



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

KIDS IN FOCUS: GUARDIAN ADMISSIONS PACKET

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*** Indicates Client Signature is REQUIRED**



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A. WELCOME FROM EXECUTIVE DIRECTOR

Final Report and Recommendations DUE DATE

WELCOME to *KIDS IN FOCUS!*

We are pleased to inform you that your child/client has been found appropriate for placement in our program. Thank you for your referral to *KIDS IN FOCUS*.

Your child/client will receive a comprehensive evaluation while residing in a safe, nurturing and non-secure home within the community. Therapeutic and Educational services will be provided on site.

Upon completion of our evaluation, *KIDS IN FOCUS* will work with you to locate and establish the necessary services to support his or her continued success. Your child's/client's final report due date is listed below.

We look forward to working with you and your child/client. Please feel free to contact me if you have any questions or concerns.

Thank you for your confidence in our program.

Sincerely,

CeCe Smith, Executive Director
KIDS IN FOCUS

Phone: (804) 714-1812

cecesmith@rescare.com

***Final Report & Recommendations DUE DATE: _____

- *KIDS IN FOCUS' Final Report & Recommendations* will be mailed / delivered on the above date.
- Recommendations are part of our comprehensive evaluation process; therefore, recommendations are NOT submitted prior to completion of the *Final Report and Recommendations* document.
- Your signature on this page indicates your acknowledgement of and agreement with the DUE DATE listed above.



KIDS IN FOCUS

Date: Client's Name:

Admissions Staff:

Guardian Signature:

B. MEDICAID

Official Notification of MEDICAID CERTIFICATION,
MEDICAID: Eligibility, Application and Coverage,
REQUEST for REQUIRED DOCUMENTS

***** All KIDS IN FOCUS programs are MEDICAID CERTIFIED.**

MEDICAID: Eligibility, Coverage, and Application

MEDICAID Eligibility - Your child/client may be eligible for Medicaid coverage to help defer potential personal costs.

MEDICAID Application - Please contact the Eligibility Division of your local Department of Social Services for information about how to apply for Medicaid coverage for your child/client.

MEDICAID Coverage - Medicaid insurance is vital for your child/client as it may cover the cost of combined residential services as well as many medical services and medications.

*****KIDS IN FOCUS will not be responsible for cost of medication.**

REQUEST for REQUIRED DOCUMENTS

We encourage you to obtain Medicaid insurance coverage for your child/client, but we do not have the authority to assist in the completion of this process. **We CAN** expedite Medicaid application and coverage for a portion of the cost of our program when you provide required documents necessary for benefits.

*****PLEASE PROVIDE the following REQUIRED DOCUMENTS:**

- Completed Certificate of Need with Doctor's signature, ,
- Rate Certification form,
- CAFAS or CANS assessment dated within thirty dates of the client's placement,
- Treatment Foster Care plan (if applicable), and Court Order and/or Custody Verification documents.



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C. VISITATION

Approved Contact List,
Visitation Guidelines, Procedures, Norms, Items Permitted/Not Permitted

APPROVED CONTACT LIST

It is the policy of *KIDS IN FOCUS* to support guardian's authority to determine a list of appropriate contacts for their child/client. Please advise us of any person that has your permission to have contact with your child/client.

Name	Address	Written contact only	Telephone #/ supervised Telephone (S)
	Physical	N/A	Fax:
	Mailing	N/A	
		N/A	
		N/A	

I understand that only persons above are authorized to have contact with my child/client without further written permission.

Parent / Guardian Signature: _____

Client Signature: _____

*****CLIENT SIGNATURE REQUIRED**



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

(VISITATION, continued)

VISITATION GUIDELINES

WHEN: Sundays between 1:30 PM and 4:30 PM

APPROVED VISITORS: Approved Visitors include **only** parents, grandparents, and stepparents and guardians listed on the **Approved Contact List**

“SPECIAL VISITS” for siblings or other family members may be permitted **IF:**

- The Visitor is listed on the Approved Contact List, AND
- The Visit has been pre-arranged through the Kids in Focus Clinical Director.

