SEQUEL Pomegranate Health Systems
Acute Hospital & Center for Psychiatry

ADMISSION PACKET

Shelter Care, Residential Treatment

Parent/Guardian:

Welcome to SEQUEL-Pomegranate Health Systems Residential and Emergency Shelter Care Placement programs. The goal of SEQUEL-Pomegranate Health Systems is to alleviate suffering, promote holistic development and provide an enabling environment in which traumatized children will thrive.

Enclosed you will find:

1) Admission Packet
2) Westwood-Lumin Academy Enrollment Packet
3) A copy of the Resident Handbook your client will receive

If your client should need to be enrolled into school during their stay here, please submit the following documentation with the Westwood-Lumin Academy Enrollment Packet:

1) Copy of Birth Certificate
2) Judgment Entry outlining School District
3) Order of Custody Agreement
4) Immunizations

General Visiting Hours:
Monday – Friday 6:00-7:30PM for 20 minutes.
Saturday – Sunday 10:00AM-12:30PM and 5:00-7:30PM for an hour.

Please contact me at 614-223-1650, Ext. 339. I am happy to assist you with your placement needs and answer any questions you may have. (Fax: 1-800-476-3139)

Sincerely,

Tiffany Folmar
Tiffany Folmar,
Director, Admissions/UR
Referrals.pomegranate@sequelyouthservices.com

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Please complete this form in its entirety. All sections are required to complete admission.

Today's Date:_____ Scheduled Admission Date:_____

SECTION I:
Resident's Name:_____ SACWIS#_____ (OH Resident's Only)

SS#:_____ Sex: ( ) Male ( ) Female Date of Birth:_____

Who has custody of this youth? ( ) Parent ( ) CSB ( ) Juvenile Court ( ) Other_____

Address of Legal Guardian:_____

SECTION II:
Name of Referring Agency:_____ Contact:_____

County:_____ District/Region (if applicable):_____ Phone:_____

Supervisor's Name:_____ Phone:_____

Probation Officer:_____ Phone:_____

Emergency Contact:_____ Phone:_____

SECTION III:
Medicaid Eligible ( ) Yes ( ) No If no, Name of Responsible Party:_____
Insurance/Medicaid Billing #:_____
Contact Name/Phone # if insurance not available:_____

SECTION IV:
Court Ordered? ( ) Yes ( ) No If yes, a copy of the court order must be present on or before admission.
Title IV-E eligible: ( ) Yes ( ) No

Name of School District for Educational Billing:_____

Contact:_____ Phone:_____ Fax:_____

Does this child have an IEP? ( ) Yes ( ) No If yes, a copy of the IEP must be present on or before admission.

MACSIS Residency Verification

Adolescent Psychiatry
765 Pierce Drive
Columbus, Ohio 43223
www.SEQUEL-PomegranateHealthSystems.com
HEALING, HOPE & RESILIENCE

1-800-476-0868 Acute Hospital
Fax 1-888-679-9808
1-800-476-3139 Residential Fax
1-614-223-1650 Main Office
residential admissions ext. 339

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- *The county of the treating facility does not match the legal county of residence of the client s noted on the enrollment form (child or adult out-of-county).*
- *The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult out-of-county).*
- *The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of county).*

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residencies or facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult?

( ) Yes (X) No If yes, complete the following information

N/A
Client Name (please print)

N/A
Street Address for Residency Determination Purposes

N/A N/A
Signature of Client Date

Minor

Client is a minor?

(X) Yes ( ) No If yes, indicate if child is in legal custody of the following (this is not the foster parent)

( ) Parent ( ) CSB ( ) DYS ( ) Court ( ) Other (specify)_____

Client Name (please print)

Name of Legal Custodian Marked Above/ Phone Number of Legal Custodian

County of Legal Custodian

If Parent, Addresses of Parent (if different from client's physical address on enrollment form)

Signature of Legal Custodian Date

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Treatment Authorizations and Consents

I, the Legal Representative of _____, date of birth _____ :
hereby grant my permission for the following authorizations and consents;

Please initial on the lines below:

_____ **Informed Consent for Residential/Related Services**
I hereby authorize personnel of SEQUEL-Pomegranate Health Systems to perform such diagnostic and therapeutic procedures as the physician deems necessary for care of the above minor. I understand that the above minor will not be given treatment against his/her wishes and may discuss refusal with the attending physician.

