REQUEST FOR PROPOSAL

Electronic Medical Records System
for
Residential Treatment Facility, Lignum, VA

Date: May 10, 2016

Proposals are due: July 11, 2016 by 4:00 p.m. PST

Childhelp, Inc.
National Headquarters
4350 E. Camelback Road, Bldg. F250
Phoenix, AZ 85018
(480) 922-8212

TABLE OF CONTENTS

INTENT & SCOPE OF THE REQUEST FOR PROPOSAL

Childhelp is issuing this Request for Proposal (RFP), for the purpose of selecting a qualified contractor (a.k.a. vendor/bidder) to provide a comprehensive Commercial Off-The-Shelf (COTS) Software-as-a-Service (SaaS) Web Hosted Practice Management Residential Treatment Facility Electronic Medical Records System (hereafter known as "RTF EMR").

Childhelp is seeking a Vendor to provide and implement an RTF EMR with major modules/components/tools including (but not necessarily limited to):

- Client Registration
- Clinical Records
- Appointment Scheduling
- Billing
- Care & Case Management
- E-Prescribing/Medication Management
- Quality Assurance and Reporting.

Childhelp is not interested in beta systems or purchasing professional services to design and/or develop a system. The EMR must meet the required functionality 'out-of-the-box' without extensive customization.

The Childhelp Residential Treatment Facility (known as the Childhelp Alice C. Tyler Village), is located in Lignum, Virginia. Additional information and processes of Childhelp's RTF is located in Current Environment section of this RFP.

Childhelp identified user access breakdown (178 to 180 total users):

- Psychiatrist – 1
- Medical/Nursing – 19
- Clinicians – 11
- Residential staff – 99
- Educational staff - 28
- Utilization Reviewer (Individualized Plan of Care) – 1
- Nutritionist/Dietician (nutritional assessment) - 1
- Chaplain (spiritual assessment) - 1
- Recreational staff (assessment) – 3
- Admissions – 2
- Occupational Therapist/Speech Therapist – 2

- Quality Assurance – 1
- Claims Processor – 2
- Accounting/Controller Staff – 1
- Contract Administrator – 1
- Program/System Administrator – 4
- Auditor – 1

- E-Prescription users
    - Full-time (doctors/NP) – 2
    - Part-time – 1
    - Reviewer/Reporting – 1
    - Administrators - 2

Pricing should include the cost of licensing, hosting and maintaining/support for all software required to operate the system in the manner described in this document as well as all related implementation services. Proposals should include details concerning the implementation schedule and project milestones with realistic completion dates during the implementation process.

Proposals must detail the amount of training to be provided, the number of Childhelp's staff/clinicians to be trained, a training syllabus, and the technical qualifications of bidder's training staff.

A. SCHEDULE OF EVENTS

It should be noted, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal & posted on Childhelp's website: http://www.childhelp.org	5/10/2016
2.	Last day to submit questions – Round One	5/27/2016
3.	Childhelp responds to first round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.childhelp.org	6/6/2016
4.	Last day to submit questions – Round Two	6/15/2016
5.	Childhelp responds to second round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.childhelp.org	6/21/2016
6.	Last day to submit "Proposal Response"	7/11/2016
7.	Proposal evaluation period - Submit question(s) to designated Contractor(s) for clarifications if necessary	7/25/2016
8.	Selected Contractors to perform Oral Interviews/Presentations and/or Demonstrations	7/28/2016
9.	Contract negotiation & finalization period	8/15/2016
10.	Contract award	8/22/2016
11.	Contractor start date	9/5/2016

There will not be a Pre-Bid/Pre-Proposal Conference.

CHILDHELP INFORMATION & PROCEDURES

A. CHILDHELP OVERVIEW

Childhelp was founded in 1959, and remains one of the oldest and largest national non-profit organizations dedicated to meeting the physical, emotional, educational, and spiritual needs of abused, neglected and at-risk children.

While most efforts to address abuse are broken down into three separate and distinct areas: prevention, treatment, and removal of the child, Childhelp is one of the few non-profit organizations today to address the full continuum through community awareness, prevention education, child advocacy centers, residential/group homes, and foster care programs. Childhelp offers victim advocacy, intervention, prevention, and treatment programs and services in Arizona, California, Tennessee, and Virginia. Childhelp's National Child Abuse Hotline and Speak Up Be Safe Prevention Education Programs are available in all 50 states.

Childhelp's most widely known programs are national programs: Speak Up Be Safe (SUBS) and the National Child Abuse Hotline. Childhelp's Speak Up Be Safe program was originally authored as Good Touch/Bad Touch program in 1983. It is a research-based, comprehensive body safety and abuse prevention education curriculum targeting Pre-K-6th grade school children. The curriculum has a long history of use and acceptance in classrooms across the U.S., has been used with hundreds of thousands of children, and has been proven as a successful child abuse prevention education program.

Childhelp's National Child Abuse Hotline (1-800-4-A-CHILD®) provides 24/7 crisis intervention and referral services to over 100,000 callers each year. The toll-free hotline serves the entire U.S., Canada, the U.S. Virgin Islands, Guam and Puerto Rico. Although dedicated to the prevention of child abuse, the Hotline's primary focus is to defuse potentially volatile situations through crisis intervention, offer callers a plan of action, and connect them with primary resources in their area. A team of professional Bachelor and Masters level crisis counselors deliver help and hope every day. Communication in 140 languages is available through state-of-the-art technology that also enables three-way conversations with the counselor, the caller, and the closest available resource/assistance. While every effort is made to ensure the caller's confidentiality and anonymity, the appropriate local authorities are contacted if the child or other members of the household are in immediate danger.

In addition to programs, Childhelp operates child advocacy centers in Arizona and Tennessee. Childhelp's Arizona Child Advocacy Center serves Maricopa County and was the first of its kind in the state to house CPS, law enforcement and medical professionals in one facility. The center serves as a best practice model for developing advocacy centers across the country. In addition, a mobile advocacy center in, Northern Arizona, serves children in remote areas. Childhelp also operates a community center in Arizona's west valley serving at-risk and economically disadvantaged children and families. Foster family agencies in California and Tennessee unite children with loving, compassionate families and provide potential foster families with parenting training, as well as, ongoing supportive services.

Childhelp's Mission Statement

Childhelp exists to meet the physical, emotional, educational, and spiritual needs of abused, neglected and at-risk children. We focus our efforts on advocacy, prevention, intervention, treatment and community outreach.

Across 260 acres, the Childhelp Alice C. Tyler Village (RTF) in Lignum, Virginia, has provided a healing home environment for abused, neglected and at-risk children since 1993. In a community atmosphere, the Village houses as many as 67 children from 5 to 14 years of age. Clients are referred by schools, parents, nearby judicial authorities and child welfare offices, often arriving with severe emotional and behavioral problems as a result of abusive or neglectful situations. Childhelp's team of mental health professionals greet each child upon arrival, equipped to develop an individualized treatment plan tailored to the child's individual needs. While at the village, children receive on-site clinical services provided by Childhelp's multi-disciplinary team under the direction of a staff psychiatrist. Comprehensive treatment, including:

- Clinical therapy
- Educational services
- Art therapy
- Animal-assisted therapy
- Music & Speech therapy
- Recreational therapy
- Occupational therapy

On the Village campus is a non-public school academy that serves children requiring a therapeutic environment as part of their elementary or secondary education. The academy enrolls students with needs that cannot be accommodated in a public school by providing high quality supervision, structure and intervention to ensure academic success for every student in the least restrictive environment.

The Village's partners include the Virginia Association of Independent Special Education Facilities and the Virginia Coalition of Private Provider Association. The Village is a Virginia and West Virginia Medicaid provider, and is accredited with the Joint Commission as a behavioral health care provider. Residents of the Village have access to enrichment programs such as:

- Ranch and animal care
- Recreation/outdoor activities
- Special friend program
- Chapel services

The Village has one of only four licensed residential and day-school special education programs open to children in the community. Childhelp provides a staff to child ratio of 1:3 during daytime hours and a therapist to child ratio of 1:8. Childhelp employs a full-time recreational therapist, a music therapist, an animal therapy specialist, and offers speech and occupational therapy to residents. Childhelp provides specialized clinical services for children who have suffered severe abuse, employing a full-time child psychiatrist, 24-hour medical nursing care, and a full-time staff psychologist. Individualized treatment plans and an in-patient sensory integration program are given to all children with developmental needs. The major revenue source funds is from Virginia Medicaid and West Virginia Medicaid.

There are 8 classrooms with an average of 8 students per classroom. The village school program enroll student placement by the state that are non-RTF clients.

Fifty children on average are enrolled per year with an average length of stay of 10-months at the Village.

What Childhelp offers

- Specialized Services: 24 hour child psychiatrist coverage, 24 hour nursing care, registered dietitian, occupational therapy/speech therapy, horticulture assisted services, and social skills development.
- Assessment: Psychiatric evaluation, physical examination, educational assessment, recreational assessment, nutritional assessment, psychological and neuropsychological testing.
- Psychiatry/Medical: On-site board certified psychiatrist and 24-hour nursing care.
- Therapy: Individual therapy, family therapy, group therapy, art therapy, daily milieu therapy, experiential therapy techniques, trauma focused therapy and intervention supported by attachment research, evidenced-based treatment interventions, equine assisted therapy and animal assisted therapy.
- Therapeutic Recreation Activities: Hiking trails, biking, swimming pools, gymnasium, equestrian programs, fishing ponds and streams, meditation techniques, ropes course, gardening program, go carts, and more!
- Education: Licensed private residential school for students with disabilities serving grades k-8, private day school, and member of VAISEF. The Village uses a multi-modal approach using individualized instruction, small teacher to student ratio with direct instruction and progress monitoring.
- Interdisciplinary Treatment Team: Board certified child psychiatrist, registered nurse, licensed practical nurse, nurse practitioner, licensed or license-eligible therapists, art therapist, special education certified teachers, occupational therapy, speech language therapist, recreation staff, registered dietitian, and on-site staff.

License & Accreditations

- Virginia Department of Behavioral Health & Developmental Services
- Commonwealth of Virginia Department of Education
- The Joint Commission

Program Statistics, Fiscal Year 2013

124 Children Served (Under Age 18)
3,857 Service Units Provided
67 Residential Capacity
76% Average Daily Occupancy
15 Non-Residential Non-Public School Students
1:3 Staff to child ratio during waking hours

Childhelp maintains a philosophy of excellence in all of its programs. Childhelp expects its Contractors to provide and adhere to the same standard of excellence and the products and/

or services provided must be reflective of this quality. Childhelp expects the Contractor to provide the customer service, time, resources and personnel necessary to provide excellent products and/ or services.

B. PROPOSAL SUBMITTING LOCATION

Vendors Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name: John Hopkins (RTF EMR RFP)
Agency: Childhelp, Inc.
Address: 4350 E. Camelback Road, Bldg F250
Phoenix, AZ 85018

C. CHILDHELP CONTACT PERSON

The point of contact for this RFP:

Name: John Hopkins
Telephone: 480-922-8212
Facsimile: 480-922-7061
E-Mail: **jhopkins@childhelp.org**

D. GENERAL INFORMATION, CONDITIONS & EXPECTATIONS

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal (RFP). Prospective bidders are expected to carefully examine all documentation, schedules and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed. Proposals should be prepared simply and economically, providing a description of the bidder's capabilities to satisfy the requirements of the RFP.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract. Submitted proposals shall remain valid for one-hundred (100) calendar days after the proposal due date. Costs for developing the proposals and any subsequent activities prior to contract award are solely the responsibility of the bidders. Childhelp will provide no reimbursement for such costs.

Childhelp is not liable for any errors, omissions or misinterpretations in responding to the RFP.

Childhelp reserves the right to undertake or award other contracts for additional or related work to other entities. The Contractor shall fully cooperate with such other Contractors and Childhelp employees and carefully fit its work to such additional work.

Childhelp's vision and objective is to implement a similar RTF EMR at Childhelp's Merv Griffin Village in Beaumont, California (a 121 acres, 24-hour treatment of severely abused, neglected, and at-risk children), however this is a future project and is not part nor the intent of this Alice C. Tyler Village RFP project. The contract resulting from this RFP (Childhelp Alice C. Tyler Village) is a non-exclusive and contractor acknowledges that nothing in this contract shall prohibit Childhelp from entering into contracts similar to this one for other areas/locations of Childhelp.

The contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the contractor's proposal, and the resulting contract. Following execution of the contract, the contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract. The contractor warrants that all persons assigned to the project shall be employees of the contractor or specified subcontractors, and shall be fully qualified to perform the work required herein. Replacement of key personnel, shall be with personnel of equal or greater ability and qualifications. In respect to its employees, the contractor agrees to be responsible for any and all vehicles used by the contractor's employees, including all insurance required by state law; damages incurred by contractor's employees within the scope of their duties under the contract; maintaining workers' compensation; and determining the hours to be worked and the duties to be performed by the contractor's employees. The contractor shall use its best efforts to ensure that its employees, agents and subcontractors comply with site rules and regulations while on Childhelp's premises. All Contractor & Sub-contractor personnel assigned to work on-site at Childhelp Village campus on the EMR project may be required to undergo a criminal history check. Childhelp reserves the right to reject any on-site personnel proposed by the Contractor and/or Sub-contractor for any reason.

Childhelp shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal (RFP), in the interview/presentation/demonstrations, or in any other activity related to bidding on this Request for Proposal.

The requirements contained in the RFP become a part of the terms and conditions of the contract resulting from this RFP. Any deviations and/or exceptions from the RFP must be clearly defined by the bidder in its transmittal and, if accepted by Childhelp, will become part of the contract.

Childhelp may terminate the contract, in whole or in part, if the contractor fails to perform its obligations under the contract in a timely and proper manner. Childhelp may, by providing a written notice of default to the contractor, allow the contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at Childhelp's discretion considering the gravity and nature of the default). If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from Childhelp, the contractor shall deliver assurances in the form of additional contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected. In the event that the contractor fails to perform any substantial obligation under the contract, Childhelp may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event.

Payments shall not be made until contractual deliverable(s) are received and accepted by Childhelp.

The contract may be terminated as follows: (1) Childhelp and the contractor, by mutual written agreement, may terminate the contract at any time. (2) Childhelp may terminate the contract immediately for the following reasons: (a) contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business; (b) fraud, misappropriation, embezzlement,

malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders; (c) a voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code; (d) contractor intentionally discloses confidential information; (e) contractor has or announces it will discontinue support of the deliverable.

If the requirement, software operation/function, material or document is determined to be in non-compliance, Childhelp will send written notification to the contractor's Project Manager outlining the reason(s) for the determination. If Childhelp accepts the requirement, software operation/function, requirement material or documents, an acceptance letter, signed by Childhelp, will be submitted to the contractor.

Whenever the contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the contractor shall immediately give notice thereof in writing to Childhelp reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

The Childhelp hosted data must be housed within the United States. The contractor shall develop a Disaster Recovery Plan as required in Terms and Conditions of the contract.

The Childhelp EMR application data including but not limited to entered data, processed data/files, imported data, scanned documents, uploaded files, document library forms and other data regardless of format are and will remain the sole property, interest, and ownership of Childhelp and shall be made available to Childhelp to allow for full access to that data. This is not meant to include proprietary programs or other intellectual property unique to the Contractor's/Sub-contractor's solution.

Project Management Services

The awarded contractor shall at a minimum deliver the following documents as part of the project management services:

- Kick-off Meeting Agenda
- Detailed Project Work Plan & Updates (i.e., project tasks, subtasks, activities, milestones, start and end dates, and deliverables)
- Detailed Design/Requirements Document (including but not limited to: data flow diagram(s) to illustrate the flow of information throughout; web-forms, screen & data definitions, functions the process performs, data inputs/outputs processes & validations; identified functions/components/modules, report layouts, with approval acceptance sign-off)
- Change Management Plan/Change Order (Change Orders must be acknowledged and accepted in writing or signature by Childhelp before any additional work is undertaken). Each Change Order Request submitted by the Contractor will:
    - Provide a clear description of what is included in each change request.
    - Delineate impacts to the project's scope or budget.
    - Estimated item service hours, hourly rate, and total cost.
    - Estimated completion date.
    - Signature(s) & title(s) of Contractor and Childhelp.
    - Incorporate multiple levels of priority for change requests (e.g., critical, must-have, desired, etc.).
    - Support the Change Management Process by estimating impacts, investigating solutions, identifying alternatives, participating in the decision-making process, and implementing the agreed-upon solution.

- Project Status Reporting
- Prototype Review & Pilot Review Document (i.e. functional testing, web-based processes (as appropriate) of each component/module, operating successfully according to the Design/Requirements Document & RFP responses, stress/ performance/security/system review testing)
- Requirements Validation Document (i.e. reports matrix of the requirements to verify validity, accuracy, and reliability of the system)
- Issue/Resolution Plan (if needed)
- Acceptance Testing Document (final acceptance test must use a dataset approved by the Contractor's Project Manager and Childhelp; must exercise all functionality, components, benchmarks and performance successfully including full service cycle of a client from referral, admission, treatment, billing and discharge, plus report generation)(note: Contractor must test back-up/recovery feature successfully)
- Training Plan (Agenda; Copy of the program (including test database) on a test site so that Childhelp trainers are fully able to demonstrate the program). Childhelp prefers end-user training of clinical and administrative staff conducted on the Childhelp's campus once the system is available.
- User Guides (printed & electronic operational manuals & administration)
- Product Implementation Plan & Acceptance Document (including planning & work necessary for the Contractor and Childhelp to achieve a smooth transition to the new System)
- Final Readiness Assessment
- Final Approval of Deliverables

The bidder shall develop a viable Project Management Plan (PMP) according to industry standards and best practices that meets contractual requirements and timelines and provides the timing necessary for successful pre-implementation activities. Once the PMP is approved by Childhelp, the contractor shall maintain and modify the approved PMP throughout the project, by updating it to reflect the evolving schedule, priorities, and resources risks, etc. (i.e., it is a living document).

Submittal of Status Reports should have key information including (but limited to): indications of variance from contracted scope, schedule, summary of recent accomplishments, identification of, resolution plans and documentation for critical issues and risks, activities planned for the next reporting period, and a summary of the project's progress according to the schedule, budget, and task list. Status Meetings should be held at least bi-monthly along with the Status Report submittal.

A description (when it presents itself) of the contractor's standard process for resolution of problems identified and reported by the contractor and Childhelp staff. This description must include the contractor's plan for ensuring that issues, requests, and decisions are recognized, agreed upon, assigned to an owner, incorporated to an issue log, monitored, documented, and managed.

The Acceptance Testing activity is designed to demonstrate that the EMR solution meets Childhelp's specifications, performs all processes correctly, and passes acceptance criteria identified during requirements validation. Contractor must allow sufficient time to complete all the requirements of the Acceptance Testing Task. It will follow completion of unit, system, and integration testing, and verification by the contractor that the system is free from defects and ready for acceptance testing. This includes the proper functioning of software, hardware devices and connectivity components/subsystems/modules, format and content of all system web-forms & outputs, latency/stress/targeting testing, process workflows, roles/permissions to

specific areas/levels of access, including outputs from reporting functions. Childhelp will not procure testing tools for this project and any testing tools proposed shall be provided by the contractor and licensed by the contractor for use by its staff and the applicable Childhelp staff for the project at the testing site.

The contractor shall create the Final Readiness Assessment to assist in the determination of final implementation readiness. Written approval of this Assessment constitutes Childhelp's decision to move forward with implementation. At a minimum, the Assessment must address the following: (a) status of data migration/conversion efforts and its completion; (b) an assurance that Disaster Recovery, where applicable, is documented and ready; (c) documentation of user acceptance testing approval by Childhelp; (d) knowledge transfer sign-off by Childhelp; (e) documentation for all software products (i.e., reference guides, user guides, technical guides/manuals, technical documentation (system administration), and explanations of system error or performance messages to users and administrators); (f) assurance that system users, and security profiles have been identified and set up; (g) assurance that both test and production environments of Childhelp's solution are in-place and ready; (h) statement that Support Service Desk is ready and staffed for deployment.

The contractor must submit the Training Plan to Childhelp one month prior to the first training session.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to Childhelp and clearly marked "RTF EMR RFP Questions". It is preferred that questions be sent via e-mail to jhopkins@childhelp.org. Questions may also be sent by facsimile to 480-922-7061, but must include a cover sheet clearly indicating that the transmission is to the attention of Latrice Hickman.

It is recommended that Bidders submit questions as follows:

Respondent Contact Information

- Name of contact
- Name of contractor
- Contractor mailing address
- Contact e-mail address & phone number

RFP Questions in the following format

- Sequentially numbered
- RFP section reference
- RFP page number
- RFP question

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://www.childhelp.org on or before the date shown in the Schedule of Events.

F. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Proposal evaluation acceptable that oral interviews/presentations and/or demonstrations are required in order to

determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; Childhelp reserves the right to select any bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores to the bidder's Proposal. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of Childhelp and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed Childhelp reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by Childhelp.

G. SUBMISSION OF PROPOSALS

The following describes and specifies the items and requirements to be addressed in the proposal submission, proposal handling and review by Childhelp. Bidders should read it carefully and address it completely and in the order listed to facilitate Childhelp's review of the proposal.

Proposals shall be organized into the sections identified below. The content of each section is detailed further below. The bidder may provide sample screen shots of their proposed solution to show a standard representation of the requested question/information/feature/functionality to assist Childhelp's understanding and review.

- Cover Sheet
- Transmittal Letter
- Table of Contents
- Executive Summary
- Bidder's Profile Overview & Qualifications
- Bidder's References
- Implementation Services, Process/Methodology & Schedule
- Support Services
- System Security
- Data Center Facility
- Requirements Responses (Matrix, Web-form, Narrative)
- Additional Information
- Costs
- Appendix

To facilitate the proposal evaluation process, two (2) copies of the entire proposal (one original) in paper form should be submitted, with an electronic version on CD or thumb drive. Proposals must be submitted by the proposal due date and time. Submission of a proposal in response to this RFP serves as an indication of willingness to meet with the Review Committee if requested by the Review Committee to discuss the proposal.

The proposal should be packaged on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. Proposals may be stapled, in folders, or three-ring binders. Proposals received after the closing date and time will not be considered.

Proposal section response details:

1. **Cover Sheet** – Should include: "Residential Treatment Facility EMR RFP", name of organization, the main office address/city/state/zip code, phone number (including area code), and issue date.

2. **Transmittal Letter** – On organization letterhead. Must include:
   a. Contractor has read and understand the entire RFP with a statement of compliance with all requirements of the RFP specifications.
   b. Submitted proposal shall remain valid for one-hundred (100) calendar days after the proposal due date.
   c. Any contracts that may result from the RFP shall specify that the Contractor or Contractors is (are) solely responsible for fulfillment of the contract with Childhelp. The Contractor(s) is/are totally responsible for all actions and work performed by its subcontractors.
   d. Contractor(s) shall not assign the contract in whole or in part without the prior written consent of Childhelp.
   e. A statement referencing all addendums have been received. All written questions with answers/clarifications to the RFP issued by Childhelp must be included in the Appendix. If no addendums have been received, a statement to that effect should be included.
   f. Indicate any deviations, exceptions or ambiguity to the RFP including detailed justification/clarification/inability to comply for the deviation, exception or ambiguity by clearly identifying the subject matter and if the bidder suggests a recommended statement/condition/alternative. Childhelp may reject in whole or in part on the basis of deviation or exception.
   g. Contractor shall list the designated contact person who will be responsible for responding and communicating to Childhelp during the RFP submission, evaluation, questions/clarifications, and setting up the interview/presentation/demonstration (if required). Contact information should include: Contact person name & title; email address; and telephone numbers (office & cellular).
   h. Signed by an authorized legally binding representative of the organization.

3. **Table of Contents** – Include section number, title, and page number(s) with proper sub-section indentations.

4. **Executive Summary** – Condense and highlight the contents of the proposal and how you meet the requirements in such a way as to provide the evaluation committee with a broad understanding of the entire proposal, and why you are best qualified to perform the work required herein (should not exceed two pages in length). If a bidder plans to utilize a subcontractor(s) to fulfill any portion of the responsibilities outlined within the RFP, each subcontractor must be identified (name, address, phone), and the qualifications and roles played of each subcontractor must be outlined within this section. Also, briefly describe the proposed application architecture (i.e. framework,

platform, language, database (is the DBMS on a separate server?), structure (REST, component based), etc.) and continuous availability (e.g. 24/7/365, 7-years or more of client data storage).

