
ENTRANCE REQUIREMENTS

In order to best meet the needs of students and their families, we would greatly appreciate your assistance in providing the following information.

In order to meet these needs, the following information must be included in the placement packet:

A. Psychological - Within the last year

1. I.Q. test, e.g., WISC-R or WAIS, etc.
2. Achievement, e.g. - WRAT or PIAT, etc.
3. Behavior and/or Personality measurement, e.g. - Rorschach, TAT or MMPI, etc.

B. Social History

1. Information on family
2. Information on student
3. Copy of birth certificate
4. Copy of Social Security Card

C. Information on Student's Education

1. Copy of current and past Multi-factored Evaluations (MFE), past and current Individual Educational Plans (IEP) if applicable
2. Transcripts-complete (release forms enclosed)
3. Immunization records
4. Court order specifying school district responsible for the education of the student

D. Medical

1. Physical-within the last twelve months (form enclosed)
2. Vision and hearing screening. If a student has a hearing or vision problem, a statement from a physician declaring this does not affect his learning ability.
3. Motor abilities and speech screening
4. Signed documentation of most recent dental exam
5. 30 day supply of medication (if currently prescribed)

The guidelines from the Federal and State Government undoubtedly cause inconvenience for both of us. We have been able to meet these guidelines in the past due to your cooperation. Our goal is to better assist you in the future by providing forms and explanations that will aid you in expediting the referral process.

If there are any questions, please feel free to contact Mr. Michael Kitson, Assistant Director/Intake.

CHECK-OFF SHEET

Student Name: _____

Entrance Forms

Social History _____
Psych. Eval. _____
I.Q. Scores – Wisc. Yes ___ No ___
Court Order _____
Placement Agreement _____

Family & Visitation _____
Athletic Agreement _____
Clothing Agreement _____
Smoking Policy _____
Missing Persons Report _____
Client's Right Policy _____
Copy of S.S. Card _____
Billing Info _____
Interstate Com. Agreement _____
Behavioral Interv. Plan _____
Adopted Child Form _____
Publicity Agreement _____

School Forms

School of Record Rel. _____
School Trans. _____
Educ. History _____

MEDICAL FORMS

Medical Ins. _____
Emergency Medical _____
Med. Exam ___ Date ___
Birth Certificate _____
Immunization Form _____
Hospital Agreement _____
Drug Screening _____



