

Maryland Sheriffs' Youth Ranch
RECORDS & ADMISSIONS CHECKLIST

Name: _____

Client ID # _____

Date of Admission _____

Chessie # _____

MA Number _____

Placement Agency and worker: _____

- | | | | |
|----------|-------------------------------------------|-----------|----------------------------------------------------|
| _____ 1. | 818 Referral Information | _____ 6. | Custody information, court orders or documentation |
| _____ 2. | MSYR Application Form | _____ 7. | Social Security Card |
| _____ 3. | Social & Family History | _____ 8. | Birth Verification |
| _____ 4. | Medical | _____ 9. | Initial Service Plan |
| _____ | Physical Exam (10 before or 30 after) | _____ 10. | Agreement to participate in program |
| _____ | Medical Passport | _____ 11. | Temporary Placement Agreement |
| _____ | Medical Assistance Card or Insurance Card | _____ 12. | Consent Forms |
| _____ | Medical Consent Form | _____ | Publicity |
| _____ | Immunization Record | _____ | Travel |
| _____ | List current medication | _____ | Work Permit |
| _____ | 5 days physical meds & 30-day supply) | _____ | Educational records |
| _____ 5. | Evaluations | _____ | Records for mental health |
| _____ | Psychological | _____ | Recreational |
| _____ | Psychiatric | _____ | Spiritual |
| _____ | Other(s) | _____ | Movie Consent |
| | | _____ | Retrieval of belongings |
| | | _____ | Mentoring |
| | | _____ 13. | Visitation and contact list |

Required Academic Information

The following information *must* be supplied within ten (10) working days of a child's admission to the Ranch. If the following information is not supplied within ten (10) working days, the Ranch retains the right to discharge the resident.

- _____ Academic Transcript (Including attendance)
- _____ Test Information
- _____ Psychological evaluation (For level 5 students)
- _____ Health records (Including immunization information)
- _____ Special Education files (if applicable)
- _____ Current year report card(s) and grades at time of W/D
- _____ Disciplinary file-suspensions, expulsions, etc.

Explanation of Telephone and Visiting Regulations

TELEPHONE:

MSYR residents may receive daily phone calls from those family members and other individuals approved by Department of Social Services. Approximately 10 minutes will be allotted for each phone call.

MSYR residents are allowed to make two 10-minute long distance phone calls to approved individuals per week on Wednesday or Sunday.

MSYR residents are permitted to make local phone calls to approved family members on a daily basis

VISITING:

MSYR residents may visit with family members and other individuals approved by Department of Social Services.

Arrangements must be made in advance with Ranch social worker. For weekend visitation, the Ranch social worker must be contacted by Wednesday afternoon. One-day notice must be given to the Ranch social worker for visits during the week.

MAIL:

You may send mail and packages to MSYR residents using the following address:

Name of resident
M.S.Y.R.
P.O. Box 42
Buckeystown, MD 21717-0042

Primary Care Provider

FM: Jenna Clark, Medical Coordinator

SJ: Medical Care Provider

DT: 10/03/08

Your child must have his primary care provider switched to Maryland Physician's Care. Listed below is the name, address and phone number of Maryland Physician's Care and the primary care provider we presently use at the Maryland Sheriffs' Youth Ranch. If this is not done with in 12 business days, your agency will be charged and agree to pay for a complete physical exam and all necessary immunizations to be done at the local emergency care facility.

Maryland Physician's Care (800-953-8852)
Dr. Asuncion, Primary Care Physician
Parkview Medical
1564 Opossumtown Pike
Frederick, MD 21702
(301/694-7004)

Any concerns, please call me at (301) 874-4701 ext. 113. Thank you.

Date

Parent or Legal Guardian Signature

Verification of Medical Assistance Card

Date: _____

This is to advise that _____ date of birth; _____, and Social Security Number; _____, is in the custody of the _____ Department of Social Services and is currently placed at the Maryland Sheriffs' Youth Ranch (MSYR). The MSYR address is 7902 Fingerboard Road, Frederick, Maryland 21702. Mailing address is, P. O. Box 42, Buckeystown, Maryland 21717. The telephone number at MSYR is (301) 874-4701.

_____ Medical Assistance card is currently being re-issued and will be forwarded as soon as possible. _____ Medical Assistance number _____.

If you have any concerns and/or questions, please contact Mark Grover at the following phone number (301) 874-4701 ext 108.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Witness

Authorization for Emergency Medical Care

As parent or legal guardian of _____
Name of Youth

I herby give consent to the Maryland Sheriffs' Youth Ranch to make arrangements for my child _____ to have emergency medical care, including, the administration of medication, diagnostic testing, emergency dental services and other emergency services deemed necessary by a physician.

ALLERGIES YES() NO ()

If yes, describe allergies _____

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Witness

Authorization for Dental Care

As parent or legal guardian of _____
Name of Youth

I herby give consent to the Maryland Sheriffs' Youth Ranch to make arrangements for my child
_____ to have routine dental care, including, diagnostic testing, prescribed
reappointment medications and yearly dental exam inclusive of routine diagnostic testing.

ALLERGIES YES() NO ()

If yes, describe allergies _____

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Witness

Authorization for Medical Care

As parent or legal guardian of _____
Name of Youth

I herby give consent to the Maryland Sheriffs' Youth Ranch to make arrangements for my child _____ to have routine medical care, including immunization vaccinations, diagnostic testing, TB tests, prescribed urine tests, sports physicals and yearly physicals inclusive of routine diagnostic testing.

ALLERGIES YES() NO ()

If yes, describe allergies _____

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Witness

Authorization for Emergency Psychiatric Hospitalization

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to the following:

Due to this child’s past history of psychiatric hospitalizations I authorize the Maryland Sheriffs' Youth Ranch to affect a psychiatric hospitalization. The hospitalization must be preceded by a pre-certification for psychiatric hospitalization from Frederick Memorial Hospital or another licensed hospital.

I understand that once two physicians have consented and authorized for psychiatric hospitalization, my child will be placed in a psychiatric hospital for evaluation and treatment. This treatment may include the administration of new psychotropic medication or adjustments to existing medications.