******All visitors must cooperate with the child's / client's scheduled activities and appointments.***

VISITATION PROCEDURES

- **Identification** must be provided upon request.
- All visitors must **SIGN IN and SIGN OUT** in the Visitor's Roster upon arrival and at departure.
- A **maximum of three visitors per client per visit** (includes children of all ages) will be permitted.
- **All valuables** (purses, cash, cell phone, etc.) must be left in a locked vehicle.
- **STAFF SUPERVISION** of the child / client is required at all times, so a designated area will be assigned during the visit.

VISITATION NORMS

ALL Visitors must adhere to the Visitation Norms in order to appropriately support their child / client. **The Executive Director** may EXPAND these norms at any time to ensure the safety and well being of both child / client and the milieu.

- **Dress Code:** **“Casual but Covered.”** (No halters, tank tops, see-through shirts, short skirts or short shorts, etc.),
- **CONSIDERATE, SUPPORTIVE and APPROPRIATE behavior and conversation when engaging with ANY person** on campus.
- **TERMINATION of a VISIT:** Senior Staff members have the right to terminate a visit that is perceived as a threat to the safety and well being of the child / client or milieu.

******EXCESSIVE NOISE IS DISRUPTIVE TO OTHERS WHO ARE VISITING.***



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

(VISITATION, continued)

VISITATION - ITEMS PERMITTED

***** ANY ITEMS YOUR WISH TO BRING MUST BE PRE-APPROVED** by the Clinical Director, Therapist, or Group Leader. Games, special foods, etc. are considered privileges. Visitors should contact the house to check the client's daily/weekly average and obtain approval BEFORE bringing any items to campus so that treatment goals will be consistently reinforced.

- **Food** may be brought on the premises to share with your child / client, but must be consumed during visitation hours. Please bring only enough for your child / client and yourself. Special permission to bring food or treats for all residents to share must be **PRE-APPROVED** by the Clinical Director, Therapist, or Group Leader.
- **Any Clothing or Item** must be packaged securely, sealed, and labeled with the printed name of the child / client on the outside of each package. All packages must be given to the Group Leader or designee who will inventory the items, with the assurance that the items will be given to the Client shortly after visiting hours.
- **Any Money** (personal check, money order or cash) will be deposited in the child's / client's account. Maximum amount allowed is \$20 unless special permission has been granted by Clinical Director, Therapist, or Group Leader. Money should be given to the staff member on duty. Staff will complete a receipt of funds form that must be signed by the person providing money for the child's / client's account.

VISITATION - ITEMS NOT PERMITTED

ITEMS NOT PERMITTED on KIDS IN FOCUS property AT ANY TIME include:

- Weapons of any kind (including pocket knives), and
- Alcohol, Drugs or other contraband items (including lighters, matches, cigarettes, etc.).

*****IF YOU ARE UNSURE WHETHER AN ITEM IS/IS NOT PERMITTED, PLEASE ASK STAFF.**

Parent / Guardian Signature: _____

Client Signature: _____

*****CLIENT SIGNATURE REQUIRED**

PLEASE KEEP THIS COPY AS A REFERENCE



KIDS IN FOCUS

Date:	Client's Name:
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Guardian Signature:	

D. MEDICAL

Medical Alert and Medical Administration Policy
 Consent for Medical / Dental / Psychiatric / Optician / Hearing Services
 Record of Immunizations

MEDICAL ALERT

- Please advise *KIDS IN FOCUS* of **ALL** medical conditions and history.
- Attach additional paper if needed.

LIST ALL Reported Medical Conditions:	Treatment and / History:
<p>***NO MEDICAL CONDITIONS HAVE BEEN REPORTED.</p> <p>Parent / Guardian INITIALS: _____</p>	

MEDICATION ADMINISTRATION POLICY

It is the policy of *KIDS IN FOCUS* to follow Doctor/ Psychiatrist orders for medications.

