POSITIVE ALTERNATIVES, INC.

Administration Office
603 Terrill Road, Menomonie, WI 54751
Phone: (715) 235-9552 • Fax: (715) 235-1075
www.positive-alternatives.org

Lost or Stolen Belongings Agreement

I understand as a group home resident, my child is responsible for all of his/her belongings during their stay at Positive Alternatives, Inc. Positive Alternatives, Inc. is not responsible for any belongs that are lost, stolen, or broken. Positive Alternatives, Inc. will provide a lockbox and a locked closet for all possessions and it is the resident's responsibility to keep their belongings secured.

_____ _____

Parent/Guardian Signature Resident Signature

Urine Analysis Consent

I give permission for Positive Alternatives, Inc. staff to conduct a urine analysis drug screen on my child during his or her placement. I understand that this can be done if staff believes my child has used drugs and has obtained consent to administer a drug screen from both my child and me. I also understand that my child's social worker or the juvenile court system can order a urine analysis without my consent. ***(All urine analysis done will be documented in the search log and in an incident report)***

_____ _____

Parent/Guardian Signature Resident Signature

Non-Prescription Medication Consent

I give permission for trained group home staff to administer non-prescription medications (Over-The-Counter) *unless otherwise specified below.* ***List any medications you wish your child NOT to take while in the group home.***

_____ _____

Parent/Guardian Signature Resident Signature

Note: *Consents will expire at date of discharge or no later than 1 year of authorization. These consents can be revoked at any time.*

_____ _____

Parent/Guardian Signature Date

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

INTAKE INFORMATION – GROUP FOSTER HOME RESIDENT

Use of form: Use of this form is voluntary; however, completion of this form for placement in the resident record will provide base information in accordance with DCF 57.38(1) of the Wisconsin Administrative Code. Personally identifiable information gathered on this form will be used only to determine compliance with licensing regulations. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. For a complete listing of resident record requirements, see the DCF-F-CFS379, Child Record Checklist – Group Foster Homes. If additional space is needed when completing this form, attach separate sheet(s).

Instructions: If the facility is a family-operated group home, a DCF-F-CFS872A-E, Information for Physical Custodians – Part A and a DCF-F-CFS872B-E, Information for Physical Custodians – Part B must also be completed.

I. RESIDENT INFORMATION

Name – Last	Name – First	Alias (Nickname)

Birthdate (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Date of Placement (mm/dd/yyyy)	Check all that apply: ☐ Voluntary placement ☐ Custodial parent ☐ Respite care ☐ Court-ordered placement ☐ Expectant mother ☐ Homeless / runaway youth

Religious Preference (Child or Family)

II. PLACING AGENCY / PARENT / GUARDIAN / LEGAL CUSTODIAN RESPONSIBLE FOR RESIDENT

Name	Relationship to Child ☐ Placing agency ☐ Parent ☐ Guardian ☐ Legal custodian

Physical Address	Mailing Address, if different

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell

III. EMERGENCY CONTACTS

A.	Name – **Agency** to be contacted in an emergency	Name – Contact Person	Relationship to Child
	Address (Street, City, State, Zip Code)		Telephone Number
B.	Name – **Person** to be contacted in an emergency		Relationship to Child
	Address (Street, City, State, Zip Code)		Telephone Number
C.	Name – **Physician** to be contacted in an emergency		Telephone Number
	Address (Street, City, State, Zip Code)		

IV. HEALTH INFORMATION

A.	Name – **Physician** to be contacted in an emergency	Telephone Number
	Address (Street, City, State, Zip Code)	

B. Name – **Dentist** to be contacted in an emergency	Telephone Number
Address (Street, City, State, Zip Code)	

C. Allergies (including allergies to food or medication) – Specify.

D. Physical Limitations – Specify.

E. Medications and Treatments – Specify.

F. Illnesses and Accidents – Specify.

V. SCHOOL INFORMATION

Name	Current Grade	Telephone Number

VI. INVENTORY OF RESIDENT CLOTHING AND POSSESSIONS AT PLACEMENT

Name – Person Completing Form	Position	Date Completed (mm/dd/yyyy)

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

MEDICAL SERVICES CONSENT

Use of form: Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely health care is provided. The form is to be completed by the parent or guardian of a child placed in foster care or treatment foster care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate medical care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: If additional space is needed, attach a separate sheet or use reverse side of this form.

