



## Admission Application

Participant Information			
Participant Name:		Date Of Admission:	
Preferred Name:	Preferred Pronouns:	Date of Birth:	Age:
Social Security Number:		Gender Identity:	Sex Assigned at Birth:
Medicaid Number:		Religious Affiliations:	
Weight:	Height:	Ethnicity:	Language:
Eye Color:	Hair Color:	Identifying Marks	
Permanency Goal:			
Reason Youth Entered Care:			
Reason for Placement:			
Last Placement of Discharge:		Date of Discharge:	
Reason for Discharge:			
Participant's Interests:			
Legal Custodian Information			
Referral Source:		Legal Custodian:	
Case Manager Name:		Case Manager Email:	
Case Manager Cell:		Office Number:	
Office Address:			
Supervisor Name:		Supervisor Email:	
Supervisor Cell:		Supervisor Office Number:	
Emergency Contact Information:			



## Family Visitation

In accordance to RBWO Minimum Standard 3.10 and 3.11 children and young people are supported and encouraged to maintain and strengthen connections with their birth families, especially their parents and siblings. Children are provided with practical support to maintain contact with parents, family and other significant people unless expressly prohibited by DFCS. If sibling visitation is not required, the reason(s) why must be documented in the case record. Sibling visitation plans should be coordinated and agreed upon with the DFCS case manager.

Family Information		
Father Name:	Mother Name:	
Address:	Address:	
Cell Phone:	Cell Phone:	
Alternate Phone:	Alternate Phone:	
Marital Status:	Marital Status:	
Approved Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Supervised	Approved Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Supervised	
Sibling Information		
Name:	Name:	Name:
Relationship to youth:	Relationship to youth:	Relationship to youth:
Phone Number:	Phone Number:	Phone Number:
Address:	Address:	Address:
Contact Allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Supervised	Contact Allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Supervised	Contact Allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Supervised
Frequency of Contact:	Frequency of Contact:	Frequency of Contact:
Type of Contact allowed: <input type="checkbox"/> Phone <input type="checkbox"/> Face-to-face <input type="checkbox"/> Overnight	Type of Contact allowed: <input type="checkbox"/> Phone <input type="checkbox"/> Face-to-face <input type="checkbox"/> Overnight	Type of Contact allowed: <input type="checkbox"/> Phone <input type="checkbox"/> Face-to-face <input type="checkbox"/> Overnight



**Adult Visitation and Contact**

*Is there a parent, guardian, relative, or other potential permanency placement adult with whom the youth need to maintain contact? If yes, please list the information below.*

Name:	Name:	Name:
Relationship to youth:	Relationship to youth:	Relationship to youth:
Phone Number:	Phone Number:	Phone Number:
Address:	Address:	Address:
Contact Allowed: ( ) Yes ( ) No ( ) Supervised	Contact Allowed: ( ) Yes ( ) No ( ) Supervised	Contact Allowed: ( ) Yes ( ) No ( ) Supervised
Frequency of Contact:	Frequency of Contact:	Frequency of Contact:
Type of Contact allowed: ( )Phone ( )Face-to-face ( )Overnight	Type of Contact allowed: ( )Phone ( )Face-to-face ( )Overnight	Type of Contact allowed: ( )Phone ( )Face-to-face ( )Overnight

**Unapproved Contact**

Are there any persons with whom contact is not allowed? ( ) Yes ( ) No  
*\*If yes, please enter their information below*

Name:	Name:	Name:
Relationship to youth:	Relationship to youth:	Relationship to youth:
Phone Number:	Phone Number:	Phone Number:

\_\_\_\_\_  
DFCS Case Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tharros Place Staff

\_\_\_\_\_  
Date



## Every Parent Every Month

In accordance with RBWO Minimum Standard 8.5 Providers must communicate with DFCS to understand each individual child's permanency plan, the DFCS EPEM plan, and to establish the provider's EPEM plan.

If you are requesting Tharros Place to conduct an EPEM please indicate below by printing your name on the corresponding line. Provide the frequency, type, mode, and purpose of the contact. Also, include the parent, guardian, or other permanency person name and contact information.

If you *are not* requesting Tharros Place to conduct an EPEM please indicate below by printing your name on the corresponding line.

