

**Respite Use of Logan County Children's Services
Licensed Family Foster Homes**

To: _____ **From:** _____

Fax #: _____ **Re:** _____

The following forms **must** be completed and faxed to Logan County Children's Services prior to placement at (937) 599-7296, Attn: Libby McClure. The lead agency is also responsible for providing a copy to the foster parent at the time of respite.

Required documentation to be completed:	
	Respite Search Fact Sheet
	Right to Treat/Transportation Form
	Consent to Treat Agreement
	Medical Insurance Coverage Agreement
	Copy of Medical Card/Proof of Insurance
	Copy of Genogram
	Copy of Crisis Plan

Instructions for Completing Respite Forms

- 1.) **For the Respite Search Fact Sheet-** Please make sure that all of the areas on the Fact Sheet are completed. If the area is unknown, obtain the information from the family, etc.
- 2.) **Medical card/proof of insurance-** A copy of the child's medical card or proof of insurance needs to be submitted with the rest of the respite forms.
- 3.) **Genogram-** A genogram of the family also needs to be submitted with the rest of the respite forms. The genogram should contain at least the following items: 3 generations of family members and the names and addresses of the family members (see attached genogram information).
- 4.) **Crisis plan-** If there is a crisis plan, the plan needs to be submitted with the rest of the respite forms.

Office Use:

	Date	Workers Initials
Packet Received	_____	_____
Client Status Completed	_____	_____

RESPITE/PLACEMENT SEARCH FACT SHEET AND AGREEMENT

INFORMATION ABOUT THE CHILD

Child's name: _____ DOB: _____ Age: _____
 Race: _____ Child's SSN: _____
 Current location of the child: _____
 Person completing form: _____ Date: _____

Presenting Problems: *past or present*
 (check all that apply to child)

Past	Present/Last 3 Months	
___	___	Sexually abused Perpetrator's relationship to child:
___	___	Physically abused Perpetrator's relationship to child:
___	___	Neglected Perpetrator's relationship to child:
___	___	Inappropriate sexual behaviors Describe:
___	___	Sex offender Adjudicated?
___	___	Encopresis
___	___	Enuresis Day wetter, Bed wetter?
___	___	Aggression (verbal/physical) Towards others, who?
___	___	Animal Abuse
___	___	Anger management problems
___	___	Lying
___	___	Stealing
___	___	Runaway
___	___	Truancy
___	___	Sleep disorder Medications?
___	___	Eating Disorder Past Tx?
___	___	Fire Setting
___	___	Authority Issues With women, With men?
___	___	ADD/ADHD Medications?
___	___	Alcohol and/or drug abuse Please describe:
___	___	Smoker (smoking should not be permitted for a youth under 18)
___	___	Suicidal Ideation Please describe:
___	___	Self-esteem problems
___	___	Hygiene problems
___	___	Other (please specify)

Is the child on probation? _____ If yes, who is their probation officer? _____
Why are they on probation? _____

If the child has been adjudicated delinquent, please describe the act that resulted in the child being found delinquent, and the disposition made by the court: _____

Please give any information on any violent acts committed by the child: _____

Child's personality (please try to consider activities the child enjoys and list some good characteristics as well as the negative) _____

Health Considerations

Name of doctor: _____ Name of dentist: _____

___ Allergies (please specify...food, medications, etc.) _____

___ Physical/Health Problems (please specify) _____

___ Currently on Medications (please specify, including dosage) _____

Does the child have any problems (such as allergies or asthma) that would prevent him/her from being placed in a foster home with animals/smokers? _____ If so, please describe: _____

Child's approximate height _____ Approximate weight _____

School Information

Home school: _____ Current School: _____

Grade Level: _____ Program:(LD, SBH, MR, etc.) _____

Academic performance?(A's, B's, C's, etc.) _____

School behavioral issues(including peer relationships) _____

Counseling

Is the child currently in counseling? _____ With whom? _____

Contact telephone number: _____

Has the child had a psychological evaluation and/or assessment in the last year? _____

If so, date _____ Completed by?(name and agency) _____

What is the current diagnosis, if any? _____

Please attach conclusions and recommendations of the psychological evaluation.

Visitation

Is the child allowed to have contact with birth family members or friends during respite? _____

Please list restrictions _____

Setting

Are there any restrictions that would prevent the child from being in a home with other children? _____ If so, please describe: _____

Are there any restrictions that would prevent the child from being in a single parent home? If so, please describe: _____

Other pertinent information: _____

Financial Arrangements

The current foster care per diem for children ages birth-4 years old is \$28.00 a day, 5-12 years old is \$26.00 a day, and 12-18 years old is \$30.00 a day. This is for Logan County Children’s Services foster homes only.

Emergency Procedures

The foster parents should contact _____ if there is a problem with the child during this respite at the following number(s) _____

By signing below, we agree that this information is accurate to the best of our knowledge and that we will be available if the foster parent should need to contact us during this respite.

Lead Worker Signature

Date

By signing below, we acknowledge that this information was shared with us prior to agreeing to provide respite for the above named child.