We will notify the guardian in writing of any medication changes and request consent to administer new medications.

- If we do not hear from the guardian **within 24 hours**, *KIDS IN FOCUS* will begin administering the medication to the child as prescribed.
- If a medication is making a child sick, we will follow doctor's orders and immediately discontinue the medication.



KIDS IN FOCUS

Date:	Client's Name:
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Guardian Signature:	

CONSENT FOR MEDICAL / DENTAL / PSYCHIATRIC / OPTICIANS/ HEARING SERVICES

The purpose of this form is to request your permission to provide medical, dental, psychiatric, opticians, hearing services as deemed necessary by a licensed practicing medical care provider while your child / client is residing at *KIDS IN FOCUS*. Your child's / client's good health depends on our ability to give appropriate physical and mental care when required. The procedures for which this consent will be used are commonly regarded as regular health maintenance and do not involve an unusual risk.

If Emergency psychiatric services, such as Temporary Detention Order (T.D.O.) need to be initiated to protect a child /client who is at risk of harming self or others; you will be notified as soon as the child / client is safe.

This form authorizes the staff of *KIDS IN FOCUS* to provide the above named Client with services deemed necessary by licensed practicing professionals caring for your child / client while admitted to Kids in Focus.

I understand that the guardian's specific consent will be sought if a non-routine procedure or treatment is required, or if an invasive procedure is required, unless the treatment or procedure is an emergency and deemed necessary by a licensed professional.

Medicaid #	Insurance Carrier:
	Medical #
	Dental #
	Optical #
	Co-pay \$
<p>***<i>KIDS IN FOCUS</i> IS NOT responsible for any medical costs (including, but not limited to MEDICATIONS, TDO expenses, etc.).</p> <p>***We will re-invoice responsible parties if insurance is denied</p>	

***24-HOUR EMERGENCY CONTACT	
Name	
Phone:	



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

RECORD OF IMMUNIZATIONS

As part of the admission process to *KIDS IN FOCUS*, it is necessary to make every effort to retrieve an immunization history. Please assist us by completing this form. Be aware that current immunizations are required. Your client may begin a series of necessary immunization vaccinations while at KIF.

Date of last TB Test	Results
New test administered at Kids in Focus on Date:	Results
Staff signature	Comments

DOSE #	HEP B MO/D/YR	DPT MO/D/YR	TD MO/D/YR	POLIO MO/D/YR	MEASLES MO/D/YR	MUMPS MO/D/YR	RUBELLA MO/D/YR
DOSE #1							
DOSE #2							
DOSE #3							
DOSE #4							
DOSE #5							

Please INITIAL to Indicate Action Taken to obtain Immunization Records.

	Immunization Records are ATTACHED .
	REQUEST for Immunization Records WAS SUBMITTED to: Contact Name _____ PHONE _____ Name of Facility _____ FAX _____ DATE OF REQUEST _____ <i>***Confirmation has been requested. If not received within 24 hours, testing will take place.</i>
	Immunization records CAN BE REQUESTED FROM: Contact Name _____ PHONE _____ Name of Facility _____ FAX _____



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

E. PERMISSIONS

Media – IN HOME & EXTERNAL

Authorization for Release of Information FROM *KIDS IN FOCUS*

Authorization for Release of Information TO *KIDS IN FOCUS*

Recreational / Special Activities Consent

Art Therapy: Release of Information Authorization

MEDIA PERMISSIONS

MEDIA PERMISSION: *IN HOME*

I do	I do not	<p>Give permission for <i>KIDS IN FOCUS</i> to use photographic materials within the house for the purpose of client recognition and staff training.</p> <ul style="list-style-type: none"> The use of audio recording devices while transporting may be used to protect the client and the staff during said transport. Audio recordings may be used to record treatment team notes these tapes will be given the same protection as a written document.
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MEDIA PERMISSION: *EXTERNAL*

