Administrative Offices
715 S.W. Ramsey Ave., Grants Pass, OR 97527
(541) 474-5579 Fax (541) 541-476-7410

KAIROS

The moment when change is possible

INSTRUCTIONS FOR MAKING A REFERRAL FOR RESIDENTIAL RESPITE

To make a referral during regular business hours, please call the Access Department at 541-956-4943 ext. 1106; after hours, please call the program directly at 541-476-3302 ext. 5 regarding bed availability. You will be asked for basic demographic and clinical information.

The program will fax you a referral packet. Please use only this paperwork to ensure that you have the most current forms.

It is important for the legal guardian to understand the following:

- Respite stays are typically 3-5 days depending on what is authorized by the county
- Psychiatric services, including medication management, are not included unless specifically authorized by the county
- The program is not a locked facility

Please note that KAIROS does not provide transportation to or from the program.

The parent/legal guardian **must** sign admitting papers before admission, either by being present at admission or by filling out paperwork, faxing it to the program, and sending **original signatures** with the youth. Remind parent/legal guardian to bring all medications and clothing for the youth. The following is a complete list of all admitting paperwork needed and who is responsible for completing it.

Form	Parent/Legal Guardian	MH Crisis Worker/ County Representative	Authorized Designee
Admission Consent & Release Form (8 pages)			
Authorization for Release of Information (Schools, Physicians, Counselors, Mental Health Agencies)			
Resident Personal Needs Plan			
Diet Instructions Form			
Brief Health History			
Provide Medical / Insurance Card or OHP number			
Residential Respite Service Authorization (3 pages)			
Referral Face Sheet and Referral Information Sheet			
Ensure all above forms are completed			
Ensure valid Medical or Insurance Card is faxed to program			

KAIROS REFERRAL FACE SHEET

Service Requested: ☐ Psychiatric Residential Treatment ☐ Psychiatric/Residential Respite ☐ TFC
☐ Day Treatment ☐ ICTS ☐ Young Adult Program ☐ Outpatient

Youth's Name: ______________________ **Date of Birth:** __________ **Referral Date:** __________

Gender: M / F **Marital Status: S / M / D / W** **County of Origin:** ______________________

Original Referral Source: ______________________________ **Phone:** ______________

Client's Legal Status: ☐ Ward of the State ☐ Voluntary ☐ Civilly Committed/TVA ☐ OYA **JJIS # :** __________

Social Security Number: ______________ **Race/Ethnicity:** __________ **Religion:** __________

Legal Guardian ☐ DHS ☐ OYA ☐ Other : ______________________ **Phone:** ______________

Caregiver Name: ______________ **Relationship:** ______________ **Phone:** ______________

Caregiver Address: ____

Client's Current Placement and Address: (if different) ______________________________

____

Client's Current School Placement ______________________ **Last Grade Completed** __________

Medicaid/OHP/Prime Number: ______________ **MHO:** ______________________

Private Insurance: ______________________________ **ID Number:** ______________

Hep B Status: positive / negative date: ________ **TB Test Results**: Positive / Negative date: __________

SSI / SSD: ☐ Yes ☐ No **Advanced Directive:** ☐ Yes ☐ No **Mental Health Directive:** ☐ Yes ☐ No

TRAUMA HISTORY: **PREVIOUS BEHAVIORS:**

☐ **Emotional abuse**	☐ **Animal Cruelty/Abuse**	☐ **Developmentally Disabled**
☐ **Exposure to domestic violence**	☐ **Drug &/or Alcohol Involvement**	☐ **Fire Setting**
☐ **Neglect**	☐ **Runaway**	☐ **Self Harm**
☐ **Physical abuse**	☐ **Sexual Aggression**	☐ **Sexual Reactivity**
☐ **Sexual abuse**	☐ **Violent Behaviors**	

________ **Number of prior out-of-home placements**

________ **Number of prior psychiatric hospitalizations**

________ **Known or estimated IQ**

AXIS I Diagnoses: ______________________________ **CGAS/GAF score:** ______________

Treatment Considerations (what does the team want this client to accomplish during his / her stay?):

____

____

____

Referring Party (please print): ______________________________ **Phone:** ______________

Agency: ____ **Date:** ______________

KAIROS

Authorization for Release of Information

We can help you better if we are able to work with other professionals and organizations that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

I authorize Kairos to share information about:

Name: ______________________ D.O.B.: ______________ ID #: ________

with the following individuals or agencies:

______________________ ______________________
______________________ ______________________
______________________ ______________________

including records of: ***(Please initial each item)***

Family History: ___ Yes ___ No
Employment/Unemployment: ___ Yes ___ No
Educational Reports: ___ Yes ___ No
Alcohol/Drug Treatment: ___ Yes ___ No
Medical/Psychiatric Treatment: ___ Yes ___ No
Mental Health Services: ___ Yes ___ No
Other, as listed: ______________________
____

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. ___ Yes ___ No ***(Please initial)***

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified: ______________________
____
____

This permission is good until 180 days following discharge from all Kairos programs: ______***(Please initial)***

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

______________________ ____________
Parent or Guardian Date

______________________ ____________
Client Date

______________________ ____________
Kairos Representative Date

To those receiving information under this authorization: **This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.**

This is a true copy of the original authorization document ______________________
Kairos Representative

KAIROS

Intensive Treatment Service
Referral Information Form

To be completed by the referring Care Coordinator, or by a QMHP with knowledge of the child's condition.

Child's Name:____ Date of Referral:________________

Name of person completing this form: ____

Agency: ____

Presenting problem; reason for request for services:

Description of individual's current behavior/function:

Description of mood; affect; thought processes:

Evidence/estimation of risk to self/other:

Provisional Axis I diagnoses:

Estimated CGAS: **CASII Score:**

Family Information:

Problems/strengths in current placement:

School function: ☐ On IEP ☐ Spec. Ed (< 50%) ☐ Spec. Ed (50- 99%) ☐ Spec. Ed (100%)

School Setting: ☐ Public School ☐ Private School ☐ Alternative School ☐ Home School

Name of last school attended: ____

Last Grade Completed: ____________

What interventions have occurred thus far?

Current medications:

Note previous assessments/evaluations/reports *(please include with referral)***:**

Specific assessment questions or treatment goals:

1.

2.

3.

4.

5.

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RESIDENTIAL RESPITE SERVICE AUTHORIZATION

Name of Youth ____ DOB __________________

Name of Referral Worker ___________________________________ County________________

I/we the referring party hereby stipulate that the above-named youth meets Kairos' established admission criteria for Residential Respite Services

- ☑ The youth is between the ages of 7 & 17 years of age.
- ☑ The youth is medically stable and does not require immediate medical care in a hospital setting.
- ☑ There is no known ingestion of harmful substances or evidence of such ingestion. This includes drugs and/or alcohol.
- ☑ The youth is experiencing acute emotional or behavioral instability but **does not** require a locked setting or a level of psychotropic medication management which necessitates 24 hour nursing or physician care
- ☑ The youth's primary need is not detention or incarceration.

I am authorizing Kairos to provide services as designated below. Please initial by each service requested. Please see service component grid on next page to determine what services meet the needs of the youth.

_____ Residential Respite ($375/day)

_____ Psychiatric Respite without 1:1 services ($457/day)

_____ Psychiatric Respite with 1:1 services ($550/day)

I understand that all Psychiatric Respite clients initially admit under the 1:1 service, unless it has already been confirmed that this level of care isn't needed. If a client initially admits under the non 1:1 service, but it is determined that 1:1 service is needed, then Kairos will contact the referring agency.

I understand that in signing below, I am guaranteeing that Kairos receives reimbursement for services provided at the rate quoted.

Estimated Length of Stay: ____

____

Authorized Payment Representative **Date**

____

KAIROS Representative **Date**

While we do not normally provide medical care during a residential respite stay, nor do we typically prescribe medication during these stays, provision must be made for the payment of medical costs in the event of an emergency. Please feel free to discuss with us your questions or concerns regarding these matters prior to your child's admission to the program.

My child is currently covered by the following medical insurance policy **(please fill out a release of information form for the insurance company):**

____

Insurance Company **Group Number** **Identification umber**

* I agree to accept financial responsibility for any emergency medical or other expense not covered by other medical insurance. Such expenses should be billed to the following address:

____

Name **Address** **City** **State** **Zip**

____

Parent/Guardian Signature **Date**

Service Components	Residential Respite	Psychiatric Respite without 1:1 services	Psychiatric Respite with 1:1 services
Typical length of stay	3-7 days	Up to 14 days	Up to 14 days
Who can authorize	Authorized County MH Representative	Authorized County MH Representative	Authorized County MH Representative
Observation and behavioral stabilization through client involvement within the therapeutic living environment.	✓	✓	✓
24 hour awake supervision; staff ratio 1:3	✓	✓	✓
Case assignment to an available QMHP	✓	✓	✓
Initial Risk Assessment and Plan conducted by QMHP or QMHA.	✓	✓	✓
On campus activities only	✓	✓	✓
Intensive evidence based therapeutic interventions	✓	✓	✓
Discharge instructions	✓	✓	✓
Phone case management for discharge planning	✓	✓	✓
Psychiatric assessment within 3 days	Requires additional authorization and expense	✓	✓
Weekly medication management	Requires additional authorization and expense	✓	✓
Discharge planning with youth, referral source, and parent or guardian for crisis debriefing, transition planning.	Conducted by phone	Conducted in person and/or by phone	Conducted in person and/or by phone
Comprehensive assessment (Only if stay is authorized and client is present for 21 days or more)		✓	✓
Family therapy around crisis		✓	✓
Individual therapy around crisis		✓	✓
Discharge summary		✓	✓
1:1 supervision			✓

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KAIROS

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Admission Consent and Release Form

Individual's Name: ____

D.O.B.: ______________________________ Admission Date: ______________________

Request for Admission and Consent to Treatment

I/we, the undersigned, as the responsible party(ies), hereby request admission of the above named child to Kairos, and consent to his/her care and treatment as recommended and provided by the Care Team.

______________________________ ______________________
Individual Date

______________________________ ______________________
Parent or Guardian Date

______________________________ ______________________
Kairos Representative Date

Agreement to Participate in Treatment and Aftercare Planning

I/we, the undersigned, as the responsible party(ies) hereby agree to participate in the treatment and discharge planning of the above named individual while s/he is in the care of Kairos.

______________________________ ______________________
Individual Date

______________________________ ______________________
Parent or Guardian Date

Voluntary Medical Consent

The legal status of my/our child, named above, at the time of signing this release is ___________ ____. I/we, the undersigned, voluntarily authorize Kairos to provide health services for the above named individual as deemed necessary or desirable. This may include, but is not limited to, physical and mental examinations, ordinary medical, dental, psychiatric, psychological, hygiene and other remedial treatment, including immunizations (as well as seasonal vaccinations, i.e. flu) and the use of psychiatric medication. This does not delegate consent for abortion for those under 15, extraordinary or controversial medical or surgical procedures, any medical or surgical procedure to which the legal parent or guardian is opposed, or sterilization or any medical procedure, treatment or operation for the purpose of rendering the child permanently incapable of procreating.

☐ I do not give consent for seasonal vaccinations.

I wish to be informed about medication prescriptions or changes in medication:

☐ In writing immediately following any prescription or change in prescription.

☐ Before any prescription or change in prescription. I understand that choosing this option may result in delays in implementation of the prescription which could prolong my child's stay in the program.