Foster Parent Signature(s)

Date

By signing below, we agree to the provision of respite care by _____, licensed by Logan County Children’s Services.

Foster Parent’s Address: _____

LCCSB Staff Signature

Date

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Right to Treat

As the parent/guardian of _____, I agree to allow Logan County Children's Services to treat him/her, using various resources of the agency, as appropriate. I also authorize Logan County Children's Services to sign for emergency medical treatment in the event I cannot be reached. I accept financial responsibility for all medical expenses.

Non-Prescription Medications

I authorize the Logan County Children's Services foster parent, or staff member to administer minor treatment (the normal treatment that would normally be administered at home), if the need arises.

Transportation

As the parent/guardian of _____, I give my permission for him/her to travel with a Logan County Children's Services staff member or Logan County Children's Services foster parent.

This consent expires the date of discharge unless an earlier date is specified.

Parent/Guardian/Custodian

Relationship to Youth

Date

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The undersigned being the legal custodian of _____ and having entered into an agreement with Logan County Family & Children First Council, hereafter referred to as FCFC, under the terms of which they have entrusted the care of the above youth, and under terms of which FCFC has accepted such care, do in consideration for the signing of such agreement, authorize FCFC to arrange with Logan County Children's Services for respite placement of the above youth, not to exceed 10 days:

- 1.) Acquire or provide any and all routine medical, dental and psychiatric care, treatments and medication prescribed by a licensed physician, psychiatrist or dentist; including any necessary diagnostic tests and immunizations with prior approval of the parent/guardian when applicable.
- 2.) Take whatever steps necessary to aid said child should a medical or dental emergency arise, including but not limited to providing consent for the administration of anesthesia and the performance of any emergency operation or medical procedure found necessary by competent medical examination.
- 3.) Provide consent for appropriate school activities in which said child participates with prior approval of the legal custodian when applicable.

With initial here _____, I understand that I have the right to withdraw my consent at any time.

Legal Custodian

Date

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The undersigned being the legal custodian of _____, and having entered into an agreement with Logan County Family & Children First Council, under the terms of which they have entrusted to its care their ward, and under the terms of which FCFC has accepted such care, do in consideration for the signing of such agreement,

- 1.) Authorize Logan County Children's Services to acquire and/or provide medical treatment for said child
- 2.) Authorize the submission of billing for treatment as follows:

Please check all appropriate boxes and fill out the needed information:

- MEDICAL CARD # _____
Copy of card enclosed yes no, sending later
County Issuing Card: _____
- Youth is Medicaid eligible and a Medical Card is pending
- Youth is covered by other medical insurance (which shall be billed as primary)
Insurance Company Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Mental Health/Substance Abuse pre-certification (tel.) _____
Policy #: _____ Effective Date: _____
Enrollee's Name: _____ D.O.B.: _____
Enrollee's SSN: _____ Employer: _____
- Deductible is to be paid by: _____

If third-party coverage is unavailable (including absence of actual medical card causing medical/dental provider to refuse to treat) at any time during placement, the legal custodian do hereby assume responsibility and authorize the medical/therapeutic provider or Logan County Children's Services to submit the proper billing for services rendered to said child to the following address for payment:

Name of Placing Agency/Parent: _____
Attn: (e.g. Fiscal Department): _____
Mailing Address: _____
City, State and Zip Code: _____

Legal Custodian

Date

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COMMUNICATION PROCESS

Communication Process and Responsibilities

- 1) The lead worker is the single point of contact for the family requesting respite.
- 2) The CSB Resource Care Facilitator will be the primary point of contact for the Resource Family and/or Purchased Care Agency. Contact information for the Resource Care Facilitator:
Libby McClure Agency phone: 599-7290 Agency Fax: 599-7296
Email mcclue@odjfs.state.oh.us Cell: 937-210-0748

I. Initial Request:

- a. The lead worker and family will complete the respite packet and identify how often respite is requested.
- b. The lead worker will communicate with the family to determine requested respite dates.
- c. The lead worker will submit the respite packet to the Resource Care Facilitator, when possible at least one week before requested respite.

II. For Emergency Respite:

- a. The lead worker will contact the Resource Care Facilitator, as soon as possible with request (include times for drop off and pick up).
- b. The lead worker will communicate with the family requesting respite, assure transportation, and assure that the child has all required items for respite (clothes, hygiene supplies, medications).
- c. The Resource Care Facilitator will work to identify a Respite Provider and will provide the lead worker with the Respite Providers contact information and arrangements for the respite.

III. For Ongoing Respite:

- a. The lead worker will communicate with the family requesting respite to identify requested respite dates.
- b. The lead worker will provide the Resource Care Facilitator with requested dates at least two weeks prior to the requested dates.
- c. The Resource Care Facilitator will confirm arrangements with the Respite Provider and provide confirmation and any additional information to the lead worker.
 - i. NOTE: Families requesting respite should not be arranging respite dates directly with the Respite Provider.