Appalachian Children's Home

Barbourville, Kentucky

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 via email to jamie.hobbs@achky.org, 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 ALP or CANS (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
- ☑ 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.

Referral Specialist

Date

Appalachian Children's Home

Barbourville, Kentucky

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

_____ _____

Resident Date

Appalachian Children's Home

Barbourville, Kentucky

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: _____

Resident 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.

Appalachian Children's Home
Barbourville, Kentucky

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

_____ _____

Resident Date

Appalachian Children's Home
Barbourville, Kentucky

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

_____ _____

Resident Date

Appalachian Children's Home
Barbourville, Kentucky

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

Appalachian Children's Home
Barbourville, Kentucky

OUT OF STATE PERMISSION

Outings are one of our many activities to reward residents who are doing well in our program. These may include movies, sporting events, restaurants, theme parks, bowling alleys, caving, white water rafting, trips to parks, etc. At times, some of these outings may take place out of state (such as Dollywood). These trips will be supervised by staff at all times.

Please sign below to indicate whether you grant permission for your child to participate in out of state trips.

Resident _____

____MAY have reward trips out of state with the facility and staff supervision

_____may NOT have reward trips out of state with the facility and staff supervision

_____ _____

Social worker/Guardian Date

Appalachian Children's Home
P.O. Box 550
Barbourville, KY 40906
(606) 546.3805 (606) 546.3903 Fax

PERMISSION TO TREAT AND INFORMED CONSENT FORM FOR SPECIALIZED EQUINE-ASSISTED PSYCHOTHERAPY/LEARNING SERVICES

This form must be completed, approved, and signed by the child's legal guardian/Department of Community Based Services (DCBS.) This consent is specifically for the participation in equine-assisted psychotherapy/learning facilitated by EAGALA and OK Corral certified practitioner teams which include a qualified mental health professional and an equine specialist.

1. Participant Information

Name: _____

Date of Birth: _____

Guardian's Name: _____

Guardian's Emergency Contact Information: _____

2. Description of Equine-Assisted Psychotherapy/Learning (EAP/EAL)

The participant will engage in equine-assisted psychotherapy and learning sessions conducted by certified professionals trained in the EAGALA Model and OK Corral methodology. This therapy is solution-oriented and involves interaction with live horses. It is designed to enhance emotional, social, and behavioral development. Psychotherapy may include interventions such as grooming, leading, groundwork, and mounted work all under the supervision of a licensed mental health therapist and equine specialist.
EAGALA Model: The EAGALA Model is a solution-oriented, client-centered therapy approach involving live horses as part of the therapeutic process. This is the belief that all participants can discover the best solutions for themselves when given the opportunity. It does not include riding but focuses on ground-based interactions.
OK Corral Certification: The OK Corral Series offers specialized training in equine-assisted learning and therapy, emphasizing safety, ethical practices, and effective outcomes that enhance resilience for participants to keep themselves safe and healthy.

3. Benefits of EAP/EAL

Offering a much different experience than traditional talk therapy, EAP/EAL brings participants outdoors and offers an opportunity to use all senses while learning and processing through emotional challenges. Participants can learn and build upon assertiveness, confidence, developing and maintaining relationships, emotional awareness, empathy, impulse control, problem-solving skills, social skills, trust in others, trust in self, adaptability, distress tolerance, emotional awareness, independence, impulse control, self-esteem, social awareness, and social relationships. EAP/EAL provides the participant the opportunity to manage vulnerability as well as mirroring and feedback techniques that increase self-awareness. Equine-assisted psychotherapy and learning has also been shown to reduce symptoms of PTSD, anxiety, depression, and ADHD. These therapy techniques have also had a positive impact on improving emotional response to trauma, learning mindfulness skills, and a decrease in drug use.

4. Potential Risks of EAP/EAL

Horses, like all of us, have choices in which they may behave in ways we cannot control. It is your responsibility to always be mindful of your surroundings. Participants must understand the potential for risks in engaging in equine-assisted psychotherapy/learning. These risks include things such as physical injury that may result in serious bodily harm (i.e., falls, bites, kicks, and being stepped on) and environmental concerns (i.e., weather conditions, uneven ground, allergic reactions, insects.) Proper attire must be always worn while in the horse corral. A list of proper attire will be given to you upon request. Appalachian Children's Home is also not responsible for the damage of any personal property that you choose to bring into the horse corral.
Safety Measures: The therapy sessions will follow EAGALA and OK Corral safety protocols, including the use of protective equipment, a controlled environment, and trained personnel to minimize risks.
Emergency Procedures: In case of a medical emergency, the following steps will be taken:
- Immediate first aid will be administered.
- Emergency medical services will be contacted.
- The legal guardian and assigned social worker will be notified promptly.

5. Confidentiality

I understand that my information regarding therapy services is protected under Federal Confidentiality Law and will not be disclosed by the therapy staff without my written consent except under the following circumstances or conditions:

1. Records or information is subpoenaed under an appropriate court order following a "good cause" hearing.
2. If you commit or threaten to commit a crime either at a program or against any person who works for the program.
3. To qualified personnel for research, audit or program evaluation. Personnel conducting or performing these functions may not directly or indirectly identify the participant in any written report or disclose participant identities in any manner.
4. Staff have reason to believe you pose an imminent threat of danger to yourself or others.
5. Staff have reason to believe there is evidence of child abuse or adult abuse.

I, _____ (participant's/guardian's printed name) do hereby give permission for certified equine-assisted therapy staff at the Appalachian Children's Home to provide equine-assisted psychotherapy/learning services as a component of my therapeutic episode, which I can terminate at any time I choose.

_____

Participant's Signature (16+) Date

_____

Legal Guardian/DCBS Worker Signature Date

_____

ACH Case Manager Signature Date

_____

ACH EAP/EAL Therapist Signature Date