

ROBERT J. KINSEY YOUTH CENTER ADMISSIONS POLICY AND PROCEDURE

POLICY

It is the policy of the Robert J. Kinsey Youth Center to accept those children for admission to any residential unit who are appropriately referred by persons having detention and placement authority. Priority placement will be given to those Howard County Agencies that have such authority with secondary consideration given to those other jurisdictions as a courtesy when beds are available. All admissions will meet the requirements as specified in the Indiana Juvenile Code. All admissions other than those coming directly from the court will be cleared through the appropriate authority representing the Robert J. Kinsey youth Center.

PROCEDURE

1. When a child is deemed appropriate for detention or residency by a caseworker all required paperwork for admission is to be completed by the placing agency.
2. The placing caseworker contacts the appropriate authority from the Youth Center to obtain clearance for admission.
3. Once clearance for admission is obtained the child can be transported to the appropriate facility and must be accompanied by the paperwork. No one will be accepted without the appropriate documentation.
4. Information regarding the clearance and arrival of the child will be given to the respective facility by the Youth Center staff giving clearance.
5. The placing caseworker will provide the parent or guardian with the information regarding the place of detention and the policy regarding contact with their child.
6. The placing caseworker will assist the facility in obtaining any necessary medication, clothing, and school materials.
7. All agencies placing a child in a facility of the Robert J. Kinsey Youth Center will make face to face contact with that child at least once per week throughout the term of child's stay. Those agencies from outside Howard County can substitute a telephone call weekly for the personal contact.
8. A signed Court Order is also necessary for placement within 48 hours of the child's arrival at the Robert J. Kinsey Youth Center.

**ROBERT J. KINSEY YOUTH CENTER
ADMISSIONS AGREEMENT
RESIDENTIAL UNIT, CBC PROGRAM**

DATE _____

_____, licensed child placement agency, does hereby request the Robert J. Kinsey Youth Center to receive for care _____ . I believe that this child poses a threat to self or others only as described below. I further believe that this child is under the influence of drugs or non-prescription drugs only as described below. I agree if the Robert J. Kinsey Youth Center accepts this child for care that:

1. Said child shall remain in the care of the Robert J. Kinsey Youth Center designated by the Court.
2. Said child may be visited by approved visitors as stipulated on the authorized visitors list and under conditions stipulated by the Robert J. Kinsey Youth Center.
3. We, the undersigned, will be available for conferences regarding said child as requested by Robert J. Kinsey Youth Center.
4. We, the undersigned, agree to provide written documentation of said child as requested by the Robert J. Kinsey Youth Center.
5. Any placing agency outside Howard County agrees to immediately remove any child whose removal is deemed appropriate and/or necessary by the Robert J. Kinsey Youth Center.
6. We, the undersigned, agree to make monthly payments, as billed, at the per diem rate of \$140.00

PER DIEM IS BILLED FOR THE DAY OF ADMISSION IF PRIOR TO 10:00 PM AND RELEASE DAY IF AFTER 6:00 AM.

I believe this child to be a threat to self or others: Y N

EXPLANATION

WE MUST REQUIRE THAT YOU PROVIDE A TELEPHONE NUMBER AND PERSON WHO CAN BE CONTACTED ON A 24 HOUR BASIS.

Contact Person & Title

Telephone

Placement Agency Staff Signature

Date

Kinsey Youth Center Staff Signature

Date

Residential Care Unit, CBC Program
701 S. Berkley Road
Kokomo, IN 46901
(765) 457-1408

ADMISSION APPLICATION

INSTRUCTIONS:

This form should be completed promptly, in detail (consult your doctor for assistance if you wish). If you need more space for answers, additional sheets may be attached.

PLEASE TYPE OR PRINT CLEARLY

APPLICANT refers to the name of the individual being considered for admission. It is the policy of the Kinsey Youth Center to admit and treat all applicants without regard to race, creed, color or national origin.