FACE SHEET

Student: _____ Case #: _____

Cottage: _____ C.S.W.: _____

Date of Birth: _____ Race: _____

Date of Entrance: _____ S.S. #: _____

Date of Release: _____ Monthly S.P.: _____

Name of Mother: _____ Home Ph.: _____

Address: _____ Work Ph.: _____

_____ Cell Ph.: _____

_____ E-mail: _____

Name of Father: _____ Home Ph.: _____

Address: _____ Work Ph.: _____

_____ Cell Ph.: _____

_____ E-mail: _____

Ref. Agency: _____ Case Worker: _____

Address: _____ Phone: _____

_____ Fax: _____

Transported by: _____ E-mail: _____

County: _____ Supervisor of Caseworker: _____

Publicity: _____

Per Diem: _____ Phone: _____

Paid By: _____ Emergency/After Hours Phone: _____

Address: _____

_____ Attention: _____

Home School District: _____

Last School Attended: _____

Insurance-Primary: _____

Insurance-Secondary: _____

Clothing: _____

Reason for Placement: _____

NOTES: _____

MISSING PERSON REPORT FOR NCIC RECORD ENTRY

Date _____

Message Key (See definitions on page 1) (MKE) <input type="checkbox"/> Disability (EMD) <input type="checkbox"/> Juvenile (EMJ) <input type="checkbox"/> Endangered (EME) <input type="checkbox"/> Victim (EMV) <input type="checkbox"/> Involuntary (EM) <input type="checkbox"/> Caution		Reporting Agency (ORA)	Name of Missing Person (PDR)								
Sex (SEX): <input type="checkbox"/> Male (M) <input type="checkbox"/> Female (F)	Race (RAC): <input type="checkbox"/> Asian or Pacific Islander (A) <input type="checkbox"/> Black (B) <input type="checkbox"/> American Indian/Alaskan Native (I) <input type="checkbox"/> Unknown (U) <input type="checkbox"/> White (W)	Place of Birth (POB)	Date of Birth (DOB)	Date of Emancipation (DOE)							
Height (HGT):	Weight (WGT):	Eye Color (EYE): <input type="checkbox"/> Black (BLK) <input type="checkbox"/> Hazel (HAZ) <input type="checkbox"/> Blue (BLU) <input type="checkbox"/> Maroon (MAR) <input type="checkbox"/> Brown (BRO) <input type="checkbox"/> Multicolored (MUL) <input type="checkbox"/> Gray (GRY) <input type="checkbox"/> Pink (PNK) <input type="checkbox"/> Green (GRN) <input type="checkbox"/> Unknown (XXX)	Hair Color (HA): <input type="checkbox"/> Black (BLK) <input type="checkbox"/> Brown (BRO) <input type="checkbox"/> Blonde/Strawberry (BLN) <input type="checkbox"/> Gray/Partially Gray (GRY) <input type="checkbox"/> Red/Auburn (RED) <input type="checkbox"/> White (WHI) <input type="checkbox"/> Sandy (SDY) <input type="checkbox"/> Unknown (XXX)	FBI Number (FBI)							
Skin Tone (SKN): <input type="checkbox"/> Fair (FAR) <input type="checkbox"/> Olive (OLV) <input type="checkbox"/> Albino (ALB) <input type="checkbox"/> Light (LGT) <input type="checkbox"/> Lt Brown (LBR) <input type="checkbox"/> Ruddy (RUD) <input type="checkbox"/> Black (BLK) <input type="checkbox"/> Medium (MED) <input type="checkbox"/> Sallow (SAL) <input type="checkbox"/> Dark (DRK) <input type="checkbox"/> Med Brown (MBR) <input type="checkbox"/> Yellow (YEL) <input type="checkbox"/> Dk Brown (DBR)		Scars, marks, tattoos, and other characteristics (SMT) (See check list)	Fingerprint Classification* (FPC)								
Other Identifying Numbers (MNU)		Social Security Number (SOC)	Operator's License Number (OLN)	Operator's License State (OLS)	Operator's License Year of Expiration (OLE)						
Missing Person (MNP): <input type="checkbox"/> Missing Person (MIP) <input type="checkbox"/> Catastrophe Victim (CV)		Date of Last Contact (DLC)	Originating Agency Case Number (OCA)	Miscellaneous (MIS) Include build, handedness, any illness or diseases, clothing description, hair description, etc.							
Miscellaneous Information											
Below is a list of clothing and personal effects. Please indicate those items the missing person was last seen wearing. Include style, type, size, color, condition, labels, or laundry markings. (MIS)											
Item	Style/Type	Size	Color	Markings	Item	Style/Type	Size	Color	Markings		
Head Gear					Shoes/Boots/Sneakers						
Scarf/Tie/Gloves					Underwear						
Coat/Jacket/Vest					Bra/Girdle/Slip						
Sweater					Stockings/Pantyhose						
Shirt/Blouse					Wallet/Purse						
Pants/Skirt					Money						
Belt/Suspenders					Glasses						
Socks					Other						
LICENSE PLATE AND VEHICLE INFORMATION											
License Plate Number (LIC)	State	License (LIS)	Year Expires (LYE)	License Plate Type (LIT)							
Vehicle Identification Number (VIN)	Year (YR)	Make (MA)	Model (MO)	Style (ST)	Color (CO)						
Does the missing person have corrected vision? (SMT) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Glasses <input type="checkbox"/> Con Lenses		Has missing person ever donated blood? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?		Has the missing person ever been fingerprinted? <input type="checkbox"/> No <input type="checkbox"/> Yes If so by whom?							
Blood Type (BLT): <input type="checkbox"/> A Positive (APOS) <input type="checkbox"/> B Positive (BPOS) <input type="checkbox"/> AB Positive (ABPOS) <input type="checkbox"/> O Positive (OPOS) <input type="checkbox"/> A Negative (ANEG) <input type="checkbox"/> B Negative (BNEG) <input type="checkbox"/> AB Negative (ABNEG) <input type="checkbox"/> O Negative (ONEG) <input type="checkbox"/> A Unknown (AUNK) <input type="checkbox"/> B Unknown (BUNK) <input type="checkbox"/> AB Unknown (ABUNK) <input type="checkbox"/> O Unknown (OUNK)		Circumcision (CRC): <input type="checkbox"/> Was (C) <input type="checkbox"/> Unknown (U) <input type="checkbox"/> Was not (N)		Footprints Available (FFA): <input type="checkbox"/> Yes (Y) <input type="checkbox"/> No (N)		Body X-Rays (BXR): <input type="checkbox"/> Full (F) <input type="checkbox"/> None (N) <input type="checkbox"/> Partial (P)					
Corrective Vision Prescription (VRX)		Jewelry Type (See check list) (JWTT)		Jewelry Description (JWFL)							
Address		Reporting Agency Telephone Number			Reporting Officer						
Complainant's Name		Complainant's Address			Complainant's Telephone Number						
Relationship of Complainant to Missing Person		Missing Person's Address			Missing Person's Occupation (MIS)						
NIC Number (NIC)		Places missing person frequented									
Close friends/relatives		Possible destination									
Investigating Officer and Telephone Number (MIS)		Complainant's Signature			Date						



MISSING PERSONS FORM CONTINUED

Juvenile in leads/NCIC Computer Release Form

I, _____, the legal guardian or parent of _____, age _____, do hereby request or authorize the Van Wert County Sheriff's Department to enter the necessary information regarding the above named in the Leads/NCIC Computer. I further agree to provide for the necessary transportation required or the return of the above named from where he/she may be located.

Parent/Guardian Signature

Date

Witness

Date

Witness

Date



AUTHORIZATION TO SECURE EMERGENCY HEALTH CARE SERVICES

Authorization is granted to Starr Commonwealth and its designated agents and employees to act on behalf of the undersigned in securing and authorizing necessary health care services for:

Student Name

The conditions of this authorization are that:

1. A licensed physician, dentist or other health care person or agency determines that the above named minor is in immediate or emergency need of health care services.
2. If Starr Commonwealth or its designated agents and employees exercise the authority herein granted, they shall have no liability for the negligent acts or omissions of any health care professional or agency who undertakes to provide health care services to the minor.

Date: _____

Witnessed by:

Signed:

___ Parent ___ Guardian ___ Other

___ Parent ___ Guardian ___ Other

Is the minor covered by any medical, dental or hospitalization insurance?

___ Yes ___ No

Insurance Carrier _____

Group or Policy #: _____



MEDICAL INSURANCE INFORMATION

Student's Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Name of Policyholder: _____

Social Security # of Policyholder: _____

Date of Birth of Policyholder: _____

Phone # for Verification of Benefits: _____

Insurance Group #: _____

Name of Insured Group: _____

Contract #: _____

Code #: _____

Blue Cross/Blue Shield – Service Code #: _____ (3 or 4 digit number)

Parent/Guardian Signature

Date

If student is on ADC – please provide ADC card or copy of same.

PLEASE NOTIFY THE CLINIC COORDINATOR AT STARR COMMONWEALTH IMMEDIATELY WITH ANY CHANGES TO YOUR INSURANCE COVERAGE.