☐ I give consent for routine urinalyses upon admission, and/or as needed, including screening for Sexually Transmitted Diseases such as Chlamydia and Gonorrhea as recommended by the County Health Department.

☐ I do not give consent to be screened for the above named STDs.

☐ I have an Advanced Health Directive to direct Kairos in making health care decisions for me should I become unable to do so. It is located at:

____

☐ I have an Advanced Behavioral Health Directive to direct Kairos in making health care decisions for me should I become unable to do so. It is located at:

____

☐ I do not have an Advanced Directive but would like information and assistance in creating one. Until one is created and signed by me, I hereby give Kairos permission to seek emergency medical treatment, such as surgery or other drastic treatment, for me in the event that I am unable to do so.

☐ I do not have an Advanced Directive and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

Signature:

____

I/we further authorize Kairos in an <u>emergency</u>, to give consent to extraordinary health care, such as surgery or other drastic treatment, when a qualified physician determines that there is an emergency and the health and welfare of this child warrants such extraordinary treatment.

I/we understand that I am responsible for payment of prescription medication or any other services not covered by or paid for by Medicaid or any insurance policy I may carry. I promise to keep the above named provider informed of our current address and telephone number for billing purposes.

I, by signing this document, confirm that I have carefully read, or have had someone carefully read to me and fully explain this <u>Voluntary Medical Consent</u> and that I understand what it says and have signed it for the best interests of this individual.

This consent may be revoked by me in writing at any time except to the extent that action has been taken in reliance hereon.

The consent is given voluntarily for the above stated purpose and will continue for as long as this individual remains at Kairos, expiring upon discharge.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Use of Restraint and Seclusion Procedures
(Residential / Day Treatment Programs Only)

I/we, the undersigned, understand that Kairos staff may at times be required to employ therapeutic physical hold techniques or seclusion in order to preserve the safety and security of residents. These procedures have been described to me/us. I/we agree that in the event the above named child/adolescent requires this level of intervention, staff may do so. I/we understand that I/we will be notified of each incident. I/we have been informed that I/we can discuss these procedures with clinical or administrative staff for further clarification of the techniques, circumstances and reasons at any time.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Drug Screening

I/we, the undersigned, as the responsible party(ies), hereby grant permission for drug/toxicology screening of the above named child while s/he is in Kairos.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Consent for Pregnancy Testing (for female residents)

I/we the undersigned, as the responsible party(ies), hereby grant permission for pregnancy testing for the above named individual at time of admission to Kairos Assessment & Evaluation Program.

Individual ______________________ Date ____________

Parent or Guardian ______________________ Date ____________

Kairos Representative ______________________ Date ____________

Field Trip and Excursion Trip Consent

I/we grant permission for the above named individual to participate in supervised field trips, excursions and off campus group recreational activities, as planned and implemented by Kairos staff.

Individual ______________________ Date ____________

Parent or Guardian ______________________ Date ____________

Kairos Representative ______________________ Date ____________

Swimming Activities

I/we grant permission for the above named individual to participate in supervised swimming activities.

Individual ______________________ Date ____________

Parent or Guardian ______________________ Date ____________

Kairos Representative ______________________ Date ____________

Consent for Photograph

Per the Join Commission, a photograph of the above named individual will be obtained upon admission for electronic records completion.

Individual ________________ Date ________

Parent or Guardian ________________ Date ________

Kairos Representative ________________ Date ________

Consent for Client Audio Recording

I/we grant permission for the above named individual to have Collaborative Problem Solving sessions audio recorded for the purpose of training and education, not limited to: feedback from Massachusetts General Hospital in honing our skills in the Collaborative Problem Solving Method.

Individual ________________ Date ________

Parent or Guardian ________________ Date ________

Kairos Representative ________________ Date ________

Consent for Haircuts (New Beginnings Program Only)

Staff at the Merlin facility routinely provides haircuts to residents. Your permission is required in order for your child to participate in this activity.

