

WOODWARD ACADEMY

REFERRING WORKER INFORMATION/CONSENT PACKET

MAIL OR FAX TO:

Woodward Academy

% Admissions

1251 334th St.

Woodward, Iowa 50276

Phone: 515-438-3481

Fax: 515-438-3489

E-Mail: avanwinkle@wwacademy.com

Please have paperwork completed prior to admission

EMERGENCY NOTIFICATION TO REFERRING WORKER: Home phone # _____
 TRUANCY other # _____

If after working hours, do you want to be notified at home? Yes/No
 How soon after the student goes truant? _____

MEDICAL EMERGENCY

If after working hours, do you want to be notified at home? Yes/No
 How soon after the student goes to the hospital? _____

OFF-CAMPUS NOTIFICATION (circle one)

Would you like to be notified prior to every off-campus event or just home visits.

STUDENTS STRENGTHS	WEAKNESSES	GOALS YOU HAVE FOR STUDENT

What is the anticipated discharge plan for your client? Where will he go, who will he live with etc.

Are there any persons you do not wish for you student to have contact with? _____

CHECK LIST

- _____ COURT ORDER ADJUDICATING DELINQUENT STATUS OR WARD OF STATE
- _____ COURT ORDER AUTHORIZING PLACEMENT IN RESIDENTIAL TREATMENT
- _____ TITLE XIX INFORMATION SENT TO DHS OFFICE
- face sheet _____ 4-E eligibility form _____ medical application _____ exchange of info _____
- court order for placement _____ medical letter family _____
- _____ FINANCIAL APPROVAL INFORMATION (IFMC AUTH. DATE ___ / ___ / ___ IA only)
- _____ CURRENT PERMANENCY PLANS AND/OR COURT REPORTS
- _____ SIGNED PARENT CONSENT FORMS (Woodward Academy Packet)
- _____ CURRENT SOCIAL HISTORY AND PRE-DISPOSITION REPORTS
- _____ PSYCHOLOGICAL EVALUATIONS IF AVAILABLE
- _____ INTERSTATE COMPACT PACKET SENT
- _____ SOCIAL SUMMARY
- _____ ADJUDICATORY COURT ORDER
- _____ DISPOSITIONAL COURT ORDER (MOST CURRENT)
- _____ INTERSTATE COMPACT REQUEST TO PLACE CHILD FORM # 100 A

IOWA I.C.P.C. % SARA STARR
DIVISION OF ADULT & CHILDREN FAMILY SERVICES
HOOVER BLDG. 5TH FLOOR
DES MOINES, IA 50319-0114
(515)281-3123

STUDENT'S NAME: _____

WOODWARD ACADEMY UNAPPROVED TELEPHONE / MAIL // VISIT LIST

PLACING WORKER AND/OR PARENTS: Please complete the following information for our records:

I hereby acknowledge that I have read, understand and agree to the conditions contained in the Woodward Academy Mail/Telephone/Visitation Policy. I understand that contact with a child's immediate family cannot be disallowed without a court order per licensing regulation 114.13(3)a.

The following individuals are UNAPPROVED for contact:

Date Initiated:	Reason for no or limited contact:	
Name of Individual:		
Relationship to the student:	Unapproved For:	
	<input type="checkbox"/> telephone contact	<input type="checkbox"/> mail contact
	<input type="checkbox"/> on-campus visits	<input type="checkbox"/> off-campus visits
Date referring worker was notified:	Plan to regain contact:	
Date parents were notified:		
Court Order:	Student's Initial:	Date Discontinued:
YES NO		

Date Initiated:	Reason for no or limited contact:	
Name of Individual:		
Relationship to the student:	Unapproved For:	
	<input type="checkbox"/> telephone contact	<input type="checkbox"/> mail contact
	<input type="checkbox"/> on-campus visits	<input type="checkbox"/> off-campus visits
Date referring worker was notified:	Plan to regain contact:	
Date parents were notified:		
Court Order:	Student's Initial:	Date Discontinued:
YES NO		

STATE OF IOWA
WOODWARD ACADEMY/WOODWARD YOUTH CORPORATION

PLACEMENT AGREEMENT
Child Placing or Child Caring Agency (Provider)

