Preston Homes

Intake Packet

INTAKE PACKET **DATE** _____

Name _____ D.O.B _____ Age ____ Race _____ Gender ____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Referral Source: _____ Phone #: _____

CPS, MRDD, JDC, Parent, Mental Health Agency, Community Program, Hospital, School

A B K F **MRDD** **FAMILY DYNAMICS** **EMOTIONAL/BEH**

Type of Intake: Planned Emergency Respite Other: _____

Caregiver Information:

Name, address, phone number and relationship to client:

Parent 1 _____ Parent 2 _____

(H)_____(W)_____ (H)_____(W)_____

Who does the client currently live with?

Who has custody of the client?

Emergency Contacts:

Person 1 _____ Person 2 _____

_____ _____

(H)_____(W)_____ (H)_____(W)_____

Relationship to client: _____ Relationship to client: _____

Reason for Referral:

Who currently live in the home?

Relation	Name	Age	Gender	Comments
Self				

Specific information related to clientôs primary family. Focus should be on the primary needs and strengths of the family and how respite will help.

Agency Involvement:

Please list the name, address, phone number and contact person for each agency that have been or are currently involved with the client or the family. Please list agencies that are currently providing services for the client/family first.

Agency 1: _____ **Contact person:** _____
Date of service(s): _____ Phone number: _____
Address: _____
What services were provided? _____

Agency 2: _____ **Contact person:** _____
Date of service(s): _____ Phone number: _____
Address: _____
What services were provided? _____

Agency 3: _____ **Contact person:** _____
Date of service(s): _____ Phone number: _____
Address: _____
What services were provided? _____

Has the client or siblings ever been in the custody of a Client Protective Service agency? Y N
If yes, who, when and why? _____

Is the client currently on probation or under the supervision? Y N
If yes, why? _____

Current therapist/counselor:

Name _____ Agency _____

Address _____ Phone # _____

Current Diagnosis (DSM-IV):

Psychologist or Psychiatrist name, address and phone number: _____

_____

_____

Date of Exam: _____

Axis I: _____

Axis II: _____

Axis III: _____

Describe the general mental health concerns and behaviors:

Placements:

Client Age	Name of Agency	Date	Length	Primary issues

Special Instructions:
Please describe any details that will assist the provider in meeting the individual needs of the client while they are in our respite care.

Are there any bedtime routines or concerns that Preston Homes should be aware of?

Are there any eating habits or preferences that the provider should be aware of?

Is there a safety plan or special supervision requirement that the provider should be aware of?

Medical Information:

Primary Doctor
Name _____
Clinic _____
Address _____
Phone # _____

Primary Dentist
Name _____
Clinic _____
Address _____
Phone # _____

In case of an emergency, can client be transported to nearest hospital? _____
If no, where? _____

Name of Insurance coverage: Group Insurance #

Current Medications:

Medication	Dosage	Time(s)	Prescribed for

AUTHORIZATION TO ADMINISTER SPECIFIED MEDICATION

I hereby authorize the Preston Homes referred by Preston Homes, to administer the above medications prescribed by his/her physician. All attempts will be made to administer the above medications to the client, but we cannot guarantee that they will be taken. If this has been a concern in the past, please explain:

_____ _____
Parentôs signature Date

List all special needs, allergies or special diets of the client:

CONSENT FORM

CLIENT'S NAME: _____

Preston Homes is committed to providing the highest level of therapeutic and safe environment for your client. Initialing beside each of the specialized activities listed below indicates that you are permitting your client to participate in such activities while in our program with the understanding that our staff will take every measure possible to prevent risk of injury to your client.

ACTIVITIES CONSENT
Respite client may participate in a number of indoor and outdoor activities. Preston Homes will provide constant supervision of all client in the program to minimize the potential for physical injuries. Initiating in this area indicates that you are permitting your client to participate in general art, recreational, music and educational activities while in our care. _____

Initialing beside each of these identified activities gives your client permission to participate in the specific activities that may be more physically involved and have a greater risk of injury than other more general activities.
_____ Horseback Riding _____ Canoeing _____ Roller Skating _____ Swimming

MEDICAL CONSENT
I knowingly and voluntarily authorize Preston Homes to procure such emergency medical, dental, or optical treatment upon competent medical advice, as deemed necessary and in the best interest of my client. I understand that except in the case of a life-threatening emergency, I will be notified in advance of any serious medical, dental or optical problems requiring treatment. Preston Homes & Preston Homes II shall not be liable for the performance of such medical care, which will be procured only upon the advice of a licensed physician.
_____

PHOTO/VIDEO MATERIALS CONSENT
I understand that Preston Homes collects photographs of client during therapeutic activities and special events. I give my permission for my client to be photographed and videotaped as it relates to their respite care services. I understand that no pertinent identifying data will be given to the media or used for any publicized activity without first getting my written permission. _____

TRANSPORTATION CONSENT
I give permission for Preston Homes staff, respite care providers and volunteers to transport my client in their own personal and/or agency care/van/truck as needed. I understand that they will have the State minimum of liability insurance. I also permit my client to travel outside of our county in order to participate in some activities.
I understand that I will be notified before my client leaves the county for such activities. _____

_____	_____	_____
Signature of Parent/Guardian	**Relationship to Client**	**Date**
_____	_____	_____
Witness	**Title**	**Date**

RESPITE SERVICE PLAN

Client Name: _____ Caregiver Name: _____

Service Plan Time Frame: _____ to _____ (Good for six (3) months and then will be reviewed)

Frequency of respite care for client: _____

Respite Primary Objective: (List the purpose for accessing respite services for the client.)

Client's Strengths:

Client's Needs:

Goal 1: To Improve Family Stability

Objective 1: Provide consistent and therapeutic respite services in order to decrease stress among family members.

Objective 2: Assist family in developing a stronger support system by connecting them with community resources in their neighborhood.

Goal 2: To Improve Social Skills

Objective 1: Preston Homes will assist the client in interacting appropriately with peers at least daily while in respite care.

Objective 2: Preston Homes will assist the client in accessing community activities at least once during each respite period in order to assist the individual in maintaining appropriate behaviors during such activities.

Goal 3: To Improve Self-Esteem and Confidence

Objective 1: Preston Homes will give positive statements and reinforcements to the client about his/her behaviors, social skills and family situation on a consistent basis.

Objective 2: Preston Homes will assist the client in completing all of his/her personal hygiene and grooming needs at least daily or more as needed while in respite care.

CLIENT'S NAME: _____

The information provided in this intake packet is used to best meet the needs of your client. Signing this form indicates that you understand the services provided by our program and that you would like your client to participate in our program. We will provide all services as directed by you and the client's individualized service plan in order to meet the individual needs of your client and his/her family.

Team Members participation:

Client: _____ Date: _____

Parent 1: _____ Date: _____

Parent 2: _____ Date: _____

Preston Homes: _____ Date: _____

Program Coordinator: _____ Date: _____

CSP worker: _____ Date: _____

Case Worker: _____ Date: _____

Other: _____ Date: _____

Comments: