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

Woodward Academy
1251 334th Street
Woodward, Iowa 50276

MUST COMPLETE PRIOR TO ADMISSION

Referring Worker:

RE: **DOB:** **STATE ID#:**
SS#:

Please note the following forms ***MUST*** be turned into the Department of Human Services to **ACTIVATE STATE ID#** on your student.

___ **MEDICAL APPLICATION** ___ **MEDICAL LETTER TO FAMILY**

___ **EXCHANGE OF INFORMATION** ___ **COURT ORDER FOR PLACEMENT**

If your student has **NEVER** been in the system, they will also need a copy of:

___ **FACE SHEET** ___ **4-E ELIGIBILITY FORM**

IMPORTANT NOTICE

Please note to your DHS contact that if your student is currently in the system and active, the following medical providers will be used and, depending on the county coverage, there may need to be changes made while in placement. If your student is currently in a FIP, MEDIPASS or HMO program, it is necessary to have changes made to cover their medical needs while in placement.
THIS MUST BE DONE PRIOR TO PLACEMENT, AS STUDENTS START RECEIVING MEDICAL SERVICES THE 1ST WEEK ON CAMPUS.

We also need any information on **private insurance** that the parents may have, as often they do not provide the information to us.

AGENCIES USED WHILE STUDENT IS AT WOODWARD ACADEMY:

PHYSICIAN:
U of I Family Care
616 10th Street
Perry, IA 50220
515-465-3553

HOSPITAL:
Dallas County Hospital
610 10th Street
Perry, IA 50220
515-465-3547

PSYCHIATRY:
Dr. Krishna Murthy
Bluffs Psychiatry
201 Ridge St., #105
Council Bluffs, IA
712-328-1858

Susan Smith, ARNP, CS
9 North 4th Avenue
Marshalltown, IA
641-752-1585

DENTIST:
Dr Joel Wright & Dr Greg Steffen
1305 2nd Street
Perry, IA 50220
515-465-3501

PODIATRY:
Dr. Todd Miller
612 10th Street
Perry, IA 50220
515-465-5688

OPTOMETRY:
Boone Vision
621 Story Street
Boone, IA 50036
515-432-2973

PHARMACY:
Medicap Pharmacy
411 Annex Road
Madrid, IA 50156
515-795-4252

AUDIOLOGY:
Michael Gentz Audiology
Emilie Hansen
1401 50th
Regency #2, Suite 112
W Des Moines, IA 50266
800-246-1891

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:** ☐ telephone contact ☐ mail contact ☐ on-campus visits ☐ off-campus visits	
Date referring worker was notified:	**Plan to regain contact:**	
Date parents were notified:		
Court Order: YES NO	**Student's Initial:**	**Date Discontinued:**

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

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 ther pertinent data. Note there are a few releases that also require your signature. You will find a check list at ie 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:______________
ADDRESS:______________
TELEPHONE #:(W)______________
TELEPHONE #:(H)______________
FAX #:______________
EMERGENCY #:______________
SUPERVISOR NAME:______________

DHS WORKER:______________
ADDRESS:______________
TELEPHONE #:(W)______________
TELEPHONE #:(H)______________
FAX #:______________
EMERGENCY #:______________
SUPERVISOR NAME:______________

RESTITUTION: YES/NO
Restitution to:______________
Amount $:______________
Contact Person:______________
Telephone #:______________

COMMUNITY SERVICE: YES/NO
# of Hours to be served:______________
Contact Person:______________
Telephone #:______________

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 e home when discharged.**

ollar 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: ☐ telephone contact ☐ mail contact ☐ on-campus visits ☐ off-campus visits
Date referring worker was notified:	Plan to regain contact:
Date parents were notified:	
Court Order: YES NO	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