



APPLICATION CHECK LIST

Please utilize this list to aid you in the completion of the necessary application materials

Application

- _____ CHC Application Form
- _____ CHC Medical Intake Form

Consent Forms

- _____ Informed Consent for Assessment and Treatment
- _____ Consent for Medical Care
- _____ Publicity Clearance/Use Consent Form

Release of Information

- _____ CHC Authorization to Release Information
- _____ Consent for Exchange of Confidential Information

Other materials ("*" denotes required documentation)

- _____ Birth certificate* (photocopy)
- _____ Social security card* (photocopy)
- _____ Immunization records*
- _____ Insurance card* (photocopy of front and back)
- _____ Court records* (adjudication, disposition) - including school district of origin and court order for placement at CHC
- _____ School records/transcripts (including IEP if applicable)
- _____ Psychological testing (if done)
- _____ Social summary/Predisposition reports (including an outline of child's developmental background as well as current and past information on family functioning)
- _____ Physical examination record (within last month)
- _____ Reports from other agencies having had contact with child (treatment programs, therapists, probation officer, etc.)



APPLICATION

All information in this application will be kept confidential. Please fill out this application completely.

CHILD IDENTIFYING INFORMATION			
Child's name : <i>(Last, First, Middle)</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:		Social Security Number:	
Adjudication:			
Weight:	Height:	Hair:	Eyes:
Build:	Ethnic Origin:	Religion:	
Identifying features and relevant cultural variables:			

REFERRING AGENCY INFORMATION

Referring Agency:		
Caseworker:		
Address:		
Office Phone:	Cell Phone:	
Fax Number:	Email Address:	
Preferred Method of Contact:	<input type="checkbox"/> Office Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Standard Mail	
What problems has the child been having? <i>(Please include problems at home, school or in the community and indicate when the problems began. You may attach additional information to this application)</i>		
Previous Treatment/Therapy <i>(Please list if the child has been treated by a psychiatrist, psychologist, social worker, or mental health agency)</i>		
Dates	Reason	Agency/Location
Previous Out of Home Placements		
Dates	Reason	Agency/Location

FAMILY INFORMATION

Biological Father Does this parent have: Parental Rights? Y / N Educational Rights? Y / N	Name:			DOB:	
	Address:		Phone Numbers		
			Home:		
			Work:		
			Cell:		
	Email Address:				
Preferred Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Standard Mail					
Is contact restricted with this parent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If "yes" please explain:</i>					
Biological Mother Does this parent have: Parental Rights? Y / N Educational Rights? Y / N	Name:			DOB:	
	Address:		Phone Numbers		
			Home:		
			Work:		
			Cell:		
	Email Address:				
Preferred Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Standard Mail					
Is contact restricted with this parent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If "yes" please explain:</i>					
Step/Adoptive Father Does this parent have: Parental Rights? Y / N Educational Rights? Y / N	Name:			DOB:	
	Address:		Phone Numbers		
			Home:		
			Work:		
			Cell:		
	Email Address:				
Preferred Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Standard Mail					
Is contact restricted with this parent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If "yes" please explain:</i>					
Step/Adoptive Mother Does this parent have: Parental Rights? Y / N Educational Rights? Y / N	Name:			DOB:	
	Address:		Phone Numbers		
			Home:		
			Work:		
			Cell:		
	Email Address:				
Preferred Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Standard Mail					
Is contact restricted with this parent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If "yes" please explain:</i>					
Siblings	Name	DOB	Bio, 1/2 , Step	This sibling resides with:	

MEDICAL INSURANCE INFORMATION

A COPY OF THE CHILD'S BIRTH CERTIFICATE, SOCIAL SECURITY CARD, AND INSURANCE CARDS IS REQUIRED

Does the child have Medicaid (Title XIX)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicaid Number:			
Does the child have private insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Insurance Company:			
Address:			
Phone:			
This insurance covers (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Name of Insurance Holder:			
Date of Birth of the Insured:		Social Security # of the Insured:	
Address:			
Daytime Phone:		Cell Phone:	
Do you have an original birth certificate and social security card in your possession?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

SSI

Does the child receive SSI (Supplemental Security Income)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>*If the child is receiving SSI you must provide documentation of benefits*</i>			
Who is the payee representative?			
Address:			
Office Phone:		Cell Phone:	
Fax Number:		Email Address:	
Preferred Method of Contact: <input type="checkbox"/> Office Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Standard Mail			

ADDITIONAL DOCUMENTAION

Please attach copies of the following documentation to the completed application.