TO BE COMPLETED BY PARENT OR AGENCY REPRESENTATIVE



IMMUNIZATIONS

Student Name _____

The State of Ohio requires all immunizations to be completed before a child may attend school. Please send student's immunization records at the time of admission to the school.

Requirements include four doses of DPT, three doses of polio and immunization against measles, mumps and rubella (MMR). We must have the month, day and year on all. Please use the space provided below. If these records are not complete we must re-immunize with the necessary doses.

Dates of:

(month, day,
year)

1st

2nd

3rd

4th

POLIO

DPT

MEASLES/MUMPS/RUBELLA

HEPATITIS

I do NOT want my son/ward to be immunized for the following reasons: _____

Parent/Guardian Signature _____

Date _____

You have my permission to immunize this student to get him up to date.

Parent/Guardian Signature _____

Date _____



ATHLETICS AND RECREATION

Student Name: _____

I hereby give consent for my son (ward) to participate in Starr Commonwealth's physical education, intramural, interscholastic and recreational programs, and to travel with the coach or other representatives of the school on any trips or camp outs.

List any sport(s) or activities in which he is not to participate in due to medical reasons.

Parent/Guardian Signature

Date



MEDICAL HISTORY FORM

Student Name

The State of Ohio requires a complete health history for each child in residential placement. This includes information regarding any hereditary medical problems of the biological parents of an adopted child, plus a copy of the birth certificate for each student.

Any available information regarding the biological parents should be included with the child's medical history, and this signed document, verifying that your agency did attempt to obtain this information.

Representative, Starr Commonwealth, Van Wert Campus Signature

Referring Agency Representative Signature

HEALTH EXAMINATION RECORD

This form is to be completed and returned to Starr prior to the student's entrance: Note items 20 thru 30 of Section 2 are to be filled out and signed by a physician. If you have any questions concerning this matter please give us a call at 1.419.238.4051.

HEALTH EXAMINATION RECORD

Lincolnview Langley School
 Starr Commonwealth Campus
 15145 Old Route 30
 Van Wert, Ohio 45891

Instructions

Parents or Guardian
Physician

Complete items 1 - 19 of Section 1
 Complete items 20 - 33 of Section II
 on reverse side

SECTION I (To be completed by parents or guardian)

1. NAME (Last, First, Middle)	2. Sex	3. Date of Birth
4. RESPONSIBLE AGENCY OR PERSONS	5. COUNTY	
6. MAILING ADDRESS	7. CITY, STATE, ZIP CODE	

8. PERSONAL HISTORY (Check and give approximate ages at which these conditions occurred)

	X	AGE		X	AGE		X	AGE
Allergies			Kidney Trouble			Scarlet Fever		
Appendicitis			Measles - regular			Seizures		
Asthma			German			Tonsillitis		
Chicken Pox			Mumps			Tuberculosis		
Diabetes			Muscle or Nerve Disorder			Venereal Disease		
Heart Trouble			Pneumonia			Whooping Cough		
Hearing Problem			Rheumatic Fever			Other		

9. FAMILY HEALTH HISTORY

FATHER (name)	(age)	(health condition)
MOTHER (name)	(age)	(health condition)
NATURAL BROTHERS AND SISTERS (number only)		(health condition)

10. IMMUNIZATION RECORD (Send copy)

DOSE	1st DOSE	2nd DOSE	3rd DOSE	4th DOSE
Polio				
DPT or TD (Adult)				
M-R or M-M - R	M	R	M-R	
Mumps				

12. ANY SPEECH ABNORMALITIES

13. MEDICATIONS NEEDED OR USED (including psychiatric)

PURPOSE	KIND	DOSAGE	CURRENTLY BEING GIVEN ____YES ____NO

14. SPECIAL CONDITIONS TO BE WATCHED FOR SUCH AS ALLERGY (Reactions to Penicillin or other drugs) BEDWETTING, FAINTING, SLEEP WALKING, BLEEDING TENDENCY, ETC.

HEALTH EXAMINATION RECORD CONTINUED

15. DATE LAST SEEN BY DENTIST	17. IF YES, EXPLAIN DENTAL NEEDS <i>(Send copy of records to Starr)</i>
16. ARE THERE DENTAL NEEDS NOW? ____YES ____NO	
18. ARE GLASSES NEEDED? ____YES ____NO	19. ARE GLASSES WORN? ____YES ____NO

SECTION 11 PHYSICAL EXAMINATION *(To be completed by a licensed physician)*

20. WEIGHT	21. HEIGHT	22. BLOOD PRESSURE
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23. PHYSICAL EXAM: SIGNIFICANT FINDINGS ON:

A. GENERAL NEUROLOGICAL EXAMINATION

B. MOTOR ABNORMALITIES

C. SENSORY ABNORMALITIES

24. HEARING

25. VISION

SNELLEN TEST:

WITH GLASSES OR CONTACTS

WITHOUT GLASSES OR CONTACTS

COMMENTS:

This is to certify that the above named child has had a complete physical examination including a neurological evaluation. (This neurological evaluation should include gait, station, gross and fine motor coordination, muscle power and tone, reflexes, sensory examination and cranial nerves.)

STATEMENT: I have, on this date, examined this person in order to determine physical fitness and/or apparent evidence of communicable disease. In my opinion, the applicant _____(is)_____ (is not) physically and emotionally able to participate in the indicated program.
(check one)

27. PARTIALLY ABLE TO PARTICIPATE ____YES ____NO	28. IF YES, SPECIFY RESTRICTIONS
29. DATE OF EXAMINATION	30. SIGNATURE OF LICENSED PHYSICIAN
31. TELEPHONE NUMBER	32. STREET ADDRESS
	33. CITY, STATE, ZIP CODE



PUBLICITY AGREEMENT

The work of Starr Commonwealth is heavily dependent upon the goodwill and assistance of the many friends. In order that our supporters and other interested people may be well-informed about our objectives and program, we engage in a certain amount of public relations.