I hereby authorize representatives of the Maryland Sheriffs’ Youth Ranch on my behalf to sign all forms necessary to initiate an emergency psychiatric hospitalization. I understand and acknowledge that this may/will include a promissory note from the Ranch to the psychiatric hospital promising that the child will be picked up from the psychiatric hospital on the day the child is discharged from said hospital. I understand and agree to pick up the child from the hospital on the day of discharge or I authorize the Ranch to pick the child up on day of discharge.

ALLERGIES YES() NO ()

If yes, describe allergies _____

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Witness

Acknowledgment of MSYR Restraint Policy

The Maryland Sheriffs' Youth Ranch utilizes behavior modification techniques (i.e. a points based level system, restrictions, rewards for outstanding performance...) to ensure that our youth are reaching their potential as young men. We make every effort to ensure that our youth live in a happy and safe environment. In order to protect our youth from one and other and from themselves we will sometimes need to resort to the use of physical restraints. **Physical restraints are the exception, not the rule.** Our staff is extensively trained in verbal de-escalation techniques as well as physical restraints. Our restraint training meets all COMAR regulations. Restraints may only be used when a resident poses a danger to himself or others. **Restraints may not be used to enforce compliance.** Only TACT-2 Techniques may be used during restraints.

Is there a known Medical Condition that would preclude resident from being safely restrained YES() NO ()

If yes, describe _____

I hereby acknowledge that I have read and understand the above stated policy:

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Resident

Date

Witness

Authorization for Participation in Community Sports

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Community Sports, sponsored by the community. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless all coaches, the Maryland Sheriffs’ Youth Ranch, community association officials, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Community Sports, as well as coaches, teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, and community association officials, coaches, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

The Maryland Sheriffs’ Youth Ranch staff, community association members, or volunteers will provide supervision at practice, games, and travel.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

AUTHORIZATION FOR PARTICIPATION IN ASSOCIATION SPORTS

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Association Sports. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the Maryland Sheriffs’ Youth Ranch, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Association Sports. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

The Maryland Sheriffs’ Youth Ranch staff or volunteers will provide supervision at practice, games, and travel.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Authorization for Participation in Recreational Programs

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Recreational Programs, sponsored by the community. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the all coaches, the Maryland Sheriffs’ Youth Ranch, community association officials, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Recreational Programs, as well as coaches, teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, and community association officials, coaches, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

The Maryland Sheriffs’ Youth Ranch staff, community association members, or volunteers will provide supervision at practice, games, and travel.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Authorization for Participation in Interscholastic Athletics

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Interscholastic Athletic programs, sponsored by the school. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the Board of Education of Frederick County, its members, the Superintendent of Schools, the principal, all coaches, the Maryland Sheriffs’ Youth Ranch, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Interscholastic Athletics, as well as coaches, teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, the Board of Education of Frederick County, coaches, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

Students who have made a decision to take part in the Interscholastic Athletics will be required to practice and participate in scheduled contests after school and possibly on non-school days. The school, Maryland Sheriffs’ Youth Ranch staff, or volunteers will provide supervision at practice, games, and travel.

In addition, it is recognized that all students must comply with eligibility regulations that govern athletics in Frederick County Public Schools as issued by the Frederick County Board of Education and the Maryland State Department of Education. The Maryland Sheriffs’ Youth Ranch may restrict participation based on contract of behavioral programs.

Every candidate for and participating on an Interscholastic Team must obtain and maintain insurance against possible accident or injury in school-sponsored games, practice sessions, and during travel to and from athletic contests. Such coverage may be provided by the purchase of scholastic accident insurance (through the school otherwise, proof of similar or superior coverage must be presented.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Authorization for Participation in Educational Programs

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Educational Programs, sponsored by the Maryland Sheriffs’ Youth Ranch. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the Maryland Sheriffs’ Youth Ranch, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Educational Programs, as well as teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

The Maryland Sheriffs’ Youth Ranch staff, or volunteers will provide supervision.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Authorization for Participation in Intra-Mural Athletics

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child’s participation in Intra-mural Athletic programs, sponsored by the school. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the Board of Education of Frederick County, its members, the Superintendent of Schools, the principal, all coaches, the Maryland Sheriffs’ Youth Ranch, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child’s participation in Intra-mural Athletics, as well as coaches, teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs’ Youth Ranch, the Board of Education of Frederick County, coaches, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs’ Youth Ranch to obtain and give medical information as necessary.

Students who have made a decision to take part in the Intra-mural Athletics will be required to practice and participate in scheduled contests after school and possibly on non-school days. The school, Maryland Sheriffs’ Youth Ranch staff, or volunteers will provide supervision at practice, games, and travel.

In addition, it is recognized that all students must comply with eligibility regulations that govern athletics in Frederick County Public Schools as issued by the Frederick County Board of Education and the Maryland State Department of Education. The Maryland Sheriffs’ Youth Ranch may restrict participation based on contract of behavioral programs.

Every candidate for and participating on an Intra-mural team must obtain and maintain insurance against possible accident or injury in school-sponsored games, practice sessions, and during travel to and from athletic contests. Such coverage may be provided by the purchase of scholastic accident insurance (through the school otherwise, proof of similar or superior coverage must be presented.

I hereby authorize Maryland Sheriffs’ Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Authorization for Participation in Maryland Sheriffs' Youth Ranch Programs

As parent or legal guardian of _____
Name of Youth

I hereby authorize and consent to our child's participation in Maryland Sheriffs' Youth Ranch Programs, sponsored by the Maryland Sheriffs' Youth Ranch. I understand that the program/activity in which my child will be participating may be potentially dangerous, and that physical activities may occur to my child requiring emergency medical care and treatment. I assume the risk of injury to my child that may occur in a program/activity.

In consideration of the acceptance of my child in these programs, and the benefits derived by my child from participation, I agree to released and hold harmless the Maryland Sheriffs' Youth Ranch, and any and all other of their agents, servants, and/or employees and agree to indemnify each of them from any claims, costs, suits, actions, judgments, and expenses arising from my child's participation in Maryland Sheriffs' Youth Ranch Programs, as well as teachers, and board members of other programs. I hereby give my consent and authorize Maryland Sheriffs' Youth Ranch, coaches, and their agents, designees, servants and/or employees to consent on my behalf and on behalf of my child, to emergency medical care and treatment in the event I am unable to be notified by reasonable attempts of the need for such emergency medical care and treatment.

My child is covered by medical insurance. I give permission for Maryland Sheriffs' Youth Ranch to obtain and give medical information as necessary.

