

Bosco Homes—A Society for Children and Families

6770 - 129 Avenue Edmonton, AB T5C 1V7

Phone: (780) 440-0708 Fax: (780) 440-0760

Email: abh_admin@boscohomes.ca

Website: www.boscohomes.ca

CONSENT PACKAGE

Admission Date _____

Admission Time _____

Intensive Group Care

- | | | |
|---|--|--|
| <input type="checkbox"/> Marian House
Phone: (780) 922-4790 Ext. 235
Fax: (780) 922-3290 | <input type="checkbox"/> Francis House
Phone: (780) 922-4790 Ext. 249
Fax: (780) 922-3290 | <input type="checkbox"/> Asota House
Phone: (780) 922-4790 Ext. 243
Fax: (780) 922-3290 |
|---|--|--|

Specialized Programs

- | | | |
|--|---|---|
| <input type="checkbox"/> Sexual Issues (Clare House)
Phone: (780) 448-8790
Fax: (780) 477-8790 | <input type="checkbox"/> Mental Health (Nelson House)
Phone: (780) 992-4790 Ext. 246
Fax: (780) 922-3290 | <input type="checkbox"/> FASD Program (Asota House)
Phone: (780) 992-4790 Ext. 264
Fax: (780) 922-3290 |
| <input type="checkbox"/> Alcohol and Drug Addiction Program Treatment (Bisson House)
Phone: (780) 922-4790 Ext. 251
Fax: (780) 922-3290 | | <input type="checkbox"/> Bright Bank (Under age 12)
Phone: (780) 963-3176 Ext. 221
Fax: (780) 968-6325 |

Community Group Care

- Meridian House**
Phone: (780) 963-9466
Fax: (780) 968-4610

FOR OFFICE USE ONLY

Notifications of Admission

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Nurse _____ | <input type="checkbox"/> House _____ |
| <input type="checkbox"/> Admin _____ | <input type="checkbox"/> Clinical _____ |
| <input type="checkbox"/> School _____ | <input type="checkbox"/> PAS _____ |

Revised 03/09

ABH-CAFS — *Child, Adolescent and Family Services*

6770 - 129 Avenue Edmonton, AB T5C 1V7

Phone: (780) 440-0708 Fax: (780) 440-0760

Email: abh_admin@boscohomes.ca

Website: www.boscohomes.ca

CONSENT PACKAGE

Admission Date _____

Admission Time _____

Treatment Group Care

- Oskayak House**
Phone: (780) 452-9021
Fax: (780) 452-8097

Community Group Care

- McGivney House**
Phone: (780) 963-0777
Fax: (780) 963-0784

FOR OFFICE USE ONLY

Notifications of Admission

Nurse _____

House _____

Admin _____

Clinical _____

School _____

PAS _____

Revised 03/09

IMPORTANT Must complete and sign pages 1-6. Please complete ALL information outlined on this form. For information that is not available at this time, please attach a note as to when it can be expected. For information that is not applicable, please put N/A. Thank you.

Client's Complete Name	DOB mm dd yy	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Child Welfare Status (i.e. P.C., T.C., P.G.O., etc.)	Expiry Date mm dd yy
Assessment Conference Location (OFFICE USE ONLY)		Date mm dd yy		Time <input type="checkbox"/> AM <input type="checkbox"/> PM

Upcoming Appointments					
Name of Office/Contact Person	Address	Reason For	Appointment Date	Appointment Time	Phone Number

Contact List						
Name	Relationship to Client	Complete Address				Phone Number
		Address	City	Province	Postal Code	

Comments _____

No Contact						
Name	Relationship to Client	Complete Address				Phone Number
		Address	City	Province	Postal Code	

To: School Board:

Date

Bosco Homes/ABH-CAFS
6770 - 129 Avenue
Edmonton, AB T5C 1V7

- Resident Student of Government
 Resident Student of The Board

To Whom it May Concern:

Pursuant to Section 1(2) or 1(2)(d) of the School Act, RSA (2000), this letter serves as notification that the student listed below (is/is no longer) under guardianship or custody of a Director and Family Services pursuant to an order or agreement.