This includes descriptive brochures and an occasional release to newspapers, magazines, Internet, radio, or television. Confidential material about any of our children is never released, and children are identified by first name only, unless given permission otherwise.

We desire your signed consent for involving your child should the occasion arise. If you are in agreement with this publicity agreement, please sign below:

I hereby consent for my child to be photographed, recorded, and interviewed for use in any publicity and marketing materials approved by Starr Commonwealth as described above.

Parent/Guardian Signature

Date



SMOKING POLICY

Student Name _____

To ensure a safe and healthy environment at Starr Commonwealth, we maintain a SMOKE-FREE environment. We ask for complete cooperation from students, families, visitors as well as our staff. Thank you for your cooperation.

Signed and acknowledged by: _____
Parent or Guardian

Signed and acknowledged by: _____
Student



FAMILY RECORD - APPROVED VISITORS

Student Name: _____ DOB: _____

Religious Preference: _____

Record of Family Facts and Approved Visitors

Members of Household	DOB	Relationship	Approved Visitor	
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO

Additional Family/Non-Family Members

Name	Address	Relationship	Approved Visitor	
			YES	NO
			YES	NO
			YES	NO
			YES	NO

Completed by: _____ Relationship: _____

It is very important that this be completed as correctly as possible to help us in planning meaningful visits.

CLIENT RIGHTS

- I. All clients have the right to equal access to services and impartial treatment without discrimination by race, religion, sex, ethnicity, age or handicap.
- II. Care and treatment shall recognize and respect the personal dignity of the client.
- III. All clients shall have the right to every consideration of their privacy and individuality as it relates to their social, religious and psychological well being.
- IV. All clients have the right to individualized treatment including:
 - A. A treatment plan determined by clinical assessment and available to the client.
 - B. The right to review those portions of their record which were developed at Starr Commonwealth, provided that this disclosure does not violate the confidentiality of family members or other individuals whose contacts may be contained in the record.
 - 1) Record review will be done with a client by the program director and other treatment staff, as the program director deems appropriate.
 - 2) How the record is reviewed with the client will be determined by the program director. This determination will be made based upon the nature of the material to be reviewed and the status of the client.
 - 3) A record review may range from sharing of actual material to a verbal review by the program director.
 - C. The right to insert a statement into their record about their problems or about services they are receiving or may wish to receive and that, should Starr Commonwealth add statements or responses related to the client's statement, it is done with the client's knowledge.
 - D. The treatment plan shall be individualized, include active participation of clients and/or their parent/guardian or significant other and be reviewed periodically and be implemented and supervised by competent and qualified staff.
 - E. The right to treatment provided in the least restrictive environment.
 - F. Confidentiality of communications between client and staff.
 - G. Information recorded in the client's chart shall be the responsibility of all staff members.
 - H. Complete and current information regarding diagnosis, treatment and prognosis in understandable terms and language.

CLIENT RIGHTS

- I. The right to know by name and specialty the staff member(s) responsible for the coordination and implementation of care and treatment.
 - J. The right to respectfulness and privacy as it relates to case discussion consultation, examination and treatment because these are confidential and should be conducted discreetly.
 - K. The right to expect a reasonable continuity of care and treatment.
- V. All children receiving services from Starr Commonwealth in out-of-home care have the right to:
- A. Enjoy freedom of thought, conscience and religion.
 - B. Reasonable enjoyment of privacy.
 - C. Have his/her opinion heard and be included, to the greatest extent possible, when any decisions are being made affecting his/her life.
 - D. Receive appropriate and reasonable adult guidance, support and supervision.
 - E. Freedom from physical abuse and inhumane treatment.
 - F. Protection from all forms of sexual exploitation.
 - G. Adequate and appropriate medical care.
 - H. Adequate and appropriate food, clothing and housing.
 - I. Possession of his/her own money and personal property in accordance with his/her service plan.
 - J. Clean and safe surroundings.
 - K. Participation in an appropriate educational program.
 - L. Communication with family, friends and "significant others" in accordance with his/her service plan. Communication includes visitation, telephone conversations, sending and receiving mail. Restrictions on communication necessitated by clinical indications will be continuously evaluated. Such restrictions will be explained to the child and his or her parent/guardian.
 - M. Learn to fulfill appropriate responsibilities to him or herself and to others.

CLIENT RIGHTS

- VI. The client shall not be required to work for the benefit of Starr Commonwealth; however, a client can be required in the case of out-of-home care to perform tasks of a personal housekeeping nature without compensation.
- VII. All clients and their parent/guardian (in the case of minor clients) shall be informed about:
- A. The above listed rights. In addition, notification of the existence of a Client Rights policy and the availability of that policy shall be posted throughout the organization in strategic locations accessible and visible to clients.
 - B. The nature of the care, procedures and treatment he/she will receive including the rules and regulations of the program.
 - C. Signed consent for the use of audio/visual equipment and participation in research projects.
 - D. Discharge plans.
 - E. After care plans.
 - F. The right to initiate a complaint or a grievance and the procedure therefore.
- VIII. All clients shall have the right to a review if they believe any of the above rights have been violated. Notification of a complaint/grievance shall be given to the Assistant Director or Director for the respective program or the following:

For Van Wert, Ohio programs:

1. Van Wert County Department of Job and Family Services
114-118 Main Street
Van Wert, Ohio 45891
419.238.5430

For All Ohio Programs:

1. Ohio Department of Human Services
30 East Broad Street
Columbus, Ohio 43215
614.466.7987



CLIENT RIGHTS

For All Michigan Programs:

1. Licensing Consultant
Office of Children and Adult Licensing
2121 West Stadium
Ann Arbor, MI 48103
734.665.6417

I have received a copy of this document for my information and I understand its content.