The Maryland Sheriffs' Youth Ranch staff or volunteers will provide supervision at practice, games, and travel.

I hereby authorize Maryland Sheriffs' Youth Ranch staff on my behalf to sign all forms for participation, travel, medical authorization, releases, and verification of residency.

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

MARYLAND SHERIFFS' YOUTH RANCH
AGREEMENT TO PARTICIPATE IN PROGRAM

I, _____, agree that my placement at the Maryland Sheriffs' Youth Ranch is an opportunity for me to make positive changes and continued growth in my behavior.

I understand that staff and responsible adults will be making decisions regarding educational, medical, and psychological needs. I agree to work along with staff and adults to accomplish my goals. I may need to have special services provided by teachers, counselors, and school personnel. I may also need to cooperate with medical professionals, psychologists, social workers, and psychotherapists. These services may include evaluations and treatment.

I will make a genuine effort to cooperate with their recommendations.

I also agree to participate in Maryland Sheriffs' Youth Ranch activities which include group counseling, individual counseling, and crisis counseling. I will, to my best ability, follow policies and regulations of the Maryland Sheriffs' Youth Ranch.

I agree to comply with the Ranch visitation policy.

- a. Resident must be on Level II or above without restrictions before any off Ranch visits will be approved.
- b. Ranch will provide a visiting area on grounds for resident and family when resident is below visitation level or on restriction.

SPECIAL NEEDS:

I agree to

I understand that failure to follow this agreement may indicate my need for another placement and discharge from the Ranch program.

WITNESS

YOUTH

Signature

Signature

Date

Date

APPLICATION FOR ADMISSION

YOUTH'S NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

ADMISSION DATE _____

BIRTH CERTIFICATE NUMBER _____

CASE NUMBER _____

PLACE OF BIRTH _____

PERSONAL CHARACTERISTICS:

HEIGHT _____ WEIGHT _____ HAIR COLOR _____ EYE COLOR _____

SCARS OR TATOO'S _____

ALLERGIES _____ GLASSES? YES () NO ()

OTHER PHYSICAL NEEDS OR IMPAIRMENTS _____

REFERRING AGENCY _____

ADDRESS _____

AGENCY WORKER _____ WORKER'S PHONE _____ Fax _____

AGENCY SUPERVISOR _____ SUPERVISOR'S PHONE _____

AGENCY EMERGENCY TELEPHONE/CONTACT _____

MEDICAL ASSISTANCE NUMBER _____ OTHER _____

GUARDIANSHIP/CUSTODY:

- 1. _____ AGENCY FULL GUARDIANSHIP
- 2. _____ AGENCY LIMITED GUARDIANSHIP-EDUCATIONAL/MEDICAL
- 3. _____ AGENCY CUSTODY ONLY-PARENTAL GUARDIANSHIP

PSYCHOLOGICAL DATE _____ EVALUATOR _____

PSYCHIATRIST DATE _____ EVALUATOR _____

SOCIAL HISTORY DATE _____ EVALUATOR _____

LAST PHYSICAL/MEDICAL EXAM DATE _____

PHYSICIAN _____ PHONE _____

ATTORNEY _____ **PHONE** _____

FAMILY INFORMATION

FATHER_____

MOTHER_____

ADDRESS_____

ADDRESS_____

PHONE: HOME_____

PHONE: HOME_____

WORK_____

WORK_____

SIBLINGS (Include half and step)

NAME_____

NAME_____

DATE OF BIRTH_____

DATE OF BIRTH_____

PHONE_____

PHONE_____

ADDRESS_____

ADDRESS_____

NAME_____

NAME_____

DATE OF BIRTH_____

DATE OF BIRTH_____

PHONE_____

PHONE_____

ADDRESS_____

ADDRESS_____

Reason for placement (Include most recent problems):

What goals are expected to be met while youth is placed at Maryland Sheriffs' Youth Ranch?

What are the youth's goals?

What is the expected length of stay at Maryland Sheriffs' Youth Ranch?

RELIGIOUS

RELIGION _____

LAST CHURCH ATTENDED _____

DATE OF BIRTH _____ DATE OF CONFIRMATION _____

SCHOOL HISTORY

GRADE _____

LAST SCHOOL ATTENDED _____

ADDRESS _____

PREVIOUS SCHOOL ATTENDED _____

ADDRESS _____

PERFORMANCE:

GRADES: ABOVE AVERAGE () AVERAGE () POOR ()

IF THERE HAS BEEN POOR SCHOOL PERFORMANCE, PLEASE EXPLAIN WHY: _____

SPECIAL EDUCATION: YES () NO () LEVEL _____

HANDICAPPING CONDITION _____

ATTENDANCE: GOOD () FAIR () POOR ()

BEHAVIOR PROBLEMS _____

PREVIOUS RESIDENTIAL OR FOSTER CARE PLACEMENTS

PLACE _____

ADDRESS _____

MEDICAL HISTORY

HOSPITALIZATIONS (LIST DATES AND REASONS):

INVOLVEMENT WITH OTHER AGENCIES:

POLICE: YES () NO ()

IF YES, EXPLAIN _____

JUVENILE SERVICES YES () NO ()

IF YES, EXPLAIN _____

MENTAL HEALTH SERVICES YES () NO ()

IF YES, THERAPIST NAME/PHONE # _____

PLACE OF SERVICE _____ LENGTH OF INVOLVEMENT _____

INPATIENT/INPATIENT EVALUATIONS YES () NO ()

IF YES, PLACE(S) _____

DATE(S) _____

OTHER AGENCIES (EXPLAIN) _____

HISTORY OF FIRE SETTING YES () NO ()

IF YES, EXPLAIN _____

HISTORY OF DRUG USE YES () NO ()

IF YES, EXPLAIN _____

HISTORY OF PHYSICAL OR SEXUAL ABUSE BY OTHERS YES () NO ()

HISTORY OF ALLEGATIONS OF PHYSICAL OR SEXUAL ABUSE BY OTHERS

	YES ()	NO ()	REPORTED INVESTIGATION DATE
PARENTS/FAMILY	YES ()	NO ()	_____
FOSTER PARENTS	YES ()	NO ()	_____
CHILD CARE WORKERS	YES ()	NO ()	_____
OTHER STAFF _____	YES ()	NO ()	_____
OTHER YOUTH _____	YES ()	NO ()	_____
OTHER _____	YES ()	NO ()	_____

IF YES, EXPLAIN _____

MARYLAND SHERIFFS' YOUTH RANCH TEMPORARY PLACEMENT AGREEMENT

We believe in fairness to the child, the local Department of Social Services and the Ranch staff, a child should enter the Ranch on a thirty-day trial basis.

