Admissions Department

ADMISSION PACKET

THE WILLIAM GEORGE AGENCY

INSTRUCTIONS

1. Prior to admission, the attached forms must be completed and received by the Admissions Office. This is to ensure that accurate information is available to the staff and to emergency providers from the time of the child's arrival on campus.
2. If a CONECTIONS case is or will be open for the child's placement, please assign the case to the Agency on the day of admission. The Agency is W15 and the site is 5B0.
3. Please note that several of the consent forms require a witness. Consent forms include Release of Information from schools, physicians, and previous placements or hospitals (complete the latter only if relevant).
4. ***A copy of the child's official immunization record must be attached. This can be from the school or physician.***
5. A physical examination and a TB tine test will be administered upon admission. If either of these has been performed within the past few months, an official copy of the record may be attached.
6. Consent to administer psychotropic medication only needs to be completed if the child is already receiving this sort of medication. Otherwise, please write N/A, and initial.
7. The clothing list is supplied as a guideline for children's needs during their placement at the Agency. Please try to assemble as many of the required items as possible.

IMPORTANT

If the child is being transferred from an: *****INSTITUTIONAL SETTING***** (i.e. detention, hospital, RTF, OCFS facility, group home or other residential center), a **COPY OF THE CURRENT MEDICATION ORDER *MUST*** be supplied at the time of admission.

If it is not supplied, **medication administration may be disrupted**. In cases in which no doctor's order is readily obtainable a copy of medication administration record may be substituted.

*****Pharmacy –labeled containers by themselves are not sufficient*****

Thank you for your attention to this important matter.

Chris MacCormick
Director of Admissions

Case Manager Form

RESIDENT INFORMATION

Child's Name- First, Middle, Last			Date of Birth:
Social Security Number:		Medicaid Number:	
Primary Caretaker/Legal Guardian:		Child's Permanency Planning Goal:	
CONNECTIONS Case Name:	Case Initiation Date (CID):		Role for WGA (CP or CW)
Child's Placement Status (PINS, JD, A/N, CSE, etc.):		Term and Expiration Date of Court Orders:	

CASEMANAGER INFORMATION

Caseworker/Unit responsible for supervision of case:		Caseworker email:
Phone Number:	After Hours Number:	Fax Number:

PROBATION/LEGAL INVOLVEMENT

Is there continuing probation involvement?		Probation Officer Name:
Probation Officer Address:	Probation Officer Phone Number:	Probation Officer Fax Number:
Is there an order of restitution?		
Are any orders of protection in force with respect to the child or family:		

PREVIOUS PLACEMENTS

List Previous Placements (including hospitalizations and rehab admissions):

MOST RECENT HOME SCHOOL ATTENDED

Name of most recent home school attended:		Address of school:
Dates Attended:	Grade level achieved:	CSE Classifications if any:

LAW GUARDIAN

Name of Law Guardian:	Law Guardian email:
Address of Law Guardian:	Phone Number of Law Guardian:

Person completing form:___________________________________

Agency Name:____ **Date:**_________________________

RESIDENT INFORMATION

Child's Name- First, Middle, Last	**Sex:** ☐ Male ☐ Female	
Address: Street, City, State, Zip Code	**County:**	**Date of Birth:**

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	**Race:** ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Island

PARENT/LEGAL GUARDIAN 1

Name of Parent/Legal Guardian: Last Name, First Name	**Date of Birth:**	**Birth Place:**	**Religion:**
Mandatory Correspondence: ☐ Yes ☐ No	**Medical Consent:** ☐ Yes ☐ No	**Visiting Resource:** ☐ Yes ☐ No	
Address: Street, City, State, Zip	**Phone:**	**Cell Phone:**	**Work Phone:**
Occupation:	**Nationality:**	**Education:**	**Date of Marriage:**

PARENT/LEGAL GUARDIAN 2

Name of Parent/Legal Guardian: Last Name, First Name	**Date of Birth:**	**Birth Place:**	**Religion:**
Mandatory Correspondence: ☐ Yes ☐ No	**Medical Consent:** ☐ Yes ☐ No	**Visiting Resource:** ☐ Yes ☐ No	
Address: Street, City, State, Zip	**Phone:**	**Cell Phone:**	**Work Phone:**
Occupation:	**Nationality:**	**Education:**	**Date of Marriage:**

GRANDPARENTS (if living indicate, name address and interest in applicant)

BROTHERS AND SISTERS

Name in Full	Year of Birth	Occupation	Present Address

Others in the Home

Name in Full	Age	Relationship

Person to be Contact in Emergency if Parents are not available:

Name:	**Phone Number:**	**Relationship:**

____ __________________________

Signature of Parent/Guardian Date

Consent for Release of Information

I, _________________________, do hereby consent to and authorize The William George Agency for Children's Services to disclose to / or request from:

____

Name of Person / Facility

____

Address

____

information pertaining to ____ diagnosis, prognosis or treatment. The information to be disclosed is:

( ) Presence in treatment, prognosis, description of progress.
( ) Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge Summary.
( ) Other: ____

The information is needed for the following purpose:

( ) To provide ongoing treatment.
( ) To enable judges, attorneys, probation / parole officers, and case workers to support treatment goals or make legal decisions.
( ) To coordinate treatment efforts with family / concerned persons.
( ) Other: ____

I, the undersigned, have read the above and authorized the staff of the disclosing facility named to disclose such information herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent is a continuing disclosure which shall expire when treatment is completed. I also understand that any disclosure is bound by Office of Children & Family Services Title 18, Sections 136, 372(4) and 422(4) of the Social Services Law and Part 357 and section 423.7. Disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. It is understood that the Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. This facility is a mandated reporter.