Client Signature (or parent when applicable)

Date

REQUIRED CLOTHING

Upon Intake, the following items of clothing are requested:

SHOES

- 1 Pair Shoes for Dress
- 1 Pair Gym Shoes for Cottage
- 1 Pair Gym Shoes for Gym
- 1 Pair Shower Shoes
- 1 Pair Work Boots

COATS

- 1 Winter-weight Coat
- 1 Light-weight Coat
- 1 Rain Poncho

MISCELLANEOUS

- 1 Necktie
- 1 Pair Swim Trunks
- 1 Dress Belt
- 1 School Belt
- 1 Pair Winter Gloves
- 1 Winter Cap
- 1 Sweatsuit

UNDERWEAR

- 6 Pair Undershorts
- 3 White T-Shirts
- 8 Socks (2 Dress & 6 White)

NIGHTWEAR

- 2 Pair Pajamas
- 1 Bathrobe
- 1 Pair Slippers

SHIRTS

- 2 Dress Shirts
- 4 School Shirts
- 3 Plain Colored T-Shirts
- 1 Sweater (Cardigan for Dress)

PANTS

- 1 Pair Dress Pants
- 1 Pair School / Casual Pants (Twill)
- 4 Pair Jeans
- 3 Pair Shorts (Summer)

All clothing on this list must be provided at the date of a student's admittance to the Starr Commonwealth program. Failure to do so will require Starr Commonwealth to supplement the required items and a charge will be made to the placing agency.

We do not encourage students to bring expensive personal items. If a student should decide to bring these items, it should be clearly understood that it will be at their own risk, and that the enclosed form must be signed to relieve Starr Commonwealth of responsibility in case of damage or theft.



CLOTHING PROPERTY AGREEMENT

I have read the Required Clothing List and have noted that it is recommended that expensive items not be brought when my son (or ward) enrolls in the program.

I do hereby agree that any items my son/ward brings with him will be at his own risk and that Starr Commonwealth is not responsible for any damage or theft to his possessions; including clothing, personal items, sentimental items, radios, electronics, etc.

I also understand that if I do not bring or send all items as listed on the Required Clothing List, Starr Commonwealth will supplement the items at a charge to the placing agency. Starr Commonwealth will pay for all clothing needed after this required clothing list has been filled.

Student Name

Agency Representative Signature

Date

Parent/Guardian Signature

Date



BILLING INFORMATION

Student Name: _____ Case Number: _____

Agency Responsible for Payment of Per Diem: _____

Billing party, name and address: _____

Contact Person for billing questions: _____

Phone number: _____ Fax number: _____

SCHOOL

Name of school district responsible for Tuition: _____

Billing party, name and address: _____

Contact Person for billing questions: _____

Phone number: _____ Fax number: _____

** If out of state, name of school corporation or county/state agency responsible for payment of out of state tuition. Any additional information pertaining to billing should be added on a separate sheet of paper.



ASSIGNMENT OF BENEFITS

Below is a form from our local hospital requesting a **signature by the policy holder of private insurance** (Blue Cross/Blue Shield, Aetna, etc.). This form will be kept on file here at Starr in the event your child would require medical attention during his stay. Along with the signed form we need a copy of the insurance card or cards. If there is no private insurance or medical supplement, Starr will need to know who is responsible for your child's medical expenses prior to placement. Should you have any questions concerning this matter, please contact Starr at 1.866.289.9201. Thank you for your cooperation.

I hereby authorize payment directly to Van Wert County Hospital of the benefits for hospital expenses, otherwise payable to me, not to exceed the balance due of the hospital's regular charges for the period of hospitalization shown on the attached itemized statement, such charges being for services rendered to:

Name of Patient

Relationship

I acknowledge that I am financially responsible to the hospital for charges not covered by this authorization. I also authorize the release of such information as may be necessary to file this claim for payment.

Signature of Insured

Date

Policy number, employee identification number or Social Security Number

Van Wert County Hospital
1250 South Washington Street
Van Wert, OH 45891



DRUG SCREENING – CLIENTS

Student Name: _____

For many of the students served by the programs of Starr Commonwealth, the abuse of controlled substances is a significant issue. Consequently, the goals of our work with these students include helping them to develop attitudes and habits that will assist them in remaining drug-free when they return to their communities.

Toward this end, it is the practice of Starr Commonwealth to test students for drug use by urinalysis when we have reason to believe that they may have been using illicit drugs or alcohol. Factors to be considered in our decision to test a student include his or her history of substance abuse, observed behavioral changes indicative of drug use, observations and input from the student's family that suggest substance abuse during a home visit, and the desire of the student to be tested.

The treatment impact of drug screening is two-fold. First, it has a deterrent affect in that students are less likely to use drugs if they know that such use can and will be detected upon their return to campus. Many students also find it easier to resist pressure in the community to do drugs by telling peers he can't do drugs because he may be tested. Secondly, our ability to develop effective drug treatment plans for students experiencing problems with substance abuse relies completely on our awareness of the extent of the problem throughout the course of treatment.

The purpose of drug screening will always be to help students successfully address their substance abuse problems, and to aid us in the development and implementation of effective treatment strategies for these students. The results of drug screening will not be used to exclude students from our programs. The ultimate focus remains a change in values related to substance abuse.

This policy is the result of much study and discussion. It is our conviction that it will best serve our highest priority – that of offering comprehensive treatment services for young people.

A parent or responsible adult is asked to complete and sign the attached form, signifying receipt of this policy.

STARR COMMONWEALTH DRUG SCREENING POLICY – CLIENT'S ACKNOWLEDGEMENT

I have read the policy of Starr Commonwealth, which governs drug screening.
I signify that I have received a copy of this policy.

Parent/Guardian Signature

Date

Relationship to Above-Named Client: _____

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice please contact the Starr Commonwealth Privacy Officer at 1.800.837.5591.