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### DFCS and Tharros Place Every Parent Every Month Agreement:

- Required: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Contact Information: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Type: \_\_\_\_\_  
Mode: \_\_\_\_\_  
Purpose: \_\_\_\_\_
  
- Not Required: \_\_\_\_\_

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DFCS Case Manager

Date

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Tharros Place Staff

Date



## Agency Placement Agreement

The undersigned agent hereby enters into the following agreement on behalf of the agency stated below (hereinafter referred to as "Agency") to place a child at Tharros Place, Inc. (hereinafter referred to as "Facility") for purposes of residential room, board and maximum watchful oversight (RBWO) services. Both parties agree to the following terms and conditions:

1. The Facility agrees to accept the child named below in residential care as long as both agency and facility have mutually agreed that placement in a residential facility is appropriate.
2. The Agency agrees to reimburse the Facility at the Referral Agency's approved RBWO (for maximum watchful oversight) funding rate for living costs such as food, clothing, shelter, hygiene support and other support and services while the child resides in placement.
3. The Agency agrees to be responsible for all medical expenses for the child not covered by Medicaid and/or any other insurance that the child is covered under upon admission and thereafter to the Facility.
4. The Agency agrees to cooperate with the Facility to arrange phone contact and personal visits for the child with family members, friends, associates, or other individuals so long as it is in the best interest of the child.
5. A multi-disciplinary service plan will be formulated 30 days after the child's arrival at Tharros Place. Further updates, revisions and reviews to the Service Plan will occur at least every 6 months. The Facility agrees to send all updated service plans to the Agency to keep the Agency informed of the child's current course of treatment.
6. The Facility agrees to invite the undersigned agent and/or his designee to each service plan review. The Agency agrees to make every possible effort to ensure that an agent or representative is present for said Reviews.
7. The Facility agrees to furnish written progress reports on a quarterly basis to summarize the child's progress while in the Facility's care. These summaries cover a period of one month from the treatment team date after the child's admission and four weeks thereafter.
8. The Facility agrees to immediately advise the Agency of any serious illness, accident, need for hospitalization, and/or need for surgery. Should the legal custodian of the child be an entity other than the Agency, the Facility will notify those persons as well as the Agency
9. The Agency agrees to review/approve any planning of home visits made by the Facility on behalf of the child.





## Discharge Planning

Tharros Place strives to provide services in the most efficient and effective manner possible. Tharros Place begins looking at the goals and plans for DISCHARGE as early as the admission process. Please support by answering the following questions to aid in planning for the eventual successful transition and discharge of your child from our program.

Who will aid in the discharge planning process, other than Tharros Place personnel?

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What is the best way to contact this person regarding discharge planning?

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

What minimum responsibilities will this person incur?

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Are there any family placement options for the child? Is there a reunification plan? If so, who? What are the barriers to reunification?

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What are other placement options available for this child?

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Will these options be available at the time of discharge?  Yes  No

If these options are not available, what resources will be available?

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When would you like to see discharge occur?

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What barriers exist that would prevent successful transition/discharge?

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What Tharros Place services will be needed during the discharge planning process?

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Are there any concerns or requests that you would like to make concerning discharge?

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What services will be necessary in order to maintain the child after discharge?

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Tharros Place will assist in coordinating the discharge planning process. Full participation by the custodian/caseworker is required to ensure a well-planned and positive discharge outcome.

Youth's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Legal Custodian Print

\_\_\_\_\_  
Tharros Place Staff Print

\_\_\_\_\_  
Legal Custodian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tharros Place Staff Signature

\_\_\_\_\_  
Date





## Informed Consent Post-Discharge Contact

Tharros Place begins planning for your discharge as soon as you enter our program. As you progress in the program and begin completing your goals, you will become more and more independent. Along the way, we will be talking with you about your future and helping you make future plans. The day will come when you will be leaving us and moving on to the next stage of your life.

When it is time for you to leave (discharge), we will ask you to fill out a Discharge Satisfaction Survey. After you leave us, a Tharros Place Staff will attempt to contact you within the first two months. At that time, the staff would like to talk to you, your caseworker, your guardian, and/or your new placement providers (if applicable) to learn how you are doing, to learn what progress you are making, and to learn if you need any additional services. Our staff will make these contacts through telephone calls, e-mails, or social media. If your discharge occurs as an unplanned or emergency discharge, we will attempt to contact you within 30 days of discharge.

