	P	Stealing	C	P
Suicidal threats	C	P	Cruelty to animals	C	P
Sleep difficulties	C	P	Running away	C	P
Eating disorder	C	P	Manipulation	C	P
Hyperactivity	C	P	Physical aggression	C	P
Difficulty controlling impulses	C	P	Verbal aggression	C	P

Sexual behavior problems	C P	Substance use or abuse	C P

List the youth's allergies (insect, food, drug, etc.) ☐ Not Applicable

Treatment Information

Current physical health symptoms:	Current interventions or recommended intervention:
Current physical health medications (drug name, dosage/frequency):	Prescribing physician name and phone:
Current mental health/psychiatric symptoms:	Current DSM-IV diagnosis: Axis I – Axis II – Axis III – Axis IV – Axis V (GAF) -
Current mental health (psychotropic) medications (drug name, dosage/frequency):	Prescribing physician name and phone:

EDUCATIONAL INFORMATION

Current School (include last school if not currently enrolled)

Name:	Mailing Address:
Phone:	
Fax:	Was this an alternative school placement? Yes No
Grade:	If yes, what was the reason for the placement?

Transcripts from the last school attended as well as an IEP (if applicable) and FCAT scores will be required at intake as they are required by our local schools for enrollment.

Does youth have an IEP? YES NO

Youth's academic performance in other DCF placements or the home environment

Has youth ever been suspended from school? Yes No

Has youth ever been expelled from school? Yes No

*If yes, please list the school where the expulsion originated as well as the reason for expulsion.

What work (if any) has been done toward the youth's plan after high school graduation or GED? Comment on the extent of youth's participation in this planning. What potential for independence does the youth have in your opinion?

PERMANENCY INFORMATION

Reason for referral for residential services (please list all applicable reasons):

Desired outcomes for this child from residential services:

Summary of permanency goals for this child (include progress made to date):

Independent living goals for this child (include IL referrals already made and status:

Summary of discharge plan, including specific caregiver and living arrangements and expected date of discharge:

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DCF BACKGROUND

Date first removed from the home	Length of total DCF involvement

Reason for original removal from caregivers:

Youth's habits/performance in other DCF placements or the home environment:

Complete the following table regarding placement disruptions. If possible, please include a HOMESAFENET report in lieu of completing the table. Please include ALL placements. If additional space is needed, please attach a second sheet of paper.

Placement/Agency	Type of Placement (DJJ, foster home, relative, group home, etc.)	Dates of Placement	Reason for Removal
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

OTHER INFORMATION

Does youth practice any type of religion?

If placed at our program, would youth be allowed unsupervised outings at this time?

PLACEMENT AGREEMENT

*Further correspondence with VisionQuest regarding the above named youth should be directed to (65C14.044-d):

Cindy Edwards, LMHC, CAP
Director of Clinical Services
Phone: 352-669-9444
Fax 352-669-7538
Email: cindy.edwards@vq.com

*VisionQuest agrees to participate in an ongoing evaluation of the child's parent, guardian, and the Department as appropriate and as requested by the Department (65C-14.044-c).
*The youth's visitation with department-approved individuals/agencies will occur in accordance with the visitation schedule requested by the Department (65C-14.044-e).
*Youth will be provided with daily opportunity for telephone contact with family (65C-14.044-a). Please list any restrictions as appropriate.

*VisionQuest agrees to facilitate face-to-face contact between youth and family members as approved by the Department of Children and Families/Community Based Care Agency. Please indicate below the persons to be involved as indentified by DCF/Court System:

*VisionQuest placement is funded by a contact between Family Safety (Department of Children and Families) and VisionQuest (65C-14.044g).

*Youth will be discharged from VisionQuest when all discharge/permanency plan objectives have been met (65C-14.044-h).

*The youth's post discharge objectives will be developed by the discharge planning team, which is assigned at admission and comprised of the youth's DCF representative, VisionQuest administration, and parents/guardians (when applicable) (65C-14.044-i).

*VisionQuest agrees to exchange information with individuals/agencies for which consent to exchange information has been provided. Completed consent forms will be placed in the youth's file. VisionQuest will report the youth's progress related to all identified service objectives on a monthly basis, via monthly progress reports provided to the Department of Children and Families. Formal treatment service plan reviews will be conducted every 6 months from the date of the youth's admission to report progress and modify treatment service plans if necessary. All designated treatment service plan team members will be invited to attend treatment service plan reviews. Treatment team meetings will be held monthly to review the established treatment service plan (65C-14.044-b & f).

*Youth placed at the VisionQuest program will have the opportunity to participate in adventure based outdoor and indoor activities such as camping, fishing, hiking, swimming, ropes course, equestrian programming, etc. All activities are supervised and led by staff trained in adventure programming and wilderness first aid. Agreeing to place a youth at this program and signing this document serves as formal approval for youth participation in these activities (65C-14.019).