Our staff will do all they can to understand and evaluate the child's ability to live in a group setting. Evaluations of the child's adjustment will take place during the first twenty-four days of his placement. The child's Social Worker will be informed of the results of this evaluation.

At the end of the first twenty-five days, a final assessment of the child's adjustment to the Ranch will be made by our staff and recommendation as to the compatibility of the child to the Ranch and the Ranch's ability to meet the needs of the child will be made at this time.

The Ranch's Social Worker will contact the child's Social Worker and discuss the staff's recommendations.

We anticipate that most children will be approved for permanent placement at the Ranch. However, if our Staff does not recommend placement, or if there is a significant problem in the child's adjustment to the Ranch which cannot be resolved, we anticipate the cooperation of the child's Social Worker to find an alternative placement for the child elsewhere.

All admission forms should be complete at the end of the thirty-day period.

AGREEMENT

We agree to the terms of the thirty-day temporary placement period.

Child's Name _____
County _____

Child's Social Worker

Date

Ranch's Social Worker

Date

1 DISHCARGE OF RESIDENT/RETRIEVAL OF PERSONAL BELONGINGS AGREEMENT

The Maryland Sheriffs' Youth Ranch reserves the right to discharge a resident with either a 72-hour or 30-day discharge notice. The Ranch will implement a 72-hour discharge notice for a few reasons, for example, if the resident is a threat/danger to himself or others and their safety. In the event of the resident being discharged from the program, you are signing below stating that you will have the resident removed from the Ranch on the discharge date given by the Ranch Social Worker.

In the event that _____ is discharged from the Maryland Sheriffs' Youth Ranch, all of his personal belongings must be picked up from the Youth Ranch within two weeks of the discharge date. Any items remaining at the Youth Ranch after that date will be donated to a local charity.

Parent/Guardian Signature

MARYLAND SHERIFFS' YOUTH RANCH PUBLICITY AGREEMENT

Dear Parent or Guardian:

Since the work at the Maryland Sheriffs' Youth Ranch has met with such good results, we feel that its methods should be more widely known.

In order to accomplish this, we hope to publicize these matters through articles, movies, pictures, radio, and television interviews, which will point out these successful approaches.

Would you be willing to allow your son or ward to appear in photographs, movies, or radio and television or in any way that might further this end? If you so designate, no names will be used.

Please sign your name on the line below.

I hereby give consent to have _____
Appear on television, radio, in movies and in photographs for use in any publicity that will forward the work of the Maryland Sheriffs' Youth Ranch.

Parent's or Guardian's Name

Street

City and State

2 MENTORING/VISITING RESOURCE PROGRAM

Numerous Maryland Sheriffs' Youth Ranch staff members and volunteers who are screened in accordance with COMAR Regulations 01.04.04.11 E by this agency, have expressed an interest in serving as mentors/visiting resources for youth residing at the Ranch. In furtherance of this program, we request your permission for OFF DUTY staff and volunteers working at the Ranch to:

- Take youth to religious activities.
- Take youth off property to participate in various activities, i.e. picnics, fishing, ballgames, etc.
- Travel with youth out of state.
- Visit staff and volunteer residences.
- Spend the night at staff and volunteer residences.
- Allow youth to view movies not to exceed _____ rating.

You may allow full or partial participation by striking (draw a line through) activities not approved.

Please indicate your preference by completing the following sentence by striking (drawing a line through the word "not").

_____ is **not** allowed to participate in this program.
Youth's Name

Print Name of Authorizing Agent

Signature of Authorizing Agent

Date

MARYLAND SHERIFFS' YOUTH RANCH TRAVEL CONSENT

I hereby give my consent to MARYLAND SHERIFFS' YOUTH RANCH, presently caring for my child, _____, for said child to be included in trips and travel arrangements in and out of the State of Maryland.

SIGNED: _____
Parent, Guardian or Custodian

ADDRESS: _____

TELEPHONE: HOME () _____
WORK () _____

WITNESS: _____

DATE: _____

MARYLAND SHERIFFS' YOUTH RANCH PERMISSION FOR WORK PERMIT

Youth: _____

Date of Birth: _____

_____, (relationship to youth _____)

hereby give my permission for the staff at the MARYLAND SHERIFFS' YOUTH RANCH to
sign work permits while the above youth is in their care.

NAME: _____

SIGNED: _____

DATE: _____

Maryland Sheriff's Youth Ranch

AUTHORIZATION TO EXCHANGE INFORMATION

Client Name _____ DOB _____

Address: P.O. Box 42 Buckeystown, MD 21717-0042

I give my permission for:

Maryland Sheriff's Youth Ranch and **The Jefferson School** to exchange written and verbal information about my or my child's treatment at MSYR for the following purposes(s):

- ✓ notification of beginning and/or ending of treatment
- ✓ periodic summary of progress
- ✓ coordination of service agreement/treatment planning
- ✓ educational information/records
- ✓ past treatment
- ✓ intake assessment summary
- ✓ psychological evaluation
- ✓ financial information
- ✓ discharge summary
- ✓ all pertinent information including but not limited to medical and medication
- ✓ for the purpose of treatment
- other (specify): _____

The following information is protected by State and Federal Law and requires special authorization. If applicable, please indicate if this information is to be released to the recipient noted above.

_____ Drug/Alcohol Treatment Records

_____ HIV/AIDS Testing/Results

This consent for release of information is given freely, voluntarily and without coercion, and may be withdrawn by me at any time. Any information I authorize other professionals to release to MSYR will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. I understand that I have the right to inspect the record of mental health information on the above-named individual. This authorization is effective for one year from the date below.