5. **Bidder's Company Profile Overview & Qualifications** – Contractors and subcontractors (if any) must provide information about their company so that Childhelp can evaluate the Vendor's stability and ability to support the commitments set forth in response to the RFP. Provide the company's legal name, corporate office address, when it was established, ownership (public, private, partnership, subsidiary, etc.), Federal Employer ID, total number of clients with proposed product in production, number of years marketing EMR systems as requested in this RFP, number of regional offices, full-time and part-time employees size, financial stability (e.g. annual report, Dunn & Bradstreet report and/or financial information (latest gross sales revenue)), and any affiliations/partnerships. The Prime contractor must describe their ability to meet each of the qualifications listed below.
   a. A statement that the Contractor has been regularly engaged in RTF EMR software for a minimum of three (3) years in furnishing, delivering, servicing, installing, and supporting required in this RFP.
   b. Provide evidence of technical experience, facilities, and identify its professional & support key staff that will be assigned to Childhelp to provide the products and services outlined within the RFP specifications. Indicate the location of the office where each normally works. Childhelp expects that the key individuals identified in the proposal will be actually assigned to the project. Key individuals include, but will not be limited to, the Account Representative (explain experience with the offered product and years with the organization); the Implementation Project Manager (explain experience with the offered product, academic background & degrees, credentials/certifications (e.g. PMP), years as a Project Manager and with the organization), the Trainer(s) (explain experience with the offered product, number of years training on the product).
   c. Is the system you propose developed and maintained by your staff & organization or are you a systems integrator/value-added reseller implementing another vendor's product?
   d. Describe your organization's experience in Virginia and West Virginia Medicaid including compliance reports, billing, etc.
   e. Provide an approximate unique active installed number of customers using your solution.
   f. If any anticipated change in ownership or control of the company during the twelve (12) months following the proposal due date.
   g. Has the Contractor or any of its principals even been declared bankrupt or filed for protection from creditors under State or Federal proceeding in the last seven (7) years?

6. **Bidder's References** – Vendor should provide at least three (3) customers in the last 5-years preferably residential treatment facility product implementation, include:
   a. Customer name, address, & phone number
   b. Customer contact name, phone number & email address
   c. Contract award date & contract completion date
   d. Contract name/title
   e. System description (include number of users, what type of programs being managed through the system, number of different payers, are they an active customer)

Childhelp reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the vendor in the proposal, those indicated through the explicitly specified contacts, or those that are identified during the review of the proposal/interview/presentation/ demonstration.

7. **Implementation Services, Process/Methodology, & Schedule** –
   a. Describe your project approach & implementation process methodology for the installation (include if the rollout should be phased or occur all at once). Does your company provide a prototype review and piloting the software before deployment?
   b. Provide an estimated high-level project plan milestone schedule (e.g., MS Project, Gantt chart) showing the time frame involved in the implementation process of deploying the product application to Childhelp (include distinct phases, but not limited to: discovery/kick-off meeting (design/business-rules/workflow sessions), planning & analysis, requirements design document, development, development/configuration, QA, prototype/pilot (UA), documentation (user/admin guides), training, deployment & acceptance, post implementation support & maintenance). Please provide a summarized duration in completing the project in calendar days. Also, provide expected hours of the Contractor staff on-site during each major activity.
   c. Do you provide an implementation checklist to track the milestones, progress-to-date chart & tasks for the project?
   d. Do you provide a User Acceptance Test Plan script and issue log matrix to assist Childhelp in testing the system?
   e. Describe your training methodology for end-users & system administrators (e.g. train-the-trainer approach, specialized training (e.g. ad-hoc report creation, dashboard creation/setup)). List the number of users, number of sessions, training duration you propose to train and indicate if training proposed will be on-site at Childhelp (Lignum, Virginia location) or by webcam. List any resources you would require Childhelp to provide in order to conduct training on Childhelp RTF campus. If training is conducted on-site, materiel must be in paper-form for each student. Will training materials be customized for Childhelp? If yes, can the materials be copied for use by Childhelp personnel subsequent to the initial training? Do you provide webcast training if significant system updates occur at no additional charge? Do you need to take an exam on your product to be certified?
   f. Is additional on-line training available at the customer's convenience or through webinars?

8. **Support Services** – The first thirty (30) calendar days following the acceptance of go-live implementation will be known as the 30-day warranty period. Thereafter, the next twelve (12) months following the implementation warranty period will be known as the Post Implementation Support & Maintenance Period. Describe and answer the following:
   a. Does your company offer different support help desk levels (e.g. silver, gold, 1, 2), guaranteed response times to service requests, etc.? If yes, please describe with the availabilities during Eastern Standard Time (e.g. 5x8, 7x8, 7x24, etc.). Provide the average response time to a supporting issue.
   b. What is the level of support recommended by your company for the proposed solution?
   c. Is post implementation support & services paid monthly or annually?
   d. Describe your escalation procedures for continuing, urgent or critical issues with turnaround time.

e. Describe your operating support desk processes & procedures, include how are support requests received (e.g. phone call, email, through the EMR application portal), and how are support tickets tracked, managed, assigned, resolved & status communicated to the user. Do you use a help desk ticketing system to generate ticket numbers for the customer to track?
f. Will Childhelp be assigned dedicated support personnel familiar with our requirements and installation?
g. How often are version updates to your software typically released?
h. Are version upgrades/updates included at no additional charge to customers under the support agreement?
i. Ability to adjust the system to accommodate revised State and local government third party billing regulations as part of the software maintenance agreement?
j. Describe the process methodology to apply version updates/upgrades, hot fixes & patches (e.g. established on customer test environment to test/verify/approve before migrating to production environment) and how are customers notified of the upcoming updates. All system patches, updates, new releases, and hot fixes must be customer approved on a test system before they can be installed on the live system. What responsibilities for software upgrades are assumed by Childhelp?
k. Are there limitations to the number of Childhelp staff who can contact technical support? If so, how many Childhelp staff can contact support?
l. Please provide a copy of your Service Level Agreement (SLA) that will assure continuity of service. In addition, do you provide any discount/credit based on service interruptions? If yes, please explain.
m. If there are 3rd party software components/modules/tools as part of the offering, please describe the following:
    i. List the name(s) of the 3rd party component(s)/module(s)/tool(s) and how are they integrated in the EMR as a comprehensive solution?
    ii. How is support services handled for each component/module/tool?
n. Is any support services conducted outside the United States? If so, please give details (i.e. country, describe support person(s) English proficiency, what international safeguards to PHI (Protected Health Information) are in-place, access to Childhelp's data, etc.)

9. **System Security -** The Vendor must include a detailed description of the proposed system's security features. Describe how encrypts sensitive information transmitted across the internet (i.e. rest and in transit), and specify the algorithms used. Explain user specific drill-down security, and access to audit logs (i.e. ability to filter by user, actions, etc.).
    a. Does the solution specify a to-and-from the application using https?
    b. Can a user log on to more than one workstation at a time?
    c. Can more than one user access the same client record simultaneously? If yes, please describe your locking table process when updating the same record.
    d. Does the offered application provide data encryption of emails from the EMR?
    e. Are there different levels of permissions for administrators (e.g. super admin, billing admin) or supervisors managing and controlling specific sections/capabilities of the system? If yes, explain.
    f. Is there an audit log tracking to verify user access & transactions (i.e. user ID, date/time, location (e.g. form ID, report ID/name, portlet/page ID), action (e.g. login/logoff, view/add/edit/delete/print)) and system activities & transactions? If no, explain the application's auditing capabilities.
    g. Does the system provide a configurable Risk Management (e.g. option to send email via SSL notification to appropriate personnel, intrusion alarm, real-time health surveillance, web interface/exchange of information)

h. Describe the method, condition and format you use to return Childhelp's data upon expiration or cessation of use of your EMR SaaS application.
i. Explain the universal time setup for the proposed application (e.g. server based, workstation-based). If the application server is configured for Eastern Standard Time (EST), and a user is logged in Arizona Standard Time (AST) to conduct work, what is the time stamp?

10. **Data Center Hosting Facility** – Childhelp prefers the vendor to host the application at their site/data center. Describe the electronic and physical security standards of the data center facility where Childhelp's data would be housed. Also explain how it meets the requirements of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act) compliance. Provide details of the following:
    a. Location of the primary data center facility, if there is a secondary location provide location for back-up security disaster.
    b. If the contractor is using a 3rd party hosted data center, provide the name and how long the contractor has contracted with the data center.
    c. Access availability to the proposed system (e.g. 24/7/365, 99% up time). If access to Childhelp's application is non-responsive on the side of the vendor for any reason (e.g. hardware failure, critical program error, internet failure service) greater than 24-hours, does the vendor credit back Childhelp for the time lost? If yes, please explain.
    d. What tier level is the data center (e.g. Tier 1)?
    e. Does the data center hold a SAS 70 Type II, SSAE 16 compliant and/or other certifications?
    f. Provide a high-level topology/architecture design of the proposed offering. Explain data backup procedures, and how disaster recovery is performed & its recovery site. Provide a definition of triggers for activating contingency plans.
    g. Is redundancy and mirroring taking place? If so, explain.
    h. Is there an active VirusScan on the server?
    i. What is the internet speed access up/down availability of the housed application?

11. **Functional/Technical Requirements Matrix Response** – Fill out Exhibit 1 and place in this section of your response.

12. **Functional/Technical Web-Form Requirements** – The proposed system needs the ability to capture, store, display, print/report, and validate data as necessary of the following documents/forms listed in Exhibit 5. Bidder must state or describe for each identified document/form in Exhibit 5 that they either: (a) comply, (b) comply with modifications (give details), or (c) do not comply. Place responses in this section.

13. **Functional/Technical Requirements Narrative Responses & Questions** -
    a. Describe the client searching capabilities (i.e. by system client ID, by client name, by alias name, secondary ID, etc.) to display the result(s) and/or the client's record.
        i. Can you assign a user staff member to client, and have client lists and/or a link of only their assigned clients?
        ii. System allows a secondary ID given by Childhelp to the client with searchable capabilities?
    b. Describe the general forms automation of the application (e.g. supports drop-down tables, check-boxes, radio buttons, pop-up fields, time & date calendar controls, sliding-bars, auto-generating/populating fields & calculations (e.g. DOB entry will display age, zip code entry will populate city & county), text editors, required entry,

validation schemes (e.g. phone number requiring 10-digits), informational hyper-links/hovering, etc.)

i. System supplies (auto-generate) a single, universal unique identifying number for each client?
ii. Supports special characters and symbols entry (i.e. client names (e.g. ‘, -, ´, ˜), text boxes, text editors)?
iii. System automatically generates/populates description from procedure & billing code entry?
iv. Supports diagnosis & coding table look-up values (i.e. code or description) for selection?
v. System supports auto-populating from one web-form to another (e.g. referral demographic to the intake/admission, to an assessment, etc.)?
vi. System supports spell-check capability? If yes, is spell-check incorporated in all web-forms?
vii. Does the application assist in preventing duplication of a client? If yes, describe the matching technique and given name/shorten name comparisons (e.g. William aka Bill, Soundex capabilities).
viii. Can the user conduct a pending save of a web-form to come back at a later time to finish-up? If yes, please describe the process and capability, plus state if an auto-logoff is imposed by the application without saving and/or pending save a web-form what happens.

c. Describe briefly the referral & intake/admission application web-forms & process.
   i. Does the system have the ability to collect client demographic information including OMB to categorize data (e.g. gender, race, and ethnicity), DOB, etc. within the designated web-forms?
   ii. Does the system provides & supports diagnosis & coding standards: ICD-10 & DSM-V?
   iii. Does the system offer the ability to setup document check list & check-boxes for admission completion?
   iv. Software supports tracking potential clients on a waitlist for admission?
d. Describe the solution’s staging process, status levels, and validation methods of a client flow and billing (e.g. referral to eligibility screening to admission).
   i. Is the staging configurable to check & validate lists, verify uploaded documents/forms (e.g. CANS, Rate Certificate, Certificate of Need, etc. before an intake/admission status changes to Open/Complete), and completion of a web-form (e.g. treatment plan is saved before a progress note can be entered)?
   ii. Can you have multiple staging flows (i.e. define the system staging process based on admission program/service type (e.g. client enrolled in the on-campus schooling program))?
   iii. Does the system have the ability to auto-set status levels (e.g. Open, Pending, Completed, Cancelled, Closed) based on pre-determined criteria of the web-forms? If yes, can a designated web-form become non-active or a stage on-hold if a status is Pending or Cancelled?
   iv. Does it manage the staging/process of billing services (i.e. claims and reporting encounters, track/query/correct/resubmit claims) for each payor?
e. Does the system have the ability to enter & track an outside provider registry (e.g. medical centers, hospitals, eye-doctors, dental clinics, dermatologist, etc.) when a client is referred to an outside provider for services? If yes, explain the capabilities and how it is tracked and listed in the client’s record.

f. Is there a summary profile page of the client (at a glance) with summary demographics, client picture (ability to upload a photo), completed clinical type documents, medication summary?
    i. Does it have the ability to add 'Warning' notes on the client's record profile page?
    ii. Does it have the ability to flag a record if documents are out of compliance?
    iii. Does it have the ability to associate siblings on each client's record profile page?

g. Describe the collection of vital signs, BMI, child (male/female) growth charts/charting, allergies (i.e. medications, herbs, foods, animals, pollen, etc.), immunization, estimated calorie requirements, and medical conditions of how, where (e.g. medical demographic web-form within the process), AIMS (Abnormal Involuntary Movement Scale), and continuous measurements.
    i. Is BMI & growth charting automated in displaying, calculating, plotting (average, collected data, percentiles) and giving instructional data/criteria?
    ii. Does the web-form display a summary of previous/over-time collected measurements/outcomes? Is there a limitation of duration (e.g. one-year) or number of chart comparisons?
    iii. Can you set warning triggers for the user if measurements are out-of-range and/or below/above a threshold (e.g. prompt warning if BMI calculated for obesity by age and/or gender weight and/or weight changes of 5%, 7%, or 10% in a month (plus prompting the user to collect if the child is exercising and if so how often & type); prompts warning if blood pressure is over 140/90)?
    iv. Does the system provide an Estimated Calorie Requirements chart to estimate amounts of calories needed to maintain energy balance for various gender and age groups levels of physical activity (i.e. gender, age, sedentary, moderately active, active, and reference-sized)?
    v. Does the system provide a body graphic to indicate injury and/or conditional locations?
    vi. Does the system provide the ability to generate immunization records for clients and calculate immunization rate for age groups?
    vii. Does the system produce VAERS (Vaccine Adverse Event Report System)?

h. Detail how your software solution supports scanning & document management capabilities. Include steps on how scanned documents (and other document formatted files (i.e. Word, Excel, JPG, and PDF)) are attached to a client's record. Describe the document management structure (e.g. tree-structure (folders, sub-folders, doc-type), auto-populating fields, user profile stamp (date/time), printing individual document & document grouping/record batch, etc.) Provide scanner device type information & models (e.g. Canon, Fujitsu, HP, etc.).
    i. Can you scan directly within a client's record under the document management structure or need to scan to the user/network drive and upload?
    ii. What is the upload size allowed per file (e.g. 5MB) to a client's record?

i. If your solution offers electronic signature capability, provide device type information & models (e.g. Topaz).
    i. Does the system supports multiple Electronic signatures by multiple staff members at different instances on a web form (e.g. Plan of Care)? If yes, if an edit change occurred on the web-form, does the system create

a new version of the changes(s) and new electronic signatures need to be re-applied by each signor? Can signature routing be conducted?

ii. Does the system support a summary/feature display (e.g. flag) showing the user of missing signatures needed to complete the sign-off?

iii. Can Childhelp add such devices to the software solution without the vendor's assistance?

j. Describe administrator account & self-administered site management capabilities (e.g. username/password creation & profile management (i.e. site, provider), login history & audit logs, adding/editing/disabling drop-down table values, data collection, reporting, analytics, roles-based/permission-based access, site administration)

i. Can the administrator customize content and set specific formatting of the home/front page?

ii. Software has a self-administration home page (e.g. HTML editor) to post information/notices for users to see (e.g. system will be down for scheduled maintenance, new in-house procedures/instructions, new added features, etc.)?

iii. Does the contractor provide custom branding of the site header (e.g. Childhelp logo, site application name)?

iv. Security model supports Roles-based? Please provide details.

v. Security model supports Permissions-based? Please provide details (i.e. levels, fields, etc.)

vi. System supports and requires strong passwords & does not transmit user identification or passwords in clear text?

vii. System has the ability to configure security features:

- Password change duration policy?
- User lockouts?
- Maximum consecutive invalid login attempts?
- Automatic log-off for no activity timeout?

viii. Authorized administrators to assign restrictions or privileges to users/groups, and emergency access?

ix. Describe user setup and reassigning of a user.

- If a user is disabled, is history records integrity still intact?
- If a user name has changed, can you change the user profile to reflect the new name and keep all the same settings including assigned tasks, roles/permissions, queuing, etc.?

x. System has the ability to allow authorized entities (i.e. auditors) read-only access to data (e.g. granting access to certain client records) according to agreed uses?

xi. System supports an ability to acquire a new password if the user has forgotten their password (e.g. prompting security question & user ID)?

xii. Does the provider profile setup have the ability to manage name/address/phone, start/end dates, provider types (e.g. agency, agency other locations/sites, contractors, etc.), Federal/State/Local IDs, NPI, billing IDs, taxonomy, activation/deactivation of the provider/agency, and licensure/licensing? If no, please explain how your system manages the provider/agency profile/setup.

xiii. Can you add multiple license/credential types (e.g. BHT, Art Therapist, BHPP) to an individual?

xiv. Can you setup license groups as designated staff credentials based on billing rates (e.g. M.D, N.P., LMSW, etc.)?

xv. Does the system have the ability to track staff training, credentials, certifications & re-certification, license & re-licensing numbers & dates, and EMUs? If yes, explain details.

k. Describe if the system provides relevant evidence-based information and knowledge to the point of care for use in clinical decisions and care planning/episode of care (program participation as displayed in service utilization records generated by the system).

l. Describe how the application manages duplicate client records.
   i. Can you merger client records? If yes, please explain the process.
   ii. Can you determine which web-forms are kept from one client record over the other (i.e. primary, secondary)?
   iii. Can you delete or expunge a client's record? Are deleted records erased from the database or disabled to access?

m. Describe the workflow engine & functionality of your solution (e.g. model-driven, rules-based, version control, GUI).
   i. System provides the capability for the administrator to configure the workflow processes (serial/parallel) conditionally, escalation rule, such as triggers (notifications/alerts/warnings/reminders/emails) by transaction events, & tasks to individuals and groups? There is a need for the following event services:
      - A date trigger for renewal of licensing of clinical & medical staff set in advance so that there is no lost in revenue for a lapsed license.
      - A date trigger for re-assessments due (i.e. 6-months from the original assessment)
      - A notification request for Continued Stay Authorization (triggered 10-days prior to the last day of the previous authorization) if not already entered in the system.
      - A notification to the Program Manager (user) of a client discharged.
      - A notification if a diagnosis has changed on the admissions form. Is there an identifying (e.g. flag) scheme to display at a glace of this change?
      - An alert notification to the administrator & Director (users) of an emergency login into the system.
   ii. System workflow provides load-balancing configuration, random progress note selection approval, & re-assignments (including date ranges due to vacation/out-sick)?
   iii. System workflow has a cycle-time/tracking process output to determine duration and/or completed nodes/activities of the process flow at present?
   iv. System workflow has a user queuing display with filtering capabilities to track & manage tasks to guarantee that each task is carried out and completed and give outcomes/comments on the given task?
   v. Ability to name a workflow process and actions?
   vi. Ability to conduct a simulation run when establishing a new flow/template (i.e. verify no broken nodes within chain of the flow)?
   vii. Can you establish workflow tasks with hyper-link options (i.e. ability to open a client's record or web-form in another screen window without leaving the workflow queue, ability open an attachment)?
   viii. If a task is within a group queue and the 1st user opens the task, is it then assigned to that user and the task is removed from the group queue?
   ix. Ability to open a closed/completed/archived process to view the cycle, outcomes, auditing?

x. Ability to distinguish the type of workflow task, commands & process (e.g. system generated process, user process)?
xi. Administrator has the ability to set access capability for a supervisor/manager to view/manage their users under them?
xii. Can you set cycle trigger notifications to verify missing uploaded/scanned documents (i.e. consent forms), web-form completion (e.g., re-assessment 6-month cycle)?

n. Describe the report-writing tool capability including, exporting (file types (e.g. xls, cvs)); compatibility with other applications; report formatting & sorting; tables/fields selection; conditions (i.e., <, >=, and/or, multi-level condition tiers, etc.); ability to post report for specific users & group access with report name title; ability to create graphs or charts; and data-warehouse & data mining capabilities. Explain the comprehensive & ease of use, and allowing reporting on all data elements in the system. Describe if using a 3rd party reporting tool (e.g., Crystal Reports).
    i. When running an ad-hoc report, is it executed real-time or sent to the vendor's queuing/batching process to run? If vendor's queuing/batching process, what is the turnaround time?
    ii. Propose how to address supporting on-line real-time analytics of production data and not having it affect production performance.
    iii. Is there any part of the application database that cannot be queried to view the data and produce ad-hoc reports? If yes, explain.
o. Describe the system ability to capture, store, display, and report Appointment Scheduling.
    i. Does it display as a calendar mode (e.g. day/week/month) and color coding identities (e.g. event type, users/staff)?
    ii. Does the appointment collect the following data: Date, Time, Duration, Client Name & ID, User/Staff, Location (address/building/room), Event/Appointment Type, Program, Appointment Status, Materials/Equipment Needed, Interpreter (list of languages), Distinct Warning Flag with Comments, General Comments?
    iii. Can you include multiple attendees to the appointment (i.e. non-clients, group of clients, multiple staff members)?
    iv. Can you search and/or filter categories (i.e. by user/staff, by event/appointment type, by client ID) on the calendar view and print?
    v. Can you set permission right access to view & schedule appointments to certain users calendar (i.e. supervisors, front desk administrator)?
    vi. Ability to set block-out dates/times for user/staff members (e.g. on vacation, holidays, out-of-the-office)? And conduct appointment holds for a specific duration?
    vii. Does the client appointments log into the client's record and give the action type (i.e. open, no-show, client cancelled less than 24-hours, client cancelled greater than 24-hours, staff cancelled, rescheduled, completed) of the appointment and keeping a history? Are there reason codes/comments for rescheduling?
    viii. Ability to do re-occurring appointments (e.g. scheduled every two-weeks, every month on 1st Tuesday) with a duration?
    ix. Detect overlapping & duplicate appointments with pop-up warnings (ability to override or reject): by client, by user/staff, room location?
    x. Ability to open client's record (e.g. ISP in separate menu or screen) while scheduling an appointment?
    xi. Ability to schedule notification reminders (e.g. user queuing, email, text)? And ability to print reminder cards?
    xii. Ability to notify users/staff if appointment is cancelled or rescheduled?

xiii. Ability to allow client to be active in multiple programs simultaneously?
xiv. Ability to set designated data elements required fields through data entry?
xv. Ability to pass appointments to MS Outlook and/or syncing of smartphones? If yes, explain the process and functionality (i.e. updating frequency, how far forward of scheduling a re-occurrence appointment, automatic or manually conducted updating)

p. Describe web-form data history and version change control.
   i. Can you refer back to a version to view & print?
   ii. When data has been edited on a web-form what is your process of receiving older versions?
   iii. What is included (e.g. date/time/action stamp, user, identified field changes) in an older version (e.g. data, snap-shot view)?
q. Describe the integrated e-Prescribing component in capturing, storing, displaying, and reporting (i.e. administering & dispensing medications, prescribed by, dosage, pills, start date, discontinue date, etc.).
   i. Ability to document dispensing of all pharmaceuticals?
   ii. Include a medication electronic administration record (eMAR) to ensure that all medications are administered correctly to the right children in care?
   iii. Using computer-based order entry (CPOE) for medication orders?
   iv. Includes side effect tracking, drug-drug and drug-allegory interaction checks/warnings?
   v. Includes medication duplication alerts?
   vi. Generate and transmit permissible prescriptions electronically (eRX) and/or faxes to external pharmacies?
   vii. Maintain active/inactive medication list?
   viii. Tracking reports of prescription refills?
   ix. Ability to document changes in medication and rationale?
   x. Provide a way to indicate if medications/treatments are missed and reason? Provide configurable alerts of specific medications are left?
   xi. Provide a printable schedule of daily medications/treatments?
   xii. Generate client education information and other documentation as specified?
   xiii. Includes drug-formulary checks/management (Virginia)?
   xiv. Is the e-Prescription, Surescripts compliance?
r. Describe the ability to capture, store, display, and report lab tests tracking (i.e. lab name/address/phone, order date, date received, lab results, date reviewed, etc.)
s. Describe Electronic Medication Management of your solution. The RTF provides medication management on an on-going bases and this must be part of the client's record. The RTF is also required to have shift records so that each client can have a note documented on any given shift as well as a note for the entire shift cycle, where some clients are administer medication during a shift. It may be in the form of an alert to staff or a log that is maintained for all shifts.
t. Describe the ability to capture, store, display, and report Communicable Diseases (i.e., no known communicable disease, when treated, where treated, was it reported to the local health department). Ability to list of Local Health Department Communicable Diseases for Virginia?
u. Describe your Bed Management capabilities. The system should support the ability to search for available beds or slots (for residential facilities, and day programs), admitting to open beds and managing census. Ideally, it would also support tracking when beds become available (i.e. by gender & age, expected

date), require housekeeping or medical device set-ups, or other requirements before child placement can occur.

v. Describe the solution's electronic dashboard functionalities and capabilities.
    i. Does it support dynamic real-time updating?
    ii. Can you setup multiple display pages for different levels of the organization (e.g. clinical, administration, corporate)?
    iii. Can you do click-on drill-down/breakdowns of the graph/chart and total outputs?
    iv. Is the dashboard a GUI setup (i.e. setting up templates, choosing elements, setting indicators, grouping/categories, color selections, titles, counters, graphs/charts/objects styles)?
    v. Can you print the dashboard pages?
    vi. Do you provide typical templates/layouts (e.g. demographic populations, referrals into admissions/intakes, aging)?

w. Describe the ability of your Group Progress Note setup & flow (i.e. creating a client group list, identifying attributes (e.g. location, date of service, staff, time in/out, general topic), billing codes, simultaneously separating individualize client note and become part of the individual record, Needs/Rating of Progress/Action Steps)
    i. Based on the billing service code(s), does the system check the license credential(s) of the user/staff before it saves the progress note/group note to verify if user/staff can perform that service?
    ii. Does the application allow back dating notes once the client has a discharge summary? If yes, is it configurable to set a date duration (e.g. 10-days) process past the discharge date?

x. List extensive library of canned reports with descriptions.
    i. Can you run reports or report batches at scheduled times?
    ii. Capable of creating reports for continuous quality improvement & quality assurance efforts?
    iii. Is there a service utilization and billing information report included in your canned report offering?
    iv. Are there utilization review summary reports to track/count interventions and sessions based on date ranges?
    v. Is there a canned report to run billing by category, such as by client (e.g. last name, payer source), by aging, and by clinician?
    vi. Are running the canned reports in real-time generation or do you need to submit a request to a vendor to run on their behalf?

y. Describe the contract management functionality (i.e. payor profile (e.g. organization/insurance type, addresses, phone numbers, contacts, submission/payor IDs), license groups, creating/managing billing codes (e.g. description, type of unit (e.g. daily, 15-minute increments, time-based), code groups), POS, MOD1/2/3, active/inactive, rate, maximum units allowed (e.g. daily, monthly), default units, term duration, instructional payor rules/requirements (e.g. eligibility rules, prior authorization requests & re-authorizations, co-insurance procedures, co-pay collections, usual & customary (UCR)), history changes, etc.)
    i. Can you take an existing payor contract and copy it for a new contract setup? Can you take an existing license group and copy it for a new license group under a different payor contract?
    ii. Does the system have the ability to add multiple credentials and cross reference credentials for 3rd party billing?
    iii. Can you establish maximum units override (e.g. some payors may pay a different amount of units than the billing code maximum)?
    iv. Can you suspend a billing rate from actually billing?

z. Describe the HIPAA X.12 EDI capabilities - file generation types (i.e. 837i, 837p, 835, 276, 270/271, 997, 275, etc.), application file generation & submission process (e.g. 3rd-party clearinghouse portal, pre-flight features & error checks, status completion bar/estimated duration), security connection capabilities (e.g. SFTP, HTTPS, etc.).
    i. Based on Exhibit 4, identify which payor(s) your EDI component does process/certified to that accepts X.12 HIPAA EDI files.
    ii. Does your HIPAA X.12 support HL7 outputs and Consolidated CDA?
    iii. If a payor is requiring use of a certified clearinghouse to process EDI file types, are you able to accommodate? If no, please explain your restriction.
    iv. Can you setup an error/denial reason code table/matrix descriptors per payor to elaborate the reason/remarks description message?
    v. Describe file type selection/creation when generating an outgoing file (e.g. 837i) to a payor and an incoming file (i.e. 835) from a payor to process within the application.

aa. Describe the billing and Accounts Receivable functionality (i.e. fully integrated billing, collections and revenue cycle management). Does the software support the following features:
    i. Billable & non-billable services?
    ii. Ability to store, display, and report on the following: date-of-service, diagnosis codes, HCPCS (Healthcare Common Procedure Coding System) & CPT (Current Procedural Terminology) procedure codes & reimbursement rate, program, insurance/funding, amount billed, balance, date of payment, payment amount, adjustments, voids.
        - Identify the type of voids so the user can alert staff that a claim is under research to be possibly fixed & resubmitted (e.g. Void Pending, Void, Void Not Accepted Resend, Void Not Accepted Never Resend, Void Accepted Reverse, Void Accepted Replace, Void Pending Reason).
        - Describe the system claims adjustment setup/process.
    iii. Does the system automatically create claims and service encounters from approved progress notes? If not, please describe the process/steps in creating a claim for submission.
    iv. Support editing & holding of bill generation pending completion of specific (e.g. user-defined) data elements?
    v. Ability to record and bill multiple payors for each client for third-party billing (primary, secondary, tertiary)?
        - Describe the different type of payment accepted transactions (e.g. cash, capitation credit card, check, electronic payment transfer).
    vi. Ability to notify staff if client's insurance lapses or changes?
    vii. Capabilities based upon payer requirements and authorization data to prevent billing of claims that are likely to be rejected for payment (including payer rules to limit a number of particular service that can occur in a time frame, type of services)?
    viii. Supports date-of-service payer data and service authorizations required for billing for clients in care (by fund source, units, sessions, multiple services and/or dollars)?
    ix. Support more complex billing requirements such as billing net charges instead of gross, billing bed days but not ancillary charges, bundling services, rolling-up billing codes, allowing staff to manually edit the final bills/encounter?

x. Supports standard accounts receivable functionality for billing third-party payers, including manually entering EOB remittance advice payment posting, contractual expense write-offs (i.e. reason codes, IDs, non-covered services), bad debt write-off, balance billing, and rebilling?
xi. Supports of posting a client payment as a "payment on account" to a particular claim or series of claims during the time period when the claim or claims are currently billed to another payer (e.g. to a commercial insurance)?
xii. Supports the coding of multiple write-off reasons or codes so that financial staff can better track write-offs and adjustments to the accounts receivable?
xiii. Ability to make adjustments to outstanding bills and reprints?
xiv. Ability to rebill and/or reverse claims function and track partially payments?
xv. Supports billing select payers to a clearinghouse instead of to payers directly?
xvi. Ability to restrict billing of services until appropriate documentation (i.e. progress notes linked to service plan or authorization) is complete?
xvii. Ability to control (by administrator) late progress note entry with audit tracking (e.g. 10-days from date of service)?
xviii. Ability to run a pre-flight billing run without submitting to a payer with filtering capabilities (i.e. date ranges, specific clients, and payer)?
xix. Ability to run a billing claim file run with filtering capabilities (i.e. date ranges, specific clients, payer) to generate transaction sets 837p and 837i file?
xx. Ability to run a claim file on a daily, weekly, or monthly basis, plus allow for numerous billing cycles (e.g. Medicaid, Insurance)?
xxi. Ability to produce a bill batch report to record what bills are being submitted?
xxii. Ability to re-generate output for a specific billing run?
xxiii. Ability to generate (i.e. date ranges, clients) and print billing invoices for specific payors?
xxiv. Ability to use the functional acknowledgement (transaction set 997) to indicate the results of the syntactical analysis of the electronically encoded document?
xxv. Ability to match & process all remittance (transaction set 835) payments to a specific charges?
xxvi. Is there an ability to maintain a record of past and present insurance coverage with availability dates so past services can be billed without having to change the insurance information?
xxvii. Ability to recode service code and description to comply with the codes and descriptions required by various insurance companies?
xxviii. Software can automatically assign and maintain unique claim ID number for each claim?
xxix. Ability to check for and prevent processing of duplicate claims (e.g. if services were provided with overlapping service dates)?

14. **Other Additional Information** – Describe and answer the following:
    a. Is there a user group for the system that your company is proposing? Please describe.
    b. Does your proposed solution offer a testing environment instance license without additional costs?

c. Is your SaaS application architecture a multi-tenancy or single-tenancy database structure? If multi-tenancy, (1) explain security setup based on a shared database and/or server; (2) explain how Childhelp is affected if any, if another customer is conducting updates/upgrades/patches to their system.
d. Provide a copy of your software EULA, if applicable.
e. Include a description of any products, features or other value-added components available for use with the proposed software solution that have not been specifically requested in this RFP.
f. Does your offering provide the ability to maintain client account detail for at least the minimum retention period of Virginia requirements of twenty-three (23) years (history of minor patients medical service record)?
    i. Does the system provide a method for archiving and retrieving from archive electronic medical record information?
g. Does your solution support authenticate users against an Active Directory?
h. Describe system error messages as well as help screens. Does system error messages state the problem clearly for a user to possibly diagnose the problem?
i. Describe proposed method(s) for interfacing to other systems (i.e. Open API, Web Services, XML, etc.)
j. Describe the level of customization available without a programmer or vendor support.
k. Indicate if you have the ability to securely connect your software to smartphones, tablets, handheld devices or other mobile devices. If so, describe this functionality, reliability, and acceptable performance manner. If not, discuss future plans to incorporate.
    i. If mobile availability (e.g. Android, iPhone, iPad), would the mobile application provide all the stated features and functionality of the application provided in a desktop/laptop version? If not, please explain the differences.
l. Indicate which internet browsers (e.g. Internet Explorer. 9/10 browser, Chrome) and operating systems (i.e. Windows 10, Windows 7, XP, etc.) are compliant with the offered system.
    i. Is the system 64-bit operating system compatible?
m. Please specify what software, if any, must be downloaded from the proposed application to the standard Childhelp Village PC to operate the application (e.g. Java, Active X controls, etc.)
n. Is the Village's PC hardware configuration as illustrated in Exhibit 3 acceptable in utilizing and processing the application data functionalities? If not, please recommend the PC configuration to the extent in utilizing the application by Childhelp.
o. There may be requests in the future to interface with other systems and/or Health Information Exchanges (HIE), please describe your interface features, capabilities, & interoperability, methodology approach, and industry standard(s) (e.g. HL7, XML, CCD, SOAP, Web Services, etc.). Is the data exchanged in a universal transfer of data based on federal standards for data interfaces in the healthcare field?
p. Childhelp has volunteer groups (i.e. Reading Buddies, Special Friends, etc.) involved at the Village to assist/tutor/support the children for activities/programs on-site and off-site. Presently, we track and monitor the number of hours of each activity/program by the volunteer groups. These activities/programs are not and will not be tracked within the child's record. Does your application have the ability to track such volunteer groups/programs/activities? This feature is a nice to have, but not a required requirement. Please provide some details of this feature should your application offer a volunteer tracking setup.

q. Outpatient billing (fee-for-service, capitated, bundled), per diem billing, and grant or contract fund billing, including support for the billing logic of individual payers? Please note, this item is not a requirement for this project, however, other Childhelp facilities may need this feature should the solution is expanded.
r. This item is not a requirement for this project, however if your solution has incorporated a Classroom Management tool or uses a 3rd party component, please describe the following capabilities. This would be an optional component only.
    i. Can you manage & track classes (e.g. semesters), course/subject matters, e-curriculum, codes (i.e. state), teachers, grade levels, schedules, class units/credits, gradebook/sheets & GPA, locations, and classroom capacity?
    ii. Does it track student attendance (i.e. sheet, summary, present/absent/excused/left early/tardy)?
    iii. Can you capture student behaviors and incidents in class? If yes, can you establish interventions & categories?
    iv. Can you produce academic reports? If yes, please describe.
    v. Does it have a course planning feature (i.e. help teachers track the topics)?
    vi. Can you establish standards of learning, testing, and development plan (i.e. literacy)?
    vii. Can you maintain IEPs and special needs in providing a comprehensive view of the student's learning profile & progress?
    viii. Does the tool provide LMS (Learning Management System) capabilities? If yes, please explain.
s. Please identify the availability and utilization of the offered EMR data standards applicable to behavioral health (e.g., SNOMED, LOINC, NDC, RxNORM, ICD-10 (International Classification of Diseases), CPT-4, HCPCS, DSM-V (Diagnostic and Statistical Manual), IDNT (International Dietetics & Nutritional Terminology) & DRG classifications (Diagnosis-Related Group), etc.)
t. If the bidder or any proposed subcontractor has had a contract terminated for default during the past four (4) years, all such instances must be described of the reason/circumstances (e.g. non-performance, poor performance, contract breach, non-allocation of funds), include customer name(s) and address(es).
u. Describe any near future enhancements and/or optional components/modules to the offered system (e.g. predictive analytic modeling (i.e. Big Data, NoSQL), etc.)

15. **Costs** – Childhelp intends to acquire a system and related service that provides Childhelp with the best fit and "best value". This is a firm fixed bid, Childhelp may request from the bidder their final and best offer. The fee(s) will remain firm and will include all charges that may be incurred in fulfilling the requirements of the contract. Contractors are responsible for including all costs for all components, customization/modification, professional services, training, documentation, claims processing, software licenses and support/maintenance. All travel expenses must be included in your final cost. Invoices for payments must be submitted by the contractor to Childhelp with sufficient detail to support payment. The payment schedule for the project is tied to specific deliverables. Invoices may be submitted by the bidder on specific dates based on the completion and acceptance of related deliverables. No invoice will be approved unless the associated deliverables of acceptable quality and content have been approved. Childhelp expects to have the COTS system solution in production for thirty (30) calendar days warranty period after go live with system stable and fully operational prior to making the final implementation payment for the system.

Describe how the cost of your solution is determined (by number of users (concurrent or named), system functionality utilized, claim number/amount, by bundling license & hosting fee, etc.) Also, please provide your policy regarding price increases after the 3rd year of hosting/support/maintenance.

Expected number of user licenses (75 concurrent licenses or 180 name licenses).

The bidder must include a detailed cost proposal supporting any and all costs. These details must include, at a minimum, detailed descriptions and/or specifications of the goods and/or services to be provided, quantities, unit costs, total cost, and optional value-added consideration costs, if applicable.

The bidder can propose additional software, tools and third party software and services (value-added considerations) that it believes will further address the functional requirements described in this RFP. Please identify 'Value-added' as an optional consideration with the associated costs.

The Cost Proposal – Bidder to provide as reflected of the project requirements the following separate line items (all associated expenses need to be inclusive):

The bidder may rearrange/add/modify the Cost Proposal to fit their offering, however it must be a full turnkey solution reflecting the project requirements. Please breakdown as detailed as possible, and avoid bundling major line items. If a line item is included in another line item, identify as 'Included in _____' (respected description), and if a line item is not applicable, identify as 'N/A' in the Price column.

1.0 SYSTEM SOFTWARE		
Description	**Quantities**	**Price**
EMR Software License (based on 75 concurrent licenses or 180 named licenses) Specify product name & version: _____		
Other Software License(s) (e.g. e-Prescription) if necessary. Specify product name(s) & version: _____		
Other 3rd-party Software License(s) (e.g. HIPAA X12 EDI), if necessary. If the HIPAA X12 EDI is based on processing (i.e. number of claims/amount, ERA, by month, etc.), please breakdown appropriately. Specify product name(s) & version: _____		
Custom software development/enhancement, if necessary. Specify: _____		

2.0 IMPLEMENTATION SERVICES		
Description	**Hours**	**Price**
Project Management (i.e. Project Work Plan, Design/Requirements Document, Status Reports/Meetings, Prototype/Pilot Preparation, Acceptance Testing Document/Plan, etc.)		
EMR Software Installation, Setup/Configuration/Integration, etc.		

3rd-party & Other Software Installation, Setup/Configuration/Integration, etc., if necessary Specify: _____		
Product Customizations/Modifications Development, if necessary		
Report Development/Creation		
Testing (i.e., unit/system/stress/security/performance, Acceptance Testing, refinement, etc.)		
Documentation (i.e. user guides) Specify (paper and/or electronic): _____		
Training (end-user, administration) Specify, how many users, where, method: _____		
Go-Live 30-day Warranty Support		

3.0 ON-GOING POST-IMPLEMENTATION HOSTING, SUPPORT & MAINTENANCE		
Description	**Quantities**	**Price**
First Year Post-Implementation Support, Maintenance & Hosting (EMR) Specify support level, paid monthly (1/12) or yearly, calculated by user/claim amount, etc.: _____		
First Year Post-Implementation Support, Maintenance & Hosting (3rd-party & Other software) Specify: _____		
Second Year Post-Implementation Support, Maintenance & Hosting (EMR) Specify support level, paid monthly (1/12) or yearly, calculated by user/claim amount, etc.: _____		
Second Year Post-Implementation Support, Maintenance & Hosting (3rd-party & Other software) Specify: _____		
Third Year Post-Implementation Support, Maintenance & Hosting (EMR) Specify support level, paid monthly (1/12) or yearly, calculated by user/claim amount, etc.: _____		
Third Year Post-Implementation Support, Maintenance & Hosting (3rd-party & Other software) Specify: _____		

4.0 OPTIONAL		
Description	**Quantities/ Hours**	**Price**
Additional End-User Training		

Specify (onsite, remote): _____		
Additional Administrator Training Specify (onsite, remote): _____		
Additional EMR 2-concurrent/5-name user license		
Additional EMR 5-concurrent/10-name user license		
Additional Other 5-user license Specify product name: _____		
Additional Other 10-user license Specify product name: _____		
Additional 3rd-party 5-user license Specify product name: _____		
Additional 3rd-party 10-user license Specify product name: _____		
First Year Post-Implementation Support & Maintenance (EMR) – Higher Support Level, if necessary Specify support level: _____		
Second Year Post-Implementation Support & Maintenance (EMR) – Higher Support Level, if necessary Specify support level: _____		
Third Year Post-Implementation Support & Maintenance (EMR) – Higher Support Level, if necessary Specify support level: _____		
Optional EMR Value-Added Feature/Function/Tool/Module/ Component #1 software license (all-inclusive services, e.g. implementation services, training, etc.), if necessary Specify: _____		
Optional EMR Value-Added Feature/Function/Tool/Module/ Component #2 software license (all-inclusive services, e.g. implementation services, training, etc.), if necessary Specify: _____		
Other Optional Consideration, if necessary Specify: _____		
Optional forms creation to include in EMR based in Exhibit 6		
Estimated cost in developing & setting up an additional web-form as part of the EMR client record (e.g. form is one-page with demographic header and 20 fields (text boxes/checkboxes/calendar control) and e-signature)		
Optional Classroom Management Tool (if available, not a requirement)		

Billing & Payment

The Contractor may present a recommended payment fee schedule for delivered and accepted services. This might be organized as services rendered in conjunction with development, installation, piloting, training, implementation, and go-live production.

Childhelp will negotiate with the Contractor of an acceptable payment fee schedule program. However, Childhelp will not agree to non-rendered up-front payment(s) and complete full payment before the 30-day warranty period. A hold-back payment until final written acceptance by Childhelp of the delivered solution will be encouraged.

Below is an example of a fee payment schedule for this project that is acceptable to Childhelp. If the Contractor does not present a recommended payment schedule in their response, Childhelp will use the below example as the default payment plan.

Contractor will receive compensation for each approved accepted deliverable in accordance with the awarded signed contract as follows:

i. Fifteen percent (15%) of the contracted amount upon delivery and approval of the Design/Requirements Document and Project Work Plan.
ii. Twenty-Five percent (25%) of the contracted amount upon testing & pilot delivery approval to Childhelp.
iii. Fifteen percent (15%) of the contracted amount upon end-user and administration training to Childhelp staff.
iv. Twenty percent (20%) of the contracted amount upon formal, written Final Acceptance of the successful implementation completion of the total system. The system will be formally accepted when the entire software application performs as proposed and successful correction of problems and any deficiencies noted during implementation.
v. Twenty-Five (25%) of the contracted amount upon the 30-day warranty acceptance completion period without any major deficiencies and closeout meeting, plus monthly or yearly post implementation support & maintenance fee.

16. **Appendix** – Include any and all addendums produced by Childhelp (e.g., Q&A, additional clarifications, changes to the RFP). In addition, you may but not required to attach additional company information you feel would be valuable to Childhelp (e.g., marketing collateral, user license terms, annual report, etc.)

H. REJECTION OF PROPOSALS

Childhelp reserves the right to accept in whole or in part the proposals or reject any or all proposal responses received, and at its discretion, may withdraw or amend the Request for Proposal at any time, and to waive any informalities in the evaluation award process, in its sole discretion to be in the best interest to Childhelp.

I. EVALUATION OF PROPOSALS

The Childhelp Evaluation Committee will conduct a comprehensive evaluation of all proposals in accordance with the criteria, but are not limited to the following:

- Technical Approach, Solution Requirements & Support
- Cost
- Company Profile, Stability & Qualifications
- Company References & Oral Interview/Presentation and/or Demonstration
- Misc. – Responses to questions throughout the RFP, Proposal Completion

At the conclusion of the initial evaluation phase, finalist bidders will be selected for detailed review and evaluation, including oral interview/presentation/demonstration if required.

After all qualified proposals that are submitted have been evaluated, Childhelp will negotiate with the Contractor(s) that Childhelp feels has provided the most attractive proposal(s). Once an award decision has been determined, Childhelp will submit a letter either by mail or email to those non-awarded Contractor(s) of the selection.

J. CURRENT ENVIRONMENT

1. Childhelp Alice C. Tyler Property Layout

See Exhibit 2

2. Childhelp Alice C. Tyler PC & Wiring Topology

See Exhibit 3

3. Childhelp Alice C. Tyler Claim Encountering Breakdown

See Exhibit 4

4. CURRENT FORMS/DOCUMENT

Currently, the Alice C. Tyler Village conducts and processes paper forms & documents, listed by functionality. There will be no data conversion for this project. See Exhibit 5 and Exhibit 6 (optional forms) for data collection details.

a. Referral (Initial Screening)(*single instance*)
b. Intake/Admission (*single instance*)
c. Face Sheet (*auto-populate - printout only*)
d. Assessments/Evaluations
    i. Initial Assessment (*completed within 14-dyas from the date of admission*)
    ii. Psychiatric Evaluation *(single instance – completed within 24-hours of admission)*
    iii. Comprehensive Psychosocial Assessment *(single instance)*
    iv. Intake Risk Assessment Tool *(single instance – completed within 24-hours of admission)*
    v. TB Risk Assessment *(multi-instance, conducted annually)*
    vi. Nursing Admission Assessment *(single instance – completed within 24-hours of admission)*
    vii. Recreation Therapy Assessment *(single instance)*
    viii. Educational Assessment *(single instance)*
    ix. Spiritual History & Needs Assessment *(single instance)*
    x. Animal Assisted Therapy Assessment *(single instance – completed within 24-hours of admission)*
    xi. TSCC (Trauma Symptom Checklist for Children) *(single instance)*
    xii. Nutrition Assessment *(single instance)*
    xiii. Art Therapy Assessment (*single instance*)
    xiv. Occupational Therapy Screening/Evaluation *(single instance – if treatment is determined as necessary, a Full OT Evaluation will be completed)*
e. Plans
    i. Initial Plan of Care *(single instance – completed at time of admission)*
    ii. Comprehensive Individual Plan of Care (CIPOC) *(single instance – 14-days post admission and monthly thereafter (28-days))*
    iii. Physical Holding Minimization Plan
f. Progress Notes

i. Milieu 21 Intervention Treatment Notes (*multi-instance - minimum of 21 notes/week to address the goals on the CIPOC; usually complete 4 daily depending upon the school schedule, additional forms may be generated*)
ii. Direct Care Progress Notes *(multi-instance - completed each shift*)
iii. Physical Hold Procedure Form *(multiple instances, as needed, dependent on child's behavior)*
iv. Primary Therapist Progress Notes *(multi-instances - notes to include the following services: 3 individual therapy, crisis intervention, family therapy {with or without child present}, case management, family phone contact & therapy)*
v. Group Therapy Progress Notes *(multi-instance – conducted weekly, may include art therapy, equine therapy, and therapist group therapy (required to have 3-hours weekly)*
vi. Educational Progress Notes *(multi-instance, monthly)*
vii. Occupational Therapy Note *(multi-instance, dependent on the number of sessions prescribed by physician/OT therapist (1-3 times weekly))*
viii. Medication Management Physician Note *(multi-instance – usually weekly but can be more deemed by Psychiatrist)*
ix. Nursing Progress Note *(multi-instance, as needed, dependent upon child's presenting problems – usually has a medical focus)*
x. Bio Logs *(multi-instance, daily per shift)*

g. Other
   i. Medication Management
   ii. Emergency Treatment Team Meeting *(multi-instance, dependent on the child's behavior)*
   iii. Therapeutic Pass Request *(multi-instance, as needed, typically last few months of treatment)*
      - Therapeutic Pass Success Form *(single instance, completed at the end of each therapeutic pass)*
   iv. Physical Examination – Sick & Acute Care *(multi-instance, as needed, based on child's presenting medical issues)*
      - Comprehensive Physical Examination (Commonwealth of VA)
   v. Supervision Screening Tool *(single instance, as needed, dependent upon child's behavior)*
      - Supervision Re-evaluation Screening Tool *(multiple instance, conducted daily until removal from doctor – component of the Supervision Screening Tool)*
      - Acuity Monitoring Sheet *(multi-instance, completed in conjunction with Supervision Screening Tool but only if child is placed on 1:1 supervision)*

h. Invoices (*example resides under 'Current Processes'*)
i. Discharge Summary *(single instance)*

Optional forms – See Exhibit 6 for details

Although our goal is to become a paperless environment as much as possible at the Village, we must consider costs. There are many other current forms collecting data used within the Village, however, to keep costs at a minimum for the EMR project, we have identified the following forms (Exhibit 6) that may optionally be developed or scanned & uploaded to the client's record. Depending if your solution offers a rich featured forms builder capability, these other forms maybe considered through the forms builder.