Tharros Place uses the information you give us in the Discharge Satisfaction Survey and the Post-Discharge Contact(s) as one way to plan for improvements in our program. We take your feedback very seriously and appreciate your honesty.

By signing this form below, you will give Tharros Place permission to contact you during the first 2 months after you leave. Your signature below also shows that any questions or concerns you have about the Satisfaction Survey or the Post-Discharge Contact {s) have been addressed by Tharros Place staff.

**To the legal guardian:** Please sign this form to Indicate your consent to allow our program to make post-discharge contacts(s) to ascertain the aftercare status and progress of your child and for Tharros Place quality assurance purposes. Thank you.

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Participant's Signature                      Date

\_\_\_\_\_  
Legal Custodian Signature                      Date

\_\_\_\_\_  
Tharros Place Staff Signature                      Date



## Behaviors Present in the Placement Environment

In accordance with RCCL Regulation 290-2-5-.09(2)(b), the following documentation describes the behaviors that are typical for residents. By signing this document, the custodian attests that they have received and considered this information and have determined that the placement environment is appropriate and does not represent an undue risk to the health and safety of the child or children being placed.

Tharros Place is a Maximum Watchful Oversight residential facility specializing in the care of females who are survivors of human trafficking. Our residents vary in adaptive skills. Their ages range from 12 to 17 years.

The following checked behaviors are typical of the residents at the time of admission.

### Behaviors and other Characteristics:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Attention seeking behaviors.<br><input type="checkbox"/> Bed wetting<br><input type="checkbox"/> Compulsive behaviors<br><input type="checkbox"/> Decreased concentration<br><input type="checkbox"/> Delinquent behaviors<br><input type="checkbox"/> Demanding and/or threatening<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Dishonesty<br><input type="checkbox"/> Disorganized thinking<br><input type="checkbox"/> Distractibility<br><input type="checkbox"/> Hallucinations | <input type="checkbox"/> History of sexual abuse<br><input type="checkbox"/> Homicidal threats<br><input type="checkbox"/> Hyperactivity<br><input type="checkbox"/> Impulsive behaviors<br><input type="checkbox"/> Manic Activity<br><input type="checkbox"/> Manipulation<br><input type="checkbox"/> Noncompliance with rules<br><input type="checkbox"/> Oppositional and defiant<br><input type="checkbox"/> Panic Attacks<br><input type="checkbox"/> Paranoia<br><input type="checkbox"/> Physical aggression<br><input type="checkbox"/> Poor hygiene<br><input type="checkbox"/> Poor judgment | <input type="checkbox"/> Poor personal boundaries<br><input type="checkbox"/> Poor school participation<br><input type="checkbox"/> Property destruction<br><input type="checkbox"/> Restlessness<br><input type="checkbox"/> Running away<br><input type="checkbox"/> Self-Injurious behavior<br><input type="checkbox"/> Sexually acting out<br><input type="checkbox"/> Sleep disturbances<br><input type="checkbox"/> Social withdrawal<br><input type="checkbox"/> Stealing<br><input type="checkbox"/> Substance abuse<br><input type="checkbox"/> Suicidal threats<br><input type="checkbox"/> Verbal aggression |
|---|--|---|

Your Signature indicates that you have read the above document and have determined that placement does not represent an undue risk to the health and safety of the child being placed.

Participant's Signature	Date	Legal Custodian Signature	Date
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## Authorization for Use of Physical Restraint

Tharros Place utilizes physical restraint as Emergency Safety Interventions (ESI). (Please see definitions on the next page.) These measures are utilized only as a last resort measure to control unsafe behaviors. All residential staff are trained in Mind-Set, our Behavior Management Model, accepted by Residential Child Care Licensing of the State of Georgia as an appropriate method of crisis prevention and intervention. All staff are trained annually and must pass a skills-based test on the proper use of physical restraints before being allowed to use these interventions.

1. Any known physical/medical/psychological reasons why your child should not be physically restrained? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list:

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2. Has your child ever been physically restrained? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain how the child responded to these interventions?

