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Mental Health Services

Children and Youth Day Treatment
REACH Family-Based Treatment
Conable Children's Residence
Lake Breeze Community Residence
Waiver Services
BILT Independent Living
In-Home Supervision
Respite Services
Family Interactions
Youth WRAP Around Alternative
Family Preservation Program

Child and Family Services

Kids' Adventure Club
Erwin Child and Family Center
Preschool Center-Based Program
Special Education Itinerant Teachers

Traumatic Brain Injury Services

Home and Community Support
Services
Independent Living Skills Training
and Development
Structured Day Program

Developmental Disabilities Services

Family Support Services
Service Coordination
Waiver Services
Residential Services
- First Street
- Forest Drive
- Davis Road
- Meads Creek
- Clara Street
- Wilson Street
- Fassett Road
- Field Street

Day Services
- Corning
- Elmira Heights
- Lake Street

Dear Colleague:

Attached please find the Pathways, Inc. referral packet used to apply for admission to the REACH Family-Based Treatment Program. Upon receipt of all required referral data, our multidisciplinary Referral Review Committee will consider and determine the referred youth's eligibility for admission.

Please submit the information outlined on the attached checklist to the Referral Review Committee at the following address:

Pathways, Inc.
REACH FBTP Referral Review Committee
33 Denison Parkway West
Corning, NY 14830

If I may be of assistance in the referral process, please do not hesitate to contact me.

Sincerely,

Erin E. Warr, LMSW
REACH FBTP Program Director
(607) 937-3275

Attachments



ADMINISTRATIVE OFFICES

33 Denison Parkway West • Corning, New York • 14830
(607) 937-3200 • Fax: (607) 937-3202
www.pathwaysforyou.org



REACH Family-Based Treatment Program Philosophy and Primary Goals

It is our mission to provide quality care, treatment, and services to children and youth with serious emotional disturbance and their families.

- We believe in providing an appropriate therapeutic milieu in the least restrictive, age and culturally appropriate environment.
- We are committed to providing a structured therapeutic environment to support the youth as he/she progresses through the rehabilitative process.
- We are committed to facilitating the development of the relationship between the youth and their family whenever appropriate, by building on the child and family's strengths and assisting them to develop the assets and skills needed.
- The REACH Family-Based Treatment Program is committed to effectively recruiting, training, and supporting our Professional Parents enabling them to provide intense support and care to youths participating in the program.
- We are committed to the provision of guidance and training in structured daily living and socialization/recreational activities to foster the youths' acquisition of skills necessary to perform activities of daily living and the development of age appropriate social and interpersonal skills. Behavior management training and counseling services assist the youth in developing problem solving and coping skills while supporting the reinforcement and generalization of newly-learned positive behaviors at school, home, and other community settings.
- We are committed to the flexibility and creativity necessary to meet each youth's unique needs and collaborate with community-based services to individually tailor our treatment approaches. Family members of the youths are embraced as an integral part of the service planning and encouraged to participate in their child's treatment and care.
- We are committed to providing families with education/information, emotional support, skill development, and linkage to family support programs and services. We believe in supporting each family in its effort to foster its relationship with the child and/or resume primary care for the child.

The REACH Family-Based Treatment Program fully embraces the Office of Mental Health Core Values, which include:

- Developing full partnerships with families
- Being safe, nurturing and therapeutic
- Ensuring individualized and comprehensive treatment that is creative and effective
- Striving to be culturally competent in all aspects of programming
- Using strength-based interventions, communications and practice
- Using interventions that create the possibility for each youth to reach his/her self-defined potential
- Being short-termed and community integrated
- Using the industry's best practices and
- Employing trauma-sensitive practices.



REACH Family-Based Treatment Program

Admission Criteria

To be accepted into the Pathways REACH Family-Based Treatment Program, the youth must meet the following admission criteria. The youth must:

1. Have a designated mental health diagnosis according to the DSM-IV-TR;
2. Have experienced functional limitations due to emotional disturbance over the past 12 months and meet criteria for rating of 50 or less on the Children's Global Assessment Scale

or

Meet criteria for current impairment in functioning with severe symptoms;

3. Have experienced substantial difficulties in social functioning with severe symptoms;
4. Have attained at least his/her 5th but not his/her 18th birthday;
5. Have a measured IQ above 70;
6. Have demonstrated ability and willingness to participate in school or other day programming;
7. Have the potential or functioning in the community, not needing the restrictiveness of a campus or facility-type environment. He/She must be able and willing to accept the responsibilities of being integrated into a family unit and be capable of sustaining the close one-on-one relationship of a family environment;
8. Require individualized, intensive treatment and rehabilitation services and usually exhibit a range of mental health diagnoses and characteristics;
9. Have demonstrated capability of self-preservation, as evidenced by successful completion of a Standard Capability of Self-Preservation Test.