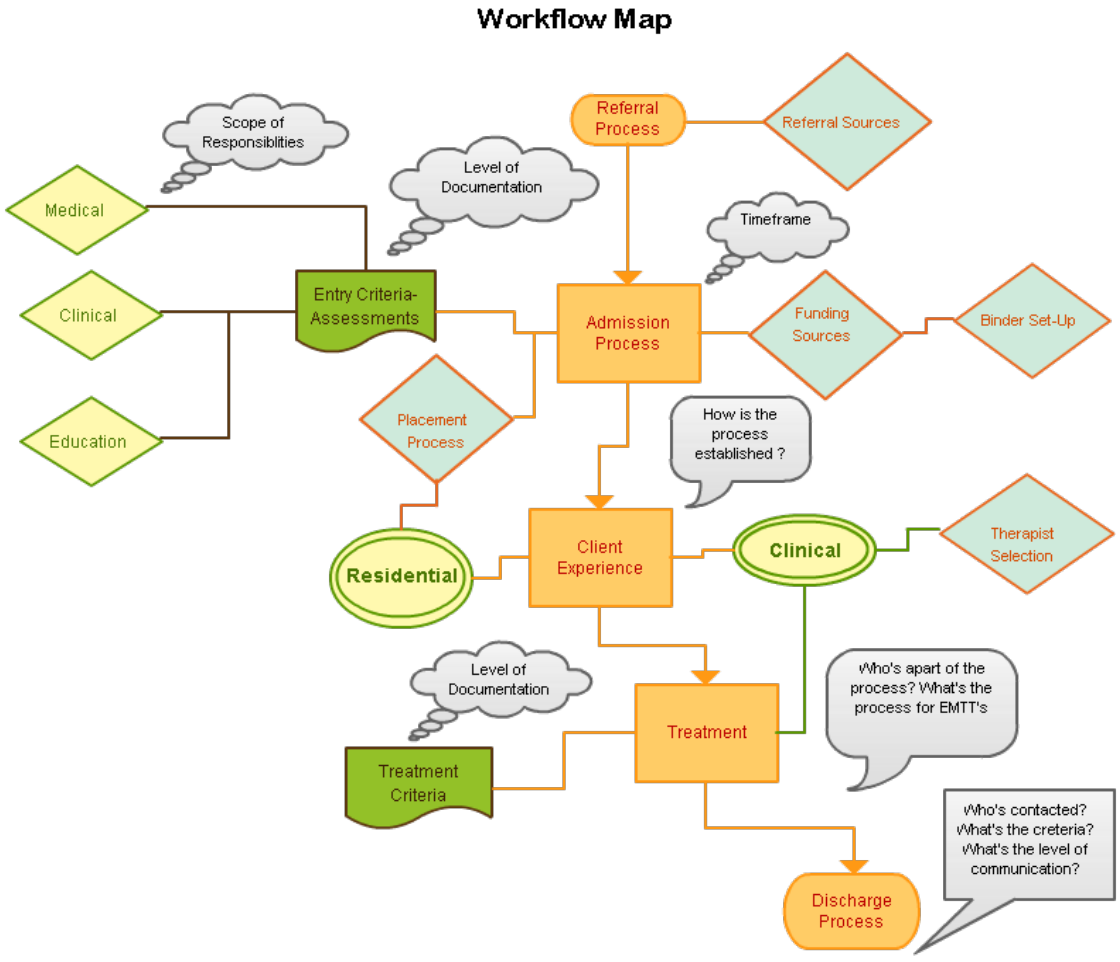
Other documents/forms are collected from external sources and would be scanned into the client's record (e.g. CANS/CanVas, CAFAS, MCM1, ICPC-100A (Interstate Compact on the Placement of Children), Medicaid Insurance Card, etc.)

Sampling of compliance requirement rules:

- It is necessary to complete 21 Group Interventions (excluding individual therapy, school attendance, & family therapy), 3 Individual Psychotherapies, and 2 Group Psychotherapies (maximum of 10 individuals) per week (Sunday through Saturday), and 2 Family Sessions per month (except when the family dysfunction is a reason for admission, then once a month; one face-to-face session; limited to one-unit/day) to fulfill the room & board charges on a monthly billing cycle.
- Maximum allowable and reimbursable therapeutic leave days (absences) is limited to 8 days per calendar year under West Virginia Medicaid. Virginia Medicaid is no more than 18-days of billable therapeutic leave annually.
- CIPOC needs to be completed within 14-days of the Initial Plan of Care and updated every 30-days.
- CANS needs to be uploaded as part of the record at time of admissions and updated within every 90-days.
- Discharge summaries are printed-out and mailed/faxed to guardians/government agencies.

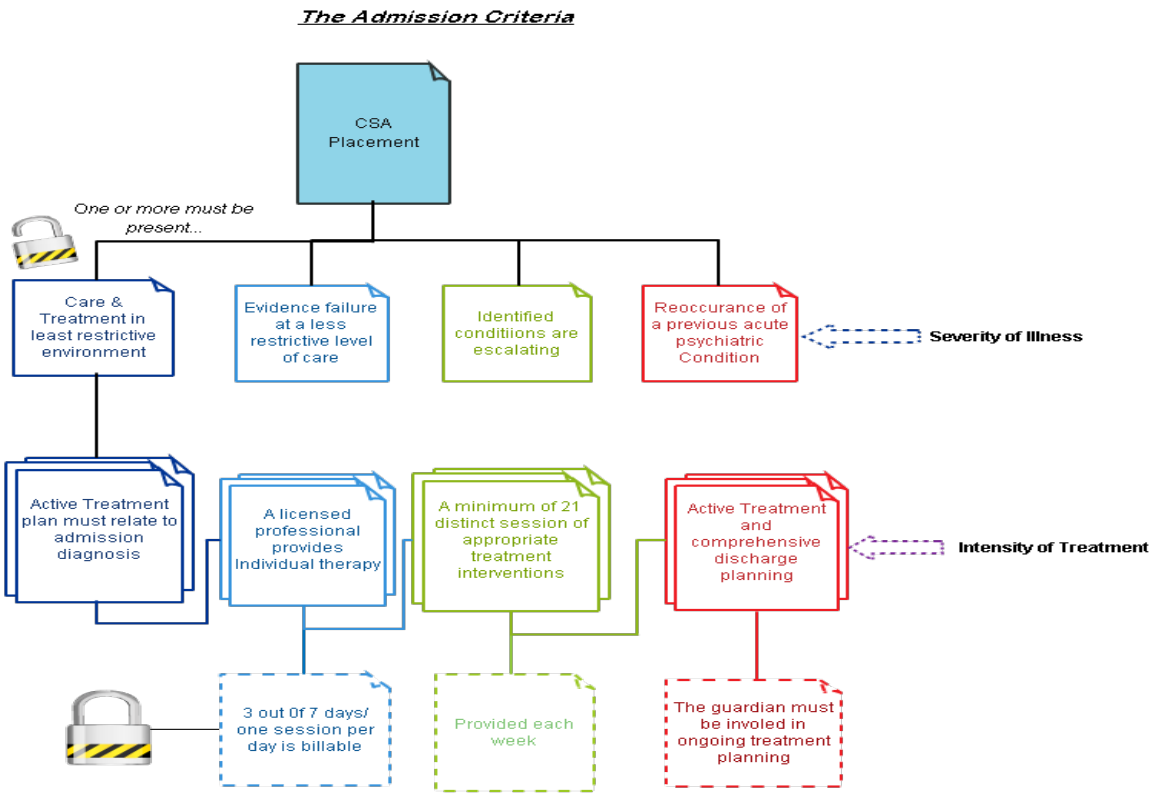
5. CURRENT PROCESSES

Summary Outline - work processes to identify the procedures, timeframes, level of documentation, and personnel that directly impact program activities that are essential to funding and compliance. The intent is to automate processes & tasks where possible within the EMR.

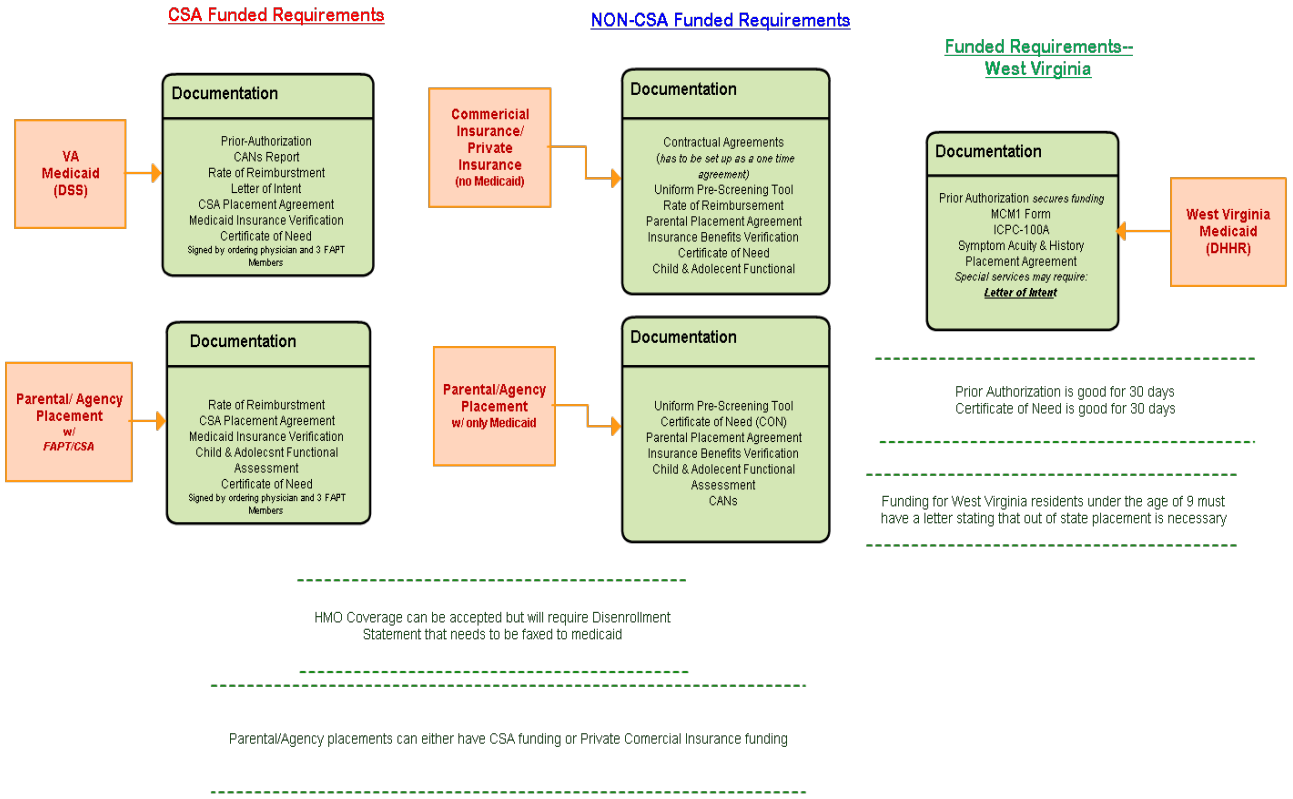


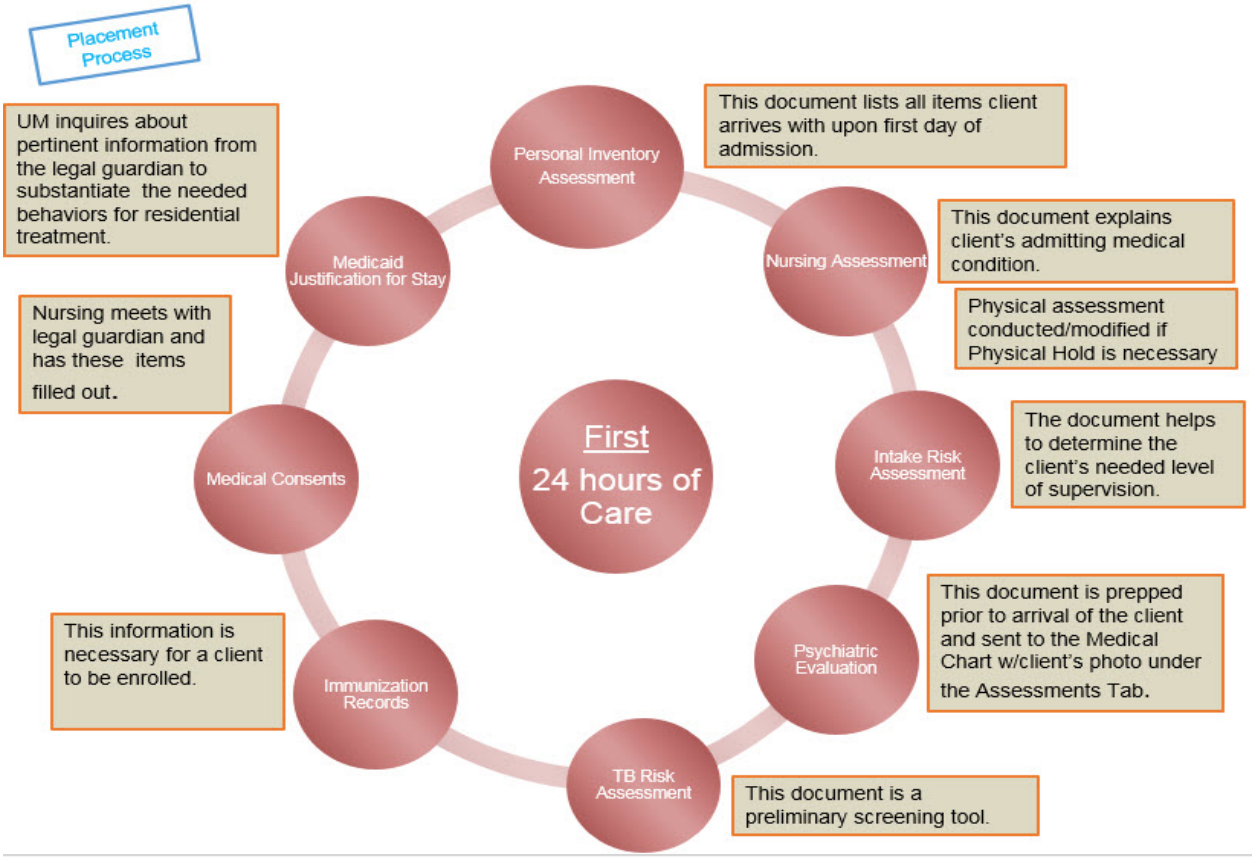
Referral Types

- Agency referrals, i.e. hospitals, treatment centers, etc.
- Department of Health and Human Resources, i.e. WV
- Department of Social Services
- Parental/Private Referrals

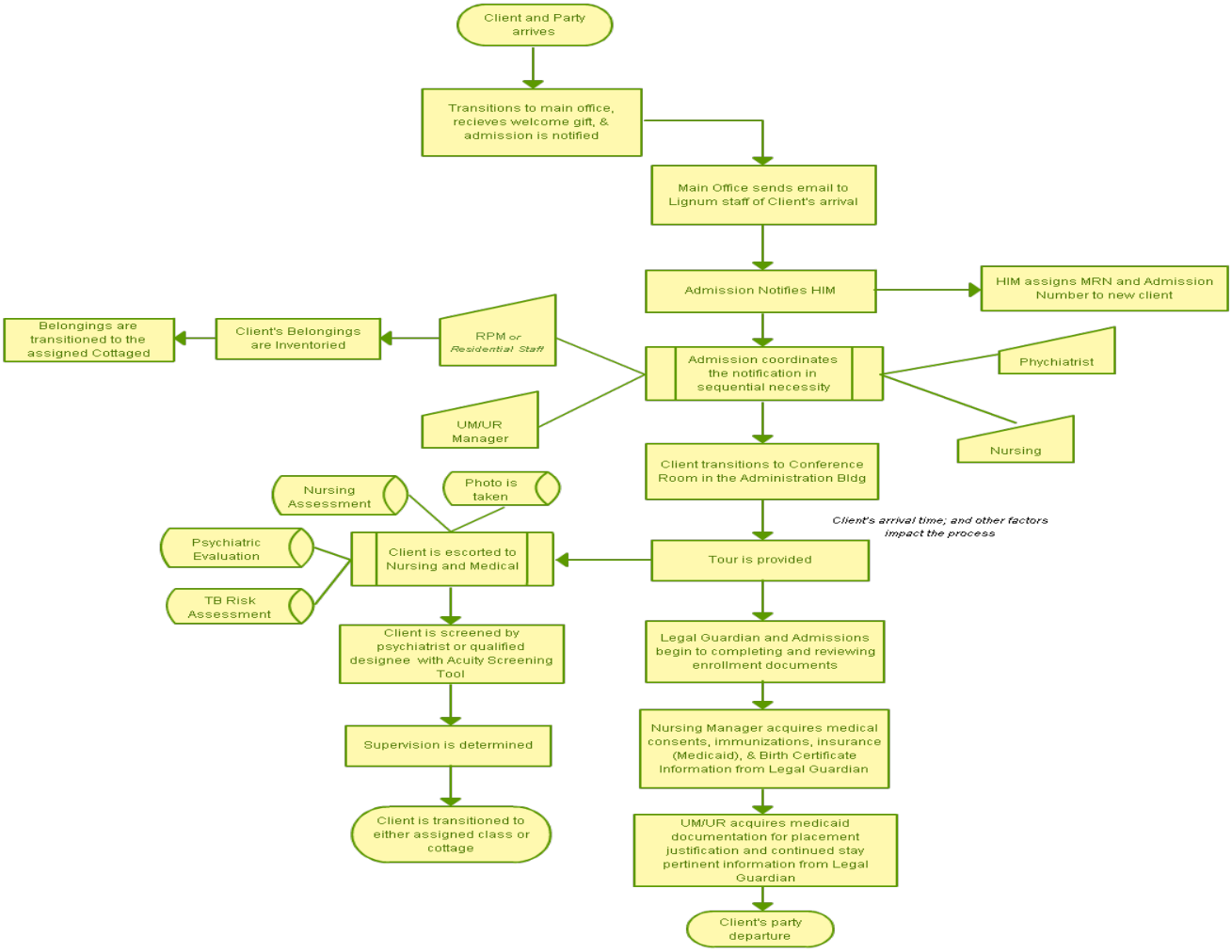


Funding Source Methods - Admissions

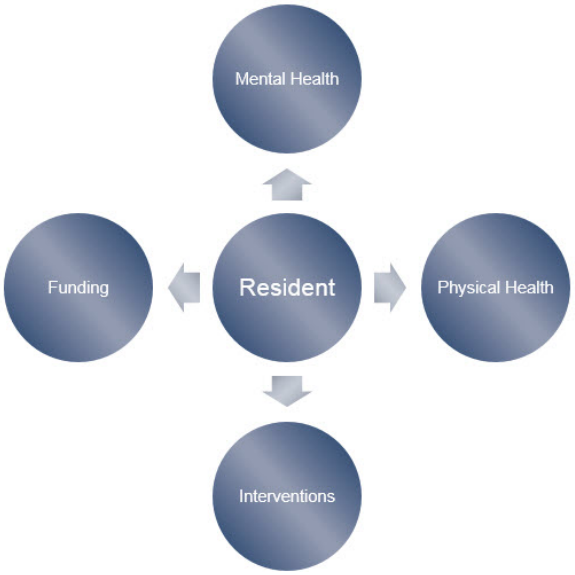



Placement Process
UM inquires about pertinent information from the legal guardian to substantiate the needed behaviors for residential treatment.
Personal Inventory Assessment
This document lists all items client arrives with upon first day of admission.
Nursing Assessment
This document explains client's admitting medical condition.
Physical assessment conducted/modified if Physical Hold is necessary
Intake Risk Assessment
The document helps to determine the client's needed level of supervision.
Psychiatric Evaluation
This document is prepped prior to arrival of the client and sent to the Medical Chart w/client's photo under the Assessments Tab.
TB Risk Assessment
This document is a preliminary screening tool.
Immunization Records
This information is necessary for a client to be enrolled.
Medical Consents
Nursing meets with legal guardian and has these items filled out.
Medicaid Justification for Stay
First
24 hours of Care

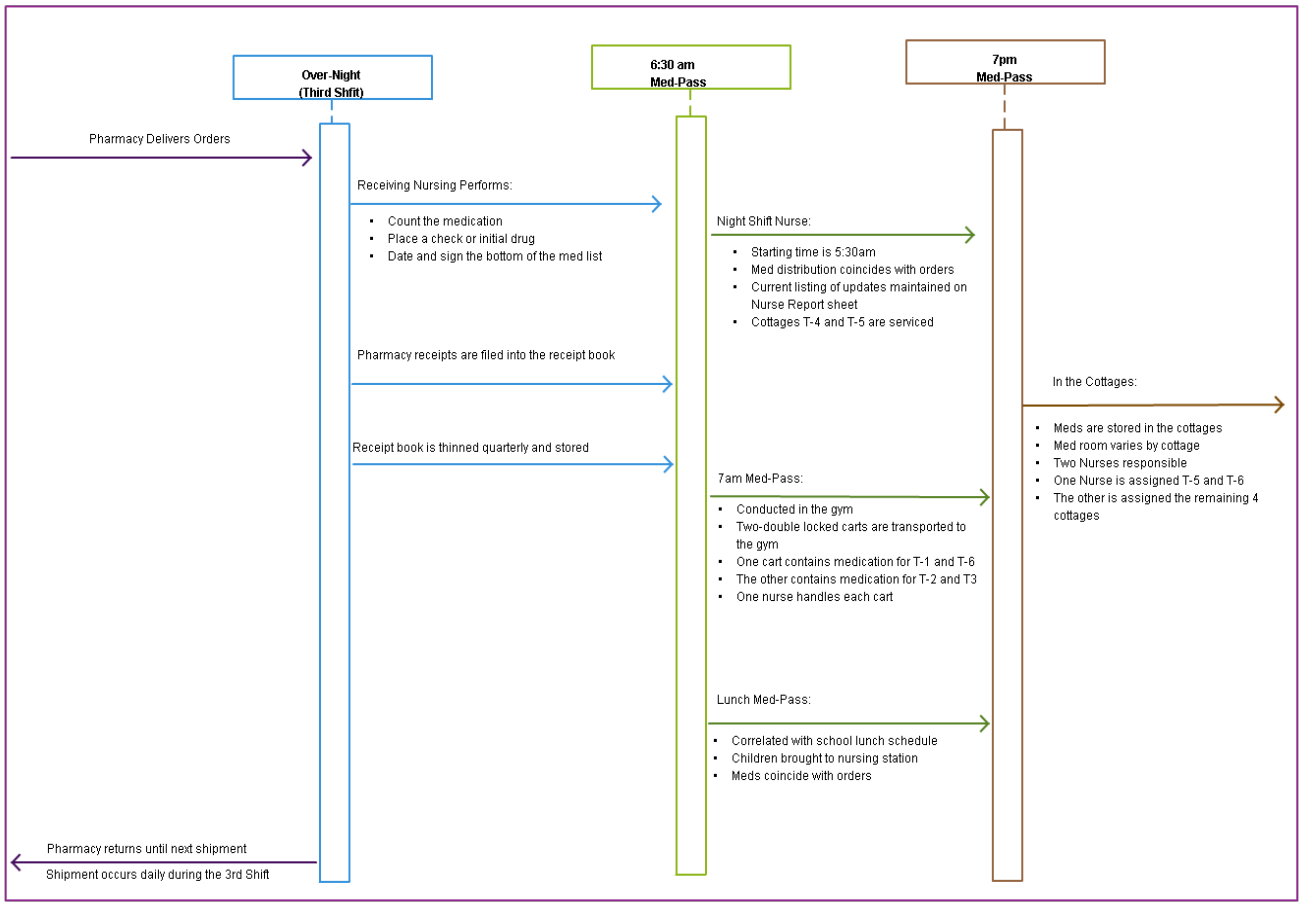
Admission Placement Procedure



Components of Treatment



Medication Management Process



EXAMPLE SCHOOL INVOICE TO A PAYOR

INVOICE

Alice C. Tyler Village of Childhelp-East
23164 Dragoon Road
Lignum, VA. 22726-2036
(540) 399-1570
(540) 399-1805 (fax)