Name – Parent or Guardian (Last, First, MI)	
Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

A. Routine Medical Services Consent and Exclusions

For purposes of routine medical services for the above named child, I hereby give my consent for the child placing agency or its designee to approve the provision of routine medical services*, including medical and dental examinations and nonemergency prescribed treatments (e.g., tooth repair, immunizations, medications, reproductive health needs assessment), with the following exceptions:

* All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

B. Routine Emergency Medical Services Consent and Exclusions

In case of a medical emergency involving the above named child, I understand that the following procedures will be used. I hereby give my consent for the child placing agency or its designee to arrange for emergency medical services using the following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures.
2. If I cannot be located within a reasonable time, the placing agency has the authority to consent to emergency surgery.
3. The juvenile court has the authority to consent to other medical services.
4. All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

I have no objections to the placing agency exercising its authority, with the following exceptions:

C. Parent / Guardian Information

Address – Home (Street, City, State, Zip Code)	Telephone Number – Home
Address – Work (Street, City, State, Zip Code)	Telephone Number – Work
Address – Other (Specify)	Telephone Number – Other (Specify)
Address – Other (Specify)	Telephone Number – Other (Specify)
SIGNATURE – Parent / Guardian	Date Signed
SIGNATURE – Child (age 14 and over only)	Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Nonmedical Consents

Use of form: Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely care is provided. The form is to be completed by the parent or guardian of a child placed in out-of-home care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: If additional space is needed, attach a separate sheet or use the reverse side of this form.

Name – Child: _____ Birthdate: _____
(Last, First, MI) (mm/dd/yyyy)

A. I give my permission for my child to be photographed, video taped or digitally recorded in some other manner. All media use will comply with the patient's rights. It may be used for treatment purposes or entertainment. Signing this consent does not allow the agency to use media for advertising in agency announcements, flyers, handbooks, placed on a social media site, the internet, etc.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

B. I give my permission for my child to participate in sports activities.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

C. I give my permission for my child to participate in school activities such as school sports, choir, plays, etc.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

D. I give my permission for my child to be transported by the agency as needed to court, school, activities, etc.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

E. I give my permission for my child to attend field trips.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

F. I give my permission for my child to receive haircuts as needed / requested by my child.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

G. I give my permission for the agency to request necessary school records, IEP records, etc.

_____ _____
SIGNATURE – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

I have no objections to the agency exercising its authority, with the following exceptions:

NOTE: Consent will expire at date of discharge. This consent can be revoked at any time.

_____ _____
SIGNATURE – Parent Date Signed

POSITIVE ALTERNATIVES, INC.

603 Terrill Road
Menomonie, WI 54751
Phone: (715) 235-9552
Fax: (715) 235-1075

1370 60th Avenue
Amery, WI 54001
Phone: (715) 268-7997
Fax: (715) 268-7973

2860 Williams Avenue
River Falls, WI 54022
Phone: (715) 426-2224
Fax: (715) 426-2225

110 24th St S, Suite B
Wisconsin Rapids, WI 54494
Phone: (715) 712-1617
Fax: (715) 712-1605

E-mail: PAI@Positive-Alternatives.org Website: www.Positive–Alternatives.org

Positive Alternatives, Inc. is a United Way Member Agency

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

I, _____ am the parent(s) or guardian(s) of _____, (DOB) _____.