This Notice of Privacy Policy describes how Starr Commonwealth may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Policy. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Policy by calling our office and requesting that a revised policy be sent to you in the mail or by visiting our website at www.starr.org.

You will be asked to sign a document saying you received a copy of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Following are examples of the types of uses and disclosures of your protected health information (PHI) that Starr Commonwealth is allowed to make. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our offices.

Treatment

We may use PHI to provide medical treatment or services. We may disclose medical information about you to Starr Commonwealth staff who are charged with your daily care and treatment. For example, cottage staff members need to know any food allergies you may have in order to plan meals accordingly. Treatment staff and counselors may need to know any medication history in order to continue quality care during your stay.

Payment

We may use and disclose your PHI for Starr Commonwealth operations. These uses and disclosures are necessary in order to show Starr Commonwealth as an effective treatment program. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Starr Commonwealth clients to decide what additional services we should offer, what services are not needed and whether new treatments are effective. We are required to remove information that identifies you from this sort of information so others may use it to study health care without learning who the specific clients are.

Business Associates

We may be required to provide PHI to entities that provide medical, dental or psychiatric and psychological care. For example, in cases of emergent care when traveling off-campus for home visits or trips; dental or doctor visits; or seeing a psychologist contracted to provide services to clients of Starr Commonwealth.

PRIVACY POLICY

As Required By Law

We will disclose PHI about you when required to do so by federal, state or local law.

Law Enforcement

We may release PHI about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.

Health Oversight Activities

We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and accreditation. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Public Health

We may disclose your PHI for public health activities. For example, we may disclose your PHI when necessary to prevent a serious threat to your or others health and safety. Public health activities generally include: (1) to prevent or control disease, injury or disability; (2) to report reactions to medications or problems with products; (3) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (4) to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence.

Fundraising

Under certain circumstances we may use and disclose medical information about you for fundraising activities for Starr Commonwealth and its operations. We will de-identify information in applying for grants from foundations or other benevolent sources.

Research

Under certain circumstances we may use and disclose medical information about you for research information and purposes. A research project by appropriate professional staff may include comparing behaviors before and after treatment at Starr Commonwealth. All research projects are subject to a special approval process through the Programs Director; the Vice President of Research, Evaluation and Training; and the Chief Operations Officer.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes.

PRIVACY POLICY

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Starr Commonwealth Records Manager using the request form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The Director of Administrative Services will review the request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel the PHI we have about you is incorrect or incomplete, you have the right to ask us to amend the information. You have a right to request to amend the information as long as Starr Commonwealth retains the information.

To request an amendment, you must submit a request in writing to the Starr Commonwealth Records Manager. In addition, you must provide a reason that supports your request. Starr Commonwealth will respond to the request within 60 days. If Starr Commonwealth is unable to take action within the applicable time period, Starr Commonwealth may extend the time for such an action by 30 days. Starr Commonwealth will provide a written reason for the delay and the date by which it will complete action on the request.

We may deny your request if it is not in writing or does not include a reason for your request. In addition, we may deny your request if it asks us to amend information we did not create, is not part of the information you would be permitted to inspect or copy or is information that is correct and accurate.

Right to an Accounting of Disclosures

You have the right to request an accounting of the disclosures of your PHI that we make. To request a list of the disclosures we have made, submit your request in writing to the Starr Commonwealth Records Manager. Your request must state the time period, which may not be longer than six years and may not include dates before October 2003. Your request should indicate in what form you want the list – paper or electronically. Your request must also specify where you want the information directed, such as postal or email address.

You may request the list at reasonable intervals, which we may determine. You may receive the first accounting per calendar year for no charge. If you request an accounting after this you will be charged fees for copying, mailing or staff time preparing the document. If this is the case, we will notify you of any charges before proceeding with the request, and you may withdraw your request before any charges are incurred.

Starr Commonwealth will respond to the request within 60 days. If Starr Commonwealth is unable to take action within the 60 days, Starr Commonwealth may extend the time for such an action by 30 days. Starr Commonwealth will provide a written reason for the delay and the date by which it will complete action on the request. Starr Commonwealth may only make one extension of 30 days for each request.

Right to Request Restrictions

You have the right to request restrictions on the uses and disclosures of your PHI by Starr Commonwealth. Requests for restrictions must be submitted in writing to the Starr Commonwealth Records Manager. Starr Commonwealth is not required to accept any requests for restrictions on the uses and disclosure of PHI.

PRIVACY POLICY

If the request for restriction on the use and disclosure of your PHI is accepted by Starr Commonwealth, the restriction can be revoked by you at any time when submitted in writing to the Starr Commonwealth Records Manager.

Right to Receive Confidential Communications

You have the right to request that we contact you about matters that involve your PHI only in certain ways or in certain locations. An example would be that we might only contact you in person or in writing to a certain address. To request confidential communications, you must make your request in writing to the Starr Commonwealth Records Manager. We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you may still request a copy of this in paper form.

You may request a copy of this notice from the Starr Commonwealth Records Manager.

Changes to this Notice

We reserve the right to make changes to this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as information we receive in the future. We will post a current copy of this notice on the Starr Commonwealth website at www.starr.org. The notice will contain the effective date in the lower left-hand corner.

Grievance

If you believe your privacy rights have been violated, you may file a grievance with Starr Commonwealth by submitting a grievance form in writing to the Starr Commonwealth Records Manager. If you are not satisfied with the response you receive from Starr Commonwealth, you have the right to file a complaint with the Department of Health and Human Services. You will not be penalized for filing a grievance.

If you would like to discuss the privacy of your Protected Health Information in detail, or if you have any concerns, please feel free to contact our Privacy Officer at 1.800.837.5591.

Other Uses and Disclosures

Other uses or disclosures of your PHI not covered by this notice or laws that apply to our use and disclosure will be made only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose your PHI for the reasons covered by your written authorization. We are unable to take back any use of disclosure that has already been made with your authorization or that has been described in this notice.

