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President & CEO

INTAKE PACKAGE INFORMATION

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO OR AT THE TIME OF ADMISSION

- Consents for child's routine medical and dental care (must be signed by parents / guardians)
- Health Services Package (to be completed by parents / guardians)
- Consent for release of information (must be signed by parents / guardians)
- Authorizations

ADDITIONAL INFORMATION NEEDED AT THE TIME OF PLACEMENT

- Supply of medication and a copy of the prescription order(s) signed by MD or e-script to Omnicare of Ballston Spa
- Birth Certificate
- Social Security Number (card if possible)
- Medical records – Immunizations
- Insurance Information – (Insurance / Medicaid Card)
- Court Orders

Mary Beth Carman LCSW-R
Vice President of Operations

7/24 Revised

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CONSENT FOR CHILD'S ROUTINE MEDICAL AND DENTAL CARE
(By Parents or Guardian)

I, _____ hereby give my consent for medical and dental care to the child listed below while under the care of Vanderheyden, Inc., or any person or agency acting as the agent of Vanderheyden, Inc.

This medical care includes, but is not limited to, physical examinations, administration of medications, immunizations against communicable diseases (including Hep B, Chicken Pox), and any necessary tests and emergency room treatment, which in the opinion of the physician, dentist, or psychiatrist treating the child listed are deemed necessary or advisable, and/or is prescribed by such physician, dentist, or psychiatrist.

This includes the right, in the case of an emergency, to admit for hospitalization and to administer necessary treatment, including surgery whenever such treatment is deemed medically necessary.

RESIDENT NAME	BIRTHDATE	RELIGION	SOCIAL SECURITY NUMBER "REQUIRED"
_____	_____	_____	_____-_____-_____

Address: _____
_____
Home Phone: _____
Work Phone: _____
Parents Email: _____

PARENT / GUARDIAN SIGNATURE _____

RELATIONSHIP _____

DATE: _____

WITNESS: _____

I understand that this authorization may not extend past the date of discharge or 1 year from the date of signing: must be renewed yearly.

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HEALTH PACKAGE

Introduction:

The purpose of the Health Service package is to enable our program to organize the health information of each individual we serve. This will help us to identify health problems and establish a plan to meet these needs. It is understood that the information requested on the forms will not always be available. However, every effort should be made so the forms are as complete as possible.

While completing the forms, please feel free to call the Health Services Office if you have any questions. We will be glad to assist you in any way we can.

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HEALTH HISTORY

_____

Name of Individual

_____

Date of Birth

_____

Place of Birth

_____

Signature of Person Completing Form

FAMILY HEALTH HISTORY

FAMILY MEMBERS: Please note any special relationships such as step-parent, foster child, adopted, etc. If deceased please include date and time of death.

Relationship	Age	Name	State of Health	Occupation / School	Grade Reached (school)
Mother					
Father					
Siblings					

Family Annual Income:

Under $5,000	$5,000 - $9,000	$10,000 - $14,999
$15,000 - $24,000	$25,000 - $34,999	$35,000 or more

Individual Racial / Ethnic Composition

White (non-Hispanic / non-Latino	Black, African American	Hispanic, Latino
Native American / Native Alaskan	Pacific Islander	Asian-Non-Pacific Islander
Multi – Racial, Multi-Ethnic	Other (please note):	

Religion:

Catholic	Jewish	Muslim	Protestant	Other

_____
Name of Individual

_____
Date of Birth

DEVELOPMENTAL HISTORY:

I. Pregnancy History – Mother

a. What number Pregnancy was this? _____
b. What number Live Birth? _____
c. Was mother under a doctor's care during the pregnancy? _____
d. Where there any complications? _____

_____
_____
_____
_____

e. Did the Baby Arrive on time? _____
   1. If premature or overdue – how long? _____
   2. Birth weight _____
f. Were there any complications with labor and delivery? _____
   Explain: _____

_____

II. History of prenatal exposure to drugs / alcohol (type, frequency, amount)
Explain:_____

_____

III. Infancy – Did this child have any problem: rolling over, sitting up, crawling, feeding, standing or walking, etc.?

Explain:_____

_____

Age of child's first words :_____

IV. Toddler – Did this child have any problems with: Speech, behavior, toileting, etc.

Explain:_____

_____

Age when child walked :_____

V. Pre-School: (3-5 Yr.) Did this child attend pre-school? Any problems with: bed wetting, soiling behavior, socialization etc.