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3. Please initial that you understand the following:

- That any time an Emergency Safety Intervention is used with my child, I will be notified by the program in a timely manner. \_\_\_\_\_ Yes \_\_\_\_\_ No
- That these Emergency Safety Interventions are approved and used to provide for the safety of my child and/or other in the program. \_\_\_\_\_ Yes \_\_\_\_\_ No
- That if I do not allow the program to utilize these interventions, my child MAY BE DISCHARGED if safety become an issue. \_\_\_\_\_ Yes \_\_\_\_\_ No
- That my child MAY BE DISCHARGE if the use of Emergency Safety Interventions are not effective in providing for safety. \_\_\_\_\_ Yes \_\_\_\_\_ No

4. Document any questions or concerns you have regarding the use of restraint and be sure these are addressed before signing this authorization. -

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The questions or concerns listed above have been satisfactorily addressed.

\_\_\_\_\_ Yes      \_\_\_\_\_ No

By signing below, I authorize the use of the Emergency Safety Interventions with my child as defined under the Behavior Management Model of THARROS PLACE. I understand that I may revoke or change this authorization at any time by contacting my child’s Human Service Professional and making my request in writing. Otherwise, it will remain in effect until my child’s discharge.

Please indicate authorization or decline of ESI usage by checking the corresponding box.

Physical Restraint

No Physical Restraint

**Definitions:**

Behavior Management: those principles and techniques used to assist a resident in facilitating self-control, addressing inappropriate behavior, and achieving positive outcomes in a constructive and safe manner. Behavior management principles and techniques are used in accordance with the individual service plan, written policies and procedures governing service expectations, service goals, safety, security and ORS rules and regulations.

Emergency Safety Interventions: those behavioral intervention techniques that are authorized under an approved emergency safety intervention plan and are utilized by properly trained staff in an urgent situation to prevent a resident from doing immediate harm to self or others.

Manual Hold or Physical Restraint: the application of physical force, without the use of any device, for the purpose of restricting the free movement of a resident's body. A manual hold or restraint does not include the following: briefly holding a resident without undue force to calm or comfort them; holding a resident by the hand or by the shoulders or back to walk them safely from one area to another where the resident is not forcefully resisting the assistance; or assisting the resident in voluntarily participating in activities of daily living.

\_\_\_\_\_  
Legal Custodian Print

\_\_\_\_\_  
Tharros Place Staff Print

\_\_\_\_\_  
Legal Custodian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tharros Place Staff Signature

\_\_\_\_\_  
Date



## Basic Human Rights of Children and Youth in Care

Every child in care has the right:

- to be treated at all times with dignity and respect, including respect and celebration of their cultural heritage;
- to enjoy freedom of thought, conscience and religious observance;
- to have their opinions heard and to be included to the greatest extent possible when decisions are being made which affect their life;
- to live in a clean, safe, comfortable and nurturing environment;
- to receive appropriate and reasonable adult guidance, support and supervision;
- to have reasonable amounts of time for privacy;
- to have their own personal property and a safe place for storage of such property;
- to be free from all forms of abuse, intimidation, and inhumane treatment;
- to be protected from all forms of exploitation, including employment and sexual; to receive adequate, nutritious and culturally appropriate food;
- to receive adequate and appropriate medical and dental care;
- to refuse services when doing so does not jeopardize their health, safety, welfare and/or the health, safety and welfare of others;
- to receive an education designed to meet their academic needs in order to maximize their potential;
- to stay connected with primary relatives, home community, and "significant others" outside the program through telephone calls, mail and visits;
- to have unlimited access to the Child Advocate and to access the grievance process in the event of violations of these or other rights.

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Participant's Signature

Date

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Tharros Place Staff Signature

Date

## Confirmation of Orientation Packet



This is to confirm that I have been provided with the Orientation Packet for Legal Guardians. The packet covers the following:

- Non-disclosure agreement.
- Mailing address.
- Business hours, phone and fax numbers, and email address.
- Name of key treatment providers.
- Information about Tharros Place.
- Approved/Acceptable gift items for residents and staff.
- Visitation Hours.
- Tharros Place Code of Ethics.
- Information on handling grievances.
- An explanation of the Tharros Place Behavioral Model Including the use of physical restraint.
- A letter of invitation to participate in treatment planning.
- Notice of Private Practice.