I/we, the undersigned, authorize Kairos staff to provide a haircut for the above named child.

Individual ________________ Date ________

Parent or Guardian ________________ Date ________

Kairos Representative ________________ Date ________

Tours and Volunteers Consent
(Residential / Day Treatment Programs Only)

I/we understand that individuals from the community may enter the treatment milieu in the context of tours and volunteer work projects. I/we understand that when possible staff will let residents know in advance about these visitors, and that they may request not to be seen, and staff will make it possible for them to be away from the group to protect their privacy.

______________________________ ______________
Individual Date

______________________________ ______________
Parent or Guardian Date

______________________________ ______________
Kairos Representative Date

Unanticipated Events
(Residential / Day Treatment Programs Only)

I / we understand that due to the fact that my child will be exposed to a variety of children and behaviors, he/she may mimic some bad habits that has been witnessed (i.e. cursing, teasing, property damage, etc). Kairos staff will continue to explain and teach children that these types of behaviors are not acceptable.

______________________________ ______________
Individual Date

______________________________ ______________
Parent or Guardian Date

______________________________ ______________
Kairos Representative Date

Documentation/Availability of Materials

Upon request, written materials may be provided in another language, as well as Braille, tape, or other alternatives. Please sign below if you wish to have materials presented in an alternative format.

Individual	Date
Parent or Guardian	Date
Kairos Representative	Date

Format Requested: ____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

KAIROS Brief Health History

In order to provide appropriate medical care if it is needed, please complete the following information about this youth's health status/history. Please complete as much information as you know about the following.

All areas must be completed for respite admissions and outpatient.

Name of current Physician: ______________________________

Location? ______________________________ Date of last visit: ______________________________

Does this youth have any food or environmental allergies? ☐ no ☐ yes

Please list and note what type of reaction occurs:

____

____

Is this youth allergic to any medications? ☐ no ☐ yes

Please list and note what type of reaction occurs:

____

____

Does this youth carry an Epi-Pen for allergies? ☐ no ☐ yes

____

____

Is this youth taking any medications? ☐ no ☐ yes Please list:

____

____

Youth name______________________________ DOB: ______________________________

Is this youth diabetic? ☐ no ☐ yes

Does this youth have any chronic medical conditions (ie: epilepsy) ☐ no ☐ yes

Please describe: ______________________________

____

____

Please list any identifying marks (i.e. birthmarks, piercings, tattoos, etc.):

____

____

____

KAIROS Brief Health History

Use of drugs, alcohol or tobacco by this youth – check any that apply & give further explanation when needed

☐ to my knowledge this youth has not used street drugs, alcohol or tobacco
☐ this youth has used alcohol- how much?____
☐ this youth has used street drugs- list type and how much______________________________
☐ this youth has used tobacco- list type and how much__________________________________

Date of last use of any of the above substances: ______________________________________
Please specify:

____

____

____

Does the youth have a history of self harm or attempted suicide? ☐ no ☐ yes

Please list the date(s) and describe:

____

____

____

____

____

____

Do you have any other health concerns regarding this youth? Please explain:

____

____

____

____

____

____

Name of Person Completing this form (please print): ______________________________

Relationship to youth: ____

Signature: ______________________________________ Date: ______________

(This signature good for 365 from the date of signature)

PRIOR NOTICE AND CONSENT FOR
DIAGNOSTIC PLACEMENT FOR EDUCATIONAL SERVICES
(INCLUDING SERVICES FOR SPECIAL EDUCATION STUDENTS ON AN IEP)
Three Rivers School District
Schools at New Beginnings and Three Bridges for KAIROS clients

Dear Parent or Guardian of ____ ,
Student's Name

Your student will receive education services while in residential treatment. Initially, this is a diagnostic placement, until records arrive from the previous school. The teaching staff requests your support in obtaining previous educational records in order to continue services in line with state and district standards; and based on your student's progress achieved to date. Please sign the release of student educational records attached.

