ORCHARD PLACE CAMPUS ACCESS FORM

Please complete the following information to the best of your ability. This information is critical to the treatment that your child and family will receive. Full and accurate information is necessary. Please return this form to the Orchard Place admissions at:

925 SW Porter Ave, Des Moines, IA 50315 or Fax to 515-287-9695 or orchardplacecampus@orchardplace.org

Date Request Made: _____

Person Filling Out Form and Relationship to Child: _____

SECTION 1 - CHILD'S DEMOGRAPHIC INFORMATION

Full Legal Name (First, Middle, Last):

_____

Preferred Name:_____

SSN #: _____ Date of Birth: _____ Age: _____

City/State Born in: _____ Religious Preference: _____

Gender: ☐Female ☐Male ☐Other/Non-Binary Legal Sex: ☐Female ☐Male

Pronouns: _____

CHILD's CURRENT LEGAL INVOLVEMENT *(Check all that apply)*

☐ CINA ☐ Consent Decree ☐ Formal Probation ☐ Adjudicated Delinquent

☐ Informal Probation ☐ Other Police Involvement ☐ No Legal Involvement ☐ Unknown

☐ DHS Involvement If DHS involvement, please explain: _____

Is Child under Court Order? ☐ Yes ☐ No Date of Adjudication: _____

CLIENT RACE / ETHNICITY *(As identified by the client)*

ETHNICITY:

☐ Hispanic, Latino/a/x or Spanish origin (select all that apply)

☐ Cuban
☐ Salvadoran
☐ Puerto Rican
☐ Honduran
☐ Columbian
☐ Guatemalan
☐ Mexican or Chicano/a/x
☐ Spaniard
☐ Hispanic, Latino/a/x or Spanish origin
☐ Self-identify: _____

☐ Not of Hispanic, Latino/a/x or Spanish origin

☐ Prefer not to answer

RACE: (select all that apply)

☐ Native/Indigenous American or Alaska Native
(Nation/Tribe_____)
☐ Asian or Asian American
☐ Self-Identify:_____
☐ Prefer to not answer
☐ Black or African {American}
☐ Middle Eastern
☐ Native Hawaiian or Other Pacific Islander
☐ White

Client/family are refugees: ☐ Yes ☐ No

CULTURAL NEEDS: Is there anything we need to consider to meet you/your child's cultural needs? For example: Hair care products, hygiene products, holidays, roommate considerations, therapist considerations, language, etc.

SECTION 2 - SERVICES PROVIDERS/SUPPORTS

Indicate all services child is currently receiving or has received. <u>Include names, addresses and phone numbers.</u>

These providers will be contacted for records. This is an important step in reviewing referrals.

Primary Care Physician _____

Psychiatrist / Medication Prescriber_____

Therapist(s)_____

Behavioral Health Intervention Services (BHIS)_____

Case Management-MCO/CCBHC _____

Substance Use Services_____

Psychological / IQ Testing_____

Hosptial Program (Inpatient/Outpatient)_____

Crisis Stabilization_____

PMIC / Residential Program_____

Shelter Stays_____

Juvenile Detention Placement_____

Juvenile Court Officer_____

DHS Worker_____

Guardian Ad Litem / Attorney_____

Other_____

SECTION 3 – FAMILY INFORMATION

Legal Custodian of Child: _____

Who Does Child Normally Live With: _____

Where is Child Living Now: _____

If Out of Home, List Date Placed at This Location: _____ Last Date Child Lived at Home: _____

Custody/Visitation Info:

_____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____

Preferred method of contact:

☐ Home _____

☐ Cell Phone _____

☐ Work Phone _____

Occupation: _____

Email Address: _____

Date of Birth: _____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____

Preferred method of contact:

☐ Home _____

☐ Cell Phone _____

☐ Work Phone _____

Occupation: _____

Email Address: _____

Date of Birth: _____

Military History / Service Record of the Parents: _____

Are There Other Caretakers for the Child: _____

Sibling Information

Sibling's Names (First and Last)	Live in Home? Y/N	Gender (F)emale (M)ale (O)ther	Age/Remarks
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____

Others in the Home

_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____

Is your child adopted? ☐ Yes ☐ No If Yes, at what age? _____

List important information about the birth family:

Family Stressors and Mental Health History: *(select all that apply and explain below)*

☐ Abandonment
☐ Abuse
☐ Child abuse investigation current or previous
☐ Child custody/visitation dispute
☐ Citizenship
☐ Court involvement
☐ DHS involvement
☐ Death
☐ Disability
☐ Domestic violence
☐ Educational
☐ Employment
☐ Financial
☐ Illness
☐ Incarceration
☐ Mental health disorder
☐ Neighborhood
☐ Numerous moves
☐ Physical illness
☐ Racial trauma
☐ Separation/divorce
☐ Sibling rivalry/conflict
☐ Substance abuse
☐ Suicides attempts in the family
☐ Suicide completions in the family
☐ Transportation
☐ Other

For each item identified, please describe:

Please describe the family mental health history below. Indicate the person and their relationship to the child.

SECTION 4 - TRAUMA HISTORY

History of Trauma: *(select all that apply and then describe below)*

- ☐ Accidents, e.g., care accidents
- ☐ Assault
- ☐ Attacked by an animal
- ☐ Care provider mental illness
- ☐ Community violence
- ☐ Contact with a sexual offender
- ☐ Death of someone important to child
- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Exploitation
- ☐ Illness
- ☐ Incarceration
- ☐ Mental health discrimination
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Physical abuser
- ☐ Racial language
- ☐ Racial trauma
- ☐ Rape
- ☐ Separation from caregiver/parent
- ☐ Sexual abuse - victim
- ☐ Sexual abuse - perpetrator
- ☐ Sexually Inappropriate with someone else
- ☐ Social trauma
- ☐ Suicide/ attempts
- ☐ Verbally abused, e.g., name calling, etc
- ☐ Witness to physical or sexual abuse
- ☐ Other (explain below)

Description of Trauma History and concerns *(please include age(s) of those involved)*:

_____

If child has any physical, or sexual abuse, please indicate by whom abuse occurred.

_____

If the child has contact with a person who is a sex offender please list person name.

_____

If the child has a no contact order of any kind, please describe below.

_____

SECTION 5 - REFERRAL INFORMATION/PRESENTING CONCERNS

Who is recommending Orchard Place Campus for your child?

_____

Reason for Referral: *(Select all that apply)*

- ☐ Throwing things
- ☐ Verbal aggression toward others
- ☐ Physical aggression toward others
- ☐ Aggression with property
- ☐ Homicidal attempts
- ☐ Homicidal thoughts
- ☐ Hurts animals
- ☐ Fire-setting
- ☐ Unusual thinking
- ☐ Inflexible thinking
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Hearing voices or seeing visions
- ☐ Bouts of severe anxiety/panics
- ☐ Responding to hallucinations
- ☐ Using racial slurs
- ☐ Paranoid or unusual fears
- ☐ Language/speech problems
- ☐ Inability to plan or organize
- ☐ Problem with authority
- ☐ Stealing
- ☐ Refuses to follow directions
- ☐ Obsessive or compulsive behaviors
- ☐ Rocking/banging
- ☐ Running away
- ☐ Self-injury
- ☐ Suicidal thoughts
- ☐ Suicidal attempts
- ☐ Pulling out eyelashes/hair
- ☐ Impulsive
- ☐ Confusion of fantasy and reality
- ☐ Substance use
- ☐ Other (*explain below*)

_____

Description of behavioral concerns within the last 2 years. (Please describe check boxes)

_____

SECTION 6 - MEDICATIONS, DIAGNOSIS, AND USE OF HISTORY OF RESTRAINT OR SECLUSION

Please list your child's **current** psychiatric diagnosis:

_____

Is child **currently** taking psychiatric medications? List current psychiatric medication and response to the medication:

Has your child taken psychiatric medications **previously?**

If **yes**, list previous psychiatric medication, response to the medication and reason for discontinuing:

_____

Has your child ever been restrained in a hospital, in a crisis stabilization unit, school at home or other setting?

If **yes**, indicate when, why and child's response.