REQUIRED	REQUESTED
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> School Transcripts
<input type="checkbox"/> Social Security Card	<input type="checkbox"/> Individualized Education Program (if applicable)
<input type="checkbox"/> Insurance card (copy of front and back)	<input type="checkbox"/> Psychological Evaluation (if done)
<input type="checkbox"/> Documentation of SSI Benefits (if applicable)	<input type="checkbox"/>
<input type="checkbox"/> Immunization Record	<input type="checkbox"/>
<input type="checkbox"/> Court Order (or Minute Order if not available)	<input type="checkbox"/>
<input type="checkbox"/> Signed Consent Forms	<input type="checkbox"/>

Person Completing Form:

Date:



INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

NAME: _____

Date of Birth: _____

As a resident of Cathedral Home for Children (CHC) you will receive a range of services that will be determined following an initial assessment and thorough discussion with your counselor and treatment team. The goal of the assessment process is to determine the best course of treatment. Typically, treatment is provided over the course of several months. The purpose of treatment is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be ready to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When you meet with your counselor and treatment team, you will discuss these problems. They will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor and treatment team. Privacy, also called confidentiality, is an important and necessary part of treatment. Most of the information you share with the staff at CHC is confidential and no information will be released outside the agency without written consent from your parent or guardian if you are under 18 years of age, or by yourself if you are an adult. There are, however, important exceptions to this rule that are important for you to understand before you share personal information in therapy. Confidentiality cannot be maintained when:

- You tell someone you plan to cause serious harm or death to yourself. Steps must be taken to inform a parent or guardian of what you have disclosed and how serious this threat is believed to be. We must make sure that you are protected from harming yourself.
- You tell someone you plan to cause serious harm or death to someone else who can be identified. Steps must be taken to inform a parent or guardian of what you have disclosed and we must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.
- You tell someone you are being abused - physically, sexually, or emotionally - or that you have been abused in the past. In this situation, we are required by law to report the abuse to the Wyoming Department of Family Services.
- You are involved in a court case and a request is made for information about your therapy. If this happens, we will not disclose information without your written agreement *unless* a court requires us to do so. If we are required by the court to disclose information, our attorney will review the validity of this request.

There may be times when your counselor and/or treatment team feel that it would be important for your parents to know what is going on in your life. In these situations, we will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, we may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Services

The psychological services we provide include individual, family, and group therapy, as well as psychological testing. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Your counselor and treatment team will offer you some sense of what therapy will entail and how they will work with you to address your concerns. If you have questions about your program, you should discuss them with your counselor whenever they arise. You have the right to ask for the rationale for any aspect of your treatment or to decline any part of your treatment.

When you participate in testing, you have the right to an explanation of what the test or tests being administered are for and how they contribute to your treatment program, and you may decline participation at any time. You also have the right to a summary (which may be either verbal or written) of any test results. This testing gives us the basis for knowing you and how to get you through your treatment program as quickly as possible.

Individual counseling appointments are generally for 50 minutes and are typically scheduled once per week. Therapy group usually meet once a week for approximately 60 minutes. Before joining a group you must meet with one of the counselors to discuss your participation in the group and any questions or concerns you may have.

A range of mental health professionals, some of whom are in training, provide services at CHC. All professionals-in-training are supervised by licensed staff.

While psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

As part of your program at CHC you may participate in recreation and/or wilderness therapy activities and travel on trips both in and out of state. Research has shown that these types of activities provide significant benefits for physical, emotional, and psychological health. There are risks inherent in these activities, and while every precaution is taken to minimize these risks, the potential exists for unintended outcomes or injury. Some of these unanticipated outcomes are reportable events to our accrediting agency (JCAHO). If you have a safety or quality of care concern that is not resolved by our administration, we encourage you to call the commission at 630-792-5264.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information (PHI) about you in your clinical record. Your clinical record includes information about your reasons for placement at CHC, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests, any past treatment records that we receive from other providers, reports of any professional consultations, and copies of any reports that have been sent to anyone. Because these are professional records, they can be misinterpreted and/or upsetting to read. If you wish to review them, we will arrange for you to review them in the presence of your therapist or Director, or have them forwarded to another mental health professional with whom you can discuss the contents. Your clinical record serves as a:

- basis for planning your care and treatment
- means of communication among the health professionals who may contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss this with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

Conclusion

Your signature below indicates you have read this information and agree to abide by its terms during your placement at Cathedral Home.

Signature of Resident

Date

Signature of Parent or Guardian

DFS Signature

CONSENT FOR MEDICAL CARE

I hereby authorize the Cathedral Home for Children (CHC) to obtain any necessary medical treatment for the following resident: _____ from the following individuals (1-8), unless any of these individuals has been marked through with a line and is followed by my initials:

1. CHC Nursing Staff
2. CHC Medical Director
3. Resident's designated physician, nurse practitioner, dentist, eye care provider, and audiologist.
4. CHC designated physician, nurse practitioner, dentist, eye care provider, and audiologist.
5. Emergency room personnel.
6. Psychiatrist
7. Psychologist
8. Hospital Personnel

I understand that the term, necessary medical treatment, pertains to the following items (1-9), and I give consent for each of these items, unless individual items are marked through with a line and followed by my initials:

1. Comprehensive history and physical exam
2. Screening exams that are deemed necessary during or after the history and physical
3. Recommended vaccinations
4. Acute illness care
5. Chronic illness management
6. Emergency medical treatment
7. Hospitalization, including psychiatric
8. Recommended dental and eye care
9. Psychological Testing/Psychiatric mental assessment

I can be reached at (phone) _____ and understand that I will be notified should emergency treatment be necessary and before any non-routine medical care (e.g. surgery, orthodontics, treatment of a new major medical illness) is initiated.

Signature of Resident

Date

Signature of Parent or Guardian

DFS Signature

**PHOTOGRAPH, VIDEO, ARTWORK, AND WRITINGS (OF RESIDENT)
PUBLICITY CLEARANCE/USE CONSENT FORM**

I, _____, the parent or legal guardian of _____, (hereafter "Resident"), grant to Cathedral Home for Children, Laramie, Wyoming, its successors and assigns, the right to use and publish for advertising, promotional and fundraising purposes, photographic portraits or any photographic likeness or picture of Resident. Resident may be included in the portraits, any photographic likeness or pictures in whole or in part, in composite or other form, in color or otherwise, make and published through any medium, including but not limited to print, video and web based means.

I waive on behalf of Resident any right to inspect or approve the finished product or the copy that may be used in connection therewith or the use to which it may be applied.

I release and discharge on behalf of such Resident such photographers, videographers or web based "page designers" and Cathedral Home for Children, their successors and assigns, and all persons acting under their permission or authority from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of the pictures or videos, or in any processing tending toward the completion of the finished product.

In addition to the rights granted herein, I further grant to Cathedral Home for Children the non-exclusive right to reproduce or publish original works of authorship (graphic and/or text) of Resident, for the exclusive purposes of advertising, promotion and fundraising purposes, **provided, however**, this grant shall not be considered an assignment of copyrights whatsoever in said original works of authorship.

Additionally, I and the resident have been made aware that Resident has the right to rescind consent for use of film, photographs, likenesses, artwork, etc. within *thirty days* of intake. Resident may do so by submitting a letter or a verbal request addressing reasons for rescind of consent to the Marketing Coordinator for review.

**Please note, when Resident is participating in public events (i.e. Jubilee Days and Cheyenne Frontier Days Parades, University of Wyoming Athletic venues, graduation parties, etc.) Cathedral Home relinquishes control of outside parties utilizing photographic portraits or any photographic likeness or picture of Resident in outside mediums.*

DATED THIS _____ day of _____ 20__.

Signature of Resident
(Must be 18 years of age or older.)