By signing this document, I in no sense bind the placing agency. This merely is to verify that the above listed information is accurate to the best of my knowledge.

____
DCM / Transporter

____
Agency

Date ________________

HISTORY OF DELINQUENCY

☐ Not Applicable

Youth Name: ______________________ DOB: ______________

According to provided face sheets, youth's current and past charges with outcomes of commitment are as follows (list charge, date, and outcome):

____

____

____

____

____

____

Youth is currently on probation for the following charges (list also county of probation):

____

____

____

____

____

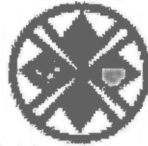
____

Youth's current court ordered sanctions are as follows:

- CS Hours ______________
- Restitution ______________
- Counseling ______________
- Stay Away Orders ______________
- Other ______________

______________________ DCM

______________________ Date



MEDICAL INTAKE

Youth Name: ______________________ DOB: ____________ DOA: ____________

Medicaid #: ______________________ Social Security: ______________________

Medications Issued at Intake

Name: ______________________ Dosage: ____________ Amount: ________

Name: ______________________ Dosage: ____________ Amount: ________

Name: ______________________ Dosage: ____________ Amount: ________

Name: ______________________ Dosage: ____________ Amount: ________

Prescriptions Issued at Intake

Name: ______________________ Doctor: ______________________

Doctor's Contact Information: ____

____

Current Medical Issues **Allergies (Food, Drug, Insect, etc.)**

____

____

____

____

____

Immunization Received ☐ Yes ☐ No **Physical Received** ☐ Yes ☐ No

______ I authorize representative of VisionQuest to continue administering all above listed medications as prescribed on the medication bottle/packet until the youth can meet with the program psychiatrist or local physician for evaluation and new prescriptions.

______ No medications were provided at intake.

______________________ ______________________ ______________

DCM / Transporter Printed Name Signature Date

NEW YOUTH REFERRAL – DOCUMENTS NEEDED

*Below is a list of comments that VisionQuest requests at intake for new youths. This form will be completed at intake to verify what was received.

*Documents that are required are marked with an (*) asterisk. Please bring these documents with you on the date of the intake unless already provided during the referral process.

*Documents listed in italics will be completed at intake.

Document Description	Provided?			
	Yes	No	If No, Date Promised	N/A
General				
*Application with list of previous placements (w/dates)				
Consent for Release of Information				
*Consent for Medical Treatment				
Allowed and Restricted Contact/Call List				
Legal				
*Shelter Order and Shelter Petition				
*Most Recent Judicial Review				
***Psychotropic Medication Court Order**				
*Department of Juvenile Justice Face Sheet				
History of Delinquency				
*Discharge Summary from Residential DJJ Program				
Personal Documents				
*Original Birth Certificate (Copies are required)				
*Original Social Security Card (Copies are required)				
Medical				
*Most Recent Physical				
*Immunization Records				
Medicaid Card (Medicaid number is required.)				
Most Recent Psychological Assessment				
Most Recent Psychiatric Assessment				
Most Recent Suitability Assessment				
*Comprehensive Behavioral Health Assessment				
Medical Intake Form • Please bring youth's medications and prescriptions. • Please know medical history and current conditions. • Know any known allergies.				
Educational Records				
*Individual Education Plan (IEP)				
*Copy of last school transcript and withdrawal form				
*Last school's contact information				
Most recent report card or progress reports				

The documents checked "yes" above were provided at intake for the youth file. The documents checked "no" above will be provided to the program. Case Manager/Transporter was given a copy of this form at intake with a list of documents still required by the program.

DCM/Transporter ____________ Date ____________ VQ Staff ____________ Date ____________

Time __________ AM PM

Youth Name: ______________________________ Date of Intake: ______________

Blue Book/Resource Book Received?	☐ YES	☐ NO	
Original Social Security Card Received?	☐ YES	☐ NO	
Original Birth Certificate Received?	☐ YES	☐ NO	
Original Medicaid/Insurance Card Received?	☐ YES	☐ NO	
Psychotropic Medication Court Order Received?	☐ YES	☐ NO	☐ N/A

I, ________________________________, certify that the above information is accurate
(DCM /transporter name)

at the time of the above mentioned youth's intake.

____
DCM / Transporter Name

____
VQ Staff Member Name

____
DCM / Transporter Signature

____
VQ Staff Member Signature

____
Date

____
Date

YOUTH CORRESPONDENCE LIST

Youth Name: ______________________ Today's Date: ______________________

Listed below are those the youth is **RESTRICTED FROM** contacting and visiting with as of the above mentioned date:

Name/Relationship	Contact Information

Listed below are those the youth is **ALLOWED TO** contact and visit with (excluding friends) as of the above mentioned date:

Name/Relationship	Type of Contact	Contact Restrictions?	Contact Information

______________________ ______________________
Youth Date

______________________ ______________________
DCM Date