Signature of client

Date

Signature of Parent/Legal Custodian of Minor

Date

Signature of Witness: _____

AUTHORIZATION TO EXCHANGE INFORMATION

Maryland Sheriff's Youth Ranch

AUTHORIZATION TO EXCHANGE INFORMATION

Client Name _____ DOB _____

Address: P.O. Box 42 Buckeystown, MD 21717-0042

I give my permission for:

Maryland Sheriff's Youth Ranch and **Frederick County Public Schools** to exchange written and verbal information about my or my child's treatment at MSYR for the following purposes(s):

- ✓ notification of beginning and/or ending of treatment
- ✓ periodic summary of progress
- ✓ coordination of service agreement/treatment planning
- ✓ educational information/records
- ✓ past treatment
- ✓ intake assessment summary
- ✓ psychological evaluation
- ✓ financial information
- ✓ discharge summary
- ✓ all pertinent information including but not limited to medical and medication
- ✓ for the purpose of treatment
- other (specify): _____

The following information is protected by State and Federal Law and requires special authorization. If applicable, please indicate if this information is to be released to the recipient noted above.

_____ Drug/Alcohol Treatment Records

_____ HIV/AIDS Testing/Results

This consent for release of information is given freely, voluntarily and without coercion, and may be withdrawn by me at any time. Any information I authorize other professionals to release to MSYR will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. I understand that I have the right to inspect the record of mental health information on the above-named individual. This authorization is effective for one year from the date below.

Signature of client

Date

Signature of Parent/Legal Custodian of Minor

Date

Signature of Witness: _____

Maryland Sheriff's Youth Ranch

AUTHORIZATION TO EXCHANGE INFORMATION

Client Name _____ DOB _____

Address: P.O. Box 42 Buckeystown, MD 21717-0042

I give my permission for:

Maryland Sheriff's Youth Ranch and Department of Social Services/ Department of Health and Human Services
to exchange written and verbal information about my or my child's treatment at MSYR for the following purposes(s):

- ✓ notification of beginning and/or ending of treatment
- ✓ periodic summary of progress
- ✓ coordination of service agreement/treatment planning
- ✓ educational information/records
- ✓ past treatment
- ✓ intake assessment summary
- ✓ psychological evaluation
- ✓ financial information
- ✓ discharge summary
- ✓ all pertinent information including but not limited to medical and medication
- ✓ for the purpose of treatment
- other (specify): _____

The following information is protected by State and Federal Law and requires special authorization. If applicable, please indicate if this information is to be released to the recipient noted above:

_____ Drug/Alcohol Treatment Records

_____ HIV/AIDS Testing/Results

This consent for release of information is given freely, voluntarily and without coercion, and may be withdrawn by me at any time. Any information I authorize other professionals to release to MSYR will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. I understand that I have the right to inspect the record of mental health information on the above-named individual. This authorization is effective for one year from the date below.

Signature of client

Date

Signature of Parent/Legal Custodian of Minor

Date

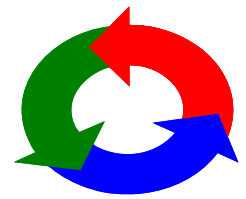
Signature of Witness: _____

AUTHORIZATION TO EXCHANGE INFORMATION

**When signing forms belonging to:
Contemporary Therapeutic Services
(Pages 33-42)
please sign in
BLACK INK ONLY!**

**It is Maryland State Law that all legal
documents be signed with black ink.**

Thank you for your cooperation.



CONTEMPORARY THERAPEUTIC SERVICES, INC.
CONSENT TO RECEIVE SERVICES

Client: _____ DOB: _____

I hereby voluntarily consent for the above named client to receive the following services from CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc. (Check as appropriate):

_____ **OMHC SERVICES**, which may include:

- * Psychopharmacology
- * Group psychotherapy
- * Individual psychotherapy
- * Family therapy
- * Psychological testing
- * Psychiatric Services
- * Referral for lab work and testing
- * Referral for substance abuse services
- * Referral for medical problems
- * Other: _____

I understand the benefits and risks of these services as well as the alternatives to recommended services and/or treatment. Unless specifically stated otherwise, this consent expires upon completion of these services from CONTEMPORARY THERAPEUTIC SERVICES, INC. I understand that I am free to withdraw consent for services at any time.

I understand that my enrollment in services may be temporarily suspended pending a review of pertinent information, and that service may be discontinued and referrals given if indicated.

I agree to receive services of the type and frequency defined in my Individual Rehabilitation Plan and/or Individual Treatment plan.

LIABILITY WAIVER

I hereby agree to release and hold harmless from any liability, Contemporary Therapeutic Services, Inc., including its paid and volunteer staff, members or its Board of Directors, Chief Executive Officer, and their heirs, executors and administrators, and any other agents or representatives of, Contemporary Therapeutic Services, Inc., for any claim or cause of action of any kind, including specifically, personal injury which may occur while participating in any program or activity of any kind conducted, approved, organized, or sponsored by , Contemporary Therapeutic Services, Inc., or its representatives, these programs or activities including but not limited to field trips and transportation to and from said programs or activities.

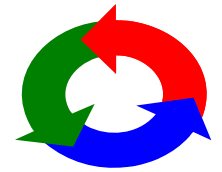
Client/Guardian's Signature

Date

CTS Staff's Signature

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



CONTEMPORARY THERAPEUTIC SERVICES, INC.
RIGHTS OF PERSONS AND FAMILIES SERVED

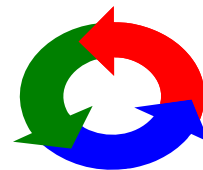
All person and families served by the Contemporary Therapeutic Services, Inc. have rights. You have the right to:

1. The right to receive appropriate humane treatment which restricts the individual's personal liberty only to the extent necessary to that individual's treatment or rehabilitation needs and applicable legal requirements.
2. The right to be protected from harm and to be free from mental, physical and sexual abuse at the facility. All allegations of patient or client abuse by staff members must be reported to the local law enforcement agency or to the program director who must report them to the local law enforcement agency.
3. The right to an individualized treatment or rehabilitation plan.
4. The right to participate, in a manner appropriate to the individual's condition, in the development and periodic review of his treatment or rehabilitation plan.
5. The right to receive treatment or rehabilitation as stated in the individualized treatment or rehabilitation plan.
6. The right to be told in appropriate terms and language of:
 - a. The content and objectives of treatment and rehabilitation;
 - b. The nature and significant possible negative effects of treatment or rehabilitation;
 - c. The name, title and role of the staff members who are directly responsible for carrying out the individual's treatment or rehabilitation, and when appropriate;
 - d. Other treatments, services or providers of mental health services.

