PLACEMENT AGREEMENT

AUTHORIZATION TO PROVIDE CARE

Gateways Group Home for Girls, Inc

1836 Tilden Rd Galena, Mo 65656 (417)538-4673

This will certify that Gateways Group Home For Girls, Inc. is authorized to:

Arrange for and provide minor medical attention and to meet emergency situations as shall be necessary from medical personnel or agencies working within the Medicaid program.

Administer medications, including Psychotropic medications, as prescribed by a duly qualified physician and non-prescription medications as needed.

Arrange for routine dental/medical care, including the administration of a local anesthetic for routine procedures, and other clinical or therapeutic services as needed.

Transport child to and from any appointments or school activities.

Retain child in immediate custody and control and assume responsibilities as would be reasonable and appropriate under the circumstances at hand.

I authorized the release of any social, clinical, academic, medical or legal information pertaining to the child noted below to Gateways Group Home For Girls, Inc. (GGH). I further authorized GGH to release any social, clinical, academic, medical or legal information pertaining to the child to outside agencies as necessary to provide the best possible care. I understand that I will be informed of any emergency or special needs or procedures. Whenever possible, consent will be sought for specific emergency procedures.

I understand that if the child is away from GGH for 7 days without approval from GGH and case manager for extended absence, the child will be considered discharged. I understand that after discharge, the referring agency or child’s family will have 15 days to pick up the child’s belongings from GGH.

Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_ Placement Date\_\_\_\_\_\_\_\_\_\_

Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Guardian ad litem\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_