INVOICE DATE: 01/12/16

AGENCY: Harrisonburg/Rockingham
Office Of Comprehensive Services
20 East Gay Street
Harrisonburg VA 22802

Attention:

Recipient Name. *Caseworker:*

BILLING CYCLE: ***Beginning*** 12/01/15 ***Invoice#*** ###### ######
Ending 12/19/15

Services Rendered:	*Rate*	*Billable Days*	*Total per Item*	*P. O. #*
IP DAY SCHOOL	160.00	14.00	2,240.00	
RTC Room & Board County	393.50	18.00	7,083.00	
Speech Therapy-SCHOOL ONLY	60.00	1.00	60.00	

*****TOTAL DUE FOR THIS INVOICE**** 9,383.00

Please remit payment to: ***Childhelp, Inc. Philadelphia***
P.O. Box 782378
Philadelphia, PA 19178-2378

Prepared by: 01/12/16

Billing/Collections Manager
bwhite@childhelp.org

VA Tax Payor I.D. # 95-2884608

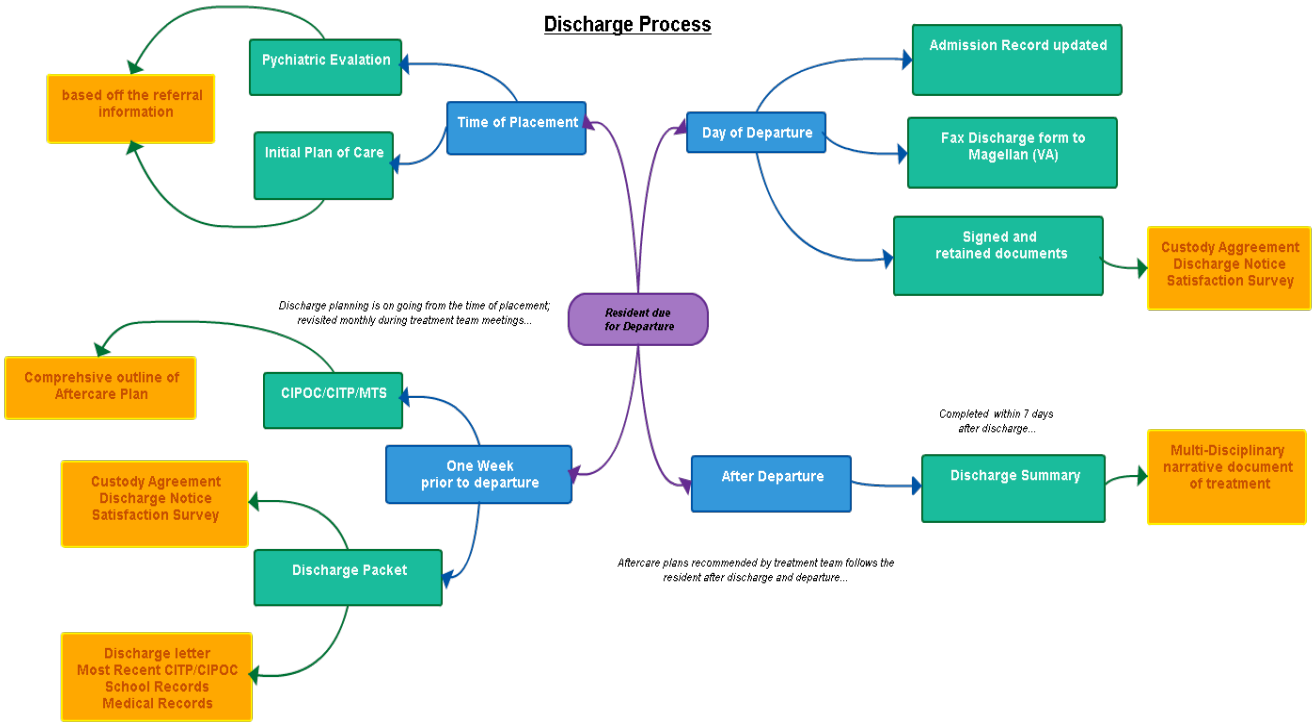

Discharge Process
Pychiatric Evalation
based off the referral information
Time of Placement
Initial Plan of Care
Admission Record updated
Day of Departure
Fax Discharge form to Magellan (VA)
Signed and retained documents
Custody Aggreement
Discharge Notice
Satisfaction Survey
Discharge planning is on going from the time of placement; revisited monthly during treatment team meetings...
Resident due for Departure
Comprehsive outline of Aftercare Plan
CIPOC/CITP/MTS
One Week prior to departure
Custody Agreement
Discharge Notice
Satisfaction Survey
Discharge Packet
Discharge letter
Most Recent CITP/CIPOC
School Records
Medical Records
Completed within 7 days after discharge...
After Departure
Discharge Summary
Multi-Disciplinary narrative document of treatment
Aftercare plans recommended by treatment team follows the resident after discharge and departure...

Exhibit 1 - Functional/Technical Requirements

Please check under the appropriate column for each specification. If a requirement response based on implementation through a third-party software, please list the manufacturer in the Comment column.

X = this is an out of the box standard feature.
T = Implemented through third-party software.
C = Customization of core software developed as part of the implementation
A = Available in future version
N/A = Not available
Comments = Any explanation needed

#	Question	X	T	C	A	N/A	Comments
1	System offers an integrated HIPAA ANSI X12N 5010 EDI function, including 837i/837p, 835, 270/271, 997, etc. transactions						
2	System has the ability to view and print UB-04 institutional claims (by selected individuals & by batch)						
3	System offers an integrated scheduling function						
4	System offers an integrated e-Prescribing solution that qualifies for current Medicaid requirements in Virginia						
5	System offers reporting functionality to include ad-hoc report writing tool						
6	System must be HIPAA compliant						
7	System is EMR certified by ONC (Stage 2 and Stage 3 meaningful use)						Provide certification number & the name of your Authorized Certification & Testing Body (ACTB)
8	System FERPA (Family Education Rights & Privacy Act) compliant						
9	System provides a Referral & Admissions functionality						
10	System provides a Psychiatry & Nursing Service functionality						
11	System provides Residential functionality						
12	System provides a Classroom Management functionality						
13	Ability to record chart vital signs (i.e. height, weight, blood pressure, calculate & display BMI, plot & display growth charts for children, automated measure calculation) and AIMS (Abnormal Involuntary Movement Scale)						
14	Ability to capture, store, display, and report on Immunization data (i.e. date of service, history, type of vaccine(s), rote of vaccine, statement date, age calculation, determine when due in series, overdue alerts, ICD Diagnosis, CPT procedure codes, maintaining/managing waivers, last tetanus shot)						

15	Ability to capture, store, display, and report the following dental data (i.e. service date, purpose of visit, provider, dental diagnosis, dental procedures, tooth number/surface, units, etc.)						
16	System has the ability to scan paper documents into the clients record with assigned parameters attributes (i.e. folder, sub-folder, doc-type, description)						
17	System has a forms library that acts as a foundation for documents/forms and stores such information and updates (managed by the administrator, i.e. PDF, Word, Excel) to access for users to print and/or fill-out (e.g., consent forms, supporting documents)						
18	System provides for a customizable workflow configuration						
19	System supports Electronic signatures by signature-pads & by user profile loaded signature stamp						
20	Forms builder/designer capability (i.e. ability to create, customize/configure/view/record forms, fields, layouts/styles, etc.)						Describe how end users (versus the vendor) are able to customize/build web forms-based inherited to the application within the electronic record. Explain functionality (e.g. setting values & function controls, class wizard methods, adding printing support, message handlers, etc.)
21	Ability to log personal items inventory in client's record (i.e. date, item description, quantity, storage location/bin, item released, etc.)?						
22	Software has the ability to log & track record of disclosure e.g. authorization to release information (i.e., requested by, to whom, when, type of information, type of release, disclosure made by (e.g. phone, email), signed authorization consent) on a client's record						
23	Software supports bed assignment & management						
24	Data import/export capabilities						Provide available formats (e.g. ASCII, delimited, HL7, EBCDIC, xls, CVS)
25	Dashboard capabilities (i.e., setup graphs, indicators, output measurements)						

Exhibit 2 – Property Layout

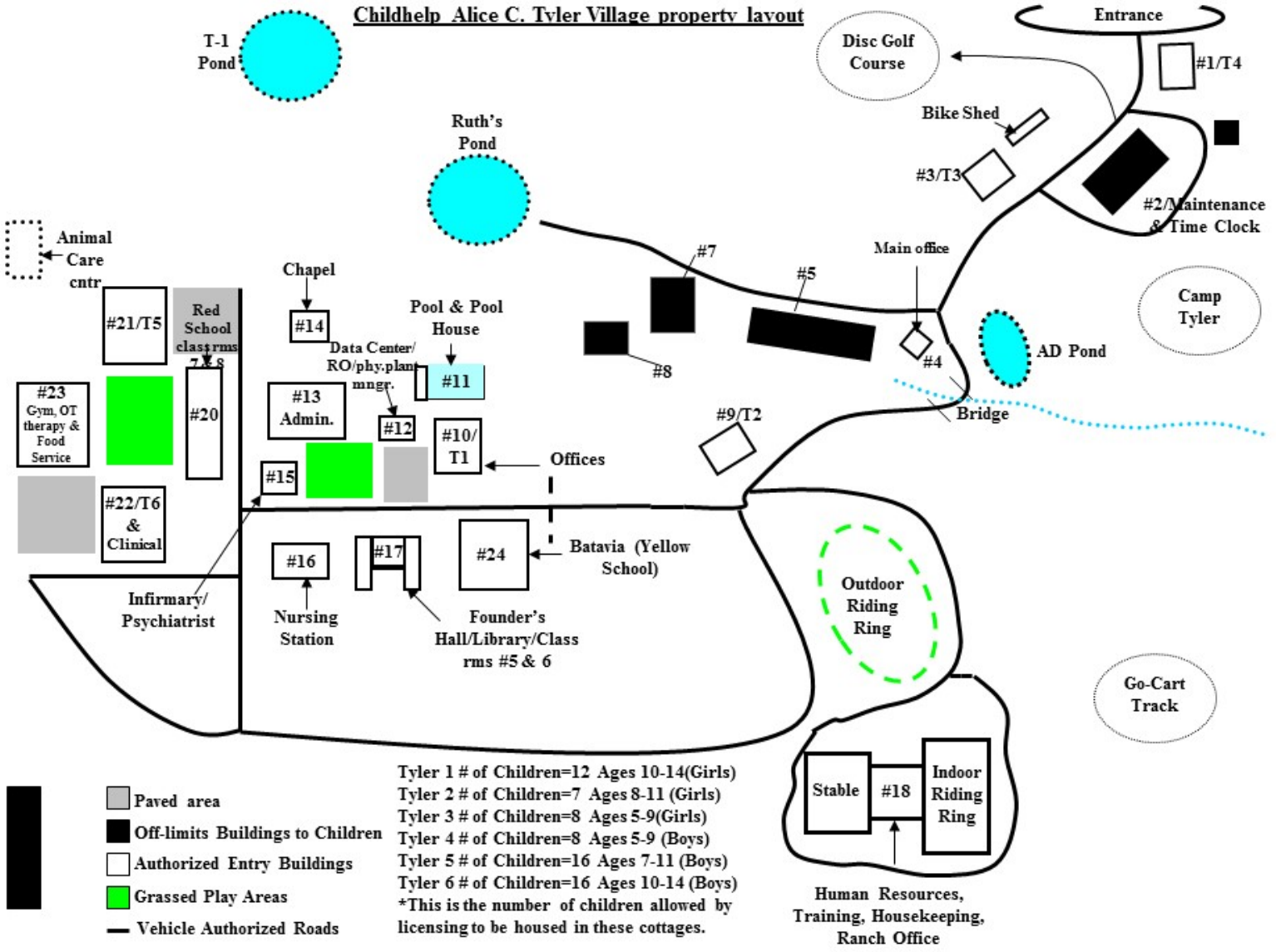
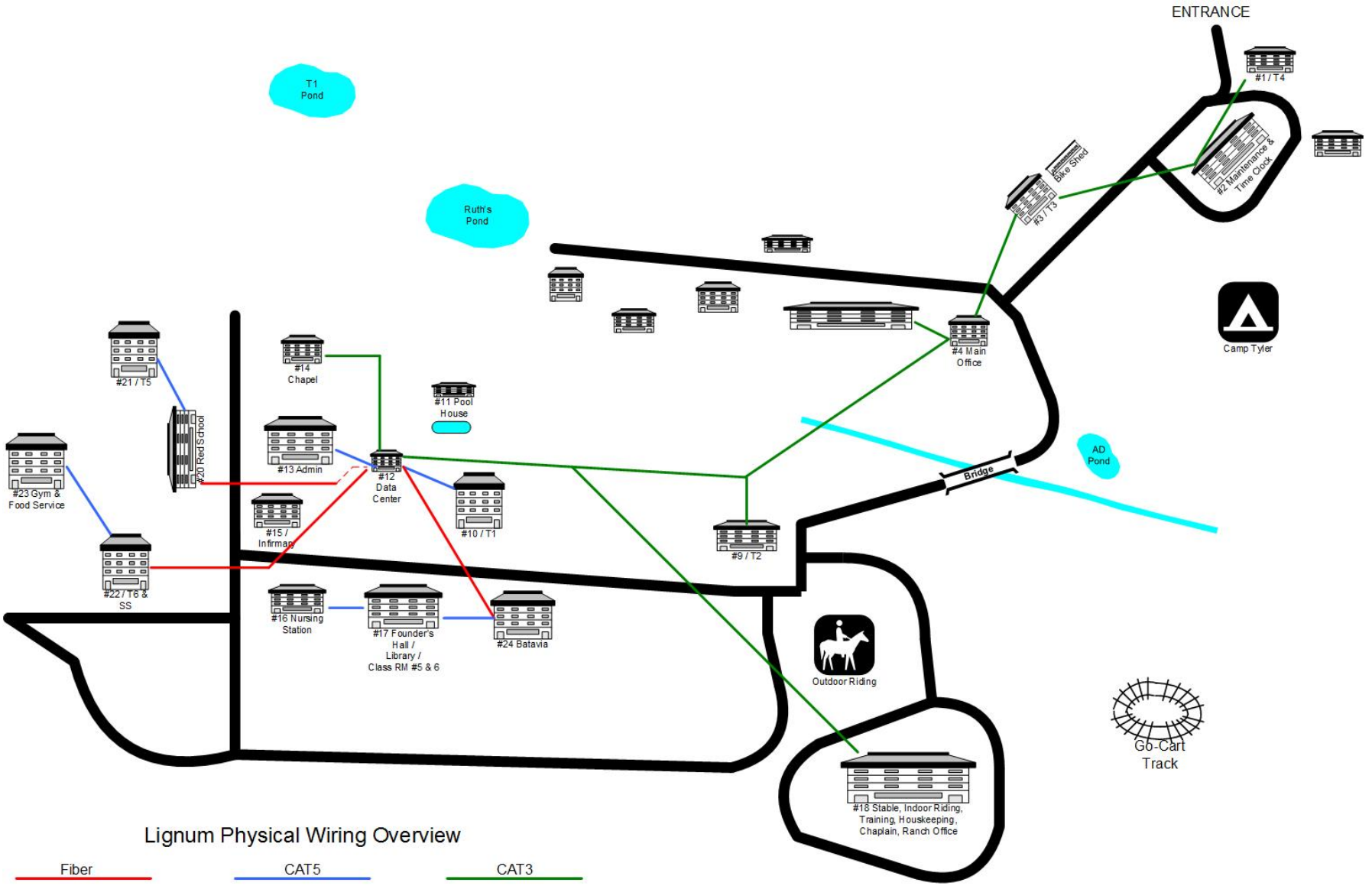


Exhibit 3 – Wiring/PC Overview



The site currently has a 4.5mbs Internet link that is shared with everyone at the location. This is being upgraded to 20mbs by April 2016. This connection comes into the admin building via bonded T1 lines. Each location that is connected via fiber has a 1gbit connection to the admin building that is shared by

computers residing in its building and beyond in that chain. For example in the diagram T5 and Red School would be sharing a 1gbit link to the admin building. Each connection that is connected via CAT5 has 100mbs connection to the admin building. This 100mbs connection is shared by computers residing in its building and beyond in that chain. Areas connected with CAT3 connections range between 3mbs – 20mbs depending on range to the admin building. Each PCs has its own LRE (long range Ethernet) device for the majority of locations. This provides a dedicated connection for those PCs back to the admin building.

The current Village campus Personal Computers are HP 280 G1 Microtower Business PCs – configuration specs: Windows 8.1 Pro (64-bit), Windows 8.1 (32bit), Intel H81 (i5 processor) with 4GB RAM, 500GB HD, integrated 10/100/1000 ethernet controller, 8 USB ports, Windows 7 OS, and Internet Explorer 11.

Exhibit 4 - Payer Submission

(Presently the Childhelp Village uses a product called Medik from Logik Solutions to electronically bill claims (UB-04s). This product will be replace with the new EMR solution)

Payer	Monthly Claim record count	Monthly Sum of RATE	Submission Type	EDI X12 acceptance
Albemarle County	51	10,020.00	Paper-UB04	No
Alexandria City	82	12,272.46	Paper-UB04	No
Amherst Cty	40	6,400.00	Paper-UB04	No
Appomattox CPMT	25	4,000.00	Paper-UB04	No
Arlington County	102	20,040.00	Paper-UB04	No
Beacon Health Strategies - WVFH Claims	31	14,229.00	Paper-UB04	No
Buckingham Co. CSA	20	3,200.00	Paper-UB04	No
Campbell County DSS	20	3,200.00	Paper-UB04	No
Carroll County DSS	65	10,860.00	Paper-UB04	No
Chesterfield County CSA	20	3,200.00	Paper-UB04	No
Cumberland County DSS	20	3,200.00	Paper-UB04	No
Dickenson County	25	3,500.00	Paper-UB04	No
Essex DSS	28	3,680.00	Paper-UB04	No
Fauquier County CSA	51	10,020.00	Paper-UB04	No
Franklin County	27	3,620.00	Paper-UB04	No
Frederick CSA	75	13,460.00	Paper-UB04	No
Greene County	22	3,560.00	Paper-UB04	No
Greene County CSA	26	3,800.00	Paper-UB04	No
Harrisonburg/Rockingham	109	22,903.00	Paper-UB04	No
Harrisonburg/Rockingham DSS	51	10,020.00	Paper-UB04	No
Hopewell County CSA	20	3,200.00	Paper-UB04	No
Lunenburg Co DSS	22	3,320.00	Paper-UB04	No
Lynchburg DSS	71	13,220.00	Paper-UB04	No

Madison DSS	24	3,620.00	Paper-UB04	No
Magellan Health Services*	1808	565,050.28	Electronic - Medik	Yes
Mecklenburg County Public Schools FAPT	71	10,595.00	Paper-Invoice	No
New Kent CSA	20	3,200.00	Paper-UB04	No
Norfolk Dept Of Human Services	40	6,400.00	Paper-UB04	No
Orange Office On Youth	20	3,200.00	Paper-UB04	No
Radford City CSA	38	11,498.50	Paper-UB04	No
Rockbridge County CSB	73	13,250.00	Paper-UB04	No
Shenandoah CSA	56	7,860.00	Paper-UB04	No
Shenandoah Valley DSS	20	3,200.00	Paper-UB04	No
Spotsylvania Co. Dept of	99	14,330.00	Paper-UB04	No
Staunton-Augusta County	312	66,240.00	Paper-UB04	No
USDA	1	9,874.02	Paper-UB04	No
Virginia Beach Dept of So	40	6,400.00	Paper-UB04	No
West VA Dept. Of Education SPED-School	1	816.00	Paper-Invoice	No
West VA Medicaid (Molina)**	128	58,752.00	Electronic-Medik	Yes
Westmoreland County DSS/CSA	27	8,289.50	Paper-UB04	No
WV DHHR - Room & Board	62	28,458.00	Paper-Invoice	No
WV DHHR REG ED-School	87	21,993.00	Paper-Invoice	No
WV The Health Plan	31	14,229.00	Paper-UB04	No
York-Poquoson DSS	20	3,200.00	Paper-UB04	No
Grand Total	**3981**	**1,045,379.76**		

*Note: Magellan Provider Services provides an EDI Testing Center (www.edi.magellanprovider.com) to independently validate EDI test files (837i) for HIPAA compliance rules and codes to submit directly from the offeror's EMR application. Downloadable EDI guideline documentation (companion guides) are available, uploading and testing EDI files, and obtaining feedback regarding the results of the validation tests.
**Note: West Virginia Medicaid Management Information System (MMIS) conducts testing transactions processes to become a certified submitted. To see existing approved clearinghouses, visit www.wvmmis.com/Provider/VBCReport.aspx.

Exhibit 5 – Functional Documents/Forms

The following documents/forms of client gathered data are used at the Village. Childhelp is needing web-forms to be able to capture, auto-populate, tool controls, trigger conditions, validate, store, display, and print/report data where necessary.