Student's Legal Surname	Given Name(s)	Date of Birth <small>mm dd yy</small>	Phone No.
Parent/Legal Guardian Name			Phone No.
Parent/Legal Guardian Address	City	Province	Postal Code

Living With

<input type="checkbox"/>	Foster Parents Name: (General Foster Home)	Home Phone No.	Work Phone No.
	Address	City	Province Postal Code
<input checked="" type="checkbox"/>	Other: (Specify—Insitution, Group Home, Foster Home) Bosco Homes/ABH-CAFS		Emergency Phone No. (780) 440-0708
	Supervisor's Name	Phone No.	Emergency Phone No.
	Address	City	Province Postal Code

Child Welfare Status

- APPREHENSION
 PERMANENT GUARDIANSHIP ORDER/AGREEMENT
 TEMPORARY GUARDIANSHIP ORDER
 CUSTODY AGREEMENT
 FAMILIES SERVICES FOR CHILDREN WITH DISABILITIES/FSCD
 INTERIM CUSTODY
 VOLUNTARY SERVICE AGREEMENT (PLAN OF CARE AGREEMENT)
 COURT ORDER ATTACHED
 ANY LIMITS TO THE SHARED PARENTAL AUTHORITY ARE ATTACHED

Expiry Date

Director or Designate (Please Print)	Signature	Phone No.
--------------------------------------	-----------	-----------

I/we, _____, of _____, _____
Print Names *City/Town/Hamlet* *Province*

Parent(s)/Legal Guardian(s) of _____, born on _____
Child's Names *D/M/Y*

Health Care # _____ hereby authorize the CFSA Case Manager and/or Bosco Homes, to complete and maintain the following, procedures, service and treatment::

- General/Annual Medical Appointments/Procedures
- Administering of Medications, special diets
- General/Annual Dental Appointments/Procedures
- General/Annual Optical Appointments/Procedures
- Psychiatric Appointments (Administering of medication prescribed as a result of a psychiatric appointment)

Exceptions To The Above Consent:

I specifically **DO NOT** authorize the following types of procedures, services or treatments, and wish to be contacted personally for my consent.

As the legal guardian, I understand I am responsible for **ALL** expenses related to the booking of medical appointments and for the provision of medical, dental and optical care to the client while he/she is in the care of Bosco Homes/ABH-CAFS. If other arrangements have been made, please indicate below:

Required Signature(s)

Parent(s)/Legal Guardian(s) Print Name *Parent(s)/Legal Guardian(s) Signature* *Contact Phone #*

Parent(s)/Legal Guardian(s) Print Name *Parent(s)/Legal Guardian(s) Signature* *Contact Phone #*

Witness Print Name *Witness Signature* *Contact Phone #*

This Consent is valid from (mm/dd/yy) _____, until (mm/dd/yy) _____.

1. Third Party Indemnity

Bosco Homes/ABH-CAFS is not responsible for errors or omissions pertaining to the terms and conditions of custody and/or service agreements between the Child Welfare Workers, who are wholly responsible for the contracting and authorizing of our services.

CFSA/FSCD Worker Initial

2. Mandatory Discharge Notification

In order to facilitate the program integrity and closure, Bosco Homes/ABH-CAFS requires:

- a) 10 days notification, prior to discharge, for Intensive Treatment Group Care (ITGC) and Treatment Group Care (TGC) programs.
- b) 72 hours notification for community-based Group Care programs to discharge a client, whether on site or AWOL.

An official notification, in writing, must be made by either the Department or the agency to initiate a discharge. This can be mailed or faxed to (780) 440-0760.

If insufficient notice is given, the corresponding per diem will be charged for the duration of the notification period, and Bosco Homes/ABH-CAFS cannot assume responsibility for any injury that may be, directly or indirectly, related to premature discharge and incomplete transition planning.