_____

Are you aware of any medical conditions or any physical disabilities that may cause problems during a physical restraint

_____

Are there any nutritional concerns or dietary needs? If yes, please explain below:

_____

SECTION 7 - LIFE SKILLS AND BEHAVIORAL INFORMATION

Life skills or hygiene your child needs assistance with:

_____

Any concerns with wetting or soiling self either during the day or at night? If **yes**, please describe:

_____

Social/Recreational History

Relationship with Peers: *(Select all that apply and explain below)*

- ☐ Age-Appropriate social skills
- ☐ Fights
- ☐ Leader
- ☐ Poor Boundaries
- ☐ Bossy
- ☐ Follower
- ☐ Problems with Peers
- ☐ Being bullied
- ☐ Bullying others
- ☐ Gang Involvement
- ☐ Outgoing
- ☐ Withdrawn
- ☐ Other

Description of Relationship with Peers:

_____

Any history that would indicate child needs a single room such as: sexual behavior, aggression, use of racial slurs or socialization issues? *(please note children needing single rooms may have to wait longer to be admitted)*

_____

What are the rules and consequences in your home?

_____

SECTION 8 - SEXUAL INFORMATION/HISTORY

Check all that apply and then describe below.

- ☐ Excessive Flirting
- ☐ Difficulties with Sexual Orientation
- ☐ Currently Pregnant
- ☐ Previous Pregnancy
- ☐ Sexually Active
- ☐ Sexually Transmitted Disease
- ☐ Online sexual behaviors
- ☐ Sexual behaviors in hospital/shelter or residential settings
- ☐ Sexual behaviors toward siblings/family members
- ☐ Seeking relationships outside of the child's age group
- ☐ Other

Description of Sexual History/ Concerns:

_____

SECTION 9 - EDUCATIONAL HISTORY

Name of Current or Most Recent School: _____

Address: _____ Grade: _____

Current Individualized Education Plan (IEP)? ☐ Yes ☐ No Current 504 Plan? ☐ Yes ☐ No

Has your child been suspended from school? ☐ Yes ☐ No If **yes**, what grade(s)? _____

What behaviors led to being suspended?

_____

Schools Attended:	Grade	Problems? Yes/No	(Learning or Behavioral? When?) Comments
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____

Has your child ever been employed? ☐ Yes ☐ No

Trials/Career Interests:

_____

SECTION 10: CHILD'S SUBSTANCE USE HISTORY/EXPOSURE

Childhood Exposure to Substance Use:	☐ Yes	☐ No	☐ Unknown
Client has a History of Substance Use:	☐ Yes	☐ No	☐ Unknown
Previous Substance Abuse Services:	☐ Yes	☐ No	☐ Unknown

Substance Use: *(if indicated a history of substance use - check all that apply)*

☐ Alcohol	☐ Heroin	☐ Stimulants
☐ Barbituates	☐ Inhalants	☐ Synthetic Marijuana
☐ Benzodiazepines (Xanax, Klonopin)	☐ Marijuana	☐ Tobacco/Nicotine
☐ Club Drugs/Hallucinogens	☐ Methamphetamine	☐ Other
☐ Cocaine/Crack	☐ Opiates	
	☐ Over the Counter	

_____

Description of Substance Use and/or Substance Abuse Services, including other involvement with drugs, dealing drugs *(please include age of use)*:

_____

Has your child experienced legal, behavioral or social consequences from the use of alcohol or drugs?

_____

SECTION 11 – FAMILY EXPECTATIONS AND PARTICIPATION REQUIREMENTS

What are your child's strengths and interests? Please be sure to comment on both.

_____

What do you think your child's treatment goals should include?

_____

Our program involves making changes for the whole family. What do you think the family treatment goals should include?

_____

Discharge Location and Plan:

_____

When one member of a family comes to Orchard Place Campus, the whole family shares concerns, worries, and the discomfort of separation. Regularly scheduled family therapy sessions and visitation will be planned by you and your family's therapist. Family sessions will be regularly scheduled and you may set up visits with your child through your family therapist.

Weekly family therapy sessions are required. At a minimum, twice per month in-person sessions are required with phone or telehealth sessions on the opposite weeks. Having all sessions in-person are preferred, when possible. Family therapy occurs between the hours of **8a—5p Monday-Friday**.