- I understand that it is the policy of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services that strict confidentiality be maintained.
- Specifically, the child's name and face will not be published and/or photographed.
- In addition, detailed information regarding the child and any offense, which may lead to possible identification, will not be used.
- However,**

I do	I do not	<p>Give permission for my child / client to be interviewed and photographed by the press, including newspaper, radio, television and magazines.</p> <ul style="list-style-type: none"> Any quotes or pictures within good taste may be used in any or all publications or fund raising activities for <i>KIDS IN FOCUS</i> or their facilities.
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I also understand that at any time I wish to withdraw my permission, I should notify *KIDS IN FOCUS* in writing and that will supersede this permission form.



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

AUTHORIZATION FOR RELEASE OF INFORMATION TO KIDS IN FOCUS

Date of Birth	Social Security #
---------------	-------------------

I hereby authorize release of all requested information pertaining to the above client to be forward to *KIDS IN FOCUS* and its affiliates:

Professional / Agency / Medical / Mental Health

Specific information requested:

- | | | |
|---|--|--|
| <input type="checkbox"/> Educational records | <input type="checkbox"/> Individual Education Plan | <input type="checkbox"/> Summary of Services |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Social History | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Social Functioning Report | _____ |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Progress Notes | _____ |
| <input type="checkbox"/> Art Therapy Evaluation | <input type="checkbox"/> Psychiatric Record | |
| <input type="checkbox"/> Substance Abuse Information | <input type="checkbox"/> Risk Assessment | |
| <input type="checkbox"/> Court Records/ Legal history | | |

I understand that this in formation will be used in the development of a therapeutic evaluation on the above client.

I understand that this consent to disclose may be revoked by me at any time by written notice, effective upon receipt of written notice. This consent will expire in three hundred and sixty five (365) days.



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

AUTHORIZATION FOR RELEASE OF INFORMATION FROM KIDS IN FOCUS

Date of Birth	Social Security #
---------------	-------------------

I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

Specific information requested:

- | | |
|--|--|
| <input type="checkbox"/> Educational records | <input type="checkbox"/> Summary of Services |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Social Functioning Report |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Art Therapy Evaluation | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> Substance Abuse Information | <input type="checkbox"/> Risk Assessment |

I hereby authorize *KIDS IN FOCUS* to release all requested information pertaining to the above client and forward to persons named to the right:

Please send information to:
Name

Fax number

Address:

To be filled out by guardian only when required and signed _____

REDISCLASURE OF THIS INFORMATION IS STRICTLY PROHIBITED.



KIDS IN FOCUS

Date: _____ Client's Name: _____

Admissions Staff: _____

Guardian Signature: _____

RECREATIONAL / SPECIAL ACTIVITIES CONSENT

During your client's stay at *KIDS IN FOCUS*, we actively seek to be involved in a variety of activities. Examples of activities include:

- Challenge Discovery © (high & low ropes course instructors present),
- YMCA programs, classes, use of equipment / facilities,
- Fitness Activities
- Interscholastic Sports,
- Skate boarding,
- Ice Skating,
- Hiking,
- Water activities (life-guards present),
- Kayaking, Rafting, Canoeing,
- Horseback Riding, (instructors present),
- Camping,
- Caving (Luray etc.), and
- Trips designed for participation in Educational, Cultural, and Community events/attractions/activities.

Some of these activities may include day trips out of state. You will be notified of these trips or if distance is more than 150 miles from the group home.

Some of these activities require us to fill out their organizational consent forms. If necessary these forms will be forwarded to you before the activities. If any activities are currently planned the paperwork should be included in this packet.

By signing above, I Authorize *KIDS IN FOCUS* and its affiliates to participate in these activities. I understand that *KIDS IN FOCUS* will only retain the services of professionals in their area of their expertise. Please write any comments or restrictions for your child / clients below:

Comments / Restrictions related to Recreational Special Activities:



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

ART THERAPY: RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the Art Therapist of *KIDS IN FOCUS, Inc.*, to discuss, present and photograph artwork created by the client indicated above for the purpose of:

- a. Inter-agency team meetings
 - b. Treatment records
 - c. Art Therapy Supervision
 - d. Research purposes
- I understand that my client's name and other identifying information will be withheld in the case of (c), (d), and whenever else it is deemed appropriate for reasons of confidentiality.
 - I understand that my permission is needed to release this information, and by signing below, I hereby give such permission.
 - I understand that in the case of (d), additional consent will be requested by *KIDS IN FOCUS* before any artwork is used.
 - I understand that *KIDS IN FOCUS* may only release information that originates with it, i.e., that it may not release information received from other sources.
 - I agree with and understand the information above. I understand that I may revoke this authorization at anytime by written notice to *KIDS IN FOCUS*.

Client Signature: _____

*****CLIENT SIGNATURE REQUIRED**



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

F. CLIENT ADVISEMENTS of POLICY

Client Advisement of Limited Confidentiality
 Client Advisement of Human Rights Policy
 Client Advisement of Responsibility / Behavior Policy

Client Advisement of LIMITED CONFIDENTIALITY

KIDS IN FOCUS STAFF ARE MANDATED REPORTERS.

- IF ANYONE DISCLOSES THAT YOU OR A CHILD HAS BEEN ABUSED OR NEGLECTED, WE HAVE TO REPORT IT TO THE LOCAL AUTHORITY.
- KIDS IN FOCUS WILL ALSO SUBMIT A FINAL REPORT TO OUR CUSTOMER WITH OUR FINDINGS AND RECOMMENDATIONS REGARDING DISCLOSED INFORMATION

I understand that *KIDS IN FOCUS, Inc.* has been requested to / granted permission to complete a COMPREHENSIVE EVALUATION by the following person(s) and/or agency: _____

I understand that *KIDS IN FOCUS, Inc.* WILL RELEASE THEIR FINDINGS AND RECOMMENDATIONS at the end of the assessment period (generally 60 days from date of admission) to the following person(s) and/or agency:

****KIDS IN FOCUS, Inc.* abides by the rules of HIPAA1996. All personal health information will be maintained and disseminated in accordance with the rules of HIPAA 1996. Failure to follow these rules could result in civil and or criminal charges.

Client Signature: _____

***CLIENT SIGNATURE REQUIRED



KIDS IN FOCUS

Date:	Client's Name:
Admissions Staff:	
Guardian Signature:	

Client Advisement of HUMAN RIGHTS POLICY

As a client of *KIDS IN FOCUS*, you are assured of treatment aligned with tenets of the human rights listed below. For a more detailed description of these rights, please see a member of the Treatment Team or ask to borrow the Human Rights Book.

It Is Your Right...

- ✓ It is your right, to be treated with dignity and respect.
- ✓ It is your right, to be told about your treatment.
- ✓ It is your right, to have a say in your treatment.
- ✓ It is your right, to speak to others in private.
- ✓ It is your right, to have your complaints resolved.
- ✓ It is your right, to say what you prefer.
- ✓ It is your right, to ask questions and be told about your rights.
- ✓ It is your right, to get help with your rights.

Your Human Rights Advocate is:	Mr. Jim Bowser, Jr. Regional Advocate PO Box 4030, Building #3 Petersburg, VA 23802 (804) 524-7247 or 1-(866) 3256-5290
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- I, the undersigned, acknowledge receipt of and fully understand the rights and responsibilities for all clients enrolled in *KIDS IN FOCUS* and agree to adhere to this policy.
- I also understand that the Human Rights Advocate is the person employed by the commissioner at the recommendation of the State Human Rights Director. This Human Rights Advocate's job is to help clients receiving services to exercise their rights under Chapter 12 VAC 35-115-250C.
- I understand that if I have any questions about my rights, I may contact my Human Rights Advocate at the address or phone number listed above.
- Furthermore, I understand that this signed receipt will be kept in my personal file.