CFSA/FSCD Worker Initial

Agreement for Payment of Additional Care:

It is also agreed that the CFSA/FSCD Office (name) _____, as the legal guardian/case manager, will be responsible for the following expenses while the client is in the care of Bosco Homes/ABH-CAFS:

- All expenses relating to the booking of medical appointments and for the provision of medical, dental and optical care to the client.
- All expenses relating to medication/prescription or not covered by health care.
- All expenses relating to the provision of, and updating of, the client's seasonal clothing outer wear (jackets, boots, shoes, etc.).
- All expenses for one to one coverage in the event the client is unable to be managed within a 3:1 staff ratio.
- All recreational expenses for programs which are specific to the client (swimming lessons, skate boards, helmet, etc.).
- All transportation costs for visits and activities which are specific to the client.

Client Care History and Family Information (Information Consolidation Report)

Also required upon intake is an information consolidation or comparable document which includes the client's care history and family information. In the event that there is no such information, it will be difficult for Bosco Homes/ABH-CAFS to assess the clients' needs and reasons for referral, or obtain information on history and risk issues.

Your signature indicates that you have been requested to provide such a document and are willing to do so in the below indicated time frame. Date information to be received by _____.

CFSA/FSCD Worker Name —Please Print	CFSA/FSCD Worker Signature	Date
Witness Name —Please Print	Witness Signature	Date

This Consent is valid from (mm/dd/yy) _____, until (mm/dd/yy) _____.

FOIP—This information is created, collected and retained by Bosco Homes/ABH-CAFS under the direction and mandate of the Ministry of Children's Services and the Child, Youth and Family Enhancement Act of Alberta; and in accordance with the Alberta Learning Student Records Regulations.

CONSENT FOR CLINICAL SERVICES OF THERAPY AND PSYCHIATRIC CONSULTATION

The purpose of this form is to request your consent as the guardian for _____
for psychological and psychiatric treatment and assessment at Bosco Homes/ABH-CAFS.

At Bosco Homes/ABH-CAFS, treatment is provided through conventional means like therapy; however, we also believe that the entire milieu provides opportunities for the child/youth to learn coping and daily living skills. As such, treatment is provided by clinicians through individual, family, and group therapy, but also through consultation with houses and school staff, as well as other caregivers. In many situations, research has shown that such consultation is more effective in changing the child/youth's behavior than one-on-one therapy. Clinicians have a masters or doctoral degree, and are registered with professional associations. Clinicians with provisional registration are provided with supervision that is required by their profession and related legislation. Occupational therapists are also registered with their appropriate professional association.

The modalities of treatment are determined through a triage process, in which the Clinical Director, Coordinator of Psychological Services, Coordinator of Group Care, House Manager, Clinicians, and/or Bosco Homes/ABH-CAFS staff meet to discuss the therapeutic needs of the child/youth. A determination is then made by the team about the types of treatment that will be provided; a letter will be sent to the guardian after this decision is made. In addition, children and youth coming into our care will receive a comprehensive psychological assessment (unless a recent such assessment as already been completed) as part of their treatment at Bosco Homes/ABH-CAFS if residing at Bosco Homes/ABH-CAFS for more than 456 days (90 days at ADAPT). Information from the child/youth may be shared with other team members as appropriate.

In therapy, it is important to note that there are risks in addition to benefits. People in therapy sometimes show declines in behavior and emotional functioning when working through especially challenging issues, for instance. With children and youth who are experiencing very substantial emotional turmoil, the risk of suicidal ideation or self-harm may increase. Clinicians will communicate to staff when the child/youth is showing increased emotional challenges related to therapy, and these will be discussed with guardians at case conferences (every 90 days) or sooner as necessary.

I consent to individual, group and family therapy, psychological assessment for _____,
as well as psychiatric consultation as deemed appropriate by the treatment team at Bosco Homes/ABH-CAFS. I understand that therapy may be provided by a provisionally registered clinician under the supervision of a psychologist. This consent lasts from _____ (intake date) until discharge from Bosco Homes/ABH-CAFS.