This notice is effective April 14, 2003.



RECEIPT OF NOTICE OF PRIVACY POLICY

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. You have the right to review this notice before signing this form. As provided by our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by calling the Starr Commonwealth Privacy Officer at 1.800.837.5591 or by visiting our web site at www.starr.org.

By signing this form you verify that you have received our Notice of Privacy Policy.

Parent/Guardian Signature

Date

Client Name



PARENT/GUARDIAN/STUDENT CONSENT FOR RECORDS RELEASE

To: _____ Re: _____
(Last school attended) (Student's name)

_____ Age: _____ Birthdate: _____
Street Address

City, State, Zip Code

From: _____	<i>15145 Lincoln Highway</i>
Name	Street Address
<i>Lincolnview Langley School</i>	<i>Van Wert, Ohio 45891</i>
Agency	City, State, Zip Code

We are requesting the following information for the above-named student:

- All personally identifiable data on file.
- The following records only: (please specify)

Reason for request: (please check)

- To aid in making present and future educational decisions.
- Other: (please specify)

With the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed, I authorize you to release educational information regarding the student named above in the manner indicated.

_____	_____
Date	Parent/Guardian Signature
	Address _____
	City, State, Zip Code _____

FOR OFFICE USE ONLY

Date Data Released: _____ By _____
Name/Position

Date Copies Mailed: _____ By _____
Name/Position



STARR COMMONWEALTH – VAN WERT RESIDENTIAL BEHAVIORAL INTERVENTION PLAN

The basis of our treatment program, and therefore our behavioral interventions, is to develop and maintain a supportive environment which brings out the inherent strengths in the students we serve. We understand that the process of change in our students can bring out intense emotions in them, and our staff members are there to help students work through crises that arise.

All staff members working directly with the students are trained in Crisis Prevention Institute (CPI) Non-Violent Crisis Intervention. This training provides staff members with strategies in preventing crises in our students. For students who are not able to control their emotions, techniques of de-escalation are employed by the staff. Please refer to the Behavioral Intervention Techniques as examples of interventions our staff employ to de-escalate students.

If a student's crisis continues to escalate to where he becomes a threat of harm to himself, to his peers, to staff members or others, physical restraint techniques may be employed by staff members. These interventions are used to prevent anyone from being hurt and are used in accordance to CPI training received by staff.

Based on a review of the student's personal file, interviews with the student, the student's parent(s) or legal guardian(s) and the referring caseworker, we have determined that there are no psychological, physical or developmental contraindications to use the behavioral interventions mentioned above with:

Student Name

Van Wert Residential Representative Signature

Date

Health Care Professional Signature

Date

Additional Interventions: _____

I acknowledge that the above information has been explained to me.

Parent or Legal Guardian Signature

Date

Reviewed on: _____

Status: _____

CPI Instructor Signature

Health Care Professional Signature



**STARR COMMONWEALTH – VAN WERT
RESIDENTIAL BEHAVIORAL INTERVENTION PLAN CONT.**

Reviewed on: _____

Status: _____

CPI Instructor Signature

Health Care Professional Signature

Reviewed on: _____

Status: _____

CPI Instructor Signature

Health Care Professional Signature

Reviewed on: _____

Status: _____

CPI Instructor Signature

Health Care Professional Signature

Reviewed on: _____

Status: _____

CPI Instructor Signature

Health Care Professional Signature

GUIDELINES FOR PLANNING ACTIVITIES

All recreational activities will be structured to enhance the youth's ability to work with each other and develop individual and group treatment goals. All activities will be set up according to the group's ability to participate and learn. Staff will be responsible for creating a safe and caring environment that will allow each youth an equal opportunity for growth.

The Cottage Coordinator of each treatment team will guide each youth specialist in planning structured group activities during each shift that does not cover school hours. The activities are planned according to the group treatment plan established by the treatment team. The group treatment plan directs staff how to supervise students.

A task analysis is to be completed in preparation for off-campus activities or any other activity in which students will interact with non-Starr adults or peers.



STATEMENT ON RELIGION

Starr Commonwealth's Creed, written by Floyd Starr in 1913, states, "We believe that to attain the full stature of man, spiritual development should go hand in hand with physical, mental and moral development." Starr Commonwealth invites and encourages all students to participate in spiritual development activities on campus.

Starr Commonwealth provides an atmosphere that respects the diverse religious beliefs of its students by providing exposure to spiritually enhancing activities and programs during the week. In addition, non-denominational worship services are provided weekly and on special occasions. When possible, services are conducted by the Chaplain or the Spiritual Director on campus.

It is not a requirement, nor is it mandated, that students participate in any of Starr Commonwealth's religious or spiritual offerings in order to complete the program. Starr Commonwealth does not require attendance or participation of any students in religious programming practices.

I have been informed of Starr Commonwealth's statement on religion:

_____ Student Signature	_____ Date
_____ Parent/Guardian Signature	_____ Date
_____ Agency Caseworker Signature	_____ Date

CLIENT GRIEVANCE PROCEDURE

- Section 1: A written copy of these procedures will be made available upon request.
- Section 2: The term "grievance" shall be defined as any dispute regarding the delivery of clinical services, including assessment, therapeutic intervention and case disposition.
- Section 3: Grievance should be considered as part of a treatment process. Every attempt should be made to secure a just and fair solution.
- Section 4: The grievant may, if he/she desires, be accompanied at any step in the grievance procedure by other persons of his choosing.
- Section 5: Step One. After the occurrence of a grievance, the client is encouraged to present the grievance to the treatment personnel involved, with the objective of resolving the matter informally.
- Section 6: Step Two. If the grievance is not resolved in Step One, the client or treatment personnel should present the problem orally to the staff members' supervisor, who shall meet with all parties involved.
- Section 7: Step Three. If the grievance is not resolved in Step Two and the supervisor is not a Director, the supervisor will present the problem to the Director who shall hold a meeting with all parties involved in the complaint.
- Section 8: In the event a grievance involves a youth in custody of another agency, representative(s) of that agency may be involved at any step.
- Section 9: The problem and resolution of the problem will be documented in the client's case record.
- Section 10: A time of one week for response to the client at each step shall be established in order to assure prompt consideration of the grievance.