Explain:_____

_____

VI. School Age: (5 Yr.- present) Did(does) this child have problems with: school, peers, clumsiness, behavior, etc.

Explain:_____

_____

VII. Present: Problem that brought this child into Vanderheyden for placement:

Explain:_____

_____

VIII. Medical History: _____

_____

_____

_____

_____

_____

_____

Completed By: _____

Date: _____

_____
Name of Individual

_____
Date of Birth

ALLERGIES:_____
_____
CURRENT MEDICAL PROBLEMS:_____
_____
ILLNESSESS / INJURIES / SURGERIES: (without being admitted to the hospital)_____
_____
_____
HOSPITALIZATIONS: (include medical / surgical / psychiatric)_____
_____
_____

CHILDHOOD DISEASES:

	Age		Age
German Measles (Rubella)	_____	Rheumatic Fever	_____
Chicken Pox	_____	Hepatitis	_____
Mumps	_____	Mononucleosis	_____
Whooping Cough	_____	Tuberculosis (T.B.)	_____
Scarlet Fever	_____	Meningitis	_____

Completed By: _____

Date: _____

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IMMUNIZATION RECORD

_____

Name of Individual

_____

Date of Birth

Specific dates must be included to comply with Public Health regulations.

Vaccine	#1	#2	#3	#4	#5	#6
Diphtheria Pertussis-Tetanus (D.P.T.)						
Oral Polio Vaccine (O.P.V.)						
Measles						
Mumps						
Rubella (German Measles)						

Completed By: _____

Date: _____

_____
Name of Individual

_____
Date of Birth

_____
County

DENTAL INFORMATION

Dentist:

Name: _____

Address: _____

Phone: _____

Please give dates for the following questions:

Has the child been seen by a dentist during the past six months?	YES	____	NO	____
Has the child had dental X-Rays?	YES	____	NO	____
Has the child had Fluoride treatments?	YES	____	NO	____
Has all necessary dental work been completed?	YES	____	NO	____

Do you have Dental Insurance? (please enclose documents)

Insurance Co. _____

ID Number _____

Completed By: _____

Date: _____

_____
Name of Individual

_____
Date of Birth

MEDICAL INFORMATION:

Family Doctor / Pediatrician / Clinic:

Name: _____
Address: _____
Phone: _____
Date of last appointment _____
Reason for last appointment _____
_____
Specialist: Reason for this appointment (eye / ear / nose / throat / skin / Etc.)
_____
_____
Do you have medical / health / insurance coverage? (please provide copy of card)
Insurance Company _____
Employer _____
Name of person carrying insurance _____
SS# of Insurance Carrier _____
DOB of Insurance Carrier _____
ID# _____
Group #_____ Plan:_____
Is this coverage a managed care policy provided by Medicaid? (Please provide copy of card)
Yes:_____ No: _____
Medicaid # _____

Completed By: _____

Date: _____

_____
Name of Individual

_____
Date of Birth

MEDICATION HISTORY:

Please list any medication the child is currently receiving and the reason they are receiving it. A doctor's prescription and a one-week supply of medication must be presented to Vanderheyden when the child is admitted.

_____
_____
_____
_____
_____
_____

Please list below, to the best of your recollection, any medication the child has received in the past.

MEDICATION	AGE WHEN GIVEN	REASON	EFFECT OF MEDICATION

Completed By: _____

Date: _____

_____
Name of Individual

_____
Date of Birth

FAMILY HEALTH HISTORY

Circle any of the following that this child or his grandparents / Parents / siblings / etc. have had.