Person completing this application: _____

Relationship to APPLICANT: _____

Family's language: _____

Applicant's present residence (check one):

_____ Home _____ Residential Center _____ Shelter Care
_____ Foster Home _____ Hospital _____ Group Home

REASON FOR REFERRAL

Presenting Problems/Reason for Referral – In your own words, please describe the problems applicant is having:

Child's Name: _____
Current Legal Status: _____

ALLEGATIONS

- (1) Date: _____ Time: _____ Offense: _____ A D
- (2) Date: _____ Time: _____ Offense: _____ A D
- (3) Date: _____ Time: _____ Offense: _____ A D
- (4) Date: _____ Time: _____ Offense: _____ A D

PREVIOUS REFERRALS

(Date/Charge/Detention/Disposition)

- (1) (/ /) _____
- (2) (/ /) _____
- (3) (/ /) _____
- (4) (/ /) _____

SCHOOL

School Name: _____ Grade: ____ Type: REG MMH EH SHE LD

Attendance: _____ Explanation: _____

Grades: A's B's C's D's F's

Suspensions/Expulsions: _____

Habitual Detentions: _____

PLEASE INCLUDE COPIES OF ALL PRELIMINARY INQUIRIES AND REVIEW SUMMARIES.

Applicant's Name: _____

Referral Agency: _____ Phone _____
Address: _____

Caseworker/Probation
Officer: _____ Phone: _____

Legal Custody: _____
(Provide Proof of Guardianship)

Adjudication: _____

SIGNIFICANT OTHER – (i.e., step-parent, custodian, guardian)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Employment: _____ Employment: _____

Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____

NON-CUSTODIAL PARENT INVOLVEMENT (i.e., visitation, support)

SIBLING (S):

Name: _____ Age: _____ Address: _____

Name: _____ Age: _____ Address: _____

Name: _____ Age: _____ Address: _____

SOCIALIZATION:

Curfew: _____ Abides: _____

Associates: _____

_____ Do Parents Approve: _____

Physical Abuse: Y N _____

Sexual Abuse: Y N _____

Neglect: Y N _____

Alcohol Use: Experimental Recreational Disruption None

Drug Use: Experimental Recreational Disruption None

Obsession W/Fire: _____

Gang Involvement: Y N Affiliate: _____

CHILDS FUNCTIONING IN THE HOME:

Does Child Respond to Discipline/Authority: _____

Is Child Abusive Towards Family Members: _____

Other: _____

DETENTION:

Has The Juvenile Ever Been Detained:

_____ Yes _____ No When: _____ Secure/Non-Secure

Why: _____ Unlikely to Appear

_____ Class A or B Felony

_____ Youth's Request

_____ Parent Not Found/Unwilling

_____ Protection Child/Community

_____ Other: _____

**ROBERT J. KINSEY YOUTH CENTER
HEALTH AND MEDICAL INFORMATION**

Child's Name: _____

Parent or Guardian: _____

Address: _____

Phone 1: _____

Phone 2: _____

Parent or Guardian: _____

Address: _____

Phone 1: _____

Phone 2: _____

Child's Address: _____

Phone: _____

Age: _____ **Yr** _____ **Mo** **DOB:** _____ **Race:** _____ **Sex:** _____

Birthplace: _____ **SSN:** _____ - _____ - _____

Height: _____ **ft** _____ **in** **Weight:** _____ **Hair:** _____ **Eyes:** _____

LIST:

- Child's Doctor _____
- Child's Dentist _____
- Mental Health Provider _____
- Insurance Carrier _____
- Insurance Number _____
- Name of Insured Person _____
- SS # of Insured Person _____
- Employment of Insured Person _____
- Date of Birth of Insured Person _____
- Medicaid No. _____
- Specific Hosp. Or Doctor _____
- Restrictions (explain) _____

Approved Contacts and Relationship to Child:

Phone _____

 Visitors _____
 (Please attempt to limit to parents/
 guardians or parental figures) _____

 Passes _____

(Shelter Care/Residential) _____

Emergency Name _____
 Emergency Phone _____
 Religious Preference _____

IS THE CHILD:

Under a physicians care? _____yes _____no
 Taking any medication? _____yes _____no
 If yes, list medication: _____

Wearing eye glasses/contacts: _____yes _____no
 Allergic to foods/medication? _____yes _____no
 If yes, explain: _____

A user of tobacco products? _____yes _____no
 Pregnant/suspect pregnancy? _____yes _____no
 Wearing a prosthesis? _____yes _____no

DOES THE CHILD:

Wet the bed? _____yes _____no
 Have sleep irregularities/
 Fall out of bed/sleepwalk? _____yes _____no
 Have convulsions and/or
 seizures? _____yes _____no
 Have asthma? _____yes _____no
 Have respiratory conditions? _____yes _____no
 Have diabetes? _____yes _____no
 Have a history of tuberculosis? _____yes _____no
 Have body piercings? _____yes _____no
 If yes, where? _____

Have a special diet? _____yes _____no
Have scheduled medical appointments? _____yes _____no

HAS THE CHILD:

Been exposed to communicable Disease in the past 3 weeks? _____yes _____no
Had the chickenpox? _____yes _____no
Been hospitalized? _____yes _____no
Had recent injuries requiring Medical attention. _____yes _____no
Had recent illnesses lasting More than one week? _____yes _____no

MISCELLANEOUS:

Medical condition not previously covered _____

Other: _____

LIST DATES OF THE MOST RECENT:

1. Tetanus Shot _____ 2. TB skin test _____

Notes: _____

AUTHORIZATION FORM

Name of Child : _____

Date: _____

I authorize the Kinsey Youth Center staff to release or receive medical, social and psychological information when the staff feels it serves the best interests of the above-mentioned child.

Child's Signature

Parent/Legal Guardian Signature

Relationship to Child

Staff Signature/Witness

Date

CONSENT FOR MEDICAL TREATMENT

I, _____ parent or legal guardian of the minor, _____, do hereby give my permission for the personnel of the Robert J. Kinsey Youth Center to take said minor child to a doctor or hospital and authorize that person to give consent for treatment and sign authorization on my behalf for any treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

Parent or Guardian Signature

Date

CONSENT FOR MENTAL HEALTH TREATMENT

I, _____, parent or legal guardian of the minor, _____, do hereby give permission for the personal for the Robert J. Kinsey Youth Center to take said minor child to a doctor, therapist or hospital and authorize that person to give consent for MENTAL HEALTH treatment and sign an authorization on my behalf for any MENTAL HEALTH treatment or procedure deemed necessary by the attending physician. I further accept all financial responsibility for costs incurred for treatment.

Parent or Guardian Signature

Date

Please list the names of all agencies which have had contact with the applicant or the applicant's family and the dates of those contacts:

_____	_____
Agency	Date
_____	_____
Agency	Date
_____	_____
Agency	Date

PLEASE NOTE, STATE LICENSING REQUIRES THAT WE HAVE A COPY OF THE FOLLOWING INFORMATION:

- **CHILD'S BIRTH CERTIFICATE**
- **SOCIAL SECURITY CARD**
- **IMMUNIZATION RECORD**
- **SCHOOL TRANSFER CERTIFICATE**

PLEASE ATTACH COPIES OF THE FOLLOWING PAPERWORK:

- **HEALTH AND MEDICAL FORM**
- **PRELIMINARY INQUIRY OR DEPARTMENT CASEPLAN**
- **PRE-DISPOSITIONAL REPORT**
- **HEALTH INSURANCE INFORMATION**
- **PSYCHOLOGICAL TESTING OR DISCHARGE SUMMARIES FROM OTHER PLACEMENTS**