Will you be able to participate weekly? ☐ Yes ☐ No

Preferred session day and time: _____

Do you have the capabilities for telehealth sessions? ☐ Yes ☐ No

Do you have means of getting to your appointments at the Orchard Place Campus? ☐ Yes ☐ No

Will you be able to visit your child weekly on campus? ☐ Yes ☐ No

When your child has progressed in treatment, will you be able to have your child come home for visits? ☐ Yes ☐ No

In addition to family therapy, we also ask out parents/guardians to attend scheduled Psychiatric Review/Treatment Planning Sessions, or staffings, as part of the treatment team. Staffings provide an opportunity to hear progress reports from the unit, school, therapist and psychiatrist as well as participate in treatment planning and review. These are held around 30 days after admission and every quarter thereafter. Staffings are held during normal business hours to accommodate the psychiatrist schedules and any other professionals involved in your child's treatment.

Would you be able to attend regularly scheduled staffings? ☐ Yes ☐ No

Would you be able to attend informational trainings/parenting classes/support groups? ☐ Yes ☐ No

Do any parents/guardians or therapy participants require accommodations such as language translator, wheelchair accessibility, hearing impaired services, etc. If yes, please list below.

_____

To my knowledge, the above information is complete and accurate. I understand that failure to provide information could result in unsuccessful treatment.

_____ _____

Signature ***Date***

ORCHARD PLACE
FINANCIAL AGREEMENT

ALL DIVISIONS

Name of Person Receiving Services: _____ SSN: _____

For the services provided by Orchard Place, I understand and agree that I and/or my insurance carrier will be billed. My insurance carrier will be billed at full fee. I understand that Medicaid is always the payer of last resort. **I agree to notify Orchard Place if there is a change in my insurance coverage and understand I may be responsible for all charges if I do not do so.** I understand I am responsible for payment of my fee regardless of insurance coverage and agree to pay my portion of the fee as the service is provided. I understand my payment will be used to cover my co-payment and any charges deemed uncovered by my insurance carrier. I understand that if my account is not paid in a timely manner, the balance may be turned over to a collection agency and court action may be pursued. I understand that payment beyond the full service charge will be returned to me.
I authorize the release of any medical or other information necessary to process insurance claims. I authorize insurance payment of medical benefits and major medical benefits to Orchard Place. I also request payment of government benefits to the party who accepts assignment. A photocopy of this assignment is considered as valid as an original. In addition, if the insurance company issues a check directly to you for services provided by Orchard Place, our psychiatric consultant or pharmacy, this check must be forwarded to our business office to be credited to your account.

FOR UPDATES ONLY: Please provide a copy of your insurance card. Also, indicate whether your insurance has changed. ☐ Yes ☐ No

SLIDING FEE ELIGIBLE CLIENTS ONLY

If I am receiving services at Orchard Place, I understand I may be eligible for a sliding fee based on my county of residence, my income, and the size of my family. I understand I will not qualify for sliding fee and may be charged full fee if I do not provide legal settlement information which includes the client's social security number and that my fee may be waived based on the program and services received.

County of Residence: _____ Gross Annual Income: _____

Size of Family Supported by Income: _____ My Fee is _____ % of Full Fee

CAMPUS CLIENTS ONLY

The Department of Human Services will make a determination as to how much of the income from sources such as child support, Supplementary/Social Security or subsidized adoption proceeds is to be paid towards the treatment expenses of the child. Orchard Place/Campus will be notified of the amount and will send the parent/guardian a statement for the monthly amount due. To estimate the amount of client participation you will owe each month, please provide the following information:

Does this child receive Social Security or Supplemental Security? ☐ Yes ☐ No If **yes**, how much per month? _____

Does this child receive any child support or subsidized adoption? ☐ Yes ☐ No If **yes**, how much per month? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Your signature indicates that you have read and understand the above and agree to pay Orchard Place the amount of client participation and insurance co-pay if either should be assessed to you.

Signature: _____ Date: _____

Name: _____

Street Address: _____

City: _____ Zip Code: _____

WITNESS SIGNATURE

For verbal consent only: I have reviewed information and verified understanding with the above signed.

Signature: _____ Date: _____

Avatar ID:

Orchard Place Client Health Screen

Client Name_____ Today's Date: _____

Has the client had the following examinations in the **PAST YEAR:**

Physical Exam?	Yes	No	Date of Last Physical Exam	
Dental Exam?	Yes	No	Date of Last Dental Exam	
Visual Exam?	Yes	No	Date of Last Vision Exam	

Residential/IHP Clients Only

Height: _____

Weight: _____

If a physical exam has **not** been completed within the **last year**, please make an appointment with a physician (excludes OP Campus). If you need assistance connecting with a doctor's office, please make the assigned staff aware of your need. We can provide resources.