	CONDITION	RELATIONSHIP TO CHILD
1.	Allergy	1.
2.	Asthma	2.
3.	Arthritis (Rheumatoid or Osteo)	3.
4.	Alcoholism	4.
5.	Cancer	5.
6.	Drug Addiction	6.
7.	Diabetes (type1 or type 2)	7.
8.	Epilepsy (convulsions / seizures)	8.
9.	Gout	9.
10.	High Blood Pressure	10.
11.	Heart Disease	11.
12.	Hemorrhagic Problems	12.
13.	Kidney Problems	13.
14.	Liver Problems	14.
15.	Migraine	15.
16.	Mental Illness (psychiatric problems)	16.
17.	Intellectual Disability	17.
18.	Nervous Breakdown	18.
19.	Obesity	19.
20.	Rheumatic Fever	20.
21.	Sickle Cell Anemia	21.

Completed By: _____

Date: _____

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President & CEO

Authorization for medical
RELEASE OF INFORMATION

I,_____, Hereby give permission to Vanderheyden Hall, Inc. to request medical or dental information from any of the physicians or dentists who have cared for _____, whenever deemed necessary by the Health Services staff.

The purpose or need for such disclosure is:

_____

_____

Specification of the date, event, or condition upon which this consent expires:

☐ 90 days from the date of consent for one-time release of information.

☐ May not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

I hereby permit the use or disclosure of the above information to the Person/Organization/Program(s) identified above. I understand that:

- Only this information may be used / obtained / disclosed, as a result of this authorization.
- This information is confidential and cannot legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden Hall. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden Hall, nor will it affect my eligibility for benefits.
- I have a right to inspect and copy my own protected health information to be used and/or disclosed as stated by law and/or regulation.

_____ Date

_____ Signature of individual

_____ Signature of Witness

_____ Signature of Parent / Guardian / Authorized Representative

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Authorization for RELEASE OF INFORMATION

This authorization must be completed by the individual or their personal representative to use / disclose / obtain protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal Laws and Regulations. A separate authorization is required to use or disclose confidential IDV related information.

I, _____ authorize Vanderheyden, Inc. to

☐ Obtain information from:

☐ Disclose information to:

Name: _____

Information to be obtained / disclosed

☐	Treatment Goals / Treatment Plan	☐	Discharge Summary/Discharge Plan	☐	Complete medical records
☐	Safety plans/behavior Management Plans	☐	Description of Progress and Prognosis	☐	Medical History and Physical, Consultation Reports
☐	Psychiatric Evaluation	☐	Assessment and Screening	☐	Individualized Education Plan (IEP)
☐	Medication Management	☐	Educational / Psychological Testing	☐	Laboratory Tests
☐	Psychosocial Assessment	☐	Other:		

The Purpose of obtaining or disclosing the information:

☐	To provide ongoing communication with referring agency	☐	To convey treatment recommendations and progress	☐	To complete an evaluation (alcohol / drug, psychiatric, psychological, etc.)
☐	To contact in case of emergency	☐	To maintain continuity in care	☐	Other:
☐	To provide ongoing treatment aftercare	☐	For treatment planning purposes	☐	Other:

Specification of the date, event, or condition upon which this consent expires:

☐ 90 days from the date of consent for one-time release of information.

☐ May not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

I hereby permit the use or disclosure of the above information to the Person/Organization/Program(s) identified above. I understand that:

- Only this information may be used / obtained / disclosed, as a result of this authorization.
- This information is confidential and cannot legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden Hall. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden Hall, nor will it affect my eligibility for benefits,
- I have a right to inspect and copy my own protected health information to be used and/or disclosed as stated by law and/or regulation.
- I have the right to receive a copy of this Release of information.

_____ _____

Date Signature of individual

_____ _____

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REQUEST FOR CONSENT TO EVALUATE

In an effort to provide appropriate educational services, it will be necessary to evaluate your child. Permission to test your child is being requested. A multi-disciplinary team will evaluate your child's abilities and recommend an appropriate education program based on evaluation results. This consent in no way causes you to waive or relinquish any rights for your child. To revoke this consent at any time, you must submit in writing your desire to do so.

Please check the box below and sign.

☐ YES, I hereby grant consent for my child _____
Childs Name

to be evaluated for the purpose of determining appropriate educational services.