_____ **Video Surveillance and Monitoring/Phone Recording**
I am aware that SEQUEL-Pomegranate Health Systems uses a video surveillance system and phone recording system for the purpose of monitoring safety concerns, proper implementation of policy and procedures, quality assurance and to review for training purposes. I understand, that private areas of the facility, (i.e., bedrooms and bathrooms), are not monitored by the surveillance system. I understand that the material recorded will be maintained in a highly confidential manner and will only be reviewed by authorized staff. SPHS will make every effort to notify all parties involved before releasing video and/or phone conversations to regulatory or law enforcement personnel.

_____ **Computer Data**
I understand that the minor's personal information and medical records may be accessible by authorized hospital personnel through computers, and SEQUEL-Pomegranate Health Systems will comply with certain safe guards established by federal, state, and local law as well as facility policy.

_____ **Consent to Photograph**
I hereby consent for a photograph to be taken by SEQUEL-Pomegranate Health Systems for the express purpose of patient identification. This consent is given freely and voluntarily without any promise, threats, or dues.

_____ **Release of Responsibility for Valuables**
It is policy of SEQUEL-Pomegranate Health Systems to request that patients do not bring items of value (electronics, jewelry, money etc.) into the facility. In the event a patient brings an item of value, SEQUEL-Pomegranate Health Systems requires the following release to be signed. I understand SEQUEL-Pomegranate Health Systems will not replace or be held liable for items, brought by patients or visitors, that become lost, stolen or broken.

_____ **Transportation/Field Trip**
I hereby allow SEQUEL-Pomegranate Health Systems to provide transportation as deemed appropriate by SEQUEL-Pomegranate Health Systems.

_____ **Handbook Acknowledgement**
I have read or have had read to me and understand the information contained in the Resident Handbook. All of the information has been explained to me and I have had all my questions answered at this time. My initials signify the receipt and understanding of the Resident Handbook.

_____ **Immunization**
SEQUEL-Pomegranate Health Systems is striving to increase awareness of childhood immunization guidelines. Enclosed is a CDC recommendation for childhood immunizations. I have read or have had read to me and understand the information provided regarding immunizations.

_____ **Hair Care**
I hereby grant SEQUEL-Pomegranate Health Systems permission to provide or arrange the following hair care services: ( ) Haircut ( ) Perm

_____ **Privacy Policy Acknowledgement**
I have read or have read to me and understand the information contained in the Notice of Privacy Practices. All of the information has been explained to me and I have had all my questions answered at this time. By initialing, I am acknowledging the receipt and understanding of the Notice of Privacy Practices.

_____ **Special Treatment and Safety Measures Policy**
It is our philosophy and goal to maintain a restraint free therapeutic environment. However, should a patient become a threat to self or others, trained staff will utilize restraint techniques as a last resort and only in emergency situations to provide for the safety of patients, visitors, and staff.

I have read all of the above and understand the terms. I certify to the best of my knowledge and belief that all information provided is complete and correct.

Signature of Legal Representative Date

Printed Name of Legal Representative Date

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Consent for Emergency Medical Treatment

I hereby grant SEQUEL-Pomegranate Health Systems (SPHS) permission to provide or arrange for the emergency and routine medical treatment for the durations of this child's stay at SPHS. For services that cannot be furnished by the provider agency. I empower the above provider agency designee to consent to necessary routine and emergency, I empower the above provider agency designee to consent to necessary routine and emergency medical, dental or optical treatment upon competent medical advice. I understand that except in cases of emergency, I will be notified in advance of any serious medical, dental, or optical problems requiring treatment. I hereby request that the medical provider release to the above named provider any and all information pertaining to the above named child.

Upon the need to administer a new medication for this resident, we will contact the agency by phone, fax, land line/ or email.

Current Medications

All doctor ordered medications, must be listed at the time of admission.