______________________________	__________________________________
Signature of Parent/ Guardian	Witness
______________________________	__________________________________
Relationship to child	Date

Medical Release of Information

______________________________________ ______________________

Child's Name Date of Birth

I give permission for ____

(Physician or Medical Office)

Address & Zip ____

____

to release evaluations and records of treatment or any other information pertinent to

______________________________ to The William George Agency.

Child's Name

____

Signature of Parent or Guardian

____

Date

INFORMED CONSENT- RESIDENTIAL & MEDICAL TREATMENT

CONSENT & ACKNOWLEDGEMENT

NAME OF YOUTH ____

Physical Restraint Policy:

Acute physical behaviors occur in children because they are temporarily overwhelmed by very strong impulses, lack of adequate self-control, or on some level, find their behaviors acceptable. The therapeutic program of the Agency has several components designed to help the residents gain increased and acceptable controls over their behavior, and help prevent situations that may lead to the use of a restraint. Despite this, some of the youth whom we work with periodically present with aggressive, out of control behaviors which requires physical restraint by staff in order to insure their safety and the safety of others. Physical restraint is the use of staff to hold a child in order to contain acute physical behavior, and is governed by the following guidelines:

- Physical restraint is appropriate when a child is about to engage in acute physical behavior which clearly indicates intent to inflict injury upon oneself or others or is destroying property.
- Physical restraint is only used when other forms of intervention are either inappropriate or have been tried and proved unsuccessful.
- Physical restraint is never used as a punishment, and should always be the intervention of last resort.
- Physical restraint is applied in a manner that minimizes the risk of harm to the child.
- Only properly trained staff of the Agency may use physical restraint.

I have read and understand the William George Agency Physical Restraint Policy:

☐ **Yes** ☐ **No**

Resident Photographic Release

The William George Agency participates in public relations activities and develops promotional materials that help us tell our story to the community. The story and/or photographs of a William George Agency client is a powerful way to explain how the Agency helps and empowers youth to reach their potential. At times, certain activities, photos, and/or written/verbal statements by residents may be considered for the Agency's website, promotional materials (printed or video) and fundraising initiatives. Residents may participate in the opportunities if their parent/guardian has given written consent below. The resident always has the choice to participate or not. We adhere to confidentiality of residents and as such, first names are only used in publication.

I hereby consent to have my child's image and name (FIRST NAME ONLY) used for the above agreed purposes:

☐ **Yes** ☐ **No**

_______________________________ Date

_______________________________ Signature: Resident's Parent/Guardian

_______________________________ Date

_______________________________ Witness

PERSONAL REPRESENTATIVE DESIGNATION FORM

Date:____________________________________ **Child's Name:** _____________________________

In the event that there is an allegation of possible child abuse at this agency, NYS Justice Center for the Protection of People with Special Needs rules require us to allow a personal representative of the child to be present during the investigation. Personal representatives may be parent, guardian, or other persons legally responsible for the child.

Please indicate below who the personal representative will be if needed:

______________________________	______________________________	______________________________
Name	**Relationship**	**Phone Number**

______________________________	______________________________
Parent/Guardian Signature	**Date**

PROHIBITED ITEMS AND PROPERTY RESPONSIBILITY WAIVER

Incoming residents are provided with a list of needed clothing and footwear items prior to admission. The William George Agency provides all clothing and footwear items that residents need during their stay that are not present upon admission. Residents need to be mindful of what they bring. Expensive clothing and shoes are not appropriate. If residents choose to bring such items, it must be understood that they do so at their own risk. The Agency is not responsible for the replacement of any lost, stolen or damaged items. This includes –though is not all inclusive- other non clothing or footwear related items such as: games, toys, movies, personal hygiene products, musical instruments, sporting equipment, MP3 players, etc.. Historically expensive items have been problematic as they are often traded, given away or taken.

Please find a list below of prohibited items, not including illegal items or items otherwise considered contraband. While this list is not all inclusive, the following items may not be brought to the Agency. If they are present upon admission they will be mailed from the stock department to the resident's home address. If residents return from a visit with prohibited items they will also be mailed home the first time. If this is a repeated problem, the item will be held until discharge: **CELL PHONES, ANY DEVICE WITH INTERNET CAPABILITY AND ANY DEVICE WITH PICTURE TAKING OR SOUND RECORDING CAPABILITIES ARE ALL PROBHIBTED.**

By signing this form I understand that the William George Agency is not responsible to replace personal items brought to campus. In addition, I understand that if I am found to be in the possession of prohibited items they will be mailed home the first time and if they return to campus, held until discharge.

______________________________	______________________________
Parent or Guardian Signature	Date
______________________________	______________________________
Resident Signature	Date

MEDICAL CONSENT

In the admission of my child,________________________________ ______________, to

Child's Name Date of Birth

The William George Agency for Children's Services, I agree and consent for the duration of placement to allow the Agency to supply my child with medical, dental, psychiatric and psychological services as needed; said care to be provided by Agency staff, or by arrangement by outside practitioners.

The Agency agrees to inform me before arranging for hospitalization or surgery.

In the event I cannot be reached during a medical emergency, I hereby authorize the Agency to take such steps, including hospitalization or surgery, as it deems necessary.

Signatures:

________________________________ ________________________

Parent or Guardian Signature

________________________________ ________________________

Parent or Guardian Signature

____

Witness

____

Date

INFORMATION FOR PARENTS/GUARDIANS—PSYCHIATRIC CARE

Child's Name______________________________ **Date of Birth:**_______________________

Dear Parent/Guardian

At WGA we provide comprehensive mental health services. We strive to provide a high quality of care and address your child's needs appropriately. This letter serves to explain our services to you and allow you an opportunity to ask any questions based upon this information.

Many residents arrive at our facility already taking psychiatric medication. We will continue this care as well as serve any additional needs that arise for each of our residents during their time here. Our psychiatrist is on campus to provide any needed psychiatric care. In addition, we have the ability to provide psychotherapy, substance abuse counseling, suicide risk assessment and monitoring, and suicide watch, if needed. Our staff is highly trained in observing the residents for signs of mental illness and for responses to treatment. It is our goal to maximize the mental wellbeing and resilience of all our residents.

After thoroughly reviewing the records, obtaining staff observations, and evaluating a resident in person, our psychiatrist will make treatment recommendations. We use psychiatric medication in conjunction with psychotherapy and other talk-based treatments. We use psychiatric medication to treat mental disorders, such as Major Depression or Posttraumatic Stress Disorder, or to help with severe problems, such as impulsive violence, which are supported by medical evidence. We never use medications to control a child, sedate a child, or as a punishment. We always attempt to use the least amount of medication that is effective, in order to minimize the chance of side effects or over-reliance on medication. We carefully assess the benefit of medications and do not continue to prescribe medications that are not beneficial. We also monitor for side effects, including laboratory monitoring, according to established professional standards. Lastly, all children receiving psychiatric treatment will have ongoing appointments with our psychiatrist at appropriate intervals, based upon need, in accordance with professional standards.

We will obtain consent from you any time we propose to start a new medication for treatment. We will provide you with information on that treatment to help you make an informed decision about providing consent for your child. In addition, any time our psychiatrist recommends lowering a dose or stopping a medication, we will inform you in a timely manner. If you have any questions or concerns, our psychiatrist will be available to discuss the situation with you at your request.

We appreciate your willingness to work together towards helping your child.

Sincerely,

Dr. Kaufman

Consulting Psychiatrist

I acknowledge I have been provided with and have read the document entitled "Information for Parents and Guardians—Psychiatric Care." My questions about mental health care at WGA have been adequately addressed. I agree with my child receiving mental health care as outlined in this document.

____ _________________________

Parent/Guardian Signature **Date**

Child's Name________________________________ **Date of Birth:**________________________

CONSENT FOR NON-PSYCHOTROPIC MEDICATION

At the time of admission to the William George Agency for Children's Services, this child has been taking the following medication for the treatment of a routine and persistent medical condition, with my consent and understanding:

1.______________________________________ 2.___________________________________

3.______________________________________ 4.___________________________________

5.______________________________________ 6.___________________________________

I hereby give permission for continued administration of this medication.

I understand that my child's medical care will be followed by the William George Agency's medical clinic, under the supervision of Mark Glosenger, MD, Medical Director.

____ __________________________

Signature of Parent or Guardian Date

CONSENT FOR PSYCHOTROPIC MEDICATION

At the time of admission to the William George Agency for Children's Services, this child has been taking the following psychotropic medications, with my consent and understanding:

1.______________________________________ 2.__________________________________

3.______________________________________ 4.__________________________________

5.______________________________________ 6.___________________________________

I hereby give permission for the continued administration of this medication.

I understand that my child will meet with Dr. Kaufman within an appropriate and timely manner of placement, and regularly thereafter, and that I will be informed of changes in the prescription, and that my further consent will be sought if there is a change in medication.

____ _________________________

Signature of Parent or Guardian Date

Insurance

At times it becomes necessary to use the services of local physicians and/or hospitals for our residents. We utilize any health insurance under which the resident has coverage. We desire to maintain a good credit rating with the medical doctor or organization providing service to our residents. Therefore, in order that we might process payment efficiently, we require the following information and request signed insurance forms for our file to use as needed. If you cannot provide an insurance form at this time, you may be requested to do so by mail should it become necessary. In either instance, please indicate on your insurance form that payment be made to the Provider of Service.

****Copies of Primary Insurance and/or Medicaid Card MUST be attached (front and back)****

Medicaid Number: (if applicable) Include Sequence Number:		
Dental Insurance:	Company Name:	Company Address & Phone Number:
Policy Holder Name:	Policy Holder Address:	
Telephone Number:	Work Phone Number:	Cell Phone Number:
Signature:		

Medical History

Past History	Yes	Date and Details	Past History	Yes	Date and Details
Drug Allergies			Rheumatic Fever		
Food Allergies			Hay Fever, Asthma, Hives		
Other Allergies			Convulsive Seizures		
Glasses/Contacts			Sinus Trouble/Tonsillitis		
Chicken Pox			Frequent Respiratory Infections		
Measles (Rubeola)			Bone or Joint Disease or Deformity		
Rubella			Diabetes		
Whooping Cough			Frequent/Severe Headaches		
Scarlett Fever			Kidney or Bladder Disease or Enuresis		
Mumps			Liver Disease or Jaundice		
Poliomyelitis			Tuberculosis		
Pneumonia			Head Trauma		

Family History: Has any parent or sibling had the following:

Type	Yes	Relation	Type	Yes	Relation
Tuberculosis			Diabetes		
Convulsive Seizures			Alcoholism		
Cancer			Hay Fever, Asthma		
Kidney Disease			Heart Diabetes		
Blood Disease			Drug Addiction		
Mental Illness or Nervous Breakdown					

Operations, injuries or illness (including date, hospital and results):___________________________________

____

____

____

Parent/Guardian Signature

GEORGE JUNIOR REPUBLIC UNION FREE SCHOOL DISTRICT

PRIOR WRITTEN NOTICE
PROPOSED REEVALUATION AND REQUEST FOR CONSENT

Dear Legal Guardian:

The purpose of this notice is to inform you in writing, of the school district's recommendation(s) regarding the identification, evaluation, educational placement and/or the provision of special education services to your child.

SUBJECT OF THIS NOTICE:
The Committee on Special Education is proposing to conduct a reevaluation of your child.

DESCRIPTION OF ACTION PROPOSED OR REFUSED:
The Committee on Special Education is requesting consent to conduct a reevaluation to determine your child's educational needs and continuing eligibility for special education services.

EXPLANATION OF WHY THE ACTION IS PROPOSED OR REFUSED:
According to the Regulations of the Commissioner of Education, the Committee on Special Education must arrange for and appropriate reevaluation of each student recommended to receive special education at least every three years, The reevaluation will be for the purpose of determining your child's educational needs and continuing eligibility for special education.

DESCRIPTION OF EACH EVALUATION PROCEDURE, ASSESSMENT, RECORD, OR REPORT USED IN THE DECISION TO PROPOSE OR REFUSE ACTION:
We will be conduction Cognitive, Achievement and Behavioral/Emotional Assessments to obtain current levels and abilities. Student's are also screened and evaluated, if needed, in the areas or Speech/Language and Occupational Therapy.

DESCRIPTION OF THE PROPOSED INITIAL OR REEVALUATION AND THE USES TO BE MADE OF THE INFORMATION:
All students at GJR are assessed in the areas of cognitive ability, achievement levels and behavioral assessments. They are also screened for Speech & Language and Occupational Therapy needs. The information helps determine educational needs and are used to develop the student's Individualized Educational Program.

DESCRIPTION OF ANY OTHER OPTIONS CONSIDERED AND THE REASONS WHY THOSE OPTIONS WERE REJECTED:
There were no other options considered at this time.

DESCRIPTION OF OTHER FACTORS THAT ARE RELEVANT TO THE PROPOSED OR REFUSED ACTION:
There were no other factors relevant at this time.

YOU HAVE PROTECTION UNDER THE PROCEDURAL SAFEGUARDS OF THE REGULATIONS OF THE COMMISSIONER OF EDUCATION:
Previously you have received a Procedural Safeguards Notice that explains your rights regarding the special education process, but if you need and additional copy, please contact Marie Moore, CSE Secretary, (607) 844-6367. Moorem@gjrmail.com.

SOURCES YOU MAY CONTACT TO OBTAIN ASSISTANCE IN UNDERSTANDING THE SPECIAL EDUCATION PROCESS:

- Mary Converse, CSE Chairperson, (607) 844-6317 – Conversem@gjrmail.com
- Center on Human Policy, Law and Disability Studies
  Syracuse University, 805 South Crouse Avenue, Syracuse, New York, 13244, (877) 824-9555

ADDITIONAL INFORMATION RELATED TO THE SUBJECT OF THE NOTICE:
Your written consent to the proposed reevaluation is requested; please sign the provided consent form.

You may also submit evaluation information which will be considered by the Committee as part of the reevaluation.

When the evaluation is completed, you will have the opportunity to discuss the test results and meet with the Committee on Special Education. You will receive a written notice of the date, time and location of the Committee meeting and we encourage your attendance.

You have the right to address the Committee, either in person or in writing, on the appropriateness of the Committee's recommendations. If you have any questions or would like to request a meeting to further discuss information contained in this notice, please contact Mary Converse, CSE Chairperson, (607) 844-6317.

Sincerely,

Mary Converse, CSE Chairperson

GEORGE JUNIOR REPUBLIC UNION FREE SCHOOL DISTRICT

24 McDonald Road

Freeville, New York 13068

District Office:

Phone: 607-844-6300

Fax: 607-844-3410

School Office:

Phone: 607-844-6365

REQUEST FOR CONSENT TO EVALUATE

All children being admitted to the William George Agency for Children's Services are evaluated. This evaluation will be reviewed by either an Educational Planning Committee or the Committee on Special Education. This ensures appropriate educational programming. Student who are already classified and receive Special Educational Services or that already have an Educational Plan may also need reevaluation or a Functional Behavioral Assessment. Parents are welcome to call the school office with questions or concerns about the evaluation process, the categories of special education services, or the school curriculum.

I have received Prior Written Notice for evaluation or re-evaluation. I hereby grant permission for my child ____________________________ to be evaluated as needed or as appropriate.

(Student Name)

____ ________________________

Parent or Guardian's Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Permission is hereby given to The George Junior Republic Union Free School District to receive and/or release information to and/or from the William George Agency for Children's Services, Inc, 380 Freeville Road, Freeville, New York 13068.

Student:________________________________ Grade Last Attended:______________

Date of Birth: ___________________________ Graduation Year:_________________

Please send a copy of the following:

________ Transcript Grades

________ Achievement Test Scores

________ Psychological Reports

________ Health Record Information including Immunizations

________ Other:__________________________

________ Attendance Record

________ Withdrawal Grades

________ IEP

____ ________________________

Signature of Parent/Legal Guardian Date

Please send records to: The George Junior Republic UFSD, 24 McDonald Road, Freeville, NY 13068

THE WILLIAM GEORGE AGENCY

Care First

RESIDENTIAL CARE FOR YOUTH & YOUNG ADULTS

Authorization for Release of Information

George Junior Republic
Union Free School District
Guidance Office
24 McDonald Road
Freeville, NY 13068
Phone: (607) 844-6365 **Fax:** (607) 844-3410

Authorization for Release of Information

Please send records to:

School Name: George Junior Republic Union Free School District
Street Address: 24 McDonald Road
City/Town: Freeville, NY 13068
Attention: Grace Benware, Guidance Counselor

Permission is hereby given to George Junior Republic Union Free School District to receive and/or release information regarding:

Student Name:____ **Grade Last Attended:**________________

Date of Birth:___________________________________ **Graduation Year:**_________________ (if applicable)

Please send a copy of the following:

__X__ Transcript Grades
__X__ Achievement Test Scores
__X__ IEP and any other pertinent information
__X__ Psychological Reports and any other pertinent information
__X__ Health Record Information including Immunizations
__X__ **Other**:____
__X__ Attendance Records
__X__ Withdrawal Grades

____ ________________________

Signature of Legal Parent/Guardian or Self **Date**

George Junior Republic
Union Free School District
Guidance Office
24 McDonald Road
Freeville, New York 13068
Phone: (607) 844-6365
Fax: (607) 844-3410

AUTHORIZATION FOR RELEASE OF INFORMATION

Permission is hereby given to The George Junior Republic Union Free School District to receive and/or release information to and/or from

County/OCFS with placement custody:____

Regarding:

Student:____ Grade Last Attended:_____________
Date of Birth:_______________________________________ Graduation Year:__________________

Please send a copy of the following:

________ Transcript Grades
________ Achievement Test Scores
________ Psychological Reports
________ Health Record Information including Immunizations
________ Other:____
_________ Attendance Record
_________ Withdrawal Grades
_________ IEP

____ ___________________________
Signature of Parent/Legal Guardian or Self Date

Please send records to: The George Junior Republic UFSD
24 McDonald Road
Freeville, New York 13068
Attention: Grace Benware, Guidance Counselor

THE WILLIAM GEORGE AGENCY
Care First
RESIDENTIAL CARE FOR YOUTH & YOUNG ADULTS

PESTICIDE NOTIFICATION

New York State Education Law Section 409-H, effective, July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The School District is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are **not** subject to prior notification requirements:

- A school remains unoccupied for a continuous 72-hours following an application;
- Anti-microbial products;
- Nonvolatile rodenticides in tamper restraint bait stations in areas inaccessible to children;
- Nonvolatile insecticidal baits in tamper resistant bait stations in areas inaccessible to children;
- Silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children;
- Boric acid and disodium octaborate tetrahydrate;
- The application of EPA designated biopesticides;
- The application of EPA designated exempt materials under 40CFR152.25;
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please obtain a "**Request for Pesticide Application Notification**" form from the Admissions Office, complete the form and return it to the School District pesticide representative:

Pat Foote, Director of Buildings & Grounds
William George Agency for Children's Services
380 Freeville Road
Freeville, NY 13068

Telephone: (607) 844-6262
Fax: (607) 844-5048
Email: footep@gjrmail.com

REQUEST FOR PESTICIDE APPLICATION NOTIFICATION

Name of School Building:
Name:
Address:
Email Address:
Day Phone Number:
Evening Phone Number:

For further information on these requirements please feel free to contact Pat Foote, School District Pesticide Representative.

BOYS INVENTORY LIST FOR NEW ADMISSIONS

General Wear

Item		Quantity
Dress Pants	____________	1
Dungarees (Jeans)	____________	6
Dress Shirts	____________	1
Short Sleeve Shirts	____________	6
Long Sleeve Shirts	____________	3
Sweater	____________	1
Heavy Socks	____________	2 prs.
Undershorts	____________	8
Undershirts	____________	3
Socks	____________	10 prs.

Nightwear

Item		Quantity
Winter Pajamas	____________	1
Summer Pajamas	____________	1
Bathrobe	____________	1

Gym and Recreation

Item		Quantity
Bathing Trunks	____________	1
Shorts – Summer	____________	4
Gym Shorts	____________	1
Sweatshirt	____________	2
Sweatpants	____________	1

Outer Clothing

Item		Quantity
Heavy Winter Jacket	____________	1
Warm Cap or Hat	____________	1
Warm Gloves	____________	1
Rain slicker with hood	____________	1
Lightweight Jacket	____________	1
Summer Cap	____________	1

Footwear

Item		Quantity
House Slippers	____________	1pr.
Dress Shoes	____________	1 pr.
Sneakers	____________	2 prs.
Winter Boots	____________	1 pr.

Accessories

Item		Quantity
Belt	____________	1

Miscellaneous

Item		Quantity
Shampoo	____________	1
Hairbrush/Comb	____________	1
Nail Clippers	____________	1
Face soap & Holder	____________	1
Hygiene Kit Bag	____________	1
Shaving Cream	____________	1
Disposable Razors	____________	1 pk.
Toothbrush & Holder	____________	1
Toothpaste	____________	1
Deodorant *(NO SPRAY CAN)*	____________	1
Suitcase or Duffle Bag	____________	1

Every item of clothing should be clearly marked with the child's name or 3 initials. Although the staff of The William George Agency for Children's Services will work with your child and other children in residence to help them respect the property of others, we cannot accept responsibility for the loss or damage of personal possessions. At special high risk are items such as radios, tape recorders, stereos, other electronic equipment, and jewelry. We strongly recommend that expensive jewelry, such as gold chains and rings, irreplaceable items, and objects which have sentimental value, not be brought to the Agency. Thank you for your cooperation.

Adolescent Chemical Dependency Program

Licensed By:

Office of Alcoholism and Substance Abuse Services (OASAS)

Your child is being referred to the adolescent chemical dependency program at The William George Agency for Children's Service. We look forward to working with you during your child's treatment. The following pages are consent forms that require a signature for your child to receive the proper treatment.

AOB- This form is required for The William George Agency for Children's Services to ensure insurance verification

Confidentiality Notice- This form is to ensure the privacy of the resident and who will have access to their treatment

Service to Minors- This is to allow the adolescent chemical dependency program to treat the resident

Consent for release of information concerning alcoholism/drug abuse patient:

Placing Agency- This form is required for The William George Agency for Children's Services to communicate with the resident's current placing agency

Medlab Incorporated- This form is required for The William George Agency for Children's Services to process urine screen samples for routine drug screens

The William George Agency for Children's Services- This form is require for the adolescent chemical dependency program to communicate with The William George Agency for Children's Services

Parent/Guardian- This form is required for The William George Agency for Children's Service to communicate with the resident's parent/guardian

Blank- This form is a blank form to release information to another facility and/or person in the event that information is needed

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OASAS Confidentiality Notice

THIS NOTICE DESCRIBES HOW MEDICAL, DRUG, AND ALCOHOL RELATED
INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMAITON.
PLEASE REVIEW IT CAREFULLY.

General Information

Information about our treatment and care, including payment for care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the Confidentiality Law **. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;

2. Pursuant to an agreement with a business associate (e.g. clinical laboratories, pharmacy, record storage services, billing services);

3. For research, audit, or evaluations (e.g. state licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illness as required by state law;
8. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking consents to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with the organization. Such a violation may result in legal consequences for you.)

*42 U.S.C. § 130d et. Seq., 45 C.F.R. Parts 160
& 1645 **42 U.S.C. § 290dd-2, 42 C.F.R. Part 2

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures for your health related information made by the program during the six (6) years prior to your request.

If your request to any of the above is denied, you have the right to request a review of the denial by the program administrator.

To make any of the above requests, you must fill out the appropriate form that will be provided by the program.

You also have the right to receive a paper copy of this notice.
The Use of Your Information at the Program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

Communication among program staff (including students or other interns) for the purpose of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning , and other treatment processes.

Communication with business associates such as clinical laboratories (blood work, urine analysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy), and long term record storage.

Reporting data to the NYS OASAS Client Data System.

<u>The Program's Duties</u>

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

<u>Complaints and Reporting Violations</u>

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint Form and submit the form to the director of the Adolescent Chemical Dependency Program.

The complaint will be reviewed by an appropriate individual, based on the nature of the complaint. That individual will complete the Privacy Complain Resolution form.

The patient may also register a complaint with the Office for Civil Rights.

Office for Civil Rights
US Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza-Suite 3313
New York, NY 10278

(212) 264-3313 phone
(212) 264-3039 fax
(212) 264-2355 TDD
(800) 368-1019 OCR Hotline

Receipt of Confidentiality Notice

You will not be retaliated against for filing such a compliant.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

I, ______________________________, have received a copy of the Confidentiality Notice and it has been explained to me.

_______________________________________ ___ | _________________________
Signature | Date

____
Relationship

____ | __________________________
Witness | Date

Authorization for Service to Minors

I, _______________________________, herby authorize the VanClef Outpatient Chemical Dependency Program at The William George Agency for Children's Services, Inc. to render professional services to

____.

____ | __________________________
Signature | Date

____
Relationship

____ | __________________________
Witness | Date

Assignment of Benefits

PATIENT INFORMATION:

Name:____ SS#:______________________________
Address: ____ Date of Birth_______________________
City: _______________State: _________Zip Code:_____________ Sex: ☐ Male ☐ Female
Phone: ____

PRIMARY INSURANCE INFORMATION:

Insurance Company: ___________________________________ Policy Holder:_____________________
☐ POS ☐ HMO ☐ PPO SS#: _______________________________

Address: ____ Relationship to Patient:
City: _______________State: _________Zip Code:_____________ ☐ Child ☐ Spouse ☐ Other
Phone: ____
Policy No:____
Group No.: ____

SECONDARY INSURANCE INFORMATION:

Insurance Company: ___________________________________ Policy Holder: ___________________
☐ POS ☐ HMO ☐ PPO SS#: _______________________________

Address: ____ Relationship to Patient:
City: _______________State: _________Zip Code:_____________ ☐ Child ☐ Spouse ☐ Other
Phone: ____
Policy No:____
Group No.: ____

I authorize payment of my medical benefits directly to The William George Agency for the service described in the attached insurance claim form. I understand that I am responsible to provide updated insurance information and to send all related correspondence (including explanation of benefits) to The William George Agency. In the event that The William George Agency submits a claim on my behalf, and the reimbursement check comes directly to me, I will sign it and endorse the back to read " pay to the order of the William George Agency" and mail the check and the related correspondence (including any explanation of benefits) to The William George Agency (address above) within five (5) working days. I authorize The William George Agency to release any medical information held about me that is needed to determine benefits or process claims for reimbursement.

I understand that my alcohol and /or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160&164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon discharge from the William George Agency and when all billing claims are filed and processed.

I understand that generally treatment may be denied if I do not sign a consent form.

Primary Policy Holder Signature: ____ **Date:** ____________

Secondary Policy Holder Signature: _______________________________________ **Date:** ____________

Patient Signature: ____ **Date:** ____________

*****IF YOU HAVE MEDICAID CHECK AND SIGN HERE ☐** ____

Concerning Alcoholism/Drug Abuse Patient

REVOKED ON ______________ STAFF SIGNATURE__________________

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		

GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's case Record. If this form is used **Instructions:** for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency With a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/[RELEASE] WITH PATIENT'S CONSENT

(Circle)

1. EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

- Presence in treatment, prognosis, brief description of progress or occurrence of relapse.
- Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge summary.
- Other ____

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

- To provide ongoing treatment and coordination of service with other appropriate people of The William George Agency for Children's Services.
- To obtain insurance, employment or government benefits.

To enable judges, attorneys, probation/Parole officers to support treatment goals or make legal decision on my behalf.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
BETWEEN: **The William George Agency For Children's Services** Adolescent Chemical Dependency Program 380 Freeville Road, Freeville, NY 13068	And:

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: <u>This consent is a continuing disclosure which shall expire when treatment is completed and all billing claims are filed and processed.</u>

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_______________________________ (Signature of Patient)

_______________________________ (Signature of Parent/Guardian, when required)

_______________________________ (Print Name of Patient)

_______________________________ (Print Name of Parent/Guardian)

_______________________________ (Signature of Witness)

_______________________________ (Print Name of Witness)

_______________________________ (Date)

_______________________________ (Date)

Concerning Alcoholism/Drug Abuse Patient

REVOKED ON ______________ STAFF SIGNATURE __________________

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		

Instructions: **GIVE A COPY OF THE FORM TO THE PATIENT**! Prepare one (1) copy for the Patient's case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency With a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/[RELEASE] WITH PATIENT'S CONSENT

(Circle)

2. EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

- Presence in treatment, prognosis, brief description of progress or occurrence of relapse.
- Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge summary.
- Other ____

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

- To provide ongoing treatment and coordination of service with other appropriate people of The William George Agency for Children's Services.
- To obtain insurance, employment or government benefits.

To enable judges, attorneys, probation/Parole officers to support treatment goals or make legal decision on my behalf.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
BETWEEN: **The William George Agency For Children's Services** Adolescent Chemical Dependency Program 380 Freeville Road, Freeville, NY 13068	And: **The William George Agency for Children's Services** **380 Freeville Road, Freeville, NY 13068**

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: <u>This consent is a continuing disclosure which shall expire when treatment is completed and all billing claims are filed and processed.</u>

> **NOTE:** Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

______________________________ (Signature of Patient)

______________________________ (Signature of Parent/Guardian, when required)

______________________________ (Print Name of Patient)

______________________________ (Print Name of Parent/Guardian)

______________________________ (Signature of Witness)

______________________________ (Print Name of Witness)

______________________ (Date)

______________________ (Date)

THE WILLIAM GEORGE AGENCY

Care First

RESIDENTIAL CARE FOR YOUTH & YOUNG ADULTS

REVOKED ON ____________ STAFF SIGNATURE________________

Concerning Alcoholism/Drug Abuse Patient

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		

Instructions: **GIVE A COPY OF THE FORM TO THE PATIENT**! Prepare one (1) copy for the Patient's case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency With a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/[RELEASE] WITH PATIENT'S CONSENT

(Circle)

3. EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

- Presence in treatment, prognosis, brief description of progress or occurrence of relapse.
- Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge summary.
- Other ____

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

- To provide ongoing treatment and coordination of service with other appropriate people of The William George Agency for Children's Services.
- To obtain insurance, employment or government benefits.

To enable judges, attorneys, probation/Parole officers to support treatment goals or make legal decision on my behalf.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
BETWEEN: **The William George Agency For Children's Services** Adolescent Chemical Dependency Program 380 Freeville Road, Freeville, NY 13068	And: **(Parent/Guardian)**

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: <u>This consent is a continuing disclosure which shall expire when treatment is completed and all billing claims are filed and processed.</u>

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Signature of Witness)	(Print Name of Witness)
(Date)	(Date)

REVOKED ON ______________ STAFF SIGNATURE__________________

Concerning Alcoholism/Drug Abuse Patient

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		

GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's case Record. If this form is used **Instructions:** for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency With a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/[RELEASE] WITH PATIENT'S CONSENT

(Circle)

4. EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

- Presence in treatment, prognosis, brief description of progress or occurrence of relapse.
- Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge summary.
- Other ____

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

- To provide ongoing treatment and coordination of service with other appropriate people of The William George Agency for Children's Services.
- To obtain insurance, employment or government benefits.

To enable judges, attorneys, probation/Parole officers to support treatment goals or make legal decision on my behalf.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
BETWEEN: **The William George Agency For Children's Services** Adolescent Chemical Dependency Program 380 Freeville Road, Freeville, NY 13068	And: **(Placing Agency)**

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: <u>This consent is a continuing disclosure which shall expire when treatment is completed and all billing claims are filed and processed.</u>

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

______________________________ (Signature of Patient)

______________________________ (Signature of Parent/Guardian, when required)

______________________________ (Print Name of Patient)

______________________________ (Print Name of Parent/Guardian)

______________________________ (Signature of Witness)

______________________________ (Print Name of Witness)

____________________ (Date)

____________________ (Date)

REVOKED ON ______________ STAFF SIGNATURE__________________

Concerning Alcoholism/Drug Abuse Patient

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		

GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's case Record. If this form is used **Instructions:** for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency With a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/[RELEASE] WITH PATIENT'S CONSENT

(Circle)

5. EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

- Presence in treatment, prognosis, brief description of progress or occurrence of relapse.
- Medical history and physical, Intake Sheet, Treatment Plan, Aftercare Plan, Discharge summary.
- Other ____

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

- To provide ongoing treatment and coordination of service with other appropriate people of The William George Agency for Children's Services.
- To obtain insurance, employment or government benefits.

To enable judges, attorneys, probation/Parole officers to support treatment goals or make legal decision on my behalf.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
BETWEEN: **The William George Agency For Children's Services** Adolescent Chemical Dependency Program 380 Freeville Road, Freeville, NY 13068	And: **Medlab Incorporated**

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: <u>This consent is a continuing disclosure which shall expire when treatment is completed and all billing claims are filed and processed.</u>

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Signature of Witness)	(Print Name of Witness)
(Date)	(Date)

Concerning Alcoholism/Drug Abuse Patient

REVOKED ON ______________ STAFF SIGNATURE__________________

INSTRUCTIONS:
GIVE A COPY OF THIS FORM TO PATIENT! Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S LAST NAME	FIRST NAME	MI
CASE NUMBER		
Facility	Unit	

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED
All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATION DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigation or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

NOTE
Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

______________________________	______________________________
(Signature of Patient)	(Signature of Parent/Guardian)
______________________________	______________________________
(Print Name of Patient)	(Print Name of Parent/Guardian)
______________________________	______________________________
(Date)	(Date)

Vaccination Information

Dear Parent or Guardian,

At the direction of our Medical Director, Mark Glosenger, MD, all children in our residential program will receive vaccines recommended by the CDC (Center for Disease Control) and the APP (American Academy of Pediatrics). These Vaccines include but are not limited to annual Influenza, Human Papilloma Virus (HPV), and Meningococcal vaccines.

If you are not in agreement with this program, you must notify us in writing within 30 days.

Sincerely,

Mary Manicnelli, RN
Nursing Supervisor, Medical Clinic

Meningococcal Disease

To Whom It May Concern:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) §2167 requiring residential schools to distribute information about meningococcal disease and vaccination to all students in grades 7-12. This law becomes effective on August 15, 2003.

The George Junior Republic UFSD is required to maintain a record of the following for each student:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the student's parent or guardian (or the student if he is 18 years of age or older); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years: OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the student's parent or guardian (or the student if he is 18 years of age or older).

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Please make sure that you complete and return the enclosed Meningococcal Meningitis Response Form within 30 days of the beginning of the Fall 2003 Semester. Please note that according to NYS Public Health Law 2167, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law. (The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.)

To learn more about meningitis and the vaccine, please see the enclosed Meningococcal Meningitis Fact Sheet, consult with your health care provider, or contact the Medical Clinic at GJR. Information on the availability and cost of meningococcal meningitis vaccine (Menomune ™) is available from your local county health department. You may also find information about the disease at the New York State Department of Health Website: WWW.HEALTH.STATE.NY.US or Website of the Centers for Disease Control and Prevention (CDC): WWW.CDC.GOV/NCIDOD/DBMD/DISEASE INFO.

Sincerely,

Mark Glosenger, MD
Medical Director
Enclosures NYSPHL§2167

Meningococcal Disease Information

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) cuase by the meningococcus germ.

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of Meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

How is the meningococcus germ spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treatment?

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (either rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis?

In February 2005 the CDC recommended a new vaccine, known as Menactra™ for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™ is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Is the vaccine safe? Are there adverse side effects to the vaccine?

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world.

What is the duration of protection from the vaccine?

Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

How do I get more information about meningococcal disease and vaccination?

Contact your physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncidod/diseases/index.htm; and the American College Health Association, www.acha.org.

Information taken from the New York State Department of Health (Revised: July 2005)