I understand that this authorization may not extend past the date of discharge or 1 year from the date of signing: must be renewed yearly.

Signature of Parent / Guardian: _____

Date: _____

7/24 Revised

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Authorizations

In the course of providing the best possible care and services for your child while at Vanderheyden Hall and operating the wide and varied programs that we do, many situations arise where parental consent is advisable or necessary. Please check the box next to each of the following and sign your name at the end.

Re: _____ _____
Name of Child Date of Birth

I agree to continue with the medications currently prescribed upon admission to Vanderheyden	☐ YES	☐NO
I agree to allow Vanderheyden Hall to administer OTC (over the counter) medications as per the approved OTC list given to me.	☐ YES	☐NO
I have been given the information sheet for Parents/Guardians on the use of physical restraints and hereby give permission for staff to utilize a physical restraint on my child if it is clinically justified.	☐ YES	☐NO
I hereby grant permission for use of any photograph or videography of my child to appeal in website, public relations brochures, pamphlets, videotapes, booklets, and exhibits compiled and used by Vanderheyden Hall. The identity of my child will not be disclosed but he / she may be identified as a resident of Vanderheyden Hall.	☐ YES	☐NO
I hereby give permission for my child to participate in any police agency investigation of assault, sexual abuse, or other crime committed against my child or other persons or property. I understand that such information concerning any such investigation will be made available to me by Vanderheyden Hall.	☐ YES	☐NO
I hereby give permission for staff to transport my child to outside appointments, recreational activities and school events, and home visitation, as needed.	☐ YES	☐NO
I hereby give permission for my child to participate in recreational programs including activities in the community: ☐ Swimming ☐ Troy Boys/Girls Club ☐ YMCA	☐ YES	☐NO

I understand that this authorization may not extend past the date of discharge or 1 year from the date of signing: must be renewed yearly.

_____ _____
Date Print Full Name

_____ _____
Signature of Witness Signature of Parent / Guardian / Authorized Representative

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President & CEO

_____
Name of Individual

_____
Date of Birth

PHOTO AUTHORIZATION

I hereby grant permission for use of any photography or videography of my child to appear in website, public relations brochures, pamphlets, videotapes (CDs, DVDs etc.), booklets, and exhibits compiled and used by Vanderheyden. The Identity of my child will not be disclosed but they may be identified as a resident of Vanderheyden.

☐ YES _____ _____
Signature of Parent / Guardian / Authorized Representative — Date

☐ NO _____ _____
Signature of Parent / Guardian / Authorized Representative — Date

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Dear Parent / Guardian:

Vanderheyden conducts thorough investigations into significant incidents and allegations of abuse, as required by the New York State Justice Center, Office for Children and Family Services, New York State Education Department, and the Office for People With Developmental Disabilities. Vanderheyden's Quality Assurance Department works closely with representatives of these agencies to ensure all significant incidents and allegations of abuse receive objective and external review.

Individuals in Vanderheyden's care may have knowledge about a situation being investigated as a witness, and Vanderheyden and / or a representative from a state agency may need to conduct an interview with them to learn that information. Personal Representatives are required to be notified within 24 hours of any significant incident or allegation of abuse in which your individual in care is directly involved. However, you may choose to consent to your individual's participation in interviews when they are identified as a witness without additional notification by signing below:

I, _____Hereby allow, _____ to participate in interviews with Quality Assurance, Justice Center, or other state agency investigators, when they are identified as a potential witness, without additional notification.

_____ _____

Signature of Parent / Guardian / Authorized Representative Date

I, _____Hereby do not allow, _____ to participate in interviews with Quality Assurance, Justice Center, or other state agency investigators, when they are identified as a potential witness, without additional notification. I am electing to be notified whenever _____ is identified as a potential witness. I understand that every effort will be made to make that notification prior to the interview occurring, however an interview can be scheduled if Vanderheyden has attempted to make a notification and been unsuccessful.

