Records Request

Resident: _____

Date of Birth: _____ SSN: _____

Date of Request: _____

The following items are required by state law to complete the files regarding the above resident. Please send the items marked below by fax to (606)546-3903 or by mail to P.O. Box 550, Barbourville, KY 40906.

- ☐ DPP-886A (Referral)
- ☐ Placement Summary
- ☐ Commitment Order
- ☐ Current Legal Records
- ☐ Current Family Case Plan
- ☐ CRP Quarterly Report/Achenbach/Reiss (if applicable)
- ☐ Current 114
- ☐ DSS-106A (Medical History)
- ☐ Educational Documentation (Records/IEP)
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Immunization Records
- ☐ Current Medical Cards
- ☐ Consents/Releases (Medical/Image/Release of Information/Disabilities/Recreation)
- ☐ Signed Treatment Plans (last page only)
- ☐ Contact Sheet
- ☐ Clothing Voucher
- ☐ Medical Passport
- ☐ Other: _____

Thank you for your time and cooperation in this matter. Please do not hesitate to contact me with any questions you may have.

_____ _____

Case Manager Date

Developmental Limitations/Disabilities

Resident: _____

DOB: _____ SSN: _____

This is to verify that the aforementioned child:

☐ Does NOT have any developmental limitations or disabilities to hinder performance of any attempted tasks or activities.

☐ Does have the following developmental limitations or disabilities that may limit his or her ability to perform certain tasks or activities as listed below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Guardian Date

_____ _____

Case Manager Date

Medical Consent

Resident: _____

Date of Birth: _____ SSN: _____

I hereby give consent to the Appalachian Children's Home or its designated agent to provide foster home or institutional care to the aforementioned child as long as he or she is under the care of the Appalachian Children's Home.

In the event that it becomes necessary for my child to have medical, surgical, psychiatric, vision, or dental treatment, I hereby authorize the Appalachian Children's Home or its designated agent to determine the necessity for such medical, surgical, psychiatric, vision, or dental treatment. Further, I hereby authorize the Appalachian Children's Home or its designated agent to seek medical or psychiatric care for my child as well as to provide consent for medication administration.

Guardian Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

DPP-106A
(R. 4/07)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services

AUTHORIZATION FOR MEDICAL TREATMENT

Indicate the most recent type of custody and date

VOLUNTARY COMMITMENT

_____
Mo./Da./Yr.

The child identified below is under a voluntary commitment to the Cabinet for Health and Family Services, Department for Community Based Services (DCBS). Under a voluntary commitment, the parents authorize the Department to provide such medical care as may be advised by the attending physician except in cases of serious illness or major surgery. In these instances, the parents are to be contacted and their written consent obtained. A representative of the Department case worker may consent when parents cannot be located. In an emergency, if the case worker cannot be located, the foster parents may authorize emergency medical treatment.

TEMPORARY OR EMERGENCY CUSTODY

_____
Mo./Da./Yr.

The child identified below is in the temporary or emergency custody of the Cabinet for Health and Family Services, Department for Community Based Services (DCBS), and a parent or district judge shall provide written approval for medical procedures. In an emergency, when the child requires immediate medical attention and the parent or judge has not granted prior written approval, or cannot be located, the case worker can authorize treatment. If the case worker cannot be located, the foster parents may authorize medical treatment.

COMMITMENT

_____
Mo./Da./Yr

The child identified below is committed to the Cabinet for Health and Family Services, Department for Community Based Services (DCBS). When any medical services are to be provided, a representative of the Cabinet, such as the child's case worker, or the parent, may approve services for the child by his or her signature. In an emergency, when the child needs immediate medical treatment, and the case worker cannot be notified, the foster parent may authorize treatment.

RIGHTS TERMINATED

_____
Mo./Da./Yr

The parental rights of the child identified below have been terminated. When any medical services are to be provided, a representative of the Cabinet, such as the child's caseworker, may approve the service for the child by his signature. In an emergency, when a child needs immediate medical attention and the case worker cannot be located, the foster parent may authorize medical treatment.

CHILD'S NAME: _____

DATE OF BIRTH: _____

DCBS WORKER: _____

WORK PHONE: _____

HOME PHONE: _____

DCBS SUPERVISOR: _____

WORK PHONE: _____

HOME PHONE: _____

File: Original, Passport Folder
Copy, Professional Section

DCBS-2
11/07

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

RELEASE OF INFORMATION FOR PHOTOGRAPHY, VIDEOTAPING OR AUDIOTAPING

This form is to be used as a consent for photography, videotaping or audiotaping of a child as required per 922 KAR 1:300.

I authorize the following agencies:

Name of Agency	Name and Relationship of Individual
Appalachian Children's Home	PCC

To allow pictures, audiotaping and videotaping for the following child:

Child's Name: _____ SSN: _____:

REASON FOR RELEASE

NATURE OF REQUEST:

_____

_____

INTENDED USE OF PHOTOS OR TAPES:

AWOL procedures; Life Book; or any Medical/Charting Purpose

_____

_____

LIMITATIONS AND PROHIBITIONS OF THIS RELEASE:

- A child may not be depicted in a photograph, videotape or audiotape for promotional purposes, or in a manner that would cause the child or family to suffer embarrassment.
- A child should not be identified as a foster child in any type of publication or public exhibit.
- Other considerations for this release include the desires of the child and the biological parents, if parental rights remain intact.

Signature_____ Date_____

☐ Parent's Signature, or

☐ DCBS worker's name & title (If TPR has been ordered)_____

NOTE:

A consent form is not required for photographs, audiotaping or videotaping that occur as part of the child's daily routine, and which are not intended for public viewing, such as family photos, photos for the child's lifebook or case file, school/yearbook pictures or videotape of a special event for the child. Photographs, videotapes or audiotapes of a child who is available for adoption and registered through the Special Needs Adoption Program (SNAP) may be used for the purpose of seeking and securing an adoptive placement for the child.

Recreation Consent

Resident: _____

Date of Birth: _____ SSN: _____

I hereby give consent for the aforementioned child to participate in the activities listed below as long as this child is placed with the Appalachian Children's Home.

- ☐ Basketball
- ☐ Fishing
- ☐ Flag Football
- ☐ Hiking at Area Parks
- ☐ Horseback Riding
- ☐ Personal Fitness Training with AFAA Certified Personal Trainer
- ☐ Softball
- ☐ Swimming at Area Pools & Waterparks with Life Guards
- ☐ Venturing Crew (Adventure Based Activities)
- ☐ Video Games
- ☐ Volleyball

Thank you for your time and cooperation in this matter. Please do not hesitate to contact me with any questions you may have.

Notes:

_____ _____

Guardian Date

_____ _____

Case Manager Date

Release of Information

Resident: _____

DOB: _____ SSN: _____

Authority is hereby given for release of any information of a dental, medical, psychiatric, social, education, legal, or financial nature to be given to representatives of the Appalachian Children's Home. In addition, authority is hereby given for the release of any information pertaining to Social Security or Social Security benefits which the child named above may be eligible to receive.

_____ _____

Guardian Date

_____ _____

Case Manager Date

Contact List

Resident: _____

Phone Day: _____

The resident is only to have contact with those listed below at the given numbers as approved by the case manager. If he or she wishes to contact someone not on this contact list, the resident must wait for approval from the case manager.

Name	Relationship	Phone Number	Type of Contact