Application Process

To Referring Agency, Case Workers, Case Managers, and Guardians:

Thank You very much for your interest in our program. We offer an array of care and therapeutic services designed to meet the needs of our female adolescent clients in a variety of ways.

Program information can be found on our website www.kaylynshouseofjoy.com, and if you need assistance in determining the best service for the client in your care please feel free to contact our **Director Kathy Malone at (502) 509-3885** or email kaylynsjoyhouse@gmail.com.

To apply for our program, please complete the attached referral form and fax the completed documents along with the required supporting documentation to (502) 362-1180. The information you provide in the referral form is protected by HIPAA and the agencies that place with us.

Once we receive a completed referral form - including all required supporting documentation- we will review the referral form with our admissions committee. Admission decisions are based on our admission criteria and availability. Please let us know if you are pressed for time with the specifics of the situation. We do our best to accommodate adolescents in a timely manner.

If your referral is accepted, we will contact you to make plans for placement and to gather additional information needed for placement, if required. We will work with you to make sure that everything needed is in place prior to placement.

If an adolescent is denied admission, we will contact you stating reasons for denial and will provide recommendations for a more appropriate placement based on the adolescent's situation. If accepted, our program expects the adolescents in our care to work towards self-improvement. We encourage adolescents to be honest with themselves, us, and others in their lives. Our program is designed to be safe and caring. Adolescents in our care can expect us to be open, fair, dependable, consistent, and demanding when appropriate. We have high hopes for the young ladies who will learn and grow with us.

Thank you very much for considering Kaylyn's House of Joy, Inc.

With Joy,

Kathy Malone

Kathy Malone, President

Referral Form

Last Name (Legal): _____ First Name: _____

Middle Initial _____ Suffix (Circle); Miss, Ms. Mrs. Preferred Name: _____

Date of Birth: _____/_____/_____ SSN: _____ -_____ - _____

Gender Identification (please circle): she/her he/him non-binary

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Homes Address (Last known address):

_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (____) _____- _____

Email: _____

Person making referral

Name: _____ Position: _____

Phone #: _____ Email:_____

Available Documentation: ☐ Birth Certificate ☐ Social Security Card ☐ Photo ID ☐ Other_____

Reason for Entering KHJ, Inc.

☐ Parents Deceased or Not Existing ☐ Client in domestic abuse

☐ Client in Guardian Abuse/Neglect ☐ Client Homeless

☐ Parent Gave Up Guardianship ☐ Client dealing with Substance Use/Abuse

☐ Client unable to be cared for by Parent/Guardian ☐ Client suffering from Mental/Emotional Health

☐ Client Truancy ☐ Court Order ☐ Independent Living Program ☐ Foster Care Placement

☐ Other: Please provide description:

_____

_____

_____

_____

Emergency Contact

Full Name: _____

Relationship: _____

Home Phone: (_____) _____ - _____ Mobile Phone: (_____) _____ - _____

Client School/ Employment Details

Highest Education Level Completed: K-5 Middle School 9th -12th grade HS Diploma GED Some College

Middle School Attended: _____

High School Attended: _____

Year of Graduation/GED Certification ("month/year" if applicable): _____ / _____

Current School Status: Enrolled in HS Need to be Enrolled on HS Need GED Enrolled in GED N/A

Employment Status: ☐ Full-Time ☐ Part Time ☐Not Employed ☐ Military ☐ Self-Employed

Employer Name (if applicable): _____

Work#: (_____) _____ - _____

Address: _____ City: _____

State: _____ Zip: _____

Student Status:

☐ Full Time ☐Part Time ☐Not a Student Current School Name:

_____

Insurance, Physician and Pharmacy Information

Does client have insurance? Yes____ No_____ If Yes, ☐ Medicaid ☐ Private ☐ Medicare

Insurance Company: _____ Policy # (if applicable): _____

Physician (if applicable): _____

Phone: (_____) _____ - _____

Address: _____

What Pharmacy does client prefer: ☐ Walgreens ☐ CVS ☐ Kroger ☐ Walmart ☐ Target ☐ Sam's Club ☐Other

Please list, if other:

_____

Pharmacy Address: _____

Pharmacy Phone#: _____

Mail Order Pharmacy (if applicable): ☐ CVS ☐Express Scripts ☐ Other:

_____

Clients' Need Assessment

Clients Current Needs:

____ Safety ____Food ____medical care ___Transportation _____Legal aid ____shelter

_____ Mental Healthcare ____ clothing _____dental care _____reunification w/family or support

_____ Drug/ Alcohol Treatment Program

Has Client:

- Ever stayed at a residential facility? Yes ___ No ___
- Ever Stay at a Recovery House? Yes ____ No_____
- Ever Stayed at a homeless shelter? Yes ____ No ____
- Ever stayed at an inpatient Psychiatric hospital? Yes ____ No ____
- Received Chemical Dependency Treatment in the past? Yes_____ No _____

  If Yes, ☐ Outpatient ☐ Inpatient Name of Program: _____

  Current Status: _____

- Ever been in a juvenile detention center or jail? Yes ____ No _____
  If Yes, what was the charge? _____
- Been diagnosed with or show signs of a severe mental health disorder? Yes____ No_____

  If Yes, what is/ are the diagnosis or signs: _____

- Been diagnosed with or show signs of a severe behavioral disorder? Yes_____ No _____
  If Yes, what is/are the diagnosis or signs: _____

Does client have any history of trauma, if so please explain:

_____
_____
_____
_____

How did you hear about Kaylyn's House of Joy? ____ Friend ___referral ___family ____other

Authorization of Release of Information

Client Name: _____

DOB: _____/ _____/ _____ SSN: _____

I give permission Kaylyn's House of Joy, Inc. to release information to the following persons and/or agencies:

I also give permission to Kaylyn's House of Joy, Inc. to obtain information from the following persons and/or agencies (Please provide contact information when possible)

Person/Agency: **Contact Info:**	**Person/Agency:** **Contact Info:**	**Person/Agency:** **Contact Info:**
Person/Agency: **Contact Info:**	**Person/Agency:** **Contact Info:**	**Person/Agency:** **Contact Info:**
Person/Agency: **Contact Info:**	**Person/Agency:** **Contact Info:**	**Person/Agency:** **Contact Info:**

The information to be released and obtained may include: medical records, mental health records, courts records, and education records.

I understand my signature authorizes the release of this information only between the above-named persons or agency. I may withdraw this authorization at any time by written notice. This document expires in 1 year.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Withdraw of Consent:

_____ _____

Client Signature Date