Medication	Dosage (mg)	Time	Other Instructions

Signature of Legal Representative Date

Printed Name of Legal Representative Date

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Childhood Immunization Schedule

	Birth	2 months	4 months	6 months	12-15 months	4-6 years	11-18 years
Hep-B Hepatitis B	✓	✓		✓			
DTap/Tdap Diphtheria, Tetanus, Pertussis		✓	✓	✓	✓	✓	✓
Hib Haemophilus Influenza type B		✓	✓	✓	✓		
IPV Polio		✓	✓	✓		✓	
PCV7 Pneumococcal conjugate		✓	✓	✓	✓		
MMR Measles, Mumps, Rubella					✓	✓	
Chickenpox Varicella					✓	✓	
Rota Rotavirus		✓	✓	✓			
Hep-A Hepatitis A					☑		
MCV4 Meningococcal							✓
HPV Human Papilloma virus							☑
Flu Influenza				***Every year beginning at 6 months of age***			

✓ - These check marks show at what ages and what immunizations a child is recommended to receive.

☑ - These check marks indicate these immunizations are a part of a series:

- Hepatitis A is a two dose series spaced 6 months apart and is given to all children at 12 months of age.
- HPV is given as a 3 dose series at 0, 2, 6 month spacing schedule.

Immunizations and regular doctor check-ups are important to your child's good health.

NEED IMMUNIZATIONS ?

Your child's health care provider can give the immunizations your child needs. Make sure that you ask about shots at every visit.

Public health department clinics provide low cost shots as well. Call either the Franklin County Board of Public Health (614-462-3635) or Columbus Public Health (614-645-7945).

Immunizations and regular doctor check-ups are important to your child's good health.

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Approved Telephone/Visitation/Mail List

_____ _____
Last Name First Name

Please list all individuals approved for telephone, visitation, and mail for the above resident. This information serves as a guide to eliminate any breach of confidentiality.

Name	Relationship	Street, City, State, Zip Code	Phone Number	Key 1	Key 2

The key below indicates whether a visitation with any of the above individuals must be:

Key 1	Key 2
1-Minimal (Visual) 2-Moderate (General Area) 3-High (Same Table/Room)	1-Visitation only 2-Mail Only 3-Telephone Only 4-Visitation, Mail and Telephone Approved

_____ _____
Guardian Signature Date

_____
Relationship

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Education Agreement

I _____(Parent/Guardian) hereby decline the education by Westwood-Lumin Academy provided by SEQUEL-Pomegranate Health Systems and I understand SEQUEL-Pomegranate Health Systems will not be held responsible for providing alternative education within the facility.

In place of Westwood-Lumin Academy, my child _____is/will:

( ) Stay enrolled in his/her current school and will need to be transported to/from school by SEQUEL-Pomegranate staff.

Name of school currently enrolled:_____
Time school day begins:_____ AM Time school day ends:_____ PM

( ) Stay enrolled in current school and child will be transported by bus to/from facility to school by current school district.

Name of school currently enrolled:_____
Bus stop location:_____
Time bus picks up:_____ AM Time bus drops off:_____ PM

( ) Stay enrolled in current school and school will coordinate distribution/return of schoolwork with the designated CPST/Therapist to be completed while in facility.

Name of school currently enrolled:_____

( ) Currently working towards a GED. (please provide additional information regarding the program):

_____

_____

( ) Graduated (must show proof of diploma/GED)

( ) Other (please explain):_____

_____

_____
Signature of Legal Representative Date

_____
Printed Name of Legal Representative Date

****If you choose to place your child in Westwood-Lumin Academy, enrollment paperwork is included at end of this packet****

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Please Acknowledge By Initialing Each Titled Section:

_____ Admission Packet Cover Letter

_____ Residents Information Sheet

_____ MACSIS Residency Verification

_____ Informed Consent for Residential/Related Services

_____ Video Surveillance & Monitoring/Phone Recording

_____ Computer Data

_____ Consent to Photograph

_____ Release of Responsibility for Valuables

_____ Transportation/Field Trip

_____ Handbook Acknowledgment

_____ Immunizations (Acknowledgment & Information)

_____ Hair Care

_____ Privacy Policy Acknowledgment

_____ Special Treatment and Safety Measures

_____ Consent for Emergency Medical Treatment

_____ Approved Telephone/Visitation/Mail List

_____ Education Agreement

_____ _____

Signature of Legal Representative | Date

_____ _____

Printed Name of Legal Representative | Date

_____

Relationship to Patient

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