

Hope Hill Children's Home Admissions Information

Thank you for choosing Hope Hill Children's Home. Please read and complete the following forms prior to admission. If you have any questions about these forms please contact us at 859-498-5230.

Below you will find a list of requirements for admission and enrollment into school.

At admission we must have at least:

- Commitment order
- Signed 114
- Permission to seek medical treatment form
- Medical card.

No admission will be done without these documents unless an exception is granted by the Hope Hill Children's Home Director.

Clothing:

Hope Hill will provide necessary daily clothing. Only the items listed on the optional clothing list will be permitted (see attached sheet) Please do not bring any other clothing items due to our limited storage space.

Medication:

Please provide a two week supply of any medications or a written prescription from the child's doctor at admission.

Before enrollment to School we must have the following:

- If at all possible – an Educational Passport
- Grade, Last school attended: city, county, state
- Birthplace & mother's maiden name
- County student resided in before coming to Hope Hill
- Copy of birth certificate & Social Security Card
- Immunization records
- Any academic or testing records available

Included in this packet you will find:

1. Notice of Privacy Practices (2pages)
2. Notice of Privacy Practices Record of Acknowledgments
3. Authorizations / Consents Form
4. Authorization for Release of Information
5. Educational Passport
6. Emergency Contact Information
7. Clothing List
8. Directions

Please be sure to return the appropriate forms upon admission.

Educational Passport

** This form is for the purpose of enrolling the student in school and is to be completed by the school/ facility from which the student is leaving. This form is mandated by KRS 158.137 and KRS 605.110(3)(e) and shall be presented to the receiving school or educational facility within two (2) days of enrollment. Information contained on this Passport is subject to confidentiality laws **

Student Name: _____ Student ID#: _____

Birth Date: _____ Grade: _____ Total Credits Earned To Date: _____

Transferring School: _____

(Include District Name) _____

Phone: _____ FAX: _____

Total Days Enrolled At Transferring School: _____

Emergency Contact's Address: _____

Phone: _____ Relationship to Student: _____

RECORDS (Please indicate if the following are in the student's school record)

Physical Exam	Yes	No
Immunization Certificate	Yes	No
Expiration Date:		
Tuberculin Skin Test	Yes	No
Birth Certificate	Yes	No
Social Security Card	Yes	No
Psychological Evaluation	Yes	No
Graduation Plan/ Transition Plan	Yes	No
Vocational Test	Yes	No
Achievement Test	Yes	No
CTBS Results	Yes	No
C.A.T.S. Results	Yes	No
Portfolio	Yes	No
Specific Health Needs	Yes	No
Specific Medications	Yes	No

I.E.P.	Yes	No
504 Plan	Yes	No
Official Transcript Record	Yes	No
Current Report Card	Yes	No
Current Classes	Withdrawal Date	
Specific Safety Issue(s):	Yes	No

Person Providing Information: _____

Date: _____

Signature of School Official: _____

**Hope Hill Children's Home
Resident Emergency Contact Information**

Youth Name: _____ SSN: _____

DJJ/ DCBS Worker: _____

Address: _____

Work Phone: _____ Home Phone: _____

On Call Pager Number: _____

Supervisor: _____

Work Phone: _____ Home Phone: _____

Parent/ Gaurdian: _____

Address: _____

Home Phone: _____ Work Phone: _____

**Hope Hill Children's Home
700 Hope Hill Road
Hope, KY 40334
Office: 859-498-5230
Fax: 859-498-2606**

Susan Orme

Ext. 24
Home: 859-498-5641
Cell: 859-274-2022

Ken Cude

Ext. 18
Home: 606-663-4467
Cell: 859-274-5696

Sandi Hamilton

Ext. 35
Cell: 606-776-3856

Elvis Alicea

Ext. 14
Cell: 859-274-2021

Eric Williams

Ext. 12
Cell: 859-585-0128

Connie Adkins

Ext. 17
Cell: 606-776-4381

Aimee Ralph

Ext. 30

Marleana Layne

Ext. 31
Cell: 859-497-2114

John Walker

Ext. 13
Home: 606-784-2915
Cell: 859-274-2023

Aaron Cude

Ext. 12
Cell: 312-307-5320

Hope Hill Children's Home
Admissions Clothing List

Hope Hill Children's Home will provide the youth with clothing. Please limit clothes brought into our facility to one outfit for going to town or court and one outfit if the youth would like to attend church. If the youth does not have a good outfit we will purchase one for them. Please do not bring jewelry or other personal items other than scrapbooks. For other exceptions please follow up with the case manager.

Other Clothing:

The youth are allowed to bring their own socks and underwear (no thongs), all bras must be sport bras without wires, house shoes with no back or heel and seasonal appropriate pajamas. If the youth does not have any of the items mentioned Hope Hill Children's Home will provide them.