7. The right of the individual to have access to his treatment or rehabilitation records and the right, with written permission, for the individual's attorney to have access to his records. In the event the individual's physician believes that it would be harmful to the individual to read his record, the individual has the right to a written summary of those sections of the record which the physician believes might be harmful.
8. The right to refuse medication.
9. The right to refuse to participate in physically intrusive research.
10. The right, prior to admission, to an explanation in terms and language that the individual can understand of admission and discharge policies.
11. The right, prior to admission, to an explanation of the individual's rights in terms and language that he can understand and to have a list of the individual's rights posted in a prominent place in the facility.
12. The right, prior to admission, to an explanation in terms and language that the individual can understand, at the charges and fees that he will be required to pay.
13. The right to an aftercare plan.
14. The right to file a grievance if the individual is not satisfied with the treatment or rehabilitation that he receives.

I have reviewed and understand my rights and responsibilities and will participate in developing an appropriate treatment plan.

_____	_____
Name of Person Served	Date
_____	_____
Guardian / Interpreter / Legal Representative	Date
_____	_____
Treatment (Foster) Parent	Date
_____	_____
Staff Signature	Date



Acknowledgement of Receipt of Notice of Privacy practices

Client Name

Client DOB

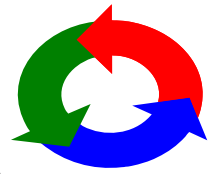
I, _____, acknowledge that Contemporary Therapeutic Services, Inc. has provided me with a copy of the Notice of Privacy Practices. I further acknowledge that I have read and understand the notice and my rights contained within.

Signature of Client / Legal Guardian

Date

Signature of Witness

Date



CONTEMPORARY THERAPEUTIC SERVICES, INC.

CONSENT TO RELEASE INFORMATION (VALUE OPTIONS/MHA)

CLIENT NAME: _____ DOB: _____

ADDRESSEE:

_____**Value Options**
PO Box 1950
Latham, NY 12110
1-800-888-1965

_____**Mental Health Authority/CORE Services**
5012 Rhode Island Avenue
Hyattsville, MD 20781
(301) 985-3890 Fax: (301) 985-3889

I freely give my consent to CONTEMPORARY THERAPEUTIC SERVICES, INC., and the addressee to exchange the information presented below. This information is to be kept confidential and may not be released to any other agency without my consent.

The purpose of this release is to provide continuity of care and to assist CONTEMPORARY THERAPEUTIC SERVICES, INC., and the addressee in planning and providing services to me. In no way will this information be used to discriminate against me or deny me service at CONTEMPORARY THERAPEUTIC SERVICES, INC.

___ Verbal exchange between CONTEMPORARY THERAPEUTIC SERVICES, INC, and Addressee

Addressee to release

- ___ Demographic Information
- ___ Social Assessment/History
- ___ Treatment Plan & Reviews
- ___ Psychiatric/Psychological Evaluation
- ___ Medication Record
- ___ Somatic History
- ___ Physical Examination Results
- ___ Immunization Records
- ___ Transfer/Discharge Summary
- ___ Physician's Recommendations for Psychiatric Rehab. Services
- ___ Aftercare Plan

CONTEMPORARY THERAPEUTIC SERVICES, INC to release

- ___ Demographic Information
- ___ Intake Assessment
- ___ Disposition
- ___ Entitlement Information
- ___ Rehabilitation Assessment
- ___ Individual Treatment Plan
- ___ Transfer/Discharge Summary
- ___ Psychiatric Evaluation
- ___ Psychological Evaluation
- ___ Diagnostic Evaluation
- ___ 6-Month Treatment Plan Review

Other Instructions/Notes: _____

Client/Guardian Signature

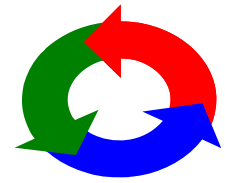
Date

End of Treatment
Date Consents Expires

CTS Staff's Signature

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



**CONTEMPORARY THERAPEUTIC SERVICES, INC
CONSENT TO RELEASE INFORMATION**

ADDRESSEE:

Primary Care Physician

CLIENT'S NAME: _____

DOB: _____

I freely give my consent to CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc., and the addressee to exchange the information presented below. This information is to be kept confidential and may not be released to any other agency without my consent.

The purpose of this release is to provide continuity of care and to assist CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc., and the addressee in planning and providing services to me. In no way will this information be used to discriminate against me or deny me service at CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc.

___ Verbal exchange between CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc. and Addressee

Addressee to release

- ___ Demographic Information
- ___ Social Assessment/History
- ___ Treatment Plan & Reviews
- ___ Psychiatric/Psychological Evaluation
- ___ Medication Record
- ___ Somatic History
- ___ Physical Examination Results
- ___ Immunization Records
- ___ Transfer/Discharge Summary
- ___ Physician's Recommendations for Psychiatric Rehab. Services
- ___ Aftercare Plan

CONTEMPORARY THERAPEUTIC SERVICES, INC to release

- ___ Demographic Information
- ___ Intake Assessment
- ___ Disposition
- ___ Entitlement Information
- ___ Rehabilitation Assessment
- ___ Individual Treatment Plan
- ___ Transfer/Discharge Summary
- ___ Psychiatric Evaluation
- ___ Psychological Evaluation
- ___ Diagnostic Evaluation
- ___ 6-Month Treatment Plan Review

Other Instructions/Notes: _____

Client/Guardian Signature

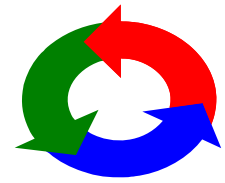
Date

End of Treatment
Date Consents Expires

CTS Staff's Signature

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



**CONTEMPORARY THERAPEUTIC SERVICES, INC
CONSENT TO RELEASE INFORMATION**

ADDRESSEE:

CLIENT'S NAME: _____

DOB: _____

I freely give my consent to CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc., and the addressee to exchange the information presented below. This information is to be kept confidential and may not be released to any other agency without my consent.

The purpose of this release is to provide continuity of care and to assist CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc., and the addressee in planning and providing services to me. In no way will this information be used to discriminate against me or deny me service at CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc.