Referral and Initial Screening

1. Completed By: (*auto-populate label*)
2. Referral Date: *(calendar control)*, Time: *(time control)*
3. Referral Type *(drop down* – e-mail, phone, fax, mail, other)
4. First Name: *(text box)*
5. Middle Name: *(text box)*
6. Last Name *(text box)*
7. Suffix: *(drop down)*
8. Date of Birth: *(calendar control),* Age: *(generate age from DOB)*
9. Place of Birth: (*text box)*
10. Gender: *(drop down)*
11. Referral Information (*title section*)
12. Referral Source (*drop-down* – School, Parent/Guardian, Agency/County, Other)
13. Referral Agency: *(text box)*
14. Referral Name: *(text box),* Title *(text box)*
15. Relationship to child/youth: *(drop down)*
16. Address/City/State/Zip Code: *(text box)*
17. County: *(text box)*
18. E-Mail: *(text box)*
19. Phone Work: *(numeric),* Extension *(numeric)*
20. Cell: *(numeric*)
21. Fax: *(numeric)*
22. Primary Language *(drop down)*, Secondary Language *(drop down)*
23. Legal Guardian Information (*title section*)
24. Guardian First Name: *(text box)*
25. Guardian Middle Initial: *(text box)*
26. Guardian Last Name: *(text box)*
27. Relationship: *(drop down)*
28. Address/City/State/Zip Code: *(text box)*
29. County: *(text box)*
30. E-Mail: *(text box)*
31. Phone Work: *(numeric)*
32. Phone Home: *(numeric)*
33. Cell: *(numeric*)
34. Fax: *(numeric)*
35. Primary Language *(drop down)*, Secondary Language *(drop down)*
36. Preferred method of contract: Phone/Email/Other (*check boxes)*

Intake Admission

1. Stage: (*pre-populate (label),* pending, complete, decline, cancelled)
2. Client information (*auto-populate* (*labels*): ClientID, Referral Date, User Name)
3. Intake Admission Date *(calendar control, default w/today's date)*
4. Medicaid #: *(text box, auto-populate)*
5. First Name: *(text box, auto-populate)*
6. Middle Name: *(text box, auto-populate)*
7. Last Name *(text box, auto-populate)*
8. Suffix: *(drop down, auto-populate)*
9. Alias First Name: *(text box)*
10. Alias Last Name: *(text box)*
11. Date of Birth: *(calendar control, auto-populate),* Age: *(generate age from DOB)*
12. Place of Birth: (*text box*)
13. Gender: *(drop down, auto-populate)*
14. Current Placement Address/City/State/Zip Code & County: *(text box)*
15. Phone: (*numeric*)
16. Primary Language *(drop down)*, Secondary Language *(drop down)*
17. Interpreter needed? Yes/No (*radio buttons*)
18. Ethnicity: Hispanic/Latino (*check box*)
19. Race: American Indian, Asian, Black, Native Hawaiian, White (*check boxes*)
20. Religion: (*drop down*)
21. Other Discharge Plan (*text box, auto-populate*)
22. Physical Description: HT: *(numeric)* ft *(numeric)* in, WT *(numeric)* lbs (*auto-populate*)
23. Type of Placement: *(drop-down*)
24. Childhelp Resident Placement: T1, T2, T3, T4 (*drop-down*)
25. Biological Mother's Information (*title section*)
26. First Name: *(text box)*
27. Last Name: *(text box)*
28. Address/City/State/Zip Code: *(text box)*
29. County: *(text box)*
30. E-Mail: *(text box)*
31. Phone Work: *(numeric)*
32. Phone Home: *(numeric)*
33. Cell: *(numeric*)
34. Is Parent Legal Guardian?: Yes/No (*radio buttons*)
35. Are Parental Rights Terminated?: Yes/No (*radio buttons*)
36. Is Child Adopted?: Yes/No (*radio buttons*)

37. Does Guardian live with child/youth? Yes/No/Don't Know (*radio buttons*)
38. Funding Information (*title section*)
39. "Childhelp will not be responsible for payment of medication costs, or any medical appointments/procedures that are not covered by Medicaid or Private Insurance." (*written notice statement*)
40. Responsible Party for Co-pays and Unpaid Medical Bills: (*text box*)
41. Funding Eligibility: Medicaid, Title IV-E, Comprehensive Service Act (CSA), Adoption Subsidy, HMO (*check boxes*)
42. Medicaid #: *(text box)*
43. Private Insurance Name: *(text box)*, Private Insurance ID#: *(text box)*, Private Insurance Phone #: *(numeric),* Primary Insurance Member Name: *(text box),* Primary Insurance Member DOB*: (date control)*
44. Reason for Referral (*title section*)
45. Reason for Referral (*text box*)
46. Abuse History: None, Trauma, Physical, Neglect, Sexual, Emotional (*check boxes)*
47. Explain Abuse History: *(text box)*
48. Is child able to complete Activities of Daily Living (ADLs)? Yes/No/Don't Know *(radio buttons*), Explain *(text box)*
49. Behaviors (*title section*)(*check boxes) (add "*Freq:*" (text box) next to each category)*
50. Sexually Inappropriate, Runaway, Suicidal Ideation, Homicidal Ideation, Physical Aggression, Verbally Aggressive, Enuresis, Self-harming Behaviors, Temper Tantrums/Outbursts, Encopresis, Fire Setter, Emotional Disturbance, Oppositional Defiant Behaviors, Hallucinations, Nightmares, Impulsive, Depressed Mood, Animal Cruelty, Stealing, Immature, Lying, Property Destruction, Anxiety Symptoms, Swearing, Hyperactive, Sexual Victim, Poor Hygiene, Wanders at Night
51. Treatment Services and Placement History for Past Year (*title section*)
52. Name of Service/Placement, Type of Service/Placement, Dates of Service (mm/dd/yy – mm/dd/yy), Reason for Removal *(sub-title column section)(text boxes)(8 rows)*
53. Education Information (*title section*)
54. Current Grade: *(drop down)*
55. Local Education Agency (LEA): *(text box)*
56. Current School: (*text box*), Address/City/State/Zip Code: (*text box*), Phone: (*numeric*), Fax: (*numeric*)
57. Full Scale Intelligence Quotient (FSIQ): *(text box)*
58. Individualized Education Plan (IEP): Yes/No/Don't Know (*radio buttons*), IEP Date: *(calendar control)*
59. General Education: Yes/No (*radio buttons*), Special Education Yes/No (*radio buttons*; *if 'Yes' pop-up (check boxes)*: Sensory impaired, Multiple handicapped, Emotionally disturbed, Physically
37. Is Parent Involved?: Yes/No (*radio buttons*)
38. Comments: *(text box)*
39. Biological Father's Information (*title section*)
40. First Name: *(text box)*
41. Last Name: *(text box)*
42. Address/City/State/Zip Code: *(text box)*
43. County: *(text box)*
44. E-Mail: *(text box)*
45. Phone Work: *(numeric)*
46. Phone Home: *(numeric)*
47. Cell: *(numeric*)
48. Is Parent Legal Guardian?: Yes/No (*radio buttons*)
49. Are Parental Rights Terminated?: Yes/No (*radio buttons*)
50. Is Child Adopted?: Yes/No (*radio buttons*)
51. Is Parent Involved?: Yes/No (*radio buttons*)
52. Comments: *(text box)*
53. Legal Guardian Information – if other than parent (*title section*)
54. First Name: *(text box)*
55. Last Name: *(text box)*
56. Relationship: (*drop down*)
57. Agency: *(text box)*
58. Address/City/State/Zip Code: *(text box),* County: *(text box)*
59. E-Mail: *(text box)*
60. Phone Work: *(numeric)*
61. Phone Home: *(numeric)*
62. Cell: *(numeric*)
63. Referral Source Information
64. Referral Source (*drop-down* – School, Parent, Agency/County, Other)
65. Referral Agency: *(text box)*
66. Referral Name: *(text box),* Title *(text box)*
67. Relationship to child/youth: *(drop down)*
68. Address/City/State/Zip Code: *(text box)*
69. County: *(text box)*
70. E-Mail: *(text box)*
71. Work Phone: *(numeric),* Extension *(numeric)*
72. Cell: *(numeric*)
73. Fax: *(numeric)*
74. Funding Information (*title section*)
75. Responsible Party for Co-pays and Unpaid Medical Bills: (*text box*)(*auto-populate*)
76. Medicaid, Title IV-E, Comprehensive Service Act (CSA), Adoption Subsidy, HMO (*check boxes*) (*auto-populate*)
77. Medicaid #: *(text box)(auto-populate),* Social Security #*: (numeric 9-digits)*
78. Private Insurance Name: *(text box)*, Private Insurance ID#: *(text box)*, Private Insurance Phone #: *(numeric),* Primary Insurance Member Name*: (text box),* Primary Insurance Member DOB*: (date control)(auto-*

disabled, Learning disabled, Other health impaired, None, Unknown), Eligibility Statement: *(text box)*

60. School History/Difficulties/Issues: *(text box)*
61. Clinical Information (*title section)*
62. DSM V (*text box, code search*), ICD-10-CM (*text box, code search*), Diagnosis Description (*text box, populate based on code*)
63. Who provided diagnosis?: *(text box)*
64. Previous Placements/Treatments: *(text box)*
65. Medical Information (*title section*)
66. Current Medication Name, Dosage, Schedule, Days Left (*sub-title columns – 5 rows*)*(text boxes)*
67. Medications Tried in the Past & Effects, Dosage, Schedule (*sub-title columns – 5 rows*)*(text boxes)*
68. Physical Description: HT: *(numeric)* ft *(numeric)* in, WT *(numeric)* lbs
69. Health and Nutrition Information (*title section*)
70. "Childhelp reserves the right to not admit a child who presents with a communicable disease (i.e. Flu, Strep, MRSA, Lice, HIV, Hep, A, B, or C, etc.) at the time of admission, unless our Medical Direct certifies that our facility is capable of providing care to the child without jeopardizing residents and staff." (*written notice statement*)
71. Current Immunization? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
72. Does child wear orthodontic braces? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
73. Does child wear glasses? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
74. Diagnosed Allergies – including drug/food allergy/intolerance: (*text box*), Is there supporting diagnosed allergy documentation uploaded to the record? Yes/No (*radio buttons*)
75. Any noted nutritional problems? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
76. Doctor Ordered Therapeutic Diet? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
77. Health Concerns: *(text box)*
78. Current Physician Information (*title section*)
79. Doctor Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric)*
80. Dentist Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
81. Other Specialist: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
82. Developmental History (*title section*)
83. Born at: (*numeric*)/months.
84. Normal Delivery? Yes/No (*radio buttons*), If No, explain: (*text box*)
85. Complications at Birth? Yes/No (*radio buttons*), If Yes, explain: (*text box*)

populate)

79. Funding/Placing Agency Information (*title section*)
80. Placing Agency/County (Agency Funding Placement): *(text box)*
81. Address/City/State/Zip Code & County: *(text box)*
82. Work Phone: *(numeric),* Extension: *(numeric)*
83. Cell: *(numeric*)
84. Fax: *(numeric)*
85. E-mail: *(text box)*
86. CSA Coordinator: *(text box)*
87. Other Involvement (Step-parent, Foster parent, GAL, CASA Worker, etc.) (*title section*)(*two rows – auto-populate*)
88. Name: *(text box)*, Relationship: *(text box)*
89. Agency Name: *(text box)*
90. Address/City/State/Zip code: *(text box)*
91. Phone: (*numeric*), Cell: (*numeric*)
92. Mental Health Information (*title section*)(*auto-populate*)
93. Reason for Referral (*text box*)
94. Abuse History: None, Trauma, Physical, Neglect, Sexual, Emotional (*check boxes)*
95. Explain Abuse History: *(text box)*
96. Is child able to complete Activities of Daily Living (ADLs)? Yes/No/Don't Know *(radio buttons*), Explain *(text box)*
97. Clinical Assessments Requested? Yes/No *(radio buttons)(if 'Yes', pop-up text box* – "Agency/Provider name, Type of assessment(s), When requested:")
98. Education Information (*title section*)
99. Current Grade: *(drop down)*
100. Local Education Agency (LEA): *(text box)*
101. Current School: (*text box*), Address/City/State/Zip Code: (*text box*), Phone: (*numeric*), Fax: (*numeric*)
102. Full Scale Intelligence Quotient (FSIQ): *(text box)*
103. Individualized Education Plan (IEP): Yes/No/Don't Know (*radio buttons*), IEP Date: *(calendar control)*
104. General Education: Yes/No (*radio buttons*), Special Education Yes/No (*radio buttons*; *if 'Yes' pop-up (check boxes)*: Sensory impaired, Multiple handicapped, Emotionally disturbed, Physically disabled, Learning disabled, Other health impaired, None, Unknown), Eligibility Statement: *(text box)*
105. School History/Difficulties/Issues: *(text box)*
106. Child and Family Information (*title section*)
107. Family Involvement: *(text box)*
108. Risk Factors for Placement: *(text box)*
109. Legal Involvement: Yes/No (*radio buttons*), If Yes, explain: *(text box)*
110. Probation Officer: *(text box),* Address/City/State/Zip Code: *(text box),* Phone: (*numeric*), E-mail: *(text box)*
111. Other Discharge Plan Information: *(text box)*
112. Is there a Protective Order in Place? Yes/No/Don't Know (radio buttons)(*if 'Yes' selection pop-up* "Explain:" *text box*)

86. Concerns with Gross Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
87. Concerns with Fine Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
88. Concerns with Speech Development? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
89. What age was child Toilet Trained? (*numeric*)/months
90. Other Information *(title section*)
91. Likes: (*text box*)
92. Dislikes: (*text box*)
93. Indicators of Success at Home/Other Placement: (*text box*)
94. History of Unsubstantiated Claims? (*text box*)
95. Current Physician Information (*title section*)
96. Doctor Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric)*
97. Dentist Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
98. Other Specialist: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
99. Developmental History (*title section*)
100. Born at: (*numeric*)/months.
101. Normal Delivery? Yes/No (*radio buttons*), If No, explain: (*text box*)
102. Complications at Birth? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
103. Concerns with Gross Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
104. Concerns with Fine Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
105. Concerns with Speech Development? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
106. What age was child Toilet Trained? (*numeric*)/months
107. Other Information *(title section*)
108. Likes: (*text box*)
109. Dislikes: (*text box*)
110. Indicators of Success at Home/Other Placement: (*text box*)
111. History of Unsubstantiated Claims? (*text box*)
112. Other Involvement (Foster Parent, Guardians Ad Litem (GAL), Court Appointed Special Advocates (CASA) Worker, Education, Psychiatrist) (*title section*)(*two rows*)
113. Name: *(text box)*, Relationship: *(text box)*
114. Agency Name: *(text box)*
115. Address/City/State/Zip code: *(text box)*
116. Phone: (*numeric*), Cell: (*numeric*)
117. Child and Family Information (*title section*)
118. Family Involvement: *(text box)*
119. Risk Factors for Placement: *(text box)*
120. Legal Involvement: Yes/No (*radio buttons*), If Yes, explain: *(text*
113. Is there any Restrictive Contact? Yes/No/Don't Know (*radio buttons*)(*if 'Yes' selection pop-up* "Explain:" *text box*)
114. Does Family have reliable transportation to attend Therapy/Treatment/Meetings? Yes/No/Don't Know (*radio buttons*)
115. Health and Nutrition Information (*title section*)
116. Current Immunization? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
117. Does child wear orthodontic braces? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
118. Does child wear glasses? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
119. Diagnosed Allergies – including drug/food allergy/intolerance: (*text box*), is there supporting diagnosed allergy documentation uploaded to the record? Yes/No (*radio buttons*)
120. Any noted nutritional problems? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
121. Doctor Ordered Therapeutic Diet? Yes/No/Don't Know (*radio buttons*), Comments: (*text box*)
122. Health Concerns: *(text box)*
123. Current Physician Information (*title section*)
124. Doctor Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric)*
125. Dentist Name: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
126. Other Specialist: (*text box*), Last Appt: *(calendar control*), Phone: *(numeric*), Fax: (*numeric*
127. Developmental History (*title section*)
128. Born at: (*numeric*)/months.
129. Normal Delivery? Yes/No (*radio buttons*), If No, explain: (*text box*)
130. Complications at Birth? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
131. Concerns with Gross Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
132. Concerns with Fine Motor Skills? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
133. Concerns with Speech Development? Yes/No (*radio buttons*), If Yes, explain: (*text box*)
134. What age was child Toilet Trained? (*numeric*)/months
135. Other Information *(title section*)
136. Likes: (*text box*)
137. Dislikes: (*text box*)
138. Indicators of Success at Home/Other Placement: (*text box*)
139. History of Unsubstantiated Claims? (*text box*)
140. Behaviors (*title section*)(*check boxes)(add "*Freq:*" (text box) next to each category)*
141. Sexually Inappropriate, Runaway, Suicidal Ideation, Homicidal Ideation, Physical Aggression, Verbally Aggressive, Enuresis, Self-harming Behaviors, Temper Tantrums/Outbursts, Encopresis, Fire Setter, Emotional Disturbance,

box)

121. Probation Officer: *(text box),* Address/City/State/Zip Code: *(text box),* Phone: (*numeric*), E-mail: *(text box)*
122. Other Discharge Plan Information: *(text box)*

Intake Risk Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, User Name & Credentials)
2. Baseline Factors (*title section*)
3. Family History (*checkboxes*: Family has Hx of mental illness, Family has Hx of Substance Use/Abuse, Non/Unknown; text box: Specify what relative(s) your referring to; as well as any other known family information)
4. Family History of Previous Suicide attempt(s) (*checkboxes*: None/Unknown, Once, Twice, Frequent Multiple Attempts; Did child witness, or was directly exposed to the attempt(s): yes, no/unknown)
5. Historical Factors (*title section*)(*grid)*
6. Past Suicidal Statements/Ideation (Low: None/Unknown; Moderate: Intermittent Statements; Severe: Frequent & Repetitive Statements)
7. Lethality of Past Attempt(s) (Low: No past attempts; Moderate: Attempts with no medical attention, Threats with no plan; Severe: Attempts with medical attention, Threats with a detailed plan)
8. Inpatient treatment due to suicide attempt(s) (Low: None, > 2+ years ago; Moderate: Within the last 1-2 years; Severe: Recent within the last year)
9. Specify Historical behaviors (*text box*)
10. External Safety Stressors (*title section*) (specify concerns)
11. Has the child deliberately set fires
12. Has the child deliberately run away from home without permission; for an extended period of time or overnight?
13. Has the child experience recent medication change?
14. Current Internal Stressors (*title section*)(*grid*)
15. Abrupt Change in Behavior (Low: None/Unknown; Moderate: Some, but with known cause (explain); High: Severe (explain)
16. Impulsivity (Low: No risky behaviors; Moderate: Minimal risky behavior with injury to self and/or others (explain); High: Frequent risky behavior with severe injury to self and others (explain))
17. Injuries resulting from recent behavior (Low: None/Unknown; Moderate: Minimal injury no medical attention; High: Moderate to Severe with medical attention required)
18. Isolation (Low: Socially active; Moderate: Frequent social isolation; High: Socially withdrawn)
19. Psychosis (Low: Not present; Moderate: Visual, Auditory, Other (explain); High: Command, Other (explain))
20. Chronic Medical Condition (Low: No active medical problems; Oppositional Defiant Behaviors, Hallucinations, Nightmares, Impulsive, Depressed Mood, Animal Cruelty, Stealing, Immature, Lying, Property Destruction, Anxiety Symptoms, Swearing, Hyperactive, Sexual Victim, Poor Hygiene, Wanders at Night
142. Treatment Services and Placement History for Past Year (*title section*)
143. Name of Service/Placement, Type of Service/Placement, Dates of Service (mm/dd/yy – mm/dd/yy), Reason for Removal *(sub-title column section)(text boxes)(8 rows)*
144. Medical Information (*title section*)
145. Current Medication Name, Dosage, Schedule, Days Left (*sub-title columns – 5 rows*)*(text boxes)*
146. Medications Tried in the Past & Effects, Dosage, Schedule (*sub-title columns – 5 rows*)*(text boxes)*
147. Suggested Participants in Emergency Treatment Team Meeting (*title section*)
    i. Participant's Name: (*text box*), Title: (*text box*), Agency Name: (*text box*), Relationship to Child: (*text box*), Type of Support: (*drop-down*), Phone Work: (*numeric*), Phone Cell: (*numeric*), E-mail: (*text box*)
    ii. Participant's Name: (*text box*), Title: (*text box*), Agency Name: (*text box*), Relationship to Child: (*text box*), Type of Support: (*drop-down*), Phone Work: (*numeric*), Phone Cell: (*numeric*), E-mail: (*text box*)
148. Disposition (*title section*), "By checking 'Accept' and signing, I acknowledge that I have assessed the admission of this individual. I do not believe this admission will pose any significant risk for other residents, staff, or the facility. I have assessed that this individual's needs as documented above can be addressed appropriately by this facility."
149. Name: *(text box)*, Signature, Accept/Deny/Pending Additional Info *(radio buttons)*
150. Disposition Summary: Accept/Deny/Pending Additional Info *(radio buttons),* Rationale: *(text box)*

Psychiatric Evaluation

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Psychiatrist User Name & Credentials)
2. Reason for Admission & Identifying Information: (*text box*)
3. History of Present Illness: (*text box*)
4. Past Psychiatric History (*title section*)
5. Previous placements or attempts at treatment: (*text box*)
6. Previous Diagnosis:
7. Past Medical History: (*text box*)
8. Allergies: (*text box*)
9. Medications tried in past
10. Current Medications: Application *(column)*, At Admission *(column) (drop-down)*

Moderate: Minimal to moderate issues causing stress; High: Severe issues causing stress)
21. Loss/Grief (Low: No loss; Moderate: Recent as of 1 year or more ago (specify who); High: Recent as of 6 months or less (specify who))
22. Trauma History (Low: Unknown, No; Moderate: Known (Physical, Sexual, Psychological)(describe))
23. Abuse History (Low: Unknown, No; Moderate: Known (Physical, Sexual, Emotional/Neglect, Exploitation)(describe))
24. Family Support Systems (Low: Family involved; Moderate: Limited Family Support; High: No family support))
25. Hopeless (Low: Optimistic; Moderate: Pessimistic; High: Frequent negative outlook)
26. Worthlessness (Low: Good sense of self-worth; Moderate: Conveys no sense of purpose; High: Believes their life is pointless)
27. Danger to Self (*title section*)
28. Current Suicidal Ideation (Low: None/Unknown; Moderate: Passive Statements; High: Active ideation, Evident plan/intent)
29. History of Self harming behaviors? (Low: None/Unknown; Moderate: One known attempt; High: Multiple attempts, Evident plan/intent)
30. Specify (if attempted) (*text box*)
31. Danger to Others (*title section*)(*grid*)
    a. Low (None seen/unknown, None made/witnessed, Doesn't appear dangerous)
    b. Moderate (Violent Temper, Sexually aggressive, Physical/Confrontational/Aggressive, Plan or intent, Safeguards necessary, Safeguards necessary)
    c. High (Cruelty to Animals/Use of weapons, Plan and intent, Alleged sexual assault, Assaultive causing serious injury, Allegation plan and intent)
    d. Specify Aggression (*text box*)
32. Action Taken (*title section – Administrative use*)(*check boxes*)
33. Standard Precautions (Heighten/24 hours)
34. Add to High Alert List (Nursing Notified)
35. Physician Ordered Precautions (Medical Order Required, specify)
36. One-to-One Supervision (Medical Order Required)
37. Referral to High Acute Placement (Admission Postponed/Terminated)
38. Other (specify)
39. Parent/Guardian, Staff, Therapist, Psychiatrist (Signature & title, date/time

Milieu 21 Interventions Treatment Note

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, User Name & Credentials)
11. Family History: (*text box*)
12. Developmental History: (*text box*)
13. Substance History and legal involvement: (*text box*)
14. Social History: (*text box*)
15. Mental Status Exam:
16. Estimated Length of Stay (*numeric, days/months/years drop-down)*
17. DSM V (*text box, code search*), ICD-10-CM (*text box, code search*), Diagnosis Description (*text box, populate based on code*)
18. Child Psychiatrist Name/Date signature

Group Therapy Progress Note

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Psychiatrist User Name & Credentials)
2. Start Time, End Time, Duration (*calculated*), Number of children in group (*numeric*)
3. Reason for non-participation (*radio buttons:* Refused, Absent, Late, Left Early with pop-up to explain why)
4. Type of Group (*radio buttons:* Process, Coping skills, Equine, Experiential, Occupational, Other with pop-up for entry)
5. Group topic/activity: (*text box*)
6. Objective(s)/Goal(s): (*text box*)
7. Interventions Used: (*text box*)
8. Mood (*check boxes:* Euphoric, Dysphoric, Irritable, Anxious, Labile, Euthymic)
9. Participation (*radio buttons:* Active, Intermittent, Passive, Defiant, Disruptive) – Explain (include behavior, mood/affect (*text box*))
10. Child's response to therapeutic session: (*text box*)
11. Summary of group session: (*text box*)
12. Assessment/Plan (follow-up for next session): (*text box*)
13. Staff Signature & title, Date/Time
14. Supervisor Signature & title (if applicable), Date/Time

Educational Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date of Enrollment, User Name & Credentials)
2. Report Date
3. Behavior Assessment (*text box*)
4. Academic Assessment (*text box*)
5. Summary: (*text box)*
6. User Name with credentials signature, Date, Time

Spiritual History & Needs Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, User Name & Credentials)
2. Spiritual History (*title section*)
3. Do you believe in God? (yes/no) (if yes, answer below via text boxes)
4. Describe God

2. Start Time, End Time, Duration (*calculated*)
3. Intervention Type (drop-down table: Morning Meeting, Night Point Meeting, Community Meeting, Team Building, Therapeutic Recreation, Night Meeting, Group Processing, Personal Growth, Art Therapy, Nature Exploration, Social Skills Group, Co-regulation, De-escalation, Other (*fill-in*))
4. Staff's Intervention: (i.e. Facilitated/Discussed Goals, etc.): *(text box*)
5. Group Individuals: *(text box*)
6. Goal or Objective (*auto-populate each goal & objective from CIPOC*) (*text box*)
7. How this intervention relates to the client's treatment goal: (What is taking place that will assist the child in meeting their goal, how is this action/activity assisting the child in working toward their goal) (*text box*)
8. Resident's Response to Intervention: (Child's level of participation as evidenced by what behaviors? Document all behaviors that demonstrate whether or not the goal of this activity was met) (*text box*)
9. Follow-up Plan (Document what will you change, continue to do, suggest for the future, etc.) (*text box*)
10. User Name with credentials signature, Date, Time

Supervision Reevaluation Screening

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Psychiatrist User Name & Credentials)
2. Current Supervision Status: Heighten, One-on-One, Precautions, Other: (*text box) (checkboxes*)
3. Reason: (*text box*)
4. Behavior Inventory (visual inspection of the child…check all that apply): (*title section*)(*checkboxes*)
5. Attitude: (calm, cooperative, defiant, angry)
6. Speech: (soft, normal, loud, rapid)
7. Affect: (reactive, labile, sad, blunted, congruent with mood)
8. Mood: (stable, irritable, anxious depressed)
9. Insight: (good, fair, poor)
10. Impulsivity: (low, medium, high, uncertain)
11. Self-Harm: (low, medium, high, uncertain)
12. Aggression: (low, medium, high, uncertain)
13. Is resident amiable to corrective teaching by staff members? Yes/No (*radio buttons*)
14. Does the resident exhibit verbal symptoms of anger toward self? Yes/No (*radio buttons*)
15. Did the resident contract for safety? Yes/No (*radio buttons*), (*if Yes*, Verbal or Written (*radio buttons*))
16. Does the resident appear to be ready to assume regular programming? Yes/No (*radio buttons*)
5. What does God expect you to do or be?
6. What do you want God to do for you?
7. Who or what is the most important thing in your life? (*text box)*
8. What do you think happens when you die? (*text box*)
9. Do you pray? (yes/no) *(if yes,* answer below via text boxes)
10. When do you pray?
11. How do you pray?
12. Do you attend church (synagogue, mosque, etc.)? (yes/no) (*if yes*, answer below via text boxes)
13. What is the name and denomination?
14. Do you go there with someone or by yourself?
15. How often do you attend?
16. What do you like or not like about that church?
17. Spiritual Needs Assessment (*title section*)
18. Do you plan to attend chapel while you are at the Village? (yes/no)
19. Can you think of any way that I, as Chaplain, can help you while you are at the Village? (*text box*)
20. What are you good at? (*text box*)
21. What are you trying to improve or change about yourself? (*text box*)
22. Summary of Findings (*title section*)
23. Strengths (*text box*)
24. Weaknesses (*text box*)
25. Spiritual Care Plan (*can be up to 3 individual item plans*)
26. User Name with credentials signature, Date, Time

