

RECOVERY HIGH PHASE ONE REFERRAL PACKET

(updated 3/3/10)

CHARLEVOIX COUNTY PROBATE COURT
301 STATE ST.
CHARLEVOIX, MI 49720

For Availability or Intake Questions,
Please Call (231) 549-7760, ext. 22

PLEASE FAX ALL COMPLETED INTAKE INFORMATION TO:
231-549-7764

**THE FOLLOWING DOCUMENTS MUST ALL BE SIGNED AND RETURNED
BEFORE THE YOUTH CAN BEGIN THE PROGRAM:**

**PART ONE MUST BE SENT FIRST, FOR RECOVERY HIGH TO DEEM THE YOUTH AN
APPROPRIATE PLACEMENT.**

**AFTER ACCEPTANCE, PART TWO MUST BE COMPLETED AND RETURNED PRIOR
TO THE YOUTH'S INTAKE TO RECOVERY HIGH.**

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RECOVERY HIGH CHECKLIST

The following information is essential and is to be RETURNED prior to the youth joining the program.

PART ONE:

- Intake information (see page 3-6)
- Copy of psychological testing and reports if available.
- Copy of Psychiatric testing and reports if available.
- Copy of Substance Abuse Assessments and reports if available.

PART TWO:

- (For Court referrals only) Court order placing youth in program.

The order shall also include 15 days of Non-Secure Detention and 15 days of Secure Detention and 15 days of Day Treatment all held in abeyance to be used at the discretion of Recovery High program staff. Prior authorization will be received from the referring court prior to use of any days held in abeyance should sanctions be required. Any and all costs incurred by these sanctions are not included in the daily per diem rate but will be billed to the referring county on a monthly basis.

- Signed Purchase of Services Agreement. (see pages 7-9)
- Copy of up-to-date Immunization Records.
- Copy of medical/hospitalization insurance information.
- Copy of parent signatures on all enclosed referral packet forms. (see pages 10-15)
- Copy of School Transcripts. (CA-60 will be requested by Boyne City Schools)

***** YOUTH CANNOT BEGIN THE PROGRAM IF THE ABOVE DOCUMENTATION IS NOT COMPLETELY PROVIDED*****

**RECOVERY HIGH
INTAKE INFORMATION**

Name _____ Address _____

City, State, Zip _____

Phone _____ Date of Birth & Age _____

Grade & School _____

Parents _____ Address _____

City, State, Zip _____

Medical Insurance Provider _____

Ethnic Group _____

Gender _____ Religious Preference _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Date of Referral _____ Referring Agency _____

Referral Address _____

Contact Person _____

Contact Phone Number _____ Contact Fax Number _____

Contact Email address _____

In case of emergency, referral contact person name and after hours contact number:

Reason for Referral of this individual (include short-term and long-term problematic areas and past interventions related to each problem area with outcome)

Please list current legal offenses, as well as prior offenses:

Legal History:

YES NO

YES NO

___ ___ PHYSICALLY ASSAULTIVE

___ ___ UNLAWFUL DRIVE AWAY AUTO

___ ___ VERBALLY ASSAULTIVE

___ ___ AGGRESSIVE BEHAVIOR

___ ___ SUBSTANCE ABUSE

___ ___ SEXUAL OFFENDER

___ ___ PHYSICAL ABUSE VICTIM

___ ___ SUICIDAL ISSUES?

___ ___ SEXUAL ABUSE VICTIM

___ ___ RUNNING AWAY

___ ___ GANG ACTIVITY (if yes list affiliations)

___ ___ SETTING FIRES / OBSESSION

Please list all prior placements and date entered/exited each placement:

Is this child currently receiving Special Education services in school that should be addressed while placed at Recovery High? YES _____ NO _____

If yes, please describe in detail any necessary accommodations for the youth:

Family History (include names & ages of immediate and extended family members; please indicate which members are in household of residence and indicate if there is a history of mental illness, major medical problems or alcohol / drug abuse concerns)

Name Relationship Age In Home (y/n) Historical concerns

Employment History (include places of employment, length, duties, outcome)

Personal Interests / Hobbies (include list of hobbies and interests and changes if noted)

Alcohol / Drug Use History

Name of chemical Age of 1st use Date of last use Frequency / Duration O.D.?

YOUTH MEDICAL INFORMATION:

Please have the parent and/or teen complete this form, checking "yes" if the teen currently has, or has had in the past, any of the following conditions. If a "yes" is checked, please explain to the right.

YES NO

- EVER HOSPITALIZED
when and why?
- HAD ANY OPERATIONS
when and why?
- ACCIDENTS OR BROKEN BONES
- UNDER THE CARE OF A DOCTOR IN LAST 9 MONTHS?
when and why?
- ALLERGIES List to what:
medications or Epipen required?
- ASTHMA inhaler needed?
- SHORTNESS OF BREATH OR DIFFICULTY BREATHING
- HAY FEVER OR WHEEZING
- RESTRICTED ACTIVITIES OR PHYSICAL LIMITATIONS
- EATING DISORDERS
- ANY SPECIAL DIET REQUIRED
- ECZEMA, HIVES OR SKIN RASHES
- FREQUENT COLDS, SORE THROATS, EAR ACHES
- FREQUENT HEADACHES, STOMACH ACHES OR OTHER WEEKLY PAIN
- MENSTRUAL PROBLEMS, PAIN, OR IRREGULARITIES
- TROUBLE SLEEPING
- DEPRESSION OR FEELINGS THAT ARE CONCERNING
- CONVULSIONS/SEIZURES
- HEART TROUBLE
- DIABETES
- TROUBLE URINATING/BM
- TROUBLE WITH EARS OR HEARING
- TROUBLE WITH EYES OR VISION
- SPEECH PROBLEMS
- TEETH OR DENTAL PROBLEMS

PLEASE CIRCLE IF THE TEEN HAS, OR HAS HAD, ANY OF THE FOLLOWING:

MEASLES	SCARLET FEVER	MUMPS	TUBERCULOSIS
ULCERS	EPILEPSY	ANEMIA	MENINGITIS
HIB (FLU)	TONSILITIS	PNEUMONIA	RHEUMATIC FEVER
BONE/JOINT PROBLEMS		HEPATITIS B	CHICKEN POX
KIDNEY INFECTION		STREP THROAT	SKIN PROBLEMS

PLEASE LIST ANY OTHER MEDICAL CONCERNS OR ISSUES:

ANY FUTURE MEDICAL APPOINTMENTS SCHEDULED?

CURRENT MEDICATIONS:

	NAME	ILLNESS?	X PER DAY?	DOCTOR?
1.				
2.				
3.				
4.				

**RECOVERY HIGH - PHASE I
PURCHASE OF SERVICES AGREEMENT**

This agreement is made and entered into between the CHARLEVOIX COUNTY 7TH PROBATE COURT, hereinafter called the "Provider" and: _____ hereinafter called "Placement Agency" in the matter concerning _____, dob: _____.

Whereas Provider's foster homes are licensed by the 7th Probate Court for Charlevoix County and the Michigan Department of Human Services, and is desirous of making such services available to the Placement Agency, and Whereas Placement Agency has the authority and desires to enter into an agreement with Provider to acquire services; now, therefore, the parties intending to be legally bound, hereby agree as follows:

1. Term of Agreement: This agreement shall be effective from (date of entry into program) _____, through (date of release from program) 90 DAYS ESTIMATED LENGTH).
2. Services: Prior to acceptance of a youth, Placement Agency shall present Provider with a completed Recovery High Referral packet, according to the Phase or level of service being requested. Placement Agency shall continue necessary and customary care management services to youth in placement such as visitation to each youth and to review progress with the Provider. Provider agrees that if it is unable to furnish care for a youth after said youth is in placement, Provider will give Placement Agency immediate notice so that an alternative plan can be made for the removal of the youth from Provider's care.
3. Programming: Provider (Phase 1) is open and performs services twenty-four (24) hours a day, seven (7) days per week.
4. Medical/Dental: It is the responsibility of Placement Agency to furnish to Provider, prior to acceptance in the program, the appropriate Medical Assistance card or third party medical insurance coverage. Placement Agency shall be responsible for the payment of prescheduled, non-emergency medical and dental care not paid by Medical Assistance or other third party insurance coverage, but only with Placement Agency's prior approval of a written estimate of the cost of the procedure. In an emergency medical/dental situation, no prior Placement Agency approval is necessary. **Placement Agency agrees to authorize all emergency medical treatment. Placement Agency shall be notified of the emergency situation as soon as circumstances permit. Provider shall attempt to bill medical/dental expenses to insurance; however, Placing Agency is responsible for any and all expenses incurred on behalf of the youth, including but not limited to medical, dental, and transportation expenses, and shall reimburse the Provider for said expenses upon submission of a statement stating such expenses were incurred and a copy of the receipts attached. Any clothing purchase shall be pre-approved by the Placing Agency.**
5. Reports: Provider shall maintain records and shall submit such reports as are reasonably required by Placement Agency including but not limited to: (unless otherwise agreed upon)
 - a. Progress Reports: Provider shall submit to Placement Agency a written progress report for each youth in the program every 45 days. This will include services provided, family's involvement and any other pertinent information concerning the youth.
 - b. Discharge Reports: Provider shall submit to Placement Agency a discharge summary within 20 working days following the notification of discharge. Upon discharge, Provider shall give Placement Agency all of the youth's important documents which are in the possession of the Provider, i.e., birth certificate, social security card, etc.
6. Payment of Services: The Placement Agency agrees to reimburse Provider for services provided to youth accepted in the program by the Provider according to the following rate: \$99.50 per day (including all days youth are on "home visits").
 - a. Court Referrals: Provider will submit a bill by the 25th of each month following the month in which services were provided to youth referred to Provider by the Placement Agency. The bill will list the name of youth for whom services were provided and the number of days services were provided. Placement Agency shall issue payment within thirty (30) days from its receipt of

Provider's bill. THE PROVIDER WILL NOT ACCEPT STATE WARDS UNLESS THE REFERRING COUNTY COURT AGREES TO REIMBURSE THE PLACEMENT AGENCY DIRECTLY. Reimbursement for bill should be addressed as follows:

Charlevoix County 7th Probate Court
Suite 9
301 State St.
Charlevoix, MI 49720

b. Private Pay/Family Referrals: Upon the youth's entry, the Family shall provide forty-five (45) days of program fees paid in advance for the Phase in which the youth is participating. On day forty-six (46) of participation, a forty-five (45) day prepayment is required as the youth continues in the program. This forty-five (45) day prepayment continues throughout participation in the program. Reimbursement for bill should be addressed as stated above. If a youth fails to complete the program, the balance of the prepayment will be returned to the Family minus a \$200.00 admission fee to offset the expense of initial screening, intake, assessment and setting up the youth's file.

7. Notification: All correspondence regarding this agreement shall be sent to the Provider at the Provider's business address. All correspondence regarding this agreement shall be sent to the Placement Agency's representative.

8. Extraordinary Expenses: Placement Agency shall reimburse Provider for any required extraordinary expense paid by Provider on behalf of any youth in its care, supported by appropriate, detailed documents substantiating such expenditure. This shall include but is not limited to the following: Charlevoix County Probate Court Day Treatment Program Placement costs, Charlevoix County Non-Secure Detention Placement Costs and transportation costs to and from home visits. Secure Detention Placement Costs will be billed directly to the Placement Agency by the Secure Detention Provider.

9. Discharges: In cases where a discharge is requested by either party, which discharge is not pursuant to the agreed upon service plan date or court ordered removal, notice is required, except in cases of emergency. An emergency is defined as acute behavior which endangers the youth or others. Whether a situation is an "emergency" shall be determined by Provider.

10. Runaway: When a youth voluntarily absents himself/herself from the supervision of Provider for any unauthorized period of time, he/she is considered a "runaway". It is the responsibility of the Provider to notify all appropriate parties, including Placement Agency. If a court referral, the Placement Agency shall determine if an "Order to take into Temporary Custody" will be issued. If a private referral, the Placement Agency shall inform the Provider as to their desires as to further intervention, including notification of local police. Notice shall be given by the Provider to the Placement Agency as soon as the incident is discovered. Likewise, the Provider shall notice the Placement Agency as soon as the youth is located or returned to the Provider's care.

When a youth is a "runaway", Provider shall continue to bill Placement Agency and maintain space for the youth for five (5) days from the time the youth truanted, unless either party notifies the other that the youth is to be considered discharged. When verbal notice is given during the five (5) day period that the youth is to be considered discharged, Provider is no longer responsible for the youth and need not accept him/her back into the program. At the end of the five (5) days from the time the youth truanted, the youth is considered "discharged", unless Placement Agency makes arrangements with Provider to continue the youth in the program.

11. Confidentiality: Provider and Placement Agency and their agents and employees shall perform all respective obligations and duties under this agreement in such a manner as to insure that all records, names and identities of person counseled, treated or rehabilitated shall be and will remain confidential, except for such disclosures which are required and/or permitted by law.

12. Hold Harmless Provision: Provider and sub-contractors hereto shall not be held responsible for delay or failure to perform hereunder when such delay or failure is due to fire, flood, epidemic, strike, acts of God or the

public enemy, unusually severe weather, legal acts of public authorities or delay or default which cannot be foreseen or provided against.

13. General Provision: This contract is effective and binding on both parties, for the term of the contract as stated, but may be terminated sooner by either party tendering a written notice to the other. It is agreed that this contract may be modified or amended by written consent of both parties. This agreement is complete and when executed, supersedes any and all other similar agreements between the participants named above.

IN WITNESS WHEREOF: the parties have executed this Agreement on the date first written above.

PROVIDER:

Charlevoix County-7th Probate Court

Recovery High Program

By:

David C. Rauch

Court Administrator

Date

PLACEMENT AGENCY:

By:

Signature_____

Printed Name_____

Date

CONSENT FOR EMERGENCY/MEDICAL/DENTAL TREATMENT

I hereby authorize the Director, or in his absence his appointed designee of Recovery High, to consent to any treatment deemed necessary on behalf of my child. In addition, I give permission for my child to receive health screening, immunization(s), tuberculin testing, and blood testing as needed. Such authorization will remain in effect while my child is in the program.

I do also hereby assume responsibility for expenses incurred as a result of said treatment.

FIRST MIDDLE LAST (participant's name)

Parent or Guardian's Signature _____ Date _____

Parent or Guardian's name _____ Social Security Number _____

Address _____ City, State, Zip _____

Home Phone Number _____ Cell Phone Number _____

Name of Employer _____ Address _____

Employer's Telephone Number _____

Name of Insurance Company _____

Policy/Contract Number _____ Group Number _____

Insured's DOB _____

Family Physician _____ Address or Phone Number _____

Family Dentist _____ Address or Phone Number _____

In the event that I cannot be reached, program personnel are authorized to

contact _____ at _____, who will act in my behalf
Telephone Number

in making any decision regarding my child.

B.A.S.E.S. /Client Information 2-Way Release Authorization

I, _____, hereby authorize BAY AREA SUBSTANCE
(name of participant in Recovery High)

EDUCATION SERVICES (B.A.S.E.S.) its director, designee, or professional staff to
release or receive information contained in my records to the individuals or organizations listed
below:

Referral Source: _____
(Name and Agency)

Parent names: _____
AND **(Parent(s) Names)**

Great Lakes Academic Center Staff, 7th Probate Court Staff, Recovery High
Programming Providers.

For the purpose of:
(please have participant initial all) Legal follow up____ Clinical Assessments____
Referral____ Substance Abuse Intervention____ Other____

I understand that my records are protected under federal regulations governing Confidentiality of
Alcohol and Drug Abuse Client records, 42 CFR Part 2, and cannot be disclosed without my
written consent unless otherwise provided for in the regulations. I also understand that I may
revoke this consent to the extent that action has been taken in reliance on it.

*If the purpose of and need for the disclosure is to inform **criminal justice agencies, listed above**, I understand that
this consent will remain in effect and cannot be revoked by me until there has been a formal and effective
termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I
was mandated into substance abuse services **(have participant initial)***

Without expressed revocation, this consent expires for the following specified reasons:
90 DAYS FOLLOWING LAST CONTACT WITH RECOVERY HIGH PROGRAM.

Participant's Signature: _____ Date: _____
(Participant Signature)

Witnessed by: _____ Date: _____
(Witness Signature)

REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

I hereby give my permission to release to Recovery High Program, all information pertaining to Psychiatric, Psychological, Academic, Social History, Medical and Dental concerning

(name of participant)

I further understand that the Charlevoix County Family Court / Recovery High may release information and/or records obtained to counsel or service providers as it may be beneficial to the treatment or placement of the minor/juvenile.

_____ Signature of Parent	_____ Date
_____ Signature of Participant	_____ Date
_____ Signature of Witness	_____ Date

PARENT PARTICIPATION AGREEMENT

Recovery High has, as part of its overall program, a parent component involving parent support groups on Sunday afternoons from 4:00-6:00 p.m. in Charlevoix and family visitation time. Your participation in the parent support group meetings will enhance your parental and communication skills, allow you to receive feedback on your child’s progress in the program, furnish you with information on social problems, and allow you to experience family recreational activities.

I understand that my involvement with my child’s treatment includes participating and being involved in the Recovery High parent component.

_____ Parent Signature	_____ Date
_____ Parent Signature	_____ Date

**PERMISSION FOR THE USE OF PHOTOGRAPHS, SLIDES AND/OR VIDEOS FOR
FUNDRAISING AND PUBLIC RELATIONS ACTIVITIES**

On occasion, Recovery High engages in public relations programs. In connection with these programs it is helpful to Recovery High to be able to use photographs, slides or video recordings of our staff and clients. The purpose of this Permission of Release Form is for you to give written permission to Recovery High to take pictures or video record our clients and to use the same in fundraising public relations activities. If you will grant such permission to Recovery High, please sign in the space provided.

I, _____ give permission to Recovery High to make and
(participant's name)

use photographs and/or recordings photographs, slides, and video recordings of me and to use them in connection with Recovery High fundraising and public relations activities. I also consent to the use of my name in connection with Recovery High public relations activities.

Signature of Participant

Date

Signature of Parent/Guardian

Date

RECREATIONAL PERMISSION/CONSENT

(Participant's Name)

I, being the parent/guardian of the above name minor, authorize Recovery High staff to supervise the recreational activities of the above named child, to permit her/him to attend and participate in all sports, camping, swimming, canoeing, picnics, visits to parks and lakes and any outings the representatives of Recovery High deem beneficial.

In consenting to my child's participation in recreational activities, I also covenant not to sue Recovery High, its agents, employees, servants and any corporation of firm under whose authority Recovery High exists, on account of or in any way growing out of any injury which occurs while my child is involved in recreational activities.

Signature of Parent/Guardian

Date

Richard M. Pajtas
Chief Judge
231-547-7243
Fax: 231-547-7264
C33@voyager.net



Frederick R. Mulhauser
Presiding Family Division Judge
231-547-7214
Fax: 231-547-7256

County Building – 301 State Street
Charlevoix Michigan

STATE OF MICHIGAN
7th Probate & 33rd Judicial Court-Family Division

**PARENTAL AUTHORIZATION
FOR CHILD TO ATTEND RELIGIOUS SERVICES**

In The Matter Of: _____ dob: _____

It is my understanding that foster parents and/or Non Secure Detention home operators may desire to attend religious services as they may schedule.

(Please check specific boxes that apply and sign.)

I as the Parent/Guardian **AUTHORIZE** my child to attend religious services while residing in a Charlevoix County Probate/Family Court licensed foster or Non Secure Detention home.

Protestant Catholic Other _____

I as the Parent/Guardian **DO NOT AUTHORIZE** my child to attend religious services while residing in a Charlevoix County Probate/Family Court licensed foster or Non Secure Detention home.

Parent/Guardian: _____
Print Name

Parent/Guardian: _____ Date: _____
Signature

RECOVERY HIGH PHASE ONE

HOME VISIT GUIDELINES

- _____ Teens must be supervised by parents at all times unless Recovery High Staff and Probation Officer have given prior approval.
- _____ The family home must be alcohol and drug free.
- _____ Teens must attend a 12-step meeting(s) when on overnight home visits – typically one meeting for each overnight
- _____ Teens will have no contact with friends without prior approval from Recovery High Staff and Probation Officer.
- _____ Nothing is to be brought back to foster home without approval from foster parents. Please no valuables. This program is not responsible for personal items.
- _____ Teens are not to be in possession of any medication. All medications are to be kept locked up. Medications are to be transferred from adult to adult only.
- _____ Follow guidelines for dispensing medication to teen. (See BASES Staff or foster parents for instruction)
- _____ Any information is to be communicated from adult to adult.
- _____ Teens are not to be in possession of any money. Any money for food or necessities must be given directly to BASES Staff or foster parents.
- _____ Pick-ups and drop-offs of home visits must be prompt and timely. Any changes to the scheduled times requires adult contact. Drop-offs must have adult-to-adult contact.
- _____ Rules of probations still apply when teens are on a home visit.
- _____ Any concerns during home visits need to be shared with foster parents or Recovery High Staff the same day that the teen returns to the program.

In case of emergency during a home visit, contact the foster parent or Charlevoix County Sheriff Department at 231-547-4461 and request that the on-call referee for Charlevoix Probate Court be paged.

You can also leave a message on the BASES answering machine (231-547-1144) and a BASES staff member will be paged after hours. If you need a return phone call, please leave your name and number so they can reach you.
(updated 2/4/09)

I have read and understand that I will be held accountable for these rules.

Teen Signature – Date

Parent(s) Signature – Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE (NUCC)

INSURANCE COMPANY (Print Name) (For Programs in any State)