___ Verbal exchange between CONTEMPORARY THERAPEUTIC SERVICES, INC, Inc. and Addressee

Addressee to release

- ___ Demographic Information
- ___ Social Assessment/History
- ___ Treatment Plan & Reviews
- ___ Psychiatric/Psychological Evaluation
- ___ Medication Record
- ___ Somatic History
- ___ Physical Examination Results
- ___ Immunization Records
- ___ Transfer/Discharge Summary
- ___ Physician's Recommendations for Psychiatric Rehab. Services
- ___ Aftercare Plan

CONTEMPORARY THERAPEUTIC SERVICES, INC to release

- ___ Demographic Information
- ___ Intake Assessment
- ___ Disposition
- ___ Entitlement Information
- ___ Rehabilitation Assessment
- ___ Individual Treatment Plan
- ___ Transfer/Discharge Summary
- ___ Psychiatric Evaluation
- ___ Psychological Evaluation
- ___ Diagnostic Evaluation
- ___ 6-Month Treatment Plan Review

Other Instructions/Notes: _____

Client/Guardian Signature

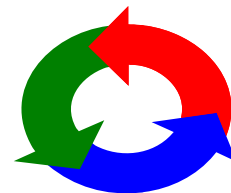
Date

End of Treatment
Date Consents Expires

CTS Staff's Signature

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



CONTEMPORARY THERAPEUTIC SERVICES, INC.
Crisis Plan

Client Name: _____ DOB: _____

1. If client is in immediate danger of hurting him/herself or someone else, the responsible adult present (i.e., parent, foster parent, coordinator, teacher, etc.) should call 911 for the client to be transported to the nearest hospital for assessment.
2. If client expresses the intent to hurt him/herself or someone else, the responsible adult present should immediately call the client's therapist (pager number) for further instruction. If there is no response from the therapist within 15 minutes, CONTEMPORARY THERAPEUTIC SERVICES, INC On-Call System (301) 779-8345 should be involved for further instruction. The therapist or CTS On-Call clinician will provide instruction and will contact needed supports (i.e., parent/guardian, case manager, etc.) to advise them of situation.
3. If client displays:
 - **RUNAWAY behavior, the responsible adult present is to:**
 - a. Escort client from the situation and talk with him/her in an attempt to calm him/her down;
 - b. Ask client what s/he needs at that time, usually, s/he can process and express what s/he needs (i.e., time alone, a walk, talk with someone, etc.);
 - c. DO NOT attempt to physically restrain client if s/he threatens to runaway; immediately call 911 and have someone else follow client until support arrives;
 - d. Notify appropriate staff at CTS.
 - **AGGRESSIVE behavior, the responsible adult present is to:**
 - a. Escort client from the situation and talk with him/her in an attempt to calm him/her down;
 - b. Speak to client in a calm and reassuring tone of voice that s/he needs to discontinue such behavior and remind him/her of the expectations of her behavior;
 - c. If behavior continues beyond 2 (two) minutes, remove yourself to another room, or a distance of 20 feet;
 - d. If behavior continues beyond 15 minutes, use CTS On-Call System for further instruction.
 - **SUICIDAL behavior, the responsible adult present is to:**
 - a. Call 911 for support or transport to nearest hospital;
 - b. Call parent/guardian to notify them of the situation;
 - c. Call CTS On-Call System to report the situation (#2);
 - d. Stay with client until parent/guardian arrives.

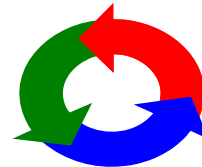
Client

Intake Coordinator

Parent/Guardian/Care Taker

Clinical Supervisor

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



CONTEMPORARY THERAPEUTIC SERVICES, INC.
EMERGENCY CONTACT SHEET

Client: _____ DOB: _____

Emergency Contact/Guardian #1: Relationship: _____

Name: _____

Address: _____

Phone Number: _____

Emergency Contact #2: Relationship: _____

Name: _____

Address: _____

Phone Number: _____

Emergency Contact #3: Relationship: _____

Name: _____

Address: _____

Phone Number: _____

Health Alert (allergies, known health problems, medications): _____

I understand that in the event of an emergency, as defined by staff, attempts will be made to contact any of the above for purposes of notification. I also authorize any treatment deemed necessary to be provided to me in the event of an emergency. It is my preference that such treatment is provided by the following physician and/or hospital.

Physician: _____

Address: _____

Telephone #: _____

Hospital: _____

Address: _____

I also freely give consent for CONTEMPORARY THERAPEUTIC SERVICES, INC., Inc., to release to this above provider pertinent information relevant to such treatment.

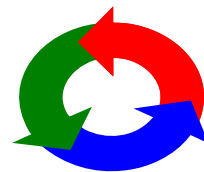
Client/Guardian Signature

Date

CTS Staff Signature

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax



**CONTEMPORARY THERAPEUTIC SERVICES, INC.
ORIENTATION CHECKLIST**

Client: _____ DOB: _____

Date of Intake/Start of Orientation: _____

Instructions: These topics should be discussed upon intake and completed within 15 days.

Topics:

1. Rights and Responsibilities
2. Fee policies, and agreements
3. Grievance procedures
4. Consent to Release Information Forms
5. Smoking Policy
6. Criteria and procedures for termination or suspension of services (both voluntary and involuntary)
7. Distribution of Consumer's Guide to CTS
8. Emergency evacuation procedures/drills
9. 24 hour access system
10. Informed Consent for Services
11. Liability Waiver
12. OMS Survey
13. Substance Abuse Policy
14. Client's health and annual physical exam status and linkage with somatic physician
15. Introduction to service team members and their roles
16. Assessment process
17. Consumer's goals and needs; ITP process
18. Assess natural support system

I have been informed of all topics listed above as appropriate and any questions have been fully answered for me.

Client/Guardian Signature

Date

CTS Staff Member

Date

6525 Belcrest Rd Suite G-40 * Hyattsville * Maryland * 20782 * (301) 779-8345 * (301) 779-8417 Fax

Understanding Of Spiritual Development At The Maryland Sheriffs' Youth Ranch

The Maryland Sheriffs' Youth Ranch is dedicated to the overall growth of each youth placed in its care-including physical, psychological, intellectual, emotional, and spiritual development.

The Ranch respects the unique background of each individual and his right to practice the religious preferences of his choice. We also respect the rights and preferences of involved guardians.

Our goal is to support each youth to follow his religious practices or explore different religions in order to make a choice. At times we offer inter-denominational educational opportunities and welcome religious leaders from the community to be involved with our youth.

If any of the above practices are not acceptable or if there are specific requests, please inform us in the special considerations section. The below signature indicates that responsible individuals have been informed and given the opportunity to express special needs or consideration.