Supervision Screening Tool

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, User Name & Credentials)
2. Type of Screening *(title) (check boxes* – Suicide (harm to self), Aggression (harm to others), ODA/Elopement, Other (specify))
3. Specify Concerning Behavior (*text box*)
4. Historical Factors (*title section*) (Known previous concerns with the child's behavior)
5. Previous reports of self-harming attempts; past 30 days? (yes/no) (*radio buttons*)
6. Previous reports of physical/sexual aggression past 30 days? (yes/no)(*radio buttons*)
7. Previous reports of observed unsafe behavior; past 30 days? (yes/no) (*radio buttons*)
8. Is this child already identified on the High Alert List? (yes/no/unknown) (*radio buttons*)
9. Behavior Inventory (title section) (interview with staff)(The child's actual act is observed to be related to…check box all that apply)(*checkboxes*)
10. Attitude: (calm, cooperative, defiant, angry)
11. Speech: (soft, normal, loud, rapid)
12. Affect: (reactive, labile, sad, blunted, congruent with mood)
13. Mood: (stable, irritable, anxious depressed)

17. Does the resident have any other presenting concerns? Yes/No (*radio buttons*)
18. Protective Factors: (Nursing will contact the following disciplines for further feedback) (*title section)(4 columns:* Discipline, Comments (*text box*),Time (*text box*), By Whom (*text box*))(*under* 'Discipline' *will be 4 rows:* Residential (observations), Medical (prescriptive plan), Clinical (next session to process), Education (when applicable observations))
19. Ordered Supervision Status: General, Heighten, One-on-One, Precautions, Other: (*text box*) (*checkboxes*)
20. Specify Order: (*text box*)
21. Order Given By: (Physician) (*text box*), Signature:
22. Order Taken By: (Nurse) (*text box*), Signature:
23. Order Date: (*calendar control*), Time (*time control*)
24. Notify Legal Guardian of Heightened or 1:1 status: (*checkbox*)
25. Time Legal Guardian notified: (*text box*)

Recreation Therapy Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Psychiatrist User Name & Credentials)
2. General Behavior (*title*): Appropriate; Minimal Moderate; Disabled; Sever Dysfunction (*categories*)
3. Appearance/Grooming: Appropriate Grooming; Slightly Unkempt; Adequate Hygiene; Poor Hygiene; Severity Disheveled
4. Attitude Towards Hospitalization: Motivated; Somewhat Motivated; Indifferent; Uncooperative; Involuntary/Hostile
5. Affect: Full Range; Restricted; Flat/Anxious; Not Congruent Depressed Mood; Labile/Hostile Overexcited
6. Recreation Interest/Barriers (*title*)
7. What are some activities that you enjoy doing? Your favorites?
8. Do you prefer to do activities with other people or by yourself?
9. Do you prefer activities that are outdoors or inside?
10. Have you been a part of any recreation classes, teams, or clubs? If so, describe.
11. What activities would you like to learn more about?
12. Are there any activities you enjoy that you won't be able to do during your stay?
13. Are there any activities that you used to enjoy but no longer participate in?
14. Ask the child to rate these activity types, 5 being their most favorite (*title*)
15. Sports – 1 2 3 4 5 N/A
16. Hobbies – 1 2 3 4 5 N/A
17. Arts/Crafts/Music – 1 2 3 4 5 N/A
18. Outdoors – 1 2 3 4 5 N/A
19. Social – 1 2 3 4 5 N/A
20. Leisure Barriers and Strengths: Ask the child to state any potential challenges they have during group based recreation activities as
14. Insight: (good, fair, poor)
15. Impulsivity: (low, medium, high, uncertain)
16. Self-Harm: (low, medium, high, uncertain)
17. Aggression: (low, medium, high, uncertain)
18. Child Interview (*title section – code 0-3*)(To be processed with the child)
19. How often do you think about harming yourself/others? (1) Almost Never (random), (2) Occasional Passing thoughts (monthly), (3) Regularly (weekly), (4) Almost Daily
20. Do you intend to hurt yourself/others; and/or kill yourself/other? (1) No intention, (2) Unlikely, (3) Likely, someday, (4) Yes, I will attempt to hurt myself/others again
21. If known, specify intent/plan/way (write N/A, if not applicable to situation) (*text box*)
22. Can you name something worth living for? (*text box*)
23. Describe something you look forward to… (*text box*)
24. Describe something you want to get… (*text box*)
25. Describe something you'd like to earn… (*text box*)
26. Who is someone you love and that loves you? (*text box*)
27. Describe an activity that you enjoy like playing ball, dancing, or singing... (*text box*) (1) Many things, (2) One thing, (3) Vague/Unsure, (4) Nothing
28. Protective Action Taken (*title section*) (As directed by Medical/Clinical Director) (*check boxes*)
29. Standard precautions (heighten/recharge)
30. Emergency Treatment Team Meeting
31. Add to High Alert List
32. One-to-One Supervision (Medical Order Required)
33. Referral to Higher Acute Placement (Pursuant to Policy SE-3 Psychiatric Emergency Transfers)
34. Physician Ordered Precautions (Medical Order Required)
35. Interpersonal (reactive to authority/oppositional) (*text box*)
36. Sexuality Related (*text box*)
37. School Related challenges (*text box*)
38. Impulsive Sporadic/Random (*text box*)
39. Peer problems (*text box*)
40. Other (specify) (*text box*)
41. Order Given By (Physician Name): (*text box*); Order Taken By (nurse): (*text box*); Order Date: (*date calendar control box);* Time (*time control box*); MD Signature:; Date
42. The identified Risk factors have been communicated via e-mail to other disciplines as appropriate and necessary (*check box*)
43. Notify Legal Guardian of Heightened or 1:1 status (*check box*); Time Legal guardian notified (*time control box)*
44. User Name with credentials signature, Date, Time

Trauma Symptom Checklist for Children (TSCC) Report

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date,

well as strengths; e.g. cooperation ability, leadership potential, or problem solving skills:
21. Goals (*title*)
22. What are the child's goals during his/her treatment process and what do they wish to accomplish during their stay?
23. Recreation Therapy Goals (check all that apply for the child's interest (*title*)
24. Functional Leisure Skill: Cognitive; Physical; Socialization/Emotional
25. Leisure Education: To develop and acquire leisure related skills/attitudes, knowledge for the establishment of an appropriate leisure lifestyle.
26. Recreation Participation: To demonstrate leisure independence and person enjoyment through participation in appropriate leisure opportunities.
27. Summary (*title*)
28. Summary of Assessment: "Be sure to include a strength based focus on the physical, cognitive, social, and emotion domains. If applicable, include information for recreational restrictions." (*text box*)
29. Signature & credentials, Date/Time

Comprehensive Psychosocial Assessment

1. Client information (*auto-populate:* ClientID, Name, DOB, Gender, Date, Date of Admission, User Name & Credentials)
2. Child's History (*title section*)
3. History of Medical (*title subsection*)
   i. Child's birth was: Full term, Premature (*checkboxes*)*(if 'Premature' pop-up text box*)
   ii. Any complications at birth? Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   iii. Tobacco, alcohol, or other substance use or medication use during pregnancy? (*text box*)
   iv. Were there any significant delays in walking, talking, or toileting? Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   v. History of wetting or soiling? N/A, Yes (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   vi. Significant illness/injuries, loss of consciousness, seizures or hospitalizations: (*text box*)
   vii. Child's current health: good, fair, poor (*radio buttons*)
4. History of neglect or emotional, physical and/or sexual abuse (*title)*
   i. Neglect: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   ii. Physical abuse: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   iii. Emotional abuse: Yes/No (*radio buttons*)(*if Yes, pop-up*: Date of Enrollment, User Name & Credentials)
2. Primary Therapist: *(text box)* Examiner: *(text box)*
3. Validity Scale: Valid, Under-response (UND), Hyper-response (HYP), Exceeded Skipped response limit *(check boxes)*
4. Clinical Scales: Clinically Significant; For Clinical Review; Within Normal Limits *(grid)*
   i. Anxiety (ANX)
   ii. Depression (DEP)
   iii. Posttraumatic Stress (PTS)
   iv. Sexual Concerns (SC)
   v. Dissociation (DIS)
   vi. Anger (ANG)
5. Critical Items Endorsed: *(text box)*
6. Comments (*text box*)
7. User Name with credentials signature, Date, Time
8. Clinical Director with credentials signature, Date, Time

Initial Plan of Care

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Medicaid #, User Name & Credentials)
2. Current Diagnosis (*title*)(*grid*)
3. DSM V Code, ICD-10-CM, Diagnosis Description (*8 rows*) (*DSM search control)*
4. Allergies (*text box)*
5. Describe Symptoms, Complaints, and Complications Indicating the Need for Admission to Residential Level of Care (include problem behaviors 7-days prior to admission): *(text box)*
6. Functional Level (Medical issues, ability to do activities of daily living): *(text box)*
7. Mental Health Treatment Plan: (*title*)(*2 section rows*)
8. Focus Area 1: *(text box)*
9. Behavioral Definition 1: *(text box)*
10. Long Term Goal 1: *(title)*
11. Short Term Objective 1, Target Date, Outcome *(text box)*
12. Interventions Focus Area 1, Frequency, Person Responsible *(text box)(3 rows)*
13. Focus Area 2: *(text box)*
14. Behavioral Definition 2: *(text box)*
15. Long Term Goal 2: *(title)*
16. Short Term Objective 2, Target Date, Outcome *(text box)*
17. Interventions Focus Area 2, Frequency, Person Responsible *(text box)(3 rows)*
18. Current Orders for Medication (*title*)
19. Medication, Dose, Frequency, Indication (*text boxes, 8 rows)*
20. Clinical Orders *(title section)*
21. Treatment(s)/Therapies (*column title one with title values*)
    i. Individual Therapy

Explain: (*text box*))
   iv. Sexual abuse as Perpetrator: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   v. Sexual abuse as Victim: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   vi. Sexual victimization of others: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   vii. Traumatic Issues or Losses: Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   viii. Past Psychiatric Treatment Yes/No (*radio buttons*)(*if Yes, pop-up*: Explain: (*text box*))
   ix. Age at Onset: (*text box*)
   x. Prior Hospitalizations with dates: (*text box)*
   xi. Prior abuse (any previous exposure to abuse including rejection, harsh discipline, or community violence): (*text box*)
5. Sexual History: Yes/No (*radio buttons*)(*if Yes, pop-up the following*)
   i. Exposure to sexual activities: (*text box*)
   ii. What sexual activity had the child seen (e.g., hugging, kissing, foreplay, intercourse, pornography)? (*text box*)
   iii. Exposure to explicit sexual materials (e.g. pornography on screen or in-print)? (*text box*)
6. Possible Risk Factors (*title section*)
   i. Chemical abuse in the home: Yes/No *(radio buttons)(if Yes, pop-up* "If the child has been exposed to this, please explain:" (*text box*))
   ii. Experienced physical abuse or seen domestic violence (If yes, please explain): (*text box*)
7. Boundaries: (*title subsection*)
   i. Sleep (where does the child sleep)? (*text box*)
   ii. Hygiene routine (including bathing, is it supervised? By whom?): (*text box*)
   iii. Family nudity (Has the child been exposed to nudity, if so who, how often, when, where?): (*text box*)
   iv. Mother/father history of sexual abuse: (*text box*)
   v. Social connectedness (Is the child's family isolated or does it have helpful social support?): (*text box*)
   vi. Legal issues current or past involving the child: (*text box*)
   vii. Summary: (*text box*)
8. History of Concerns (*title section*)
   i. First incidence of concern: (What happened? Where? When?) (*text box*)
   ii. Describe child's behavior: (*text box*)
   iii. Describe child's statements: (*text box*)
   iv. Are there other details? (*text box*)
   v. What was the reason for the disclosure? (*text box*)
   vi. How it was handled by the recipients of the information: (*text box*)
   ii. Group Therapy
   iii. Family Therapy
   iv. Psychiatric Med Management
   v. Other Therapies
22. Frequency, Staff Responsible (*column title two with title values selections)*
   i. 20 minutes sessions: 3 x weekly, 4 x weekly, 5 x weekly (*radio buttons*)
   ii. 1 - 1/hr x weekly, 3 – 1/hr x weekly (*radio button*)
   iii. Monthly face-to-face, Weekly phone contact, N/A (*check boxes*)
   iv. Ongoing (*check box*)
   v. Equine, Art, Music (*check boxes*)
23. Staff Responsible (*column title three with drop-down selections for each treatment(s)/therapies*)
24. Other Orders/Special Precautions: *(text box)*
25. Strengths, Needs *(grid text boxes, 3 rows)*
26. Prognosis (good, fair, poor, guarded): *(text box)*
27. Plans for Continuing Care and for Review of the Plan of Care: (Comprehensive Individualized Plan of Care meeting is scheduled to occur by) *(text box)*
28. Discharge Plan (including estimated date of discharge): *(text boxes, date control)*
29. Estimated Date of Discharge:
30. Placement:
31. Education:
32. Therapy:
33. Barriers:
34. Physician's & Utilization Review User Names, credentials signature, date, time

Comprehensive Individual Plan of Care Progress Update *(auto-populate from Initial Plan of Care where appropriate)*

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Enrollment, Medicaid #, Therapist User Name & Credentials)
2. Classroom: (*drop-down*)
3. DSM V Code, ICD-10-CM, Diagnosis Description (*8 rows*)(*DSM search control)*
4. Changes to Diagnosis due to DSM Criteria: (*text box*)
5. Allergies (*text box)*
6. Describe the continued need for residential level of care: *(text box)(pre-fill:* "Child continues to need a PRTF level of care and continued stay. Problem behaviors are discussed in the Summary of Progress.")
7. Describe the child's involvement/cooperation in treatment: (*text box*)
8. Strengths, Needs (*title columns)(text boxes)*
9. Clinical Orders (*title section*)
10. Treatment(s)/Therapies (*column title one with title values*)
   i. Individual Therapy

box)
vii. Were they angry? (*text box*)
viii. Did they shame or blame the child? (*text box*)
ix. Did they express or imply fear? (*text box*)
x. Did they fall apart at the disclosure versus a calm acceptance? (*text box*)
xi. What questions were asked? (*text box*)
xii. What words were asked? (*text box*)
xiii. Other incidents of concern, in order of the occurrence: Repeat the above questions for the next and each following incident: (*text box*)

9. Screening for Significant Behaviors (*title section*)
   i. What time does the child go to bed? (*text box*)
   ii. How long does it take for the child to fall asleep? (*text box*)
   iii. How long does the child sleep at night? (*text box*)
   iv. Is there a history of nightmares, night terrors, sleep walking, or teeth grinding? Yes/No (*radio buttons)(if Yes, pop-up:* Explain: (*text box*))
   v. Describe any change in the child's sleep pattern, appetite, or weight in the past several months: (*text box*)
   vi. Are there problems related to toileting? (*radio buttons)(if Yes, pop-up:* Explain: (*text box*))
   vii. Are there problems related to bathing? (*radio buttons)(if Yes, pop-up:* Explain: (*text box*))
   viii. Does the child have any friends? (*radio buttons)(if Yes, pop-up:* How many?: (*text box*), Are the friends older/younger/same age: (*text box*))
   ix. Any concerns about teasing or bullying? (*text box*)
   x. What is the child's typical mood? (text box)
   xi. Any noticeable separation problems? (*radio buttons)(if Yes, pop-up:* Explain: (*text box*))
   xii. Is there anything else you think is important about your child or your family that I haven't asked? (*text box*)
10. Complete a basic genogram including all persons living in the household: (*text box*)
11. Summary: (*text box*)
12. Observations of the child/mental status evaluation (*title section*) (*checkboxes*)
    i. Orientation: Oriented x3, Distractible, Lethargic, Somnolent, Other
    ii. Attitude: Appropriate, Guarded Sarcastic, Manipulative, Hostile, Uncooperative, Other
    iii. Mood: Fine, Euphoric, Dysphoric, Irritable, Angry, Nervous, Other
    iv. Affect: Full Range, Bright, Flat, Blunt, Labile, Anxious, Other
    v. Thought Process: Logical/Linear, Disorganized, Circumstantial, Tangential, Loose Associate, Flight of Ideas,
    ii. Group Therapy
    iii. Family Therapy
    iv. Psychiatric Med Management
    v. Other Therapies
11. Frequency, Staff Responsible (*column title two with title values selections)*
    i. 20 minutes sessions: 3 x weekly, 4 x weekly, 5 x weekly (*radio buttons*)
    ii. 1 - 1/hr x weekly, 3 – 1/hr x weekly (*radio button*)
    iii. Monthly face-to-face, Weekly phone contact, N/A (*check boxes*)
    iv. Ongoing (*check box*)
    v. Equine, Art, Music (*check boxes*)
12. Staff Responsible (*column title three with drop-down selections for each treatment(s)/therapies*)
13. Standard 21 Therapeutic Interventions (*title section*)
14. Interventions (*column title, 3 rows*), Goal Setting Group, Goal Review Session, Co-Regulation Intervention and/or Crisis Intervention (*row values*)
15. Frequency (*column title, 3 rows*), 7 x weekly, Other: _____, 7 x weekly, Other: _____, 7 x weekly, Other: _____ (*check boxes*)
16. Other Orders/Special Precautions (*title section*), (*text box*)
17. Number of Holds: (*numeric*), Number of Acute Supervision: (*numeric*), Number of Heightened Supervision: (*numeric*)
18. Problem/Focus Areas *(title section with 4 columns:* # (1, 2, 3, 4), Problem/Focus Area, Discharge Barrier, Status *(text boxes)*)
19. Treatment Summary (*title section*)
20. Focus Area 1: *(text box)*
21. Long Term Goal 1: *(title)*
22. Child's Words 1: (*text box*)
23. Short Term Objective 1 *(text box)*, Target Date (*calendar control*), Outcome *(text box)*
24. Interventions Focus Area 1 *(text box)*, Frequency *(text box)*, Person Responsible *(drop-down)(3 rows)*
25. Progress to Date Problem 1: *(text box)*
26. Focus Area 2: *(text box)*
27. Long Term Goal 2: *(title)*
28. Child Works 2: (*text box*)
29. Short Term Objective 2 *(text box)*, Target Date (*calendar control*), Outcome *(text box)*
30. Interventions Focus Area 2 *(text box)*, Frequency *(text box)*, Person Responsible *(drop-down)(3 rows)*
31. Progress to Date Problem 2: *(text box)*
32. Focus Area 3: *(text box)*
33. Long Term Goal 3: *(title)*
34. Child Works 3: (*text box*)
35. Short Term Objective 3 *(text box)*, Target Date (*calendar control*), Outcome *(text box)*

other
vi. Eye Contact: Good, Appropriate, Fair Poor, None, Other
vii. Insight/Judgment: Good, Appropriate, Fair, Impaired, Other
viii. Speech: Fluent, Pressured, Loud, Soft, Other, Prosody
ix. Motor Activity: Appropriate, Hyperactive, Impulsive Intrusive, Agitated, Slowed
x. Thought Content: Clear, Hallucinations, Paranoid Themes, Suicidal Ideation/Plan, Hopelessness, Obsessions/Compulsions
xi. General Appearance: Overweight, Underweight, Taller than average, Shorter than average, Appropriate appearance, Inappropriate appearance

13. Critical Incidents in the past year *(title section)(checkboxes*)
    i. Has exhibited problems w/behavior
    ii. Ran away form caregiver of home
    iii. Set a fire
    iv. Destroy property
    v. Physically aggressive towards others
    vi. Sexually aggressive towards others
    vii. Attempted or had homicidal ideations
    viii. Ingested drugs or alcohol
    ix. Involved in substance abuse related incident (ex., OD, DWI, etc.)
    x. Involved in self-abusive or self-destructive behavior (ex., cutting)
    xi. Attempted or had suicidal ideations
    xii. Has been truant
    xiii. Suspended/expelled from school/daycare
    xiv. Assigned to special education
    xv. Transferred out of special education
    xvi. Involved in criminal activity
    xvii. Arrested or referred to juvenile court
    xviii. Placed on probation
    xix. Placed on parole
    xx. Parents/family members incarcerated
    xxi. Family member hospitalized
    xxii. Became pregnant/got someone pregnant
    xxiii. Experienced parental neglect
    xxiv. Was physically abused
    xxv. Was sexually abused
    xxvi. Sleep difficulties
    xxvii. Eating difficulties
    xxviii. Enuresis and/or encopresis
    xxix. Anxiety (ex. Worried, nervous, or panic attacks)
    xxx. Delusions or hallucinations
    xxxi. Problems with academic performance
    xxxii. Refuses to go into class
36. Interventions Focus Area 3 *(text box)*, Frequency *(text box)*, Person Responsible *(drop-down)(3 rows)*
37. Progress to Date Problem 3: *(text box)*
38. Focus Area 4: *(text box)*
39. Long Term Goal 4: *(title)*
40. Child Works 4: (*text box*)
41. Short Term Objective 4 *(text box)*, Target Date (*calendar control*), Outcome *(text box)*
42. Interventions Focus Area 4 *(text box)*, Frequency *(text box)*, Person Responsible *(drop-down)(3 rows)*
43. Progress to Date Problem 4: *(text box)*
44. Physical hold Minimization (*title section*)(*auto-population from Physical Holding Minimization Plan*)
45. Initial assessment date: (*calendar control*), Updated on: (*calendar control*)
46. Are there physical pre-existing medical conditions or physical disabilities identified that would place this child at risk during a physical hold? Yes/No (*radio button*)
47. Is there any history of abuse that would place the child at greater psychological risk during a physical hold? Yes/No (*radio button*)
48. Behavioral Support Plan. What methods or tools have been identified to help the child manage his/her aggressive behaviors? (*text box*)
49. Summary of Progress (*title section*)
50. Individual therapy: *(text box*)
51. Family therapy: (*text box*)
52. Milieu: (*text box*)(*auto-populate user name*)
53. Education: (*text box*)(*auto-populate from Education Assessment & user name*)
54. Recreation: (*text box*)(*auto-populate from Recreation Therapy Assessment summary section & user name*)
55. Equine: (*text box*)(*auto-populate user name*)
56. Art: (*text box*)(*auto-populate for Art Therapy Assessment summary/conclusion section & user name*)
57. Music: (*text box*)(*auto-populate user name*)
58. Occupational Therapy: (*text box*)(*auto-populate user name*)
59. Speech Therapy: (*text box*)(*auto-populate user name*)
60. Medical: (*text box*)(*auto-populate user name*)
61. Overnight stays remaining: # (*numeric)* or (*numeric*), N/A (*check box, default as marked)*
62. Goal & Outcomes: (*text box*)
63. Functional Level (Medical issues, ability to do Activities of Daily Living (ADL)) (*title section*) (*check boxes in-front of each item*)
    i. Child continues to have complex presenting symptoms and/or emergence of new symptoms that are amenable to treatment in a psychiatric residential facility
    ii. Child is involved and cooperative with treatment
    iii. Child displays continued impairment in level of functioning

xxxiii. Failed a grade
xxxiv. Dropped out of school
xxxv. Other

14. Client Strengths (*title section)(checkboxes*)
    i. Good physical health
    ii. Financial support
    iii. Good academics
    iv. Good behavior at school
    v. Street survival skills
    vi. Leisure interests
    vii. Compliance meds/aftercare
    viii. Insightfulness
    ix. Motivation for treatment
    x. Good interpersonal skills
    xi. Ability to verbalized feelings
    xii. No previous history of psych problems
    xiii. No history of ETOH/drug abuse
    xiv. No criminal record
15. Clinical Impressions (*title section)(2 columns, text boxes*)
    i. DSM IV, Diagnosis (*look-up control*)
16. Clinician User Name with credentials signature, Date, Time
17. Supervisor User Name with credentials signature, Date, Time