Reach Family-Based Treatment Program Referral Checklist

To consider your referral, the following information must accompany this packet. Although the information requested is considerable, it is essential in determining the degree of the youth's impairment and his/her potential to succeed in a community-based residential services program. All assessments must have occurred within the last 90 days, except for the educational assessment, which must have occurred within the last year.

- Psychiatric Evaluation
- Psychological Evaluation
- Family/Social History or Assessment
- Educational Assessment/Current Academic Progress Report
- Current Physical/Medical Assessment
- Referral Form
- Consents for Release of Information
- Verification of SSI Application or Benefit
- Physician Authorization for Community-Based Residential Rehabilitative Services
- HIPAA Consent
- CANS Assessment
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of Insurance or Medicaid Card
- Health Intake Form

If we may be of assistance with this referral process, please contact us.

Robert E. Thorn, M.A.
REACH FBTP Program Coordinator
(607) 937-4517

or

Erin E. Warr, LMSW
REACH FBTP Program Director
(607) 937-3275



Notice of Privacy Practices

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 Pathways, Inc. Privacy Officer at 607-937-3200 or in writing at 33 Denison Parkway West, Corning, NY 14830.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at Pathways, Inc.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel at Pathways, Inc. may share information about you and disclose information to people who do not work at Pathways, Inc. in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, ordering x-rays, and scheduling other assessments. Family members and other health care providers may be part of your medical care outside Pathways, Inc. and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at Pathways, Inc. may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to operate Pathways, Inc. and make sure that you and our other consumers receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our consumers to help us decide what additional services we should offer, how we can become more efficient, or whether certain new services are effective.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures, which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we will therefore not be able to provide you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law - We will disclose health information about you when required to do so by federal, state or local law.

Organ and Tissue Donation - If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Workers' Compensation - We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities - We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement - We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors - We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable - We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends - We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

Right to Inspect and Copy - You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Pathways, Inc. Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend - If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Pathways, Inc. Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to an Accounting of Disclosures - You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Pathways, Inc. Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions - You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

We are Not Required to Agree to Your Request - If we do agree; we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical Information* to the Pathways, Inc. Privacy Officer.

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 it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Pathways, Inc. Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice at all program sites with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Pathways, Inc. Privacy Officer at 607-937-3200 or in writing to 33 Denison Parkway West, Corning, NY 14830. You will not be penalized for filing a complaint.



Pathways Inc. Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Pathways Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to provide health care services.

I understand that diagnosis or treatment of me by Pathways Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of Pathways Inc. Pathways Inc. is not required to agree to a restriction that I request. However, if Pathways Inc. agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Pathways Inc. Notice of Privacy Practices prior to signing this document.

The Pathways Inc. Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care services by Pathways Inc.

The Notice of Privacy Practices for Pathways Inc. is also provided at all program sites and on the Pathways Inc. web site at Pathwaysinonline.org.

This Notice of Privacy Practices also describes my rights and the duties of Pathways Inc. with respect to my protected health information.

Pathways Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Pathways Inc. web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Consumer or Consumer's Representative

Date

Name of Consumer or Consumer's Representative

Description of Consumer's Representative's Authority

**AUTHORIZATION FOR
RELEASE OF INFORMATION**

Name: _____

Sex: M ___ F ___ Date Of Birth: _____

Pathways Inc. REACH Program

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

1. This information is being requested:
 - by the individual or his/her personal representative; or
 - Other (please describe) _____
2. The purpose of the disclosure is (please describe):

TO FACILITATE ONGOING EVALUATION AND TREATMENT

From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information

To: Name, Address, & Title of Person/Organization/ Facility / Program to Which this Disclosure is to be Made

NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.

Pathways Inc. REACH Program
33 Denison Parkway West
Corning NY 14830

- A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/ Program(s) identified above. I understand that:
1. Only this information may be used and/or disclosed as a result of this authorization.
 2. This information is confidential and can not legally be disclosed without my permission.
 3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
 4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) Pathways Inc. REACH FBTP
I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
 5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
 6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR S164.524).