Client Health Condition	Yes	No	Ukn	Explain	Client Health Condition	Yes	No	Ukn	Explain
Allergy to:									
Environment/Other	☐	☐	☐		Hearing Loss/Ear Problems……	☐	☐	☐	
Food	☐	☐	☐		Heart Problems……	☐	☐	☐	
Medicine	☐	☐	☐		Migraines/ Chronic Headaches	☐	☐	☐	
Asthma	☐	☐	☐		Neurological Disorder	☐	☐	☐	
Bladder/ Urinary	☐	☐	☐		Reproductive Concerns	☐	☐	☐	
Cancer	☐	☐	☐		Respiratory Infections	☐	☐	☐	
Constipation/ Diarrhea	☐	☐	☐		Seizures	☐	☐	☐	
Dental Problems	☐	☐	☐		Sexually Transmitted Infection	☐	☐	☐	
Diabetes	☐	☐	☐		Sleep Problems	☐	☐	☐	
Vision Problems	☐	☐	☐		Sore Throats/Tonsillitis	☐	☐	☐	
Eczema/Skin Issues	☐	☐	☐		Stomach Aches	☐	☐	☐	
Epilepsy	☐	☐	☐		Unexplained Fever	☐	☐	☐	
Fainting	☐	☐	☐		Other	☐	☐	☐	
Head Injury	☐	☐	☐						

List significant injuries, hospitalizations or surgeries and dates. And, list any chronic medical conditions. _____

Has the client…

Had any infectious diseases such as MRSA, hepatitis, tuberculosis, meningitis, rubella, small pox, mumps, chicken pox, pneumonia, or any other?	☐ Yes	☐ No	
Had exposure to second-hand smoke and/or nicotine vapor?	☐ Yes	☐ No	
In last 3 months been exposed to lice, scabies and/or bed bugs?	☐ Yes	☐ No	
In last 3 months had unprotected sex?	☐ Yes	☐ No	
Experienced any unresolved physical pain or discomfort?	☐ Yes	☐ No	If yes, where:

If pain or discomfort indicated (please circle intensity of pain- 1:being no pain/10: being extreme pain):

1—2—3—4—5—6—7—8—9--10

☐☐☐☐☐☐☐☐☐☐

FOR STAFF USE ONLY

For any health condition, pain, and/or diseases still existing, is the client receiving medical treatment or follow-up? N/A Yes No

If **no**, please explain:_____

Staff Recommendations: Complete Yearly Physical Exam Follow-up with PCP Follow-up with Specialist

If pain/discomfort indicated- Follow-up with PCP

Other (explain):_____

Current Medications (including, Prescription, OTC, Supplements and Vitamins):

Medication	**Dose**	**Prescriber**	**Usage (What it is for)**

By signing, you are verifying the information above has been reviewed and any identified needs for medical follow up, including the need for a physical examination, have been discussed and reviewed with the client and/or parent/guardian.

Staff Signature:_____ **Date Reviewed:** _____

ORCHARD PLACE
INSURANCE INFORMATION

FOR PERSON RECEIVING SERVICES

Last Name: _____ First Name: _____

Date of Birth: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

TERTIARY INSURANCE INFORMATION

Tertiary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ◯ Female ◯ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

CAMPUS CLIENTS ONLY

Name of Dental Insurance: _____

Please provide a copy of your insurance card for our records.

At Orchard Place we are driven by our mission to develop stronger futures for every child that is admitted. A child's caregivers are absolutely essential to positive treatment outcomes during and after treatment. Therefore, we require caregivers to participate fully in the treatment process, which includes the following expectations. Please initial on the line after each item to indicate that you have read, understand and agree to each expectation.