I hereby consent to authorize the release of information which includes: verbal and written exchange of information, psychological evaluation, social history, AODA assessment, family assessments, neurological assessments, court services summary, request school records, IEP records, and enrollment in local school districts, if applicable, etc. I also give permission for the agency to transport my child to necessary court, school, activities, etc. I understand the specific information to be disclosed is for the purpose of assessment, treatment, and evaluation. I consent for Positive Alternatives, Inc. to provide and receive information as needed to the following agencies:

Positive Alternatives, Inc.
Northwest Journey Day Treatment
Mikan Day Treatment
Marshfield Clinic
Mayo Clinic Health System
Vibrant Health Clinic and Hospital
Hudson Hospital and Clinic
River Falls Police Department
River Falls School District
Menomonie Police Department
Menomonie School District
Amery School District
Amery Police Department
Polk County Sherriff's Office
Amery Medical Center
Midwest Psychological
Family Therapy and Associates
Western Wisconsin Health
LTCRx
Arbor Place

_____
(Previous School)

_____
(Therapist)

_____
(Psychiatrist/Family Doctor)

_____
(Other)

_____
(Other)

_____
(Other)

****This release will expire 30 days after discharge from Positive Alternatives, Inc.****

_____ _____
Parent/Guardian Signature Date Resident Signature Date

Client Rights for Inpatient or Residential Services

Overview

Positive Alternatives shall protect the legal and ethical rights of all clients by informing clients and guardians of their rights and responsibilities, providing fair and equitable treatment, and providing clients and guardians sufficient information so they can make informed decisions regarding the services and supports they receive.

Clients and guardians should be made aware of Client Rights during the intake and Denial of Rights processes. Clients and guardians are expected to sign the Client Rights form acknowledging receipt. Client Rights posters shall be posted in common areas for easy access and viewing.

Clients and guardians have the right to file a grievance (complaint) about any limits on your rights. Please see the Program Director to do so.

Treatment and Related Rights

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for your condition, within the limits of available funding.
- You must be allowed to participate in the planning of your treatment and care.
- You must be provided consistent enforcement of program rules and expectations.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medications may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or if a court orders it. (If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.)
- You may not be given unnecessary or excessive medication.
- You may not be subjected to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the facility, within the limits of available funding.
- You must receive services that adapt to your visual, auditory, linguistic, and motor ability needs.

- You must not be restrained or placed in a locked room (seclusion) unless in an emergency when it is necessary to prevent serious physical harm to you or to others.

Personal Rights

- You must be treated with dignity and respect, free from any verbal, emotional, sexual or physical abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You have the right to participate in diverse cultural beliefs and practices including religious services, social, recreational and community activities away from the living unit to the extent possible.
- You have the right to receive services that are respectful of and responsive to cultural and linguistic differences.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid, with certain minor exceptions.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- Your surroundings must be kept safe and clean.
- You must be given the chance to exercise and go outside for fresh air regularly and frequently, except for health and security concerns.
- You have the right to receive treatment in a psychologically and physically humane environment.

Communication and Privacy Rights

- You may call or write to public officials or your lawyer.
- Except in some situations, you may not be filmed, taped or photographed unless you agree to it.
- You may use your own money as you choose, within some limits.
- You may use a telephone daily. *
- You may see visitors daily. *
- You must have privacy when you are in the bathroom and while receiving care for personal needs. *
- You may wear your own clothing. *
- You must be given the opportunity to wash your clothes. *
- You may use and wear your own personal articles. *
- You must have access to a reasonable amount of secure storage space. *
- You may send and receive private mail. Staff may not open or read your mail unless you ask them to do so; or if there is a court order in place requiring staff to open your mail. (Staff will physically inspect your

mail/packages for contraband. However, staff may do so only if you are watching.)

Denial of Rights

Your rights may be limited or denied for treatment, safety, or other reasons. If your rights are limited or denied you must be informed of the reasons for doing so. Any denials of your rights must be documented on a Denial of Rights form and placed in your file, including any court ordered denials.

* Some of your rights may be limited or denied for treatment, safety or other reasons. (See the rights within an * after them.) Your wishes and the wishes of your guardian should be considered.

_____ _____

Client Date

_____ _____

Guardian Date

_____ _____

Staff Date