B-1. One – Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:

- When acted upon;
- 90 Days from this Date;
- Other _____

Continue on Next Page



Reach Family-Based Treatment Program

Physician Authorization For Community-Based Residential Rehabilitative Services

It is my professional opinion and recommendation as this youth's treating psychiatrist, that

_____, _____, requires the
(Youth's Name) (Youth's Medicaid Number)

services provided by the REACH Family-Based Treatment Program. Based on my face-to-face assessment of the youth conducted on _____ and review of assessments regarding the youth made available to me, I have determined that this youth would benefit from the provision of mental health rehabilitative services as known to me and defined pursuant to Part 593 of 14 NYCRR. This authorization is effective for a period of six months as of _____ / _____ / _____ .

Physician's Name (Printed)

Physician's Signature

License #



Referral Data

REFERRAL TO BE CONSIDERED FOR (Please Check):

- Conable House Community Residence Program for Children and Youth (ages 5-12)
- REACH Family-Based Treatment Program (ages 5-18)
- Lake Breeze Community Residence Program for Adolescents (ages 13-17)

YOUTH INFORMATION

Youth's Name: _____
(Last) (First) (Middle)

Current Placement (Agency or Person): _____

Placement Address: _____
(Street) (City) (State) (Zip Code) (County)

Telephone Number (Including area code): _____

Date of Birth: _____ Gender: _____ Ethnicity: _____

Name of Party Holding Custody: _____

Custodian's Address: _____
(Street) (City) (State) (Zip Code) (County)

Home Phone: _____ Business Phone: _____

REFERRAL SOURCE

Name of Referral Agent: _____

Title/Relationship to Youth: _____

Referral Agency: _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

Telephone Number (Including area code): _____

Reason for Referral: _____

Are the youth and family aware of and agreeable to this referral?

Yes: _____ No: _____

Please elaborate: _____

What is the youth's level of motivation/understanding of the need for this referral?

Please list other facilities/programs to which the youth has been referred: _____

Please note any other agencies currently involved with the youth and/or family: _____

What is the current permanency plan for this youth? _____

FAMILY INFORMATION

Mother's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Place of Employment: _____ Telephone: _____

Work Address: _____

Marital Status: _____

Father's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Place of Employment: _____ Telephone: _____

Work Address: _____

Marital Status: _____

Siblings:

NAME	AGE	ADDRESS	SCHOOL/GRADE

Name(s) of step parent(s) or other significant parental figure(s), if any, and date(s) of birth: _____

Please note any significant family history (i.e.: physical abuse, sexual abuse, substance issue, mental illness, imprisonment, etc.): _____

YOUTH'S PLACEMENT HISTORY

Psychiatric Hospitalizations:

FACILITY	DATES	THERAPIST/ PSYCHIATRIST	REASON FOR HOSPITALIZATION

Other Placements:

Please list previous placements including RTF, Community Residence, Foster Care, etc.

FACILITY/PROGRAM	DATES	THERAPIST/ PSYCHIATRIST	REASON FOR PLACEMENT

YOUTH'S MENTAL HEALTH INFORMATION

Most Recent Psychiatric Diagnosis (DSM IV):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Diagnosed by (name and title): _____ Date of Dx: _____

Current Therapist: _____ Telephone: _____

Agency/Facility Name: _____

Agency Address: _____

(Street) (City) (State) (Zip Code) (County)

Current Psychiatrist: _____ Telephone: _____

Agency/Facility Name: _____

Agency Address: _____

(Street) (City) (State) (Zip Code) (County)

Does the Youth Have a History of: Yes No Unknown

Fire Setting _____

Sexual Abuse _____

Perpetration _____

Victimization _____

Violent Acts _____

Assault/Threat w/weapon _____

Aggressive Behavior _____

Verbal _____

Physical _____

Suicidal Behaviors _____

Ideation _____

Gestures _____

Attempts _____

Criminal Activity/Legal Issues _____

Drug/Alcohol Abuse _____

Other Behaviors (please describe): _____

If any response is yes, please describe incident(s), frequency, and other pertinent information:

Youth's Assets: _____

Youth's Liabilities: _____

YOUTH'S MEDICAL INFORMATION

Physician: _____ Telephone: _____

Address: _____

(Street) (City) (State) (Zip Code) (County)

Date of Most Recent Physical: _____

Describe Any Ongoing Medical Needs/Concerns (Allergies/Sensitivities): _____

Dentist: _____ Telephone: _____

Address: _____

(Street) (City) (State) (Zip Code) (County)

Date of Most Recent Dental Exam: _____

Current Medications Frequency Prescribed By

YOUTH'S EDUCATIONAL INFORMATION

School Name: _____ Grade: _____

Address: _____

(Street) (City) (State) (Zip Code) (County)