1. INDICATE MEDICAL NECESSITY (Check one) <input type="checkbox"/> Standard <input type="checkbox"/> Urgent <input type="checkbox"/> Catastrophic		3. PATIENT'S BIRTH DATE MM DD YY		4. RELATED PARTY (Last Name, First Name, Middle Initial)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		6. PATIENT RELATIONSHIP TO INSURED		5. RELATED PARTY'S ADDRESS (St., Apt., Box)	
7. PATIENT'S ADDRESS (Street, Apt., Box)		8. PATIENT'S SEX & MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		6. CITY & STATE	
8. OTHER INSURANCE (Type, Name, Policy No.)		9. EMPLOYER'S CONDITION RELATED TO CLAIM <input type="checkbox"/> Employment <input type="checkbox"/> Termination <input type="checkbox"/> Disability		7. RELATED PARTY'S PHONE (Area Code, Number)	
9. OTHER INSURANCE (Type, Name, Policy No.)		10. EMPLOYER'S CONDITION RELATED TO CLAIM <input type="checkbox"/> Employment <input type="checkbox"/> Termination <input type="checkbox"/> Disability		8. RELATED PARTY'S DATE OF BIRTH MM DD YY	
10. OTHER INSURANCE (Type, Name, Policy No.)		11. EMPLOYER'S CONDITION RELATED TO CLAIM <input type="checkbox"/> Employment <input type="checkbox"/> Termination <input type="checkbox"/> Disability		9. EMPLOYER'S NAME OR REFERENCE NAME	
11. OTHER INSURANCE (Type, Name, Policy No.)		12. EMPLOYER'S CONDITION RELATED TO CLAIM <input type="checkbox"/> Employment <input type="checkbox"/> Termination <input type="checkbox"/> Disability		10. INSURANCE PLAN NAME OR PROGRAM NAME	
12. OTHER INSURANCE (Type, Name, Policy No.)		13. EMPLOYER'S CONDITION RELATED TO CLAIM <input type="checkbox"/> Employment <input type="checkbox"/> Termination <input type="checkbox"/> Disability		11. RETURN ANOTHER HEALTH BENEFIT PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO (Type name to and complete her date)	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

14. PROVIDER OR AUTHORIZED PERSON'S SIGNATURE (Typed name, address, phone, fax, and e-mail address of the provider or authorized person who is submitting the claim on behalf of the patient or insured.)

15. SIGNED OR AUTHORIZED PERSON'S SIGNATURE (Typed name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

16. DATE (MM/DD/YY)

17. NAME OF PROVIDING PROVIDER OR OTHER SOURCE (Print Name, Address, City, State, Zip)

18. RECEIVED FOR LOCAL USE

19. NUMBER OF EXTENSION OF BENEFIT OR DUE TO (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

20. MEDICAL HISTORY (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

21. PREAUTHORIZATION NUMBER

22. CHARGES (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

23. TOTAL CHARGE (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

24. AMOUNT PAID (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

25. BALANCE DUE (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

26. FEDERAL TAX ID NUMBER (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

27. PATIENT'S ACCOUNT NO. (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

28. SERVICE FACILITY LOCATION & POPULATION (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

29. MEDICAL HISTORY (Print name, address, phone, fax, and e-mail address of the insured or authorized person who is submitting the claim on behalf of the insured.)

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE (NUCC)

FORM CMS-1500 (08-03)

Insured signs here



RELEASE FORM

I understand if I bring my listening device to be used on the **bus only**, Recovery High will not be responsible if it gets lost, stolen or damaged.

All music must be appropriate (radio version, no sex, drugs, or violence) and may be randomly listened to. This privilege may be revoked at any time.

_____/_____/_____
Parent/Guardian Signature

_____/_____/_____
Participant Signature

RECOMMENDED ITEMS FOR YOUTH IN RECOVERY HIGH

*The following are the recommended personal items teens should bring to Recovery High.
Referring workers, please share this list with the teen and their guardian.*

GENERAL: 1 Casual Slacks
4 Jeans
2 Sweaters / Sweatshirts
1 Gym Shoes
1 School Shoes
2 Pajamas
1 Belt
1 Bathing Suit
2 Shorts
Stamps & Stationary optional

FEMALES: 4 Shirts
1 Blouse
5 Socks
1 Nylons
Dress clothes for court
1 Slip
8 Panties
3 Bras

SEASONAL: 1 Light Coat
1 Heavy Coat
1 Winter Gloves
1 Winter Hat
1 Winter Boots
1 Sandals

MALES: Dress clothes for court
that includes a tie and shirt
8 Socks
6 T-Shirts
6 Undershorts

Basic toiletries will be provided for youth. A teen may bring their own personal items, however, they are not allowed to possess any aerosol products, colognes, perfumes, or mouthwashes.