While in our program students will have access to individualized instruction including online classes and tutorial support. The school supports the residential treatment program goals by providing daily observational assessments and participating in care team meetings. Informal testing to determine placement in classes and OAKS (Oregon Assessment of Knowledge and Skills) may occur while your student is in residence.

CONSENT FOR INITIAL DIAGNOSTIC PLACEMENT

☐ I give my permission for initial diagnostic placement as described above.

☐ I refuse consent for initial diagnostic placement as described above.

____ __________________
Signature (Parent/Guardian/Surrogate Parent or Adult Student Date

Additionally, parents of a child with a disability have protection under procedural safeguards. For a copy of the procedural safeguards or for assistance in understanding this information you may contact: Leslie Clark, Special Education Teacher, 541-476-3302 x2115

THREE RIVERS SCHOOL DISTRICT
(541) 862-3111

KAIROS Psychiatric Residential Treatment Facility Schools
New Beginnings School (11-17 yr. olds) and Three Bridges School (17-24 yr. olds)
Leslie Clark, Special Education Teacher

Karen Porter, CEA / Registrar
711 Ramsey Ave., Grants Pass, OR 97527
Phone: (541) 479-5901 x1135
Fax: (541) 479-6329

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

TO: ______________________________ **RE:** ______________________________
Students Name

______________________________ **DOB:** ______________________________

I hereby authorize the Three Rivers School District to obtain or release educational, psychological and medical information concerning my child. I understand that the information is for the confidential use of the professional personnel directly concerned with helping my child. (Three Rivers School Policy on Student Records 5700).

Please send the following information:

1. Current Transcript
2. Recent Report Card/Progress Report
3. 504 Documents (if any)
4. Statewide Assessments (OAKS) Scores
5. GED referral/materials (if applicable)

Special Education Records if any:

1. Current Evaluations
   a. With most recent Consent to Test
2. Eligibility Report
   a. With initial or most recent Consent for Provision of Services
   b. With Medical Statement and Rating Scales if applies
3. Most Recent IEP and Placement
4. Original Special Education Referral

____ ________________
Parent/Guardian/Adult Student or Authorized TRSD Signature Date

This authorization is issued in conformance with the policy of the Three Rivers School District.

Federal Law 99.31: No parent or student signature required for educational records sent to another educational agency.

Form 119-Kairos
Revised 3/13/2014

Client Name:

CLIENT CONTACT LIST

We ask that the legal guardian assist us in identifying & determining your youth's needs & privileges in the areas of contact with others &/or in meeting cultural religious needs. You may request changes to any part of this plan at any time.

Emergency Contact / Legal Guardian Legal Guardian(s) will be notified of incidents and emergency safety interventions				
Name	**Relationship**	**Phone Number**	**OK to leave detailed message?**	**I want to be contacted at time of incident, even if during sleeping hours (if no, we will call next morning)**
			Y N	Y N
			Y N	Y N

CONTACT PRIVILEGES:

Name	Relationship	Phone Number	Allowed phone calls FROM	Allowed phone calls TO	Allowed to exchange mail	May visit with ON campus	May visit with OFF campus
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N	Y N

Religious/Cultural: Please identify any special needs, requests, or concerns

Signature of Legal Guardian	Date	Signature of Kairos Representative	Date

ADMISSION DIETARY INSTRUCTIONS

Name:______________________________Client ID#:______________________

❑ FOOD ALLERGIES (Please list):

Describe typical reaction if consumed:

Does the youth carry an Epi-Pen for this allergy? ☐ Yes ☐ No

❑ Regular diet

❑ Special diet:

Instructions:

Reason:

❑ Potential food/drug interaction (describe):

____ ______________

LMP Signature Date

Food Services acknowledgement of receipt: ________________________________

Initials/Date

Route: Hard Chart, Physician's Order Book, Kitchen