School Counselor: _____ Telephone: _____

Current Educational Placement:

Regular Ed. _____ Option Program _____ Day Tx. _____

Educational Classification: _____

IQ Test Results:

Full Scale: _____ Performance: _____ Verbal: _____

Date Tested: _____ Test Administered: _____

Test Administered by: _____ Title: _____

FINANCIAL INFORMATION

Youth's Social Security Number: _____

Primary Medical Insurance Provider: _____

Policy Holder's Name: _____ Policy Number: _____

Secondary Medical Insurance Provider: _____

Policy Holder's Name: _____ Policy Number: _____

Is youth currently in receipt of an SSI Benefit? Yes: _____ No: _____

If no, date SSI application was filed: _____

Is youth currently in receipt of a Social Security Survivor's Benefit? Yes: _____ No: _____

Is child support re: this youth currently being paid? Yes: _____ No: _____

To whom? _____



Health Intake Form

Youth Name _____ Completed by _____

Date of Birth _____ Date Completed _____

A. YOUTH DESCRIPTION:

Gender _____ Race _____ Height _____ ft _____ inches
Weight _____ Eyes _____ Hair _____

Physical characteristics (scars, identifying marks, pierced ears, etc.): _____

B. PROVIDERS/RECORDS:

1. Primary care provider _____
(Name) (Address)

2. Specialty care provider _____
(Name) (Address)

3. Dentist _____
(Name) (Address)

4. Last physical: _____
(Date) (Where/by Whom)

5. Health records:
Present? Yes _____ If present, where? _____
No _____ If not present, sent for? Yes _____ No _____
If yes, by whom? _____ Date requested _____

C. CHILD'S MEDICAID # _____

Is there a health insurance plan that covers this child? Yes _____ No _____

If yes, is this coverage for this child expected to continue? Yes _____ No _____

If yes, policy name and contract # _____

SIGNIFICANT FAMILY HEALTH HISTORY:

Mother _____

Father _____

Siblings _____

Extended family _____

D. HEALTH HISTORY

Problem/Issue

If yes, provide explanation or comment

Problem pregnancy Yes ___ No ___
 Problem delivery Yes ___ No ___
 Problem walking Yes ___ No ___
 Problem talking Yes ___ No ___
 Problem toilet training Yes ___ No ___
 Major illness Yes ___ No ___
 Operations Yes ___ No ___
 Head injuries Yes ___ No ___
 Seizures (History) Yes ___ No ___
 Other hospitalizations Yes ___ No ___
 Prone to strep throat Yes ___ No ___
 Prone to ear aches Yes ___ No ___

birth weight: _____

age: _____

age: _____

age: _____

E. DISEASES (state diseases child has had and age when they developed)

Infections (chicken pox, diphtheria, measles, mumps, whooping cough, typhoid, meningitis, encephalitis, syphilis, gonorrhea, poliomyelitis, scarlet fever, etc.)

Other (convulsions, diabetes, rheumatic fever, chorea, rickets, kidney disturbances, etc.)

F. IMMUNIZATIONS

DATES RECEIVED

IMMUNIZATION	#1	#2	#3	Booster	Booster
Diphtheria-Pertussis-Tetanus					
Oral Polio Vaccine Trivalent					

DATES RECEIVED

IMMUNIZATION	#1	#2
Tetanus-Diphtheria (Td)		
Mumps, Measles, Rubella		

G. CURRENT HEALTH ISSUES

Food allergies	Yes___ No___	What? _____ Reactions: _____
Pet allergies	Yes___ No___	What? _____ Reactions: _____
Bee sting reactions (life threatening)	Yes___ No___	What? _____ Reactions: _____
Medication allergies	Yes___ No___	What? _____ Reactions: _____
Other allergies	Yes___ No___	What? _____ Reactions: _____
Diabetes	Yes___ No___	_____
Hepatitis B carrier	Yes___ No___	_____
Seizures (current)	Yes___ No___	_____
Enuresis (bedwetting)	Yes___ No___	_____
Encopresis (soiling)	Yes___ No___	_____
Dental problems	Yes___ No___	_____
Wears glasses	Yes___ No___	_____
Sexually active	Yes___ No___	_____
Ever used contraception	Yes___ No___	What? _____
Ever had any venereal disease	Yes___ No___	_____
Alcohol use	Yes___ No___	_____
Tobacco use	Yes___ No___	_____
Menstruation	Yes___ No___	Started when? _____ Last period when? _____
Pregnant now	Yes___ No___	_____

