Robert J. Kinsey Youth Center
Admissions Packet

Child s Information			
First and Last Name:			
Date of birth:	Age:	Sex:	
Current address:			
City:	State:	ZIP Code:	Phone:
Height:	Weight:	Race:	SSN:
Place of birth:			

Family Background Mother			
First and Last Name:			
Date of birth:	Age:	SSN:	
Current Address:		Marital Status:	
City:	State:	Zip Code:	Phone:
Employer:			
City:	State:	Zip Code:	
Work Hours:	Allowed to visit?		

Family Background Father			
First and Last Name:			
Date of birth:	Age:	SSN:	
Current Address:		Marital Status:	
City:	State:	Zip Code:	Phone:
Employer:			
City:	State:	Zip Code:	
Work Hours:	Allowed to visit?		

Current Allegations		
Date:	Time:	Offense:
Date:	Time:	Offense:
Date:	Time:	Offense:

Previous Referrals			
Date:	Charge:	Detention:	Disposition:
Date:	Charge:	Detention:	Disposition:
Date:	Charge:	Detention:	Disposition:

Health and Medical List All Prescribed Medications	
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Has the child been exposed to any communicable diseases: Which ones: Any other medical concern, allergies, etc.?	

Insurance Carrier:	Other:
Medicaid:	

Admissions Agreement

_____, a licensed child placement agency, does hereby request the Robert J. Kinsey Youth Center to receive care for _____.

I believe that this child poses a threat to self or others only as described below.

I further believe that this child is under the influence of drugs or non-prescription drugs only as described below. I agree if the Robert J. Kinsey Youth Center accepts this child for care that:

1. Said child shall remain in the care of the Robert J. Kinsey Youth Center for the time designated by the court.
2. Said child may be visited by approved visitors as stipulated below and under conditions stipulated by the Robert J. Kinsey Youth Center.
3. We, the undersigned, will be available for conferences regarding said child as requested by the Robert J. Kinsey Youth Center.
4. We, the undersigned, agree to provide written documentation of said child as requested by the Robert J. Kinsey Youth Center.
5. Any placing agency outside Howard County agrees to immediately remove any child whose removal is deemed appropriate and/or necessary by the Robert J. Kinsey Youth Center.
6. We, the undersigned, agree to make monthly payments, as billed, at the per diem rate for:

Emergency Shelter Care ☐ Secure Detention ☐

PER DIEM:
Shelter Care: DCS contracted rate-paid by DCS
Secure Detention $130.00

7. We, the Placing Agency agree to assume responsibility for all medical, dental and psychiatric cost, when insurance/Medicaid information is not provided by the Placing Agency.

I believe this child to be a threat to self or others: ____Yes _____No

WE MUST REQUIRE THAT YOU PROVIDE A TELEPHONE NUMBER AND PERSON WHO CAN BE CONTACTED ON A 24-HOUR BASIS

Name: _____

Title: _____

Mobile/Telephone Number: (24/hr): _____

Email Address: _____

_____Date:_____ _____Date:_____

Placement Agency Staff Signature: *Kinsey Youth Center Staff Signature:*

Authorization Form

Name of child: _____ Date:_____

Child's Signature: _____

Parent/Legal Guardian Signature: _____ Relationship: _____

Staff Signature Witness: _____ Date: _____

Consent for Medical Treatment

I, _____ parent or legal guardian of the minor, _____ do hereby give permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MEDICAL HEALTH treatment and sign an authorization on my behalf for any MEDICAL HEALTH treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

_____ _____

Parent of Guardian Signature Date:

Consent for Mental Health Treatment

I, _____ parent or legal guardian of the minor, _____, do hereby give permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MENTAL HEALTH treatment and sign an authorization on my behalf for any MENTAL HEALTH treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

_____ _____

Parent of Guardian Signature Date:

ROBERT J. KINSEY YOUTH CENTER
AUTHORIZATION FORM

Name of Child :_____ Date:_____

I authorize the Kinsey Youth Center staff to release or receive educational, medical, social and psychological information when the staff feels it serves the best interests of the above-mentioned child.

_____
Child's Signature

_____ _____
Parent/Legal Guardian Signature Relationship to Child

_____ _____
Staff Signature/Witness Date

CONSENT FOR MEDICAL AND MENTAL HEALTH TREATMENT

I, _____, parent or legal guardian of the minor, _____, do hereby give my permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MEDICAL and MENTAL HEALTH treatment and sign an authorization on my behalf for any treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

_____ _____
Parent or Guardian Signature Date

APPROVED FAMILY CONTACT

Phone:

_____ _____
Name/s Phone number

_____ _____
Name/s Phone number

Visitation:

_____ _____
Name/s Relationship

_____ _____
Name/s Relationship