**Hope Hill Children's Home
Authorizations / Consent**

In regards to _____, I agree to comply with all authorizations/ consents detailed below.
(Name of Youth)

Intake: I understand the during care at Family Connection, Inc. a 501 (c) 3 corporation dba Hope Hill Children's Home and /or Triple L Youth Center, (hereafter FCI), every reasonable precaution will be taken to insure her safety, security, well-being, and prevention of injury. I release FCI of all liability in the event of accident or injury. In the case of illness or injury, I authorize the medical treatment of the youth in the care of FCI.

While at FCI, this youth may be involved in program activities both inside and outside of the county of residence. I authorize her to participate in the activities and authorize FCI to transport her to said activities. Out of state transportation will be covered on a case by case basis.

Media: Appropriate anonymous case references, pictures and video recordings may be made for public relations. I authorize respectful and responsible use of any and all media for public relations purposes, provided the actual names are not used.

Work and Transportation: I authorize the youth to hold employment while at FCI and for her to be transported to and from the job site. Transportation will be facilitated by FCI staff only.

Drug/ Alcohol Screens: I authorize staff at FCI to perform random drug/ alcohol screens for said youth. I understand that I/my agency will be responsible for costs involved with such screening.

Personal Property: I understand that all personal belongings brought with the youth to our program are the sole responsibility of that youth. FCI will not be held liable for damage or loss of said items during care. Due to storage limitations, in the case of discharge, arrangements will be made within 72hrs for the removal of such items. After 72hrs, any unclaimed items will become property of FCI and used for charitable ends.

FCI Property: I understand that damage to FCI property by youth during care will be reported and restitution will be sought. I understand that I/my agency may be held liable for such damages.

Communicable Diseases: I affirm that the youth has not been exposed to any communicable diseases, three weeks prior to admittance to FCI.

Medical: I authorize any and all medical information pertinent to the treatment and health and safety of placed youth to be exchanged between designated FCI medical providers and FCI staff.

Youth Empowerment Program: Is designed to empower youth in an individualized manner through their life experiences and talents. This program is designed to provide the adolescent with skills necessary to succeed both in placement and in life.

Safe Crisis Management (SCM): is a therapeutic behavior management technique that is based on passive restraint. SCM shall be administered as an emergency, temporary intervention to be used after progressive discipline approaches and verbal and non-verbal de-escalation techniques have been attempted and proven ineffective. SCM ceases as soon as the youth has regained control. Therapeutic holds are designed to restrict the movement of limbs and body to effectively prevent the youth from causing injury to self or others, extensive property damage, or a continued disruption of the milieu. I understand that by placing this youth in a Family Connection agency, I am consenting to the use of SCM as described here.

Video Recording for Clinical or Training Purposes: Video recording of said youth for clinical review, training and/or treatment purposes is permitted. These recordings are not to be used for public relations or made available for public viewing. These recordings will be destroyed after the use for which they were recorded is complete. No tape of this type will be maintained for an extended period of time beyond the stated purpose of the recording without my express written permission.

Residents Name: _____ **Date:** _____

Signature of Parent/ Guardian/ Placing Agent: _____

Witness's Signature: _____

Hope Hill Children's Home
Authorization for Release of Information

TO: _____
(organization name)

FROM: **Hope Hill Children's Home**

Youth's Name	SSN	Date of Birth
Street Address, City, State, ZIP		Phone #

I freely authorize _____
(Person/Facility to disclose information)

to release/ exchange with _____
(Person/ Organization to receive information)

the following information: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Admission to treatment | <input type="checkbox"/> Legal History |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Medical History/ Physical |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Recovery Plan | <input type="checkbox"/> Education Testing/ Grades |
| <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> Progress Notes/ Reports |
| <input type="checkbox"/> Substance Abuse Evaluations/
Recommendations | <input type="checkbox"/> Other (specify): _____ |

The purpose/ need for disclosure is:

- | | |
|--|---|
| <input type="checkbox"/> Comply with Court Order | <input type="checkbox"/> Determine needs and Services |
| <input type="checkbox"/> Pending Court Case | <input type="checkbox"/> Discharge Planning |
| <input type="checkbox"/> Determine Progress in Treatment | |
| <input type="checkbox"/> Other (specify): _____ | |

I understand that my records are protected and cannot be disclosed without my written consent or by specific order of the Court. This authorization may be revoked in writing any time BEFORE the release of the above information. This release is limited to the person/ organization named above and will not be used for any other purpose then specified. This authorization will automatically expire 60 days after the date of my signature.