Client Signature: _____

*****CLIENT SIGNATURE REQUIRED**



KIDS IN FOCUS

Date: _____ Client's Name: _____

Admissions Staff: _____

Guardian Signature: _____

Client Advisement of RESPONSIBILITY / BEHAVIOR POLICY

You will be held responsible for any of your behaviors or actions that are unsafe, destructive and/or unlawful.

KIDS IN FOCUS has
ZERO TOLERANCE

for unsafe, destructive and/ or criminal behavior.

- **If you break the law**, we will call the police and you will be charged.
- **Any destruction of property** will be deducted from your allowance at discharge.
- Criminal behavior is **not** a standard criterion for discharge.

KIDS IN FOCUS cares about your safety,
the safety of our clients, and
the safety of our staff.

This policy will be enforced.

Client Signature: _____

***CLIENT SIGNATURE REQUIRED



KIDS IN FOCUS

Date:	Client's Name:
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G. KIF ACADEMY: SCHOOL INFORMATION

Placement Notification, Request for Information, Testing Arrangements
Schedule for Issuing Report Cards and IEP / 504 Progress Notes

Placement Notification, Request for Information, Testing Arrangements

Dear Parent or Guardian: Upon admission, *KIDS IN FOCUS Academy* will send the following letter to your student's Local Education Agency (LEA).

To:

From: Barbara Stanton-Appleby, Ed. S.

Education Director / Principal of *KIDS IN FOCUS Academy*, Barbarastantonappleby@rescare.com

Date:

Re: **Placement Notification for:** _____ **DOB:** _____

Request for "Home School" Information
Testing Arrangements

Placement Notification

A student from your school division has been temporarily placed with us for diagnostic assessment. As we are a short-term, private facility, according to Virginia Department of Education guidelines, your school division retains status as the Local Education Agency (LEA) for this student. While this means your division is responsible for compliance with all special education issues as well as meeting state/district testing requirements, we will actively partner with you to ensure standards are met.

Request for "Home School" Information

In order to design and implement an optimal Academic Plan aligned with your school district's requirements, **please complete the attached "HOME SCHOOL INFORMATION" sheet and provide the records requested.** Upon receipt of information from your school, we will design an Academic Plan to ensure that appropriate services and core coursework are provided for your student.

Testing Arrangements

If your student is still placed with us during your division's State, District or End of Course testing window, we offer two options:

- Option #1: We will transport your student to a testing site within your division.
- Option #2: Our diagnostician or our teachers will administer assessments for you upon receipt of necessary materials (i.e. protocols, manuals, Student Identification Code for on-line administration, etc.). We will then return these items to you.

Please let us know which option you prefer. We will work with you to make any necessary arrangements in order to comply with your division's policy.

For more information about our program, please visit our website at KidsinFocus.com. Feel free to contact me if you have questions or concerns, and thank you for your help!

Partners in Education,
Barbara Stanton-Appleby, Ed. S.

Cc: Cece Smith, Executive Director of *KIDS IN FOCUS*
_____, Superintendent, _____ Schools



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***KIDS IN FOCUS* Academy: 2008-2009 Schedule for Issuing Report Cards and IEP/504 Progress Notes**

2008-2009 Report cards and IEP/504 Progress Notes will be issued to:

- **Students**
- **Custodial Parent(s)**
- **Local Education Agency (LEA, and**
- **Home School (if still enrolled)**

2008-2009	Dates Included:	Target Issue Date:
1st Quarter	9-02-08 to 10-30-08	11-5-08
2 nd Quarter	10-31-08 to 1-23-09	1-28-09
3 rd Quarter	1-26-09 to 4-03-09	4-15-09
4 th Quarter	4-13-09 to 6-05-09	6-08-09
Summer Session	6-08-09 to 8-25-09	8-31-09

I have received a copy of KIF Academy's schedule for Issuing Report Cards and IEP/504 Progress Notes.

Client Signature: _____
*****CLIENT SIGNATURE REQUIRED**