Signature of Parent/Guardian

Signature of Cathedral Home for Children Representative

If you have any questions regarding this form, please contact:

Marketing Department
Cathedral Home for Children
P.O. Box 520
Laramie, WY 82073
Phone (307) 745-8997
info@cathedralhome.org

Allergies to medications or substances	
Name the food, drug, or substance	Reaction the child had

Does the child have an allergy and/or medical identification tag? Yes No

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Optometric Date of most recent eye exam:	Name of provider:		
	Does the child wear glasses or contacts? (please check all that apply)	<input type="checkbox"/> glasses	<input type="checkbox"/> contacts
	Please list any vision issues:		
Dental Date of most recent exam:	Name of provider:		
	Please list any dental and/or orthodontic issues:		
Diet	Does the child have any special dietary needs or restrictions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, is he/she on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Please describe:		
Alcohol	Does the child drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Does the child use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Has the child used recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Has he/she ever injected street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Siblings	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
			Grandmother <i>Maternal</i>		
			Grandfather <i>Maternal</i>		
			Grandmother <i>Paternal</i>		
			Grandfather <i>Paternal</i>		

MENTAL HEALTH

Has the child been seen by a psychologist or psychiatrist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last session:		
Name and address:		
Reason for treatment:		
What problems has the child been having? (Please include problems at home, school, or in the community and indicate when the problems began):		

DEAFNESS/HEARING LOSS

Is the child deaf or does the child have hearing loss? (If no, skip to next section)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Age when first discovered:		
Discovered by whom?		
Family history of deafness or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:		
Does the child wear hearing aides?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
All the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bilateral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please explain type of device:		
Date of last fitting and audiogram:		
Child's preferred language:		
Is the child comfortable with use of an interpreter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parent's preferred language:		
If either child or parent uses SIGN, what method?		

OTHER PROBLEMS

Check if the child is under care for a current condition in any of the following areas and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	Recent changes in:	
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back		<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal		<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder		<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel		<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation		

Person Completing Form:

Date:

**CATHEDRAL HOME FOR CHILDREN
AUTHORIZATION TO RELEASE INFORMATION**

Resident Name: _____
Social Security # _____
Date of Birth: _____ Phone: _____
Address: _____
City/State/Zip: _____

Authorization to Release Medical Information **FROM:**

Please **SEND** my treatment information **TO:**

Name of Practitioner

Name of Practitioner

Name of Clinic/Hospital/Treatment Facility, etc.

Name of Clinic/Hospital/Treatment Facility, etc.

Address

Address

City, State, Zip

City, State, Zip

I authorize the release of the following records:

Medical (please specify): _____

Educational (please specify): _____

Clinical* (please specify): _____

* I specifically authorize the release of information pertaining to drug and alcohol abuse records

Purpose of this release is for: (check one or more)

- Billing and payment of bill
 Continuity of care and discharge planning
 Other: _____

My consent may be revoked at any time. The only exception is when the information has already been released as instructed in the consent. If not previously revoked, this consent will terminate one (1) year after the date of my signing it. A photocopy or faxed copy of the release may be used in place of the original.

Date

Signature

Parent/Legal Guardian Signature (if needed)

I specifically authorize the release of HIV/AIDS testing information, if this is a part of my record.

Date

Signature

CATHEDRAL HOME FOR CHILDREN

*P.O. Box 520
Laramie, WY 82070
(307) 745-8997*

CONSENT FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

I, _____ of _____
(Client's Name) (Client's Address)

authorize Cathedral Home to keep _____ of _____
(Location)

*informed about my treatment at Cathedral Home. This may include letters or telephone
conversations about my diagnosis, prescribed treatment, and response to treatment.*

***I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND
SPECIFIC STATE CONFIDENTIALITY LAWS AND REGULATIONS AND CANNOT BE
DISCLOSED WITHOUT MY WRITTEN CONSENT AND THAT IN ANY EVENT THIS
CONSENT EXPIRES AUTOMATICALLY IF***

- (1) I REQUEST THAT NO FURTHER COMMUNICATION
BETWEEN THESE PARTIES OCCUR, OR***
- (2) I TERMINATE MY TREATMENT AT CATHEDRAL HOME***

Patient's Signature

Date

Legal Guardian

Date

Witness

Date