Resident's Signature	Date
Witness Signature	Date
Parent / Guardian (for youth under 18 yrs.)	Date

FAMILY CONNECTION, INC.
Hope Hill Children's Home Triple L Youth Ranch
NOTICE OF PRIVACY PRACTICES

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment or services you receive is considered *protected health information* (PHI). As such, we are required to provide you with this *Privacy Notice* that contains information regarding our privacy practices that explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice in the main lobby. You also may request and obtain a copy of any new/revised Privacy Notice from the business office.

Should you have questions concerning our Privacy Notices, the names, addresses, telephone numbers, website addresses, etc., of whom you should contact are listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of treatment, payment, or for the operations of our facility. For other uses, your guardian must give us written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond treatment, payment and operations purposes, we are required to have your written authorization, except as permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. The name, address, telephone number of the person to contact is located on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/or our *Revocation of an Authorization* form to submit your request to us. Copies of these forms are available in the business office.

IV. Uses or Disclosures of Information Based Upon Your/Guardian's Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may

only inform the person that you suffered an apparent heart attack, stroke, etc., and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

1. When Required by Law
2. For Health Oversight Activities
3. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks
4. To Avert a Serious Threat to Health or Safety

VI. Your/Guardian's Right Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

1. To Request Restrictions on Uses and Disclosures of Your Protected Health Information
2. The Right to Inspect and Copy Your Medical and Billing Records
3. The Right to Amend or Correct Your Health Information
4. The Right to Request Confidential Communications
5. The Right to Request an Accounting of Disclosures of Protected Health Information
6. The Right to Receive a Paper Copy of This Notice

VI. How to File a Complaint About Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

The name, address, and telephone number of the person to whom you may file your complaint is listed on the last page of this document. You may submit your complaint on our *Privacy Practices Complaint* form. Copies of these forms are available in the business office.

NOTICE OF PRIVACY PRACTICES

Record of Acknowledgements

Name of Resident: _____ Date: _____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this *Privacy Notice* is _____.

Changes or Revisions to our Privacy Notice

We reserve the right to change our facility's *Privacy Notice* at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice*, we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new/revised *Privacy Notice* from the business office or download a copy from our website (as applicable).

[] Our *Privacy Notice* was revised on _____. [] No changes since the effective date listed above.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our facility's privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our facility's privacy practices, please contact:

Name of Person to Contact

Address

Telephone Number

Fax Number

Website Address (as applicable)

YOU MAY ALSO FILE COMPLAINTS WITH:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free 1-877-696-6775

Acknowledgement

I certify that I received a copy of this facility's *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

Date: _____ My Signature: _____
My Printed Name: _____
Date: _____ Signature of Witness: _____

I certify that I am the authorized representative of _____, and that I have received the *Privacy Notice* on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date: _____ Signature of Representative: _____
Printed Name: _____
Relationship to Individual: _____
Date: _____ Signature of Witness: _____

A copy of this document must be provided to the person to whom the *Privacy Notice* was provided and a copy must be filed in the medical record.

Directions to Hope Hill Children's Home

From Lexington:

Take 1-64 East to Exit 113, which is the second Mt. Sterling exit. Take a right off the exit onto Rt.60. Go to the first stoplight and turn left on Rt. 686. Go straight for about 1 ½ miles. *You will go through a stoplight and you will pass Mt. Sterling Elementary on your left* Turn left onto Rt.713. There are signs as you turn that say Hope Hill Children's Home. Stay on Rt. 713 for about 9 miles. Turn right just before the Hope First Church of God. There is a banner across the road as you are driving up the hill. Go up the hill to the Faris Building. This is the two-story building in the middle of campus with columns. Faris Building sign is out front.

From Ashland:

Take 1-64 West to Exit 113, which is the first Mt. Sterling exit. Take a left off the exit onto Rt. 60. Go to the first stoplight and turn left on Rt. 686. Go straight for about 1 ½ miles. *You will go through a stoplight and you will pass Mt. Sterling Elementary on your left.* Turn left onto Rt.713. There are signs as you turn that say Hope Hill Children's Home. Stay on Rt. 713 for about 9 miles. Turn right just before the Hope First Church of God. There is a banner across the road as you are driving up the hill. Go up the hill to the Faris Building. This is the two-story building in the middle of campus with columns. Faris Building sign is out front

From Mountain Parkway:

Take Mountain Parkway north to Stanton. Take Exit 22. Take right off exit. You will be on Rt.213. Stay on this road from approximately 10 miles. When the road comes to a "T" take a left onto Rt. 460 and then an immediate right back onto Rt. 213. This road is also called *Bedford Road*. Stay on this road for approximately 4 miles. When this road comes to a "T" take a right onto Rt. 713. *The Antioch church will be on your right.* Stay on this road for approximately 3 ½ miles. Turn right just before the Hope First Church of God. There is a banner across the road as you are driving up the hill. Go up the hill to the Faris Building. This is the two-story building in the middle of campus with columns. Faris Building sign is out front.