- **Family Sessions: Family sessions are required to take place one time a week. These sessions can take place virtually on a bi- weekly basis if needed, but two in person session must occur every month.** Face to face sessions are the preferred modality. **Sessions are scheduled to take place Monday through Friday between the hours of 8am and 5pm.** Therefore, you will need to arrange your schedule as needed in order to meet within those time frames. Furthermore, it is expected that you show up on time for your sessions as our therapists are unlikely to be able to accommodate for last minute adjustments to their schedules._____

- **Visits: In person visits with your child need to take place at least one time a week**. Visits typically start on campus but then transition to off campus visits and visits in the home per the recommendation of your child's treatment team. _____

- **Phone contact:** Your child will be assigned two phone call days a week in which they will be given an opportunity to contact you. However, **it is recommended that caregivers also call their child at least 3 to 5 times a week** or as recommended by your child's treatment team. _____

- **Openness to change: As your child is working on making their own changes, there will also be changes that you will need to make as their caregiver to support them along their journey both during and after treatment.** Your therapist, along with other members of the treatment team, will be providing various recommendations, which may include needed changes to the home environment and approaches to parenting. **It is essential for you to be open to making changes and accepting that areas of needed growth exist within the entire family unit.** _____

- **Discharge Plans- Discharge planning starts from day one, with the expectation that your child will return to your care upon the completion of their treatment.** The treatment team will provide various recommendations and support in securing services for after discharge, but **it is the caregiver's responsibility to get all aftercare appointments scheduled prior to discharge**._____

- **Communication- We expect open, respectful and non-violent communication with all members of our treatment team, regardless of their role in your child's treatment.** If you have concerns, we want to know about them, but they need to be shared respectfully so that we can

continue to work together to ensure your child's needs are being met throughout their treatment stay. **_____**

- **Sanctuary Commitments:** Orchard Place is a Certified Sanctuary Institute. Sanctuary is a trauma informed care approach which includes an agency wide adherence to following 7 commitments: Non-violence, Open Communication, Democracy, Growth and Change, Emotional Intelligence, Social Responsibility and Social Learning. **We ask that staff, parents and clients be mindful of these commitments in their interactions with each other and within the treatment environment.** _____

- **Diversity, Equity and Inclusion:** Orchard Place is additionally committed to providing an inclusive and non-discriminatory environment for all clients, families and staff. **Engagement in statements or behaviors that target a specific group of people will be addressed promptly and be accompanied by any needed education and/or restrictions as appropriate to the situation.** _____

- **Approach to treatment: This is team based care, meaning every member of the team, regardless of their role plays an equally important part in the treatment process. Treatment decisions are made as a team, which includes collaboration with caregivers and clients.** Additionally, members of our treatment teams are trained to use strategies from a variety of different evidenced based treatment modalities. All staff are trained on Sanctuary and Trust Based Relational Interventions. **As caregivers, we ask that you be open to our approaches to treatment and with the understanding that progress looks different for every client. Your child will leave treatment and need ongoing services to help them continue on their journey towards healing and achieving their goals.** _____

By signing below I am acknowledging that I have read, understand and agree to follow through on the above expectations for treatment. Furthermore, I understand that failure to do so may result in poor treatment outcomes and/or discharge from treatment due to lack of parent engagement.

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

_____ _____
Caregiver Printed Name Date

Suicide prevention "FACTS"

Warning Signs to look for:

Developing Strong Futures
Orchard Place

Feelings

- Hopelessness, Helplessness, or fear of losing control
- Worthlessness, Shame, Guilt, or extreme loneliness
- Self hate, Anger, or Worry

Actions

- Substance Abuse
- Reckless behavior
- Aggression
- Talking or writing about destruction or death

Changes

- Personality
- Behavior
- Sleep
- Sudden improvement
- Loss of interest

Threats

- "How long does it take to bleed to death?"
- "I won't be around much longer."

Signs

- Trouble at school, home, or with the law
- Recent loss through death, relationships ending, loss of opportunity, self-esteem
- Overwhelming life changes
- Exposure to suicide or death of a peer

If you notice any of these warning signs

1. Express your concern about what you are observing in their behavior

2. Ask directly about suicide

3. Encourage them to call 988, the Suicide and Crisis lifeline

4. Involve an adult they trust

If you have IMMEDIATE safety concerns call 911 right away!

988 SUICIDE & CRISIS LIFELINE

Source: 2011 Hazeldon Foundation & Society for the prevention of Teen Suicide.

spts society for the prevention of teen suicide