RECEIPT OF CLIENT GRIEVANCE PROCEDURE

By signing this form you verify that you have received a copy, read and understand our Client Grievance Procedure.

Parent/Guardian Signature

Date

Client Name

Date

Student Signature

Date

Starr Commonwealth--Ohio Authorization for Release of Information

Person's Full Name:	
Date of Birth:	SSN:

I give my permission for the staff of the Starr Commonwealth to exchange/give/receive/share/re-disclose information for the above named person with:

Name of Individual and/or Agency

Phone Number

Address

FOR THE PURPOSE OF: Assessment, service delivery planning and/or securing, coordinating, and/or providing services

THIS CONSENT EXPIRES ON THIS DATE: _____

I understand that the Consent for Release of Information expires 180 days from the date it is signed Unless otherwise indicated herein by the consumer to shorten or lengthen the authorization period.

THE TYPE OF INFORMATION TO BE RELEASED IS AS FOLLOWS:

INITIAL AFTER EACH CHECKED ITEM IS REQUIRED BY CLIENT OR PARENT/GUARDIAN:

		Initial Below			Initial Below
<input type="checkbox"/>	Identifying Information		<input type="checkbox"/>	Individual Service Plan(ISP) or Treatment Plan	
<input type="checkbox"/>	Diagnosis/Clinical Impressions		<input type="checkbox"/>	Mental Health Treatment Summary	
<input type="checkbox"/>	Social History		<input type="checkbox"/>	DYS/Juvenile Court Status	
<input type="checkbox"/>	Insurance/Medicaid Information		<input type="checkbox"/>	Toxicology/Urine Screens	
<input type="checkbox"/>	Assessments (Diagnostic)		<input type="checkbox"/>	Assessments (Vocational/Life Skills)	
<input type="checkbox"/>	School Records(includes grades, conduct, attendance)		<input type="checkbox"/>	Individual Education Plan and Multi-Factored Evaluation	
<input type="checkbox"/>	Medical Records (Physical)		<input type="checkbox"/>	Medication, history and current prescriptions	
<input type="checkbox"/>	Psychological Evaluation		<input type="checkbox"/>	Psychiatric Evaluation and Recommendations	
<input type="checkbox"/>	Discharge Summary or Termination Reports		<input type="checkbox"/>	Transition Plan/Community Linkages	
<input type="checkbox"/>	Progress Reports (could include frequency of contacts, progress on goals, safety issues, recommendations)				
<input type="checkbox"/>	Other, specify:				

Information regarding the following shall NOT be released unless initialed below by the client:

Circle below	Initial Below		
YES	NO		Substance abuse diagnosis and treatment
YES	NO		HIV and AIDS related diagnosis and treatment
YES	NO		Financial Information: Public assistance eligibility and payment information provided for establishing eligibility including but not limited to pay stubs, W2s and tax returns.

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the following information	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State and ZIP for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is an adult? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, indicate if child is in legal custody of the following (this is not the foster parent)	
<input type="checkbox"/> Parent <input type="checkbox"/> CSB <input type="checkbox"/> DYS <input type="checkbox"/> Court <input type="checkbox"/> Other (specify) _____	
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone Number of Legal Custodian
County of Legal Custodian	
If Parent, Addresses of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these and/or what documentation is needed to provide proof of residency.

NEW MEMBER ENROLLMENT/UCI REQUEST

* = Required Field

ADAMH/ADAS/CHM Board Consortium

*MACSIS UCI No. (Req'd on change only)

*Form Type
 N = New Member
 C = Change/Correction

PROVIDER INFORMATION

*Submitting Provider		Date Faxed to Enrollment Center	*UPI
*Collect Person	*Fax No.	*Phone No. (include ext.)	

CLIENT INFORMATION

*Last Name *First MI

*DOB *Gender M F

*Address #1

*Address #2

*City *State *Zip -

*Race ("X" all that apply) A = Asian B = Black/African American M = Alaskan Native N = Native American/American Indian
 P = Native Hawaiian/Other Pacific Islander W = White U = Unknown

*Ethnicity ("X" all that apply) A = Puerto Rican B = Mexican C = Cuban D = Other Hispanic E = Not Hispanic or Latino

Home Phone Business Phone

Non-English Language Code *Marital Status S = Single M = Married D = Divorced W = Widowed

Medicaid No. *SSN Client ID at Provider (medical record no.)

*Start Date - - *Family Size *Adjusted Gross Mo. Income

*County of Residence (list 4 letters of co.) Out of State

Plan Type MH - Mental Health AD - Alcohol and Other Drugs DF - Dual Funded

Client is potentially SMO/SED? Yes No

*AOD release of information signed (AOD only)? Yes No

*Consent for treatment signed? Yes No

*Client refused to sign consent for treatment (MH only)? Yes No

*In crisis at enrollment? Yes No

Sliding Fee Percentage	Member Copay	Referred to		
Provider Name	UPI	Other 1	Other 2	Other 3

Prohibition on Redisclosure: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse and/or mental health treatment. State and federal law prohibit redisclosure of this information without the client's consent. With respect to clients receiving alcohol or other drug addiction treatment, this information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ITEMS COMPLETED BY ENROLLMENT STAFF

Group Level 3 Plan Panel

Riders Term Date Term Reason

Self Entering Data	Date Entered	Date Faxed to Provider
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