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Legal Custodian Signature

Date

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Tharros Place Staff Signature

Date

Photo Release



I hereby give Tharros Place permission to take one (1) picture of the child’s name listed below when they enter the residential program and every year thereafter for identification purposes only. This picture will only be used in authorized charts and spaces.

The copies will be located in:

- Face sheet in the child chart
- Face sheet in the medical chart
- Face sheet in the staff current resident chart

Any other photos taken of the youth’s face will not be used for marketing purposes, but for the purpose of capturing memories while placed. These photos will be provided to the child, and/or the caregiver or legal guardian.

Youth 18 and over, who have the ability to advocate for themselves, will be able to provide verbal and/or written consent to Tharros Place to utilize her photos for publication.

Participant’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Legal Custodian Signature                      Date                      Tharros Place Staff Signature                      Date

### Out-of-State and Off-Campus Trip Authorization



While your child is at Tharros Place Youth Estate Center, they may need to go out of state for various purposes. These include, but are not limited to, trips for recreation, shopping, medical care etc. The Humans Service Professional will notify of travel plans prior to taking such trips.

In addition, participants attend various off-campus trips, for recreation (e.g., YMCA, water park, movies), medical services (e.g., local clinics or physician's office), independent living skills, educational activities, and other various activities to promote their well-being.

Please check the appropriate boxes below:

Out-of-State Trips:

- I grant authorization for trips as described above
- I do not grant authorization
- I grant authorization for trips with these additional stipulations:

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Off-Campus Trips:

- I grant authorization for trips as described above
- I do not grant authorization
- I grant authorization for trips with these additional stipulations:

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\_\_\_\_\_  
Legal Custodian Signature                      Date

\_\_\_\_\_  
Tharros Place Staff Signature                      Date

## Allergy Checklist







## Authorization for Medical, Dental, Behavioral/Mental Health, Vision and Hearing Treatment

As the legal custodian of \_\_\_\_\_  
(Participant's Name and Date of Birth)

- I authorize Tharros Place to obtain any medical, dental, vision, behavioral/mental health and/or hearing treatment, medication or surgery indicated for said resident.
- Tharros Place agrees to seek necessary medical, dental, vision, behavioral/mental health and hearing services when needed as indicated and to immediately advise you and/or \_\_\_\_\_ (Parent/Agency) of any serious illness, injury or need for hospitalization or surgery.
- Tharros Place also agrees to send information and a specific release form for informed consent when the resident requires psychotropic medication or specialized treatment, including surgery other than emergency surgery.
- I agree that upon receipt of the informed consent information, I will immediately respond with written permission or notify Tharros Place of questions/concerns or my denial in written form.

This authorization is effective for the period that said child is receiving services from Tharros Place or until: \_\_\_\_\_  
(Limit set by custodian)

\_\_\_\_\_  
Legal Custodian Signature                      Date

\_\_\_\_\_  
Tharros Place Staff Signature                      Date





\_\_\_\_\_  
Legal Custodian Signature                      Date                      Tharros Place Staff Signature                      Date

## Authorization for Release of Information

Minor Child's Name: \_\_\_\_\_  
Participant's Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

I HEAREBY REQUEST AND AUTHORIZE  
**Tharros Place Inc.**  
PO Box 23141  
Savannah, GA 31403  
912-332-2455

To:  Obtain records from and/or  Release records to:

Name/Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

To disclose the following specific information:

- Psychological Evaluation (Recent)
- Social Summary/Case Plan
- Immunization Certificate(s)
- Medical Summary/Physical Examination
- Custody/Commitment Order
- Dental, Vision, and Hearing Examination
- Educational Records: \_\_\_\_ Current IEP \_\_\_\_ Eligibility Report \_\_\_\_ Letter of Withdrawal

For the purpose of: \_\_\_\_\_

All information I hereby authorize to be obtained from this individual/Agency will be held strictly confidential and cannot be released by the recipient without prior consent. I may withdraw my consent at any time. If not previously revoked, this consent will terminate on \_\_\_\_\_ (not to exceed one year).



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Legal Custodian Signature

Date

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Tharros Place Staff Signature

Date