

## Voluntary Crisis Stabilization Admissions Agreement

This agreement ("Agreement") is entered into by and between \_\_\_\_\_  
 \_\_\_\_\_ (hereinafter referred to as "Provider"), a licensed  
 program and \_\_\_\_\_  
 the parent(s) and/or guardian(s) of the Youth (hereinafter referred to as the "Guardian").  
 regarding \_\_\_\_\_ (client name, hereinafter referred to as "Youth")

In consideration of the mutual promises set forth in this Agreement, Provider and Guardian (hereinafter the "Parties") mutually agree as follows:

**Provider Name:** \_\_\_\_\_  
**Provider Address:** \_\_\_\_\_  
**Provider Telephone:** \_\_\_\_\_

**Guardian's Name:** \_\_\_\_\_  
**Guardian's Address:** \_\_\_\_\_  
**Guardian's Telephone:** \_\_\_\_\_

**Name of County:** \_\_\_\_\_  
**County Representative** \_\_\_\_\_  
**County Telephone:** \_\_\_\_\_

Youth Initial	Guardian Initial
_____	_____

1. PROGRAM COSTS AND PAYMENT TERMS.
  - A. PROGRAM FEES. Youth will receive Crisis Stabilization services. The Program fee per day excludes the cost of psychotropic and other medications, laboratory fees, and medical services.
  - B. SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES.
    - (1) At the time of admission, the county providing service authorization shall fund the placement at the agreed upon daily rate.
    - (2) The county will bill the Guardian based upon that county's specific billing protocols and systems. The Guardian shall pay the amount due to the authorizing county. This is outlined in the Voluntary Crisis Stabilization Agreement.
2. CONSENT TO TREATMENT: I hereby request admission and give voluntary consent to the usual and customary treatment in the program. I consent to medical treatment or other services rendered to the client. I also understand that health care may be provided by the Provider and their employees as well as consultants who are contracted with Provider.
3. PARTICIPATION IN SERVICES: Youth agrees to engage in program services.
4. PARTICIPATION IN RECREATIONAL SERVICES: Youth agrees to participate in recreational services. I understand that certain physical risks are involved in these activities and I agree to not hold the Provider or its employees responsible for injuries that may occur while involved with these activities.



11. DISTRIBUTION OF OVER-THE-COUNTER(OTC) MEDICATIONS: I authorize the Provider to distribute the following OTC medications:

- |  |  |
|--|--|
| <input type="checkbox"/> Ibuprofen               | <input type="checkbox"/> Antihistamines          |
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> Cough Suppressants      |
| <input type="checkbox"/> Acetaminophens          | <input type="checkbox"/> Antibiotic cream        |
| <input type="checkbox"/> Decongestants           | <input type="checkbox"/> Anti-diarrhea           |
| <input type="checkbox"/> Pain relief cream/spray | <input type="checkbox"/> Head lice treatment     |
| <input type="checkbox"/> Antacids                | <input type="checkbox"/> Oral anesthetic         |
| <input type="checkbox"/> Hydrocortisone          | <input type="checkbox"/> Acne creams/washes/pads |
| <input type="checkbox"/> Other _____             | <input type="checkbox"/> Other _____             |

These medications will be distributed upon request and in accordance with the instructions on the bottle or as prescribed.

Youth has had a negative reaction and/or allergic reaction to the following medications:

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12. TRANSPORTATION: I understand that some activities may take place off grounds and in these cases clients will be transported in program vehicles and/or employees' personal vehicles. I agree to not hold Provider or employees responsible for injuries that may occur to client during transport.
13. PROPERTY DAMAGE: I agree to be billed directly for all expenses incurred for repairing/replacing damaged property that is directly attributed to the client. The rate of charge is determined by the cost for labor and materials.
14. PERSONAL PROPERTY DAMAGE: I agree that Provider is not responsible for personal property which is lost, stolen, broken, or otherwise damaged at the program site.
15. NOTICE OF VOLUNTARY RIGHT TO DISCHARGE: I understand that the average length of stay required to complete the Program is less than 5 days. If my family/legal guardian or I choose to end treatment, I hereby agree to inform the program administrator. I further agree that the Program staff have permission to contact my parents/legal guardians prior to my discharge.
16. PHYSICAL CONTACT POLICY: Youth agrees to refrain from physical contact with other children in the program.
17. SAFE INTERACTION: Youth agrees to interact in a safe and cooperative manner with staff and other clients. Youth agrees to refrain from using verbally demeaning or abusive language or attempting to physically or emotionally harm self or others.
18. EMERGENCY INTERVENTION NOTIFICATION: I am aware that the Provider staff may physically restrain the client if the client's behavior is determined to pose imminent risk of harm to self or others, and less restrictive measures are not effective or feasible. The Provider will make every effort to de-escalate the situation prior to the use of a restraint. If a physical restraint is required, in-depth processing with the client will follow such an event. Primary care providers and/or County agencies will be notified.

- \_\_\_\_\_ 19. **CONTRABAND POLICY:** I agree to refrain from bringing any items of contraband - such as alcohol, cigarettes, knives, illegal substances, lighter, or any inappropriate or unsafe items as determined by staff, to the program.
- \_\_\_\_\_ 20. **SUBSTANCE USE:** If there are suspicions that Youth is under the influence of alcohol or other illegal substances, Youth understands the Provider staff will notify his/her parent/legal guardian of the suspicion and the need for a urine analysis as a means to establish if Youth has used illegal chemicals or alcohol.
- \_\_\_\_\_ 21. **PHONE POLICY:** I will be informed of the telephone use procedures. Calls will be taken from immediate family members.
- \_\_\_\_\_ 22. **VISITATION POLICY:** I will be informed of the visitation policy and procedures. Visitation may be allowed with family members based on the child's needs. Family members should contact the Provider to schedule visitations. Parents or legal guardians are also encouraged to contact their Provider for questions, concerns, and consultation.
- \_\_\_\_\_ 23. **FAMILY INVOLVEMENT:** I understand that an important part of my child's treatment is family involvement and family services. The specific type of involvement will be determined between the program, county staff, and the family.

\_\_\_\_\_  
 Client Signature (client must sign if 12 years of age or older)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Legal Guardian Signature

\_\_\_\_\_  
 Date