Student's Name _____ Birthdate _____ Date of Placement _____
Service (State ID#) Number _____ Program Name _____
Program Code _____ Service Code _____

The parties to this agreement are Woodward Academy and the _____
(Provider Agency) (Placing Agency)

We, Woodward Academy, for and in consideration of the _____ are
(Placing Agency)
placing _____ in our care and paying therefore, we do hereby agree

to the following:

A. The provider agency agrees that:

1. As a licensed child placing or child caring agency, the agency assumes responsibility for the care and treatment of this child in accordance with the service plan developed jointly by the agency or the department.
2. The agency shall make periodic written reports covering the care and progress of the child every three (3) months to the department.
3. The agency shall report promptly any illness of the child and will cooperate with the department's plans for medical care through the use of State ID#.
4. The agency shall give a minimum of ten (10) days written notice, except in an emergency, before requesting the removal of this child from care.

B. The department agrees that:

1. The department shall provide payment for services and maintenance as agreed upon in the contractual agreement between the department and the provider as found in agreement number 2908003.
2. The department shall be actively involved in carrying out the responsibilities of the service plan.

C. Special Provisions

(Placing Agency)

(Signature of Worker)

Woodward Academy
1251 334th St.
Woodward, Iowa 50276

By _____

(Title)

(Date)

APPROVED BY:

(Name)

(Title)

(Date)

WOODWARD ACADEMY
REFERRING WORKER/STUDENT INFORMATION SHEET

ATTENTION REFERRING WORKER: Please fill out this form and return with the releases provided and other pertinent data. Note there are a few releases that also require your signature. You will find a check list at the end of this form which indicates information that must be submitted in order to serve your client at the Woodward Academy.

NAME: _____ D.O.B.: _____ PLACE OF BIRTH: _____
 first middle last

S.S.#: _____ - _____ - _____ ETHNICITY: _____ RELIGION: _____

STATE ID #: _____ DATE ACTIVATED: _____

Has student been activated for medical payment? Yes/No

DISTRICT/JURISDICTION: _____ REFERRING COUNTY: _____

LEGAL STATUS/WHO HAS CUSTODY: _____

LEGAL GUARDIAN: _____ TELEPHONE #: _____
ADDRESS: _____ CITY/STATE/ZIP: _____

PLACING AGENCY: _____	PLACING WORKER: _____
S WORKER: _____	DHS WORKER: _____
ADDRESS: _____	ADDRESS: _____
TELEPHONE #:(W) _____	TELEPHONE #:(W) _____
TELEPHONE #:(H) _____	TELEPHONE #:(H) _____
FAX #: _____	FAX #: _____
EMERGENCY #: _____	EMERGENCY #: _____
SUPERVISOR NAME: _____	SUPERVISOR NAME: _____

RESTITUTION: YES/NO Restitution to: _____ Amount \$: _____ Contact Person: _____ Telephone #: _____	COMMUNITY SERVICE: YES/NO # of Hours to be served: _____ Contact Person: _____ Telephone #: _____
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CLOTHING ALLOWANCE: (Please indicate if you would like to approve \$ up front or have billed at end of stay.) Students are issued clothing upon admission, the cost can be greatly reduced by bringing in the items on the clothing list in the referral packet. Approximately \$150-200 to clothe student initially if no clothes at intake. All students are issued some clothing/uniforms which will be billed to Placing Agency and student will pay home when discharged.	
Similar amount available: \$ _____	Date clothing allowance began(first out-of-home placement) _____
Send bills to: _____	Address: _____

STUDENT'S NAME: _____

Date Initiated:	Reason for no or limited contact:	
Name of Individual:		
Relationship to the student:	Unapproved For: <input type="checkbox"/> telephone contact <input type="checkbox"/> mail contact <input type="checkbox"/> on-campus visits <input type="checkbox"/> off-campus visits	
Date referring worker was notified:	Plan to regain contact:	
Date parents were notified:		
Court Order: <p style="text-align: center;">YES NO</p>	Student's Initial:	Date Discontinued:

SUBSEQUENT REVIEWS:

Date	Initial	Date	Initial	Date	Initial	Date	Initial

Parent/Guardian Date

Placing Worker Date

Student Date

All parties have read and agree with the above listed names