_____ _____

Signature of Parent / Guardian / Authorized Representative Date

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Hixney Electronic Data Access Form

In this Consent Form, you can choose whether to allow Vanderheyden, Inc. to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a Statewide Computer Network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Vanderheyden, Inc. to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the "**I GIVE CONSENT**" box below, you are saying "Yes, Vanderheyden, Inc.'s staff, involved in my care, may see and get access to all of my medical records through Hixny."

If you check the "**I DENY CONSENT**" box below, you are saying "No, Vanderheyden, Inc. may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision. You have two choices:

☐ **I GIVE CONSENT** for Vanderheyden, Inc. to access ALL of my medical records through Hixny in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT** for Vanderheyden, Inc. to access my medical records through Hixny for any purpose, even in a medical emergency. Unless you check this box, New York State Law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____	_____	_____
Name of Individual	Date of Birth	Date
_____	_____	
Date of Birth	Print Name of Legal Representative (if applicable)	
_____	_____	
Relationship of Legal Representative (if applicable)	Signature of Individual or Individuals Legal Representative	

Details about patient information in Hixny and the consent process:
How Your Information Will Be Used
Your electronic health information will be used by Vanderheyden, Inc, only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow Health Insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice In a separate Consent Form that Health Insurers must use.

What Types of Information About You Are Included
If you give consent, Vanderheyden, Inc, may access ALL of your electronic health Information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

o Alcohol or drug use problems *
o Birth control and abortion (family planning)
o Genetic (inherited) diseases or tests
o HIV/AIDS
o Mental Health conditions
o Sexually Transmitted Diseases (STDs)

*If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation / social support, and health insurance claims history.

Where Health Information About You Comes From
Information about you comes from places that have provided you with medical care or Health Insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, Health Insurers, the Medicaid program, and other health organizations that exchange health Information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information sources at any time by checking the Hixny website: www.hlxny.org.

Who May Access Information About You, If You Give Consent
Only these people may access information about you: doctors and other Health Care Providers who serve on Vanderheyden, Inc.'s medical staff who are involved in your medical care; Health Care Providers who are covering or on call for Vanderheyden, Inc.'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access To or Use of Your Information
There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Vanderheyden, Inc, at: (518) 283-6500; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (518) 474-4987,

Re-Disclosure of Information
Any electronic health information about you may be re-disclosed by Vanderheyden, Inc, to others only to the extent permitted by State and Federal Laws and Regulations. This is also true for health information about you that exists in a paper form. Some State and Federal Laws provide special protections for some kinds of Sensitive Health Information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period
This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent
You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Vanderheyden, Inc. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect, may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

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President & CEO

Withdrawal of Consent

I have previously signed a Patient Consent Form that granted Vanderheyden, Inc. access to my medical information through Healthcare Information Xchange of New York ("Hixny"). At this time, I no longer want Vanderheyden, Inc. to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to Vanderheyden Inc. only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.
2. I understand that, by checking the box below, I am denying Vanderheyden, Inc. the right to access my medical information:

   ☐ I do not wish my medical information to be available to Vanderheyden, Inc.
3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.
4. I understand that my withdrawal of consent for Vanderheyden Inc. does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participant(s) directly.
5. I understand that it may take several days to process this Withdrawal of Consent.
6. I understand that no Hixny Participant(s) can deny me medical care as a result of this Withdrawal of Consent. I also understand that my Health Insurance eligibility cannot be affected by this Withdrawal of Consent.

_____	_____
Print Name of Individual	Individuals Date of Birth
_____	_____
Signature of Individual/ Guardian / Authorized Representative (If Individual is unable to sign)	Date
_____	_____
Print Name of Guardian / Authorized Representative (If Individual is unable to sign)	Relationship of Guardian / Authorized Representative

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Consent to Receive Newsletters / Vanderheyden Information

I, _____, consent for Vanderheyden Hall to email me and/or mail me Newsletters and other information relating to services provided by Vanderheyden Hall.

Email: _____
Address: _____
_____
_____
Phone Number: _____

Please check preference below:

☐ Mailed Letter
☐ Emailed Letter

_____ _____
Parent / Guardian's Signature Date

If Verbal Consent received: _____
Time / Date Received

_____
Staff Signature

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