Date

Signature Parent/Legal Guardian

Special Considerations: _____

Frederick County Public Schools
7616 Hayward Road
Frederick, MD 21702

Ron Johnston, Supervisor
Phone: (301) 694-1368
Fax: (301) 695-0415

Date: _____

The student below has requested enrollment in a Frederick County Public school. The Family Education and Privacy Act (Buckley Amendment), the Code of Federal Regulations 34-CFR99 and Maryland COMAR Regulation 13A.08.02.20 allows schools to forward pupil records without obtaining parent/legal guardian permission to release records.

Please send the following records:

- _____ Academic Transcript (Including attendance)
- _____ Test Information (Including psychological evaluation)
- _____ Health records (Including immunization information)
- _____ Special Education files (if applicable)
- _____ Current year report card(s) and grades at time of W/D
- _____ Disciplinary file-suspensions, expulsions, etc.

Thank you for your promptness in handling this request.

Sincerely,

Pupil Personnel Worker

LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH
-----------	------------	--------	---------------

I hereby grant permission to _____, representative of Frederick County Public School system to secure from _____ School, the above specified information.

Date

Signature Parent/Legal Guardian

Movie Consent Form

Part of the Ranch recreational program includes allowing youth at the Ranch the opportunity to view movies on a regular basis through home videos and local movie theaters. Also, residents at the Ranch are permitted to purchase videos from the store and receive them as gifts.

The Ranch understands the responsibility of adults to make decisions about viewing choices. Therefore, the Ranch would like parental involvement in this matter. Please indicate your level of approval regarding your child. The Ranch staff will reserve the right to screen movie selections based on therapists' input and staff discretion.

I, _____, as the legal guardian of
_____, hereby give my permission for this child to watch and/or possess movies
with the following rating:

G _____

PG _____

PG-13 _____

R _____

Parent/Legal Guardian

Date

MARYLAND SHERIFFS' YOUTH RANCH INITIAL SERVICE PLAN

YOUTH: _____

D.O.B. _____

DATE OF ADMISSION: _____

GRADE: _____

PLACEMENT AGENCY: _____

RELIGION: _____

DATE COMPLETED: _____

REASON FOR PLACEMENT:

LONG TERM GOALS:

1) _____

2) _____

3) _____

SHORT TERM GOALS:

1) _____

2) _____

3) _____

SERVICES TO BE PROVIDED:

1) _____

2) _____

3) _____

4) _____

5) _____

CONTACTS

PERSON(S): _____ RELATIONSHIP TO YOUTH _____

ADDRESS: _____

PHONE: _____

TYPE OF CONTACT: **NO CONTACT** Phone Letter On Ranch Off Ranch Overnights

Please list any restrictions on type of contact (i.e. supervised, limitations on time of contact...)

PERSON(S): _____ RELATIONSHIP TO YOUTH _____

ADDRESS: _____

PHONE: _____

TYPE OF CONTACT: **NO CONTACT** Phone Letter On Ranch Off Ranch Overnights

Please list any restrictions on type of contact (i.e. supervised, limitations on time of contact...)

PERSON(S): _____ RELATIONSHIP TO YOUTH _____

ADDRESS: _____

PHONE: _____

TYPE OF CONTACT: **NO CONTACT** Phone Letter On Ranch Off Ranch Overnights

Please list any restrictions on type of contact (i.e. supervised, limitations on time of contact...)

PERSON(S): _____ RELATIONSHIP TO YOUTH _____

ADDRESS: _____

PHONE: _____

TYPE OF CONTACT: **NO CONTACT** Phone Letter On Ranch Off Ranch Overnights

Please list any restrictions on type of contact (i.e. supervised, limitations on time of contact...)

PERSON(S): _____ RELATIONSHIP TO YOUTH _____

ADDRESS: _____

PHONE: _____

TYPE OF CONTACT: **NO CONTACT** Phone Letter On Ranch Off Ranch Overnights

Please list any restrictions on type of contact (i.e. supervised, limitations on time of contact...)

YOUTH: _____

LIST OF ACTIVITIES AND PERSON RESPONSIBLE: (i.e. contact parents-agency worker arrange transportation-also reports and other meetings)

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

DISCHARGE PLAN:

1) ANTICIPATED LENGTH OF STAY: _____

2) YOUTH'S PLAN (Parent(s), relatives, foster care, adoption, independent living, other): _____

3) AGENCY PLAN: _____

4) PARENT(S)' PLAN: _____

MEDICAL HISTORY

Name: _____ Date: _____

Address: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Any Past Surgeries:

What Surgery	When	Where
1) _____		
2) _____		
3) _____		
4) _____		

LONG TERM MEDICAL PROBLEMS:

Problem	When diagnosed	Hospitalized for this problem
1) _____		
2) _____		
3) _____		

Drug allergies: _____

Please describe any reactions: _____

Current Medications (Prescription or frequent non-prescription):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Other allergies: _____

Immunizations	Date	
Tetanus	_____	Have you ever received a flu shot? ف yes ف no When _____
Hepatitis B	_____	Have you ever received a pneumonia shot? ف yes ف no When? _____
Last TB test	_____	Have you ever had a positive reaction? ف yes ف no

Last complete physical: _____ Last eye exam: _____ Last Dental exam: _____

Any recent blood or other tests: _____

Clothing Inventory

	#Owned	#Suggested	#Needed
Bathing Suit		1	
Belts		1*	
Boots		1*	
Cap (Knit Pullover)		1*	
Coat (Raincoat)		1*	
Coat (Winter)		1*	
Gloves		1*	
Gym Trunks		1	
Handkerchiefs		3	
Jacket (Lightweight)		1*	
Pajamas		2*	
Robe		1*	
Shirts (Dress)		1*	
Shirts (Long Sleeve Leisure)		2-4*	
Shoes (Non canvas)		1*	
Shoes (Leisure)		1*	
Shorts		6*	
Socks (Dress)		1	
Socks (Leisure)		6-12*	
Sport Coat/Suit		1	
Sweaters		2	
Sweatshirts		2	
Tee-shirts		6*	
Thermal underwear		1	
Ties		1	
Trousers (Best)		1*	
Trousers (Leisure)		5*	
Underwear		6-9*	

*Required by DSS

Completed for: _____

Inventoried by: _____