Guardian's Name—Please Print	Guardian's Signature	Date

Are any previous psychological assessments available? Yes No

When were these assessments done? _____

Are they included in the intake package? Yes No

if not, who can be contacted to obtain them? _____

Would you like further information about FASD assessment (\$1020 extra)? Yes No

To: CFSA/FSCD Worker - (Print Name)

From: Bosco Homes/ABH-CAFS

CC: Accounting, Client File

Date: _____

RE: One-to-One Staffing Agreement

The following agreement for one-to-one staffing support for _____ , who is presenting as high-risk or at extremely high-need. Such situations may include, (but are not limited to):

- _____ Self-Mutilation
- _____ High AWOL risk clients
- _____ Physically aggressive/abusive clients
- _____ Suicidal clients
- _____ Other _____

Client Name _____

Date(s) of requested 1:1 _____

Hours of requested 1:1 _____

Special Conditions _____

I, _____ (print name), authorize the above 1:1 coverage and agree to pay for it at a rate of \$26.03/hr.

Signature _____

Region/Office _____

Address _____

This request is valid from _____ to _____

This written agreement is required each time a 1:1 is requested and is required prior to 1:1 coverage being secured.

Animal-Assisted Therapy

This is to inform you that your child may have the opportunity to interact and work with animals that are part of Animal-Assisted Therapy (AAT) at Bosco Homes/ABH-CAFS. Eligibility and appropriateness to participate in AAT will be assessed by the treatment team.

AAT is a goal-directed therapeutic intervention that focuses on helping children discover parts of themselves through interacting with a skilled animal and a Bosco Homes/ABH-CAFS staff member who is skilled in human-animal interactions. AAT is an opportunity for children to “let down their guard”, increase their motivation, develop trust and feel good about themselves. The animal will be accompanied by an owner at all times. Although all animals used in AAT are carefully screened for good health, obedience skills, and aptitude, there may be some inherent risks. We require your permission to allow the client to participate in AAT, if deemed appropriate.

Please Initial the Following Three Sections

Initial Box

I, the undersigned, understand and acknowledge that I am aware of the risks associated with or related to the use of AAT (including the risk of severe or fatal injury) to my child or child from which I am responsible. These risks particular may include but are not limited to the following:

- a.) injuries resulting from animal scratches
- b.) injuries resulting from allergic responses to animals
- c.) injuries resulting from animal trips or bites
- d.) injuries resulting from any physical contact with an animal that may encompass more serious injuries.

Initial Box

I understand that by signing this document, my successors, heirs, assigns or personal representative waive the right to sue or otherwise claim against Bosco Homes/ABH-CAFS, or its employees, directors, agents, volunteers, affiliates, or independent contractors for any loss or damage connected with any property loss or personal injury that I sustain while participating in or preparing for any program or activity of the Bosco Homes/ABH-CAFS. I fully understand clearly that my successors, heirs, assigns and personal representatives waive the right to sue or otherwise claim contractors if the loss or injury suffered results wholly or in part of the negligence of Bosco Homes/ABH-CAFS, its employees, directors, agents, volunteers, affiliates or independent contractors or from the negligence of any third party, including other participants in the program.

Initial Box

I further agree to indemnify and save harmless Bosco Homes/ABH-CAFS, employees, directors, agents affiliates, volunteers, or independent contractors from any and all actions, claims, demands, losses or suits of any nature resulting from and arising from my participation in any program in Bosco Homes/ABH-CAFS or my use of its facilities or from the participation of my child or child for which I am responsible in any program in Bosco Homes/ABH-CAFS or from that child's use of its facilities.

Client (Participant in AAT)

Name: _____ DOB _____

Address: _____ Phone: _____

In case of Emergency: Bosco Homes/ABH-CAFS Phone: _____

Parent/Guardian of Client (Participant in AAT)

Name: _____ Phone #: _____

Address: _____ (2nd) Phone #: _____

(2nd) Emergency Contact: _____ Phone #: _____

Interaction with Animal is a Component of Animal-Assisted Therapy

I acknowledge that I have read and fully understood this agreement prior to signature.

I WITNESS that I have executed this document at the City of Edmonton in the

Province of Alberta this (day) _____ day of (Month) _____, 20__.

Signature of Parent/Guardian for Under 18 Participant

Bosco Homes/ABH-CAFS Staff Member (Witness)

Name

Signature of Witness (Bosco Homes/ABH-CAFS Staff Only)