Bio Log

1. Client information (auto-populate: ClientID, Name, DOB, Gender, Date, Date of Admission, User Name & Credentials)
2. Month/Day/Time matrix *(check box) (e.g. 1st – 31st, military time, 10-minute increments)*
3. Cottage Coding *(title)*
4. Code: BM=bowel movement, BM/D=diarrhea, BM/C=constipation, U=urination, ENU=urination in clothing, ENC=BM in night clothes, EE-excessive eating, O=not eating, PE=picky eating, RE=refused to eat, NT=night tremor, A=awake, S=asleep, SS=sleeping soundly, SW=sleep walking, RS=restless sleep, OOA=out of area *(check boxes)*
5. Patient Awake: Patient reports dreaming – describe *(text box*), Patient complains of not being able to sleep, Engaged in play with peers – describe *(text box*), Engaged in quiet/private play, Up for a drink of water, Talking with staff, Sitting up in bed, Lying awake, Up and about but not disruptive, Only up to use the restroom, Pacing, Mood (happy, sad, worried, afraid, crying, _____), Asking for mother or another *(check boxes)*
6. Patient Asleep: Drooling, Seating, Eye fluttering, Twitching, Tossing/turning, Thrashing about, Red, Pale, Hot, Cold, Drippy Nose, Crusted eyes, Talking in sleep *(check boxes)*
7. Comments *(text box)*

    iv. Child continues to require restrictive setting
    v. Ambulatory care resources available in the community will not meet this child's treatment needs
    vi. Continued services can reasonably be expected to improve their condition or prevent further regression
64. Medications (*title section*)
65. Order Date, Status, Medication with indications, Start Date (*column titles) (multi-rows – auto-populate from medication management)*
66. Change in medication and rationale: (*text box*)
67. Provider List (*title section) (list providers referred from registry (name, address, phone)) (if no providers, pre-fill* "No referrals have been made at this time."
68. Other: (*text box*)
69. Discharge Plan (*title section*)
70. Estimated Date of Discharge: (*calendar control*)
71. Placement: (*text box*)
72. Education: (*text box*)
73. Therapy: *(text box*)
74. Barriers: (*text box*)
75. Child's Feedback: (text box)
76. Child's Signature: Date:
77. Psychiatrist's Name:
78. Psychiatrist's Signature: (*select for signature, and auto-populate other fields*)
79. Date:
80. Clinical Director's Name:
81. Clinical Director's Signature: (*select for signature, and auto-populate other fields*)
82. Date:
83. Therapist's Name:
84. Therapist's Signature: (*select for signature, and auto-populate other fields*)
85. Date:
86. Nurse's Name:
87. Nurse's Signature: (*select for signature, and auto-populate other fields*)
88. Date:
89. Other – Name: (*auto-populate or text box*)
90. Signature: (*select for signature, and auto-populate other fields* or _____)
91. Date:
92. Other – Name: (*auto-populate or text box*)
93. Signature: (*select for signature, and auto-populate other fields* or _____)
94. Date:
95. Other – Name: (*auto-populate or text box*)
96. Signature: (*select for signature, and auto-populate other fields* or _____)

Physical Hold Procedure Record (*multi-part form*)

1. Client information *(auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Type: (Emergency, Physician Initiated) *(check boxes)*
3. Location of Hold: (*text box)*
4. Time Initiated: (*time box*)
5. Staff Initiating Hold: (*text box)*
6. Time Released: (*time box*)
7. Staff Assisting in Hold: (*text box*)
8. Duration (minutes): (*numeric*), Emergency (*check box*)
9. Type: (Body Control, Arm Control, Secure Escort) (*check boxes)*
10. Order Given By: (*text box*), Order Taken By (*text box*)
11. Order Date: (*date calendar*), Time (*time box*)
12. Precipitating event, prior to child's emotional escalation: (*text box*)
13. Less-restrictive interventions and child's response, prior to initiating physical hold (*title*)
14. Intervention (*text box*)
15. Response (*text box*)
16. Intervention (*text box*)
17. Response (*text box*)
18. Intervention (*text box*)
19. Response (*text box*)
20. Unsafe behavior that warranted physical intervention and to who it was directed (*text box*)
21. Clinical justification: (Danger to Self, Danger to Peer, Danger to Staff) (*check boxes*)
22. Conditions for release communicated to the resident: (*text box*)
23. Clinical rationale for discontinuing hold: (*text box*)
24. Resident debriefing following the hold (child's version of events): (*title*)
25. What led to the incident? *(text box)*
26. What could staff have done to help you? *(text box)*
27. What can you differently next time? *(text box)*
28. Vital signs: B/P (*text box*), P *(text box)*, R (*text box*)
29. Emotional Assessment following procedure: (*check boxes*)
30. Attitude: (calm, cooperative, defiant, angry, positive)
31. Speech: (soft normal loud rapid, mute)
32. Affect: (reactive labile, sad, blunted, depressed)
33. Mood: (euthymic, irritable anxious, depressed, elevated)
34. Insight: (good, fair, poor, flat)
35. Impulsivity: (low, medium, high, uncertain)
36. Risk for violence: (low, medium, high, uncertain)
37. Is resident amiable to corrective teaching by staff members? (*yes/no*)
38. Does the resident exhibit verbal symptoms of anger toward self? (*yes/no*)
39. Does the resident appear to be ready to assume regular programming? (*yes/no*)
40. Does the resident have any physical complaints? (*yes/no*)
97. Date:
98. Note: (*text box*)

Nursing Admission Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Resident, Medicaid #, User Name & Credentials)
2. Time of Assessment *(time control)*
3. Admitted from: *(check boxes)* Acute, Home, Residential, Other *(pop-up text box)*
4. Accompanied by: *(check boxes)* Parent, Relative, Social Worker, Other *(pop-up text box)*
5. Allergies and reactions shown in response to allergens or intolerances? *(text box)*
6. Temperature: *(text box)*
7. Respiration: *(text box)*
8. Pulse: *(text box)*
9. Blood Pressure: *(text box)*
10. Height: *(text box)*
11. Weight: *(text box)*
12. Temp Location: *(check boxes)* Axillary, Oral, Tympanic
13. Rate/Rhythm: *(check boxes)* Regular rate, Regular Rhythm, Shallow breathing, Short of breath
14. Location & beat: *(check boxes)* AP, Radial, Strong, Regular, Weak, Irregular
15. Patient Orientation: *(check boxes)* LA, Lying, RA, Sitting, Standing
16. Health Perception/Health Management Patterns *(title)*
17. Are you presently being treated for other illnesses? (yes/no), If "yes" please describe: (*text box*)
18. Has child been screened for communicable diseases? (yes/no), Please describe (*text box*)
19. Past Medical History: (include previous surgical procedures and hospital admissions – Medical History – Narrative History) (*text box*)
20. Substance History: (Substance Use History – Narrative History) (*text box*)
21. Has Child been able to follow prescribed meds/treatments? (yes/no), If "no" please describe: (*text box*)
22. Reason for admission in patient's own words – include source of information i.e. patient, family member (include signs & symptoms): (*text box*)
23. Problems Identified: (*check box*) Non-compliance (specify how)(Therapist Notified), None at this time
24. OT/PT Screening Mobility Status: (*check boxes*) PT Referral, Ambulatory, Other (specify)(*pop-up text box*)
25. Assistive Devices: (*check boxes*) PT Referral, Crutches, Walker, None
26. Limitations: (check boxes) PT Referral, Weakness, Fatigue, None, Other (specify)(*pop-up text box*)
27. Activities of Daily Living: (check boxes) Dressing-Needs Assist (self-

41. Assessment Notes: (*text box*)
42. User Name with credentials signature, Date, Time
43. *(part 2 of 4)*
44. Staff Debriefing: (if yes to either question complete an Incident Report) (*title*)
45. Were you injured during the procedure? (yes/no) Any property damage? (yes/no)
46. Precipitating factors that led up to the physical hold (*text box*)
47. Alternative techniques that could have prevented the physical hold (*text box*)
48. Interventions that staff will use in the future to prevent reoccurrence of a physical hold: (*text box*)
49. User Name with credentials signature, Date, Time (Initiating Staff, Debriefing Staff, Additional Staff)
50. *(part 3 of 4)*
51. Parent/Legal Guardian/Notification (within 24 hours from initiation) (*title*)
52. Date Notified: (*calendar box*), Time Notified: (*time box*), By: (*text box*)
53. Parent/Guardian's Response: (*text box*)
54. User Name with credentials signature, Date, Time
55. *(part 4 of 4)*
56. Administratively Reviewed By: *(title*)
57. User Name with credentials signature, Date, Time (Residential Director, Nursing Supervisor)

Discharge Summary

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, Medicaid #, User Name & Credentials), Date of Discharge (*calendar box, auto-populate, editable*)
2. Reason for Admission *(auto-populate, text box)*
3. Disposition Reason Type: Adoption, Foster Care, Biological Family, Emergency D/C, Kinship/Relative, Acute Hospital, Medical, RTF, Deceased, Other (*pop-up entry*) *(drop-down values*)
4. To Whom Discharge (full name & agency): (*text box*), Address/City/State/Zip code: (*text boxes*), Phone: (numeric)
5. Forwarding Address of Child: (*text boxes*)
6. Discharge Acknowledgment: (*drop-down values*)
7. Discharge Plan: (*text box*)
8. Course and Progress of the Resident (Goal 1, Progress 1, Goal 2, Progress 2, Goal 3, Progress 3, Goal 4, Progress 4) (auto-populate, text boxes)
9. Critical Events and Interactions: (auto-populate, text box)
10. Medical Summary and Current Medications (medical treatments, psychopharmacological treatment & discharge medication regime): (*auto-populate, text box*)
11. Discharge Diagnoses DSM V (*text box, code search*), ICD-10-CM (*text box, code search*), Diagnosis Description (*text box, populate based on* care deficit), Dressing-Needs Prompts (self-care deficit), Feeding-Needs Assist (self-care deficit), Feeding-Needs Prompts (self-care deficit), Grooming-Needs Prompts (self-care deficit), Grooming-Needs Prompts (self-care deficit), OT Referral, Toileting-Needs Assist (self-care deficit), Toileting-Needs Prompts (self-care deficit), Independent in all ADL, See Nurse's Notes
28. Activity Intolerances or Restrictions? (yes/no), If 'yes', explain (*text box*)
29. Problems Identified: (*check boxes*) Dressing-Needs Assist (self-care deficit), Dressing-Needs Prompts (self-care deficit), Feeding-Needs Assist (self-care deficit), Feeding-Needs Prompts (self-care deficit), Grooming-Needs Prompts (self-care deficit), Grooming-Needs Prompts (self-care deficit), Nursing Supervisor Notified, Toileting-Needs Assist (self-care deficit), Toileting-Needs Prompts (self-care deficit), Bathing/Hygiene (self-care deficit), Impaired physical mobility (PT/OT notified)
30. Oral Hygiene program instructed? (yes/no), If 'no', why? (*text box*)
31. Hand Hygiene Program Instructed? (yes/no), If 'no', why? (*text box*)
32. Sleep – Rest: (check boxes) Difficulty falling asleep, Difficulty staying asleep, Does not feel rested after sleep, No problem, Other, See Nurse's Notes, Sleep pattern disturbance (Psychiatrist notified)
33. Describe child's sleep routine, what helps them fall asleep? (*text box*)
34. Nutritional Screening/Metabolic: (* indicates potential nutritional risk. Patient to be referred to Nutritional Services for further evaluation) (*check boxes*) *Difficulty chewing, *Difficulty swallowing, *GI symptoms severe or persistent, * Insufficient knowledge of diet-food-drug interactions, *Nutritional intake fair-poor (less than 70%), *Recent unintentional weight loss, *Significant decrease in appetite, *Skin Breakdown, *Special medical concerns effecting diet (Autism, FTT, C.F., etc.), Altered Oral Mucous Membrane, GI symptoms (N/V/D/C), Loss of subcutaneous fat, muscle wasting, No identified risk, Nutritional intake greater than 70%, Nutritional Risk on Admission
35. Problems Identified: (*check boxes*) Dietitian Notified, Altered Nutrition: Less than body requires, Impaired swallowing, Knowledge deficit
36. Action to be Taken: (*check boxes*) No action needed, Nutritional Services notified for any box checked, Special Diet (describe & if special diet needed) (*text box*)
37. Cognitive/Perceptual Communication: (*check boxes*) Speech Therapy Referral, Clear, Comprehends, Comprehension Difficulty, Confused, Expressive Difficulty
38. Hearing (*check boxes*) Speech Therapy Referral, Aid, Discharge Impaired, No Difficulty, Tinnitus
39. Vision: (*check boxes*) Contacts, Far sighted, Glasses, Impaired, Near sighted, No difficulty
40. Problems Identified: (*check boxes*) Altered Visual/Perceptual senses, Impaired verbal communication (speech notified), Pain (Medical Staff notified)
41. Describe "Other" and additional comments: (*text box*)

code)
12. Problems: (*text box*)
13. Needs: (*text box*)
14. User Name with credentials signature, Date, Time

Face Sheet *(report output)(user can generate after intake/admission completed – auto-populate available fields)*

1. "Alice C. Tyler Village of Childhelp East – Psychiatric Residential Treatment Facility" "FACE SHEET" (*report title*)
2. Full Name:
3. Today's Date:
4. MRN:
5. Admission #:
6. DOB:
7. Gender:
8. Date of Admission:
9. RESIDENT INFORMATION (*title section*)
10. Age:
11. Place of Birth
12. Religious Preference:
13. Ethnicity:
14. SSN:
15. Time of Admit:
16. Type of Placement:
17. Last Known Address/City/State/Zip Code:
18. Medicaid#:
19. Private Ins #:
20. Allergies:
21. Admit Psychiatrist:
22. Therapist:
23. County of Ref:
24. Residential Group Home:
25. DIAGNOSIS (ICD code only) (*title section*)
26. Admitting:
27. Current/Billing Dxs:
28. Discharge Dxs:
29. LEGAL GUARDIAN INFORMATION (*title section*)
30. Full Name:
31. Relationship:
32. Guarantor's SSN:
33. Phone:, Cell:, Fax:
34. E-mail:
35. REFERRAL SOURCE INFORMATION (*title section*)
36. Name of Referral Source:
37. Individual Name:, Title:
38. Address:
39. Phone:, Cell:, Fax:
42. Having pain today? (yes/no), If 'yes' complete Pain Assessment form
43. Neurological History: (*text box*)
44. Neurosensory: (*check boxes*) Headache/Pain, Motor Disturbance (Describe) (*pop-up text box*), Numbness, Seizures, Tingling
45. Pupil Size: (*check boxes*) Other, PERRLA (Left), PERRLA (Right)
46. Level of consciousness & Oriented to: (*check boxes*) Event, Other Person, Place, Time
47. Problems Identified: (*check boxes*) Nursing Supervisor Notified, Alteration in mental orientation, Risk for sensory perceptual alterations (Nursing Supervisor notified)
48. Bowel movements & sounds: (*check boxes*) Hyperactive, Pain (Medical Staff Notified), Present Blood in stool, Encopresis, Constipation, All quads, Diarrhea, Hypoactive, Other (*pop-up text box)*, Absent (describe) (*pop-up text box*), No Problem
49. Problems Identified: (*check boxes*) Nursing Supervisor Notified, Altered GI Elimination, Bowel Incontinence, Constipation, Diarrhea, Dysreflexia, Encopresis
50. Genitourinary: (*check boxes*) Bladder Distension, Burring, Discharge Dribbling, Enuresis, Frequency, Hematuria, No Problem, Nocturia, Urgency
51. Problems Identified: (*check boxes*) Nursing Supervisor Notified, Enuresis, Incontinence, Stress, Urge/Incontinence, Urinary retention history
52. Integumentary: (include Skin temperature-Turgor & any wounds, bruises, etc.) (*check boxes)* Bruises, Normal, Cool, Pale, Fair, Poor, Flushed, Rashes, Good, Skin Uleer, Hot, Tinea Pedis Screen, Lesions, Warm, Impaired skin integrity, Wounds, High Risk for impaired skin integrity, Lice Screen, Other (*pop-up text box*)(include history of skin problems & any foot care needs)
53. Musculoskeletal: (include Gait & Muscle Strength) (*check boxes*) Grips Muscle Strength-None, Grips Muscle Strength-Strong, Grips Muscles Strength-Weak, Pushes Muscle Strength-None, Pushes Muscle Strength-Weak, Cramping, Joint Stiffness, Pain (Medical Staff Notified), Posture, Prosthesis, Scoliosis screening, Spasm, Steady, Swelling, Tremor, Unsteady
54. Male/Female Reproduction: (*check boxes*) Nursing Supervisor Notified, Abnormal bleeding, Abuse/Neglect, Breast Lumps, Communicable Infectious disease, Demonstrates sufficient knowledge of menstruation for present development, Discharge, Has not begun menstruation, History of sexual abuse, Itching, Knowledge deficit-(Puberty, Sexually Transmitted Diseases, etc.)(pop-up text box)(specify specifics areas), Needs information on menstruation, Other, Pain (Medical Staff Notified), Penile discharge, Scrotal abnormalities, Sexually active, Sexually inactive, Sexually transmitted communicable disease, Tender
55. Describe issues that have been checked: (If menstruation has begun, also include age of first menstruation and whether they are regular or irregular) (*text box*)

40. E-mail:
41. FUNDING/PLACING AGENCY INFORMATION (*title section*)
42. Funding Placement Agency:, County:
43. Address:
44. Phone:, Fax:
45. CSA Coordinator:
46. E-mail:
47. BIOLOGICAL PARENTS INFORMATION (if NOT the Legal Guardian) (*title section*)
48. Full Name:, Relationship: Mother
49. Address:
50. Phone:
51. Full Name:, Relationship: Father
52. Address:
53. Phone:
54. OTHER INVOLVEMENT (*title section*)
55. Full Name:, Relationship:
56. Address:
57. Phone:, Fax:
58. Full Name:, Relationship:
59. Address:
60. Phone:, Fax
61. EMERGENCY INFORMATION (*title section*)
62. Full Name:, Relationship:
63. Address:
64. Phone:
65. DISCHARGE INFORMATION (*title section*)
66. Date of Discharge:
67. Reason for Discharge:
68. Disposition Reason of Discharge:
69. To Whom Discharged:
70. Address:
71. Phone:
72. Forwarding Address of Child:

Physical Holding Minimization Plan

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. I. MEDICAL CONDITIONS (*title section*)
3. Is there any pre-existing medical conditions or disabilities that would present problems if the child were physically held? Yes/No (*radio buttons*)(*if Yes, pop-up:* Medical Condition (*text box*), Problems if resident were physically held (*text box*)
4. II. CLINICAL CONDITIONS (*title section*)
5. Is there any trauma, sexual or physical abuse or severe emotional events that could cause increased psychological distress if the child were physically held? Yes/No (*radio buttons*)(*if Yes, pop-up:* Trauma
56. User Name with credentials signature, Date, Time

Nutrition Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Nutritional Screening: (*text box*)
3. Anthropometrics: (*title, (trigger conditions*))
4. Height: percentile (*numeric*)
5. Weight: percentile (*numeric*)
6. BMI: percentile (*numeric*)
7. Kilocalorie Requirement: (*numeric*)
8. Pertinent Lab Data: (*text box*)
9. Medical Hx: (*text box*)
10. Oral Health: (*text box*)
11. Medications: (*auto-populate, text box*), Side Effects: (*auto-populate, text box*) (*multiple rows*)
12. Food/Nutrition History (*title*)
13. Intake: Likes: (*text box*), Dislikes: (*text box*)
14. Nutrition/Health Awareness: Knowledge/Beliefs: (*text box*), Past Nutrition Counseling/Education: (*text box*)
15. Physical Activity/Exercise: Activity Pattern: (*text box*), Amount of Sedentary Time: (*text box*)
16. Plan (title)
17. Diet Order: (*text box*)
18. Nutrition Diagnosis (*IDNT, look-up table, multiple entries*)
19. Supplement: (*text box*)
20. Food Allergy: (*text box*)
21. Notes; (*text box*)
22. User Name with credentials signature, Date, Time

Animal Assisted Therapy Assessment (AAT)

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Does the child have any allergies to any animals? Yes/No (*radio buttons*), *(if 'Yes', pop-up* "What animals and what reactions have been note?" (*text box*))
3. Is the child afraid of any animals? Yes/No (radio buttons), *(if 'Yes', pop-up* "What animals?" (*text box*), Unknown (*checkbox*))
4. Has the child had any experiences with animals that might contra indicate the use of AAT? Yes/No (*radio buttons*), *(if 'Yes', pop-up* "Explain?" (*text box*))
5. Has the child had any positive relationships with animals? Yes/No/Unknown (*radio buttons*)
6. Please list possible benefits for the child to have AAT in his/her treatment plan: (*3 row text boxes*)

Medication Management

Event or Experience (*text box*), Problems if child were physically held (*text box*)
6. III. EMOTIONAL/BEHAVIORAL HISTORY (*title section*)
7. A. Emotional Triggers: (Identify situations, events, etc. that trigger emotional outbursts) (*text box*)
8. B. Behavioral Manifestations: (Identify how the child displays emotional outbursts) (*text box*)
9. C. De-escalation Techniques: (Identify techniques/interventions that help calm the child) (*text box*)
10. IV. MINIMIZATION PLAN (*title section*)
11. A. Non-Physical De-escalation Intervention Strategies: (*text boxes, 8 rows numbered)*
12. B. Physical Holding Procedure: Physical holding per approved facility procedures (*checkbox*), Physical holding per approved facility procedures with accommodations (*checkbox*)
    i. If accommodations are required, list accommodations: (*text box*)
13. I have reviewed and approve the Physical Holding Minimization Plan:
14. Child: , Date:
15. Parent/Guardian: , Date:
16. Admissions: , Date:
17. Treatment Team Review:
18. Medical Director: , Date:
19. Clinical Director: , Date:
20. Therapist: , Date:
21. Nurse: , Date:
22. Direct Care: , Date:
23. Education: , Date:
24. Recreation: , Date:

Medication Physician Note

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Allergies: (*text box, auto-populate*)
3. Child observed in milleu, Medications reviewed: (*checkbox),* Time *(time control, default with system time)(text box*)
4. Additional Physician Notes: (*multi-rows*); Date (*calendar control*), Note: (*text box*)
5. User Name with credentials signature, Date

Occupational Therapy Note

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Date: (*calendar control*), Time: (*time control)*
3. Session Length: (*numeric*) minutes
4. Focus of sessions (Goals & Objectives): (*text box*)
5. Interventions Used: (*text box*)
6. Behavior/Response During Session: (*text box*)
1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Time, Date of Admission, Admission #, User Name & Credentials)
2. Allergies: (*text box, auto-populate*)
3. Date of Service: (calendar control, default today's date), Time: (*time control)*
4. Billing Code: (*text box, default* '90862')
5. Notes: (*text box*)
6. Face-to-Face contact: (*numeric, default* '15') minutes
7. Medication (*title subsection*)(*6 columns headings:* Order Date (*calendar control*), Status (*drop-down*), Medication & Indications (*text box*), Start Date (*calendar control*), Discontinued Date (*calendar control*), Observed Side Effects (*text box*)*; 4 rows*)
8. Medication effect on child's progress as measured by psychiatrist's observation, staff reports & children's reports: (*text box*)
9. Medication being considered for behaviors to be modified: (*text box*)
10. Medication Side effects observed or reported: (*text box*)
11. Mental Status Exam: (*title subsection*)(*checkboxes*)
    i. Appearance: Well-dressed or groomed, Adequately groomed, Poor Hygiene, Other: (*text box*)
    ii. Affect: Appropriate to mood & topic, Flat, Restricted, Good Range, Inappropriate to topic, Other: (*text box*)
    iii. Rapport: Able to establish & maintain eye contact, Good eye contact, Little eye contact, No eye contact, Other: (*text box*)
    iv. H/SI: Homicidal ideation, Homicidal thoughts with a plan to do harm, Homicidal threats when angry, Suicidal ideation, None after Psychiatrist's usual questioning, Suicidal thoughts with a plan for self-harm, Suicidal thoughts when angry, Suicidal thoughts, Other: (*text box*)
    v. Thought Content: Hallucinations, Delusions, Obsessions, Preoccupations, WNL for age
    vi. Alertness/Orientation: Appropriate for age (x4), Hyper-Alert, Lethargic, Sleepy, Other: (*text box*)
    vii. Cooperation: Defensive, Evasive, Excellent, Good, Minimal, Other: (*text box*)
    viii. Motor Movements: Hyperactive, Hypoactive, Involuntary movements, WNL, Other: (*text box*)
    ix. Thought Form: Disorganized, Illogical, Logical & linear, Perseveration, Thought Blocking, Other: (*text box*)
    x. Attention/Concentration: Age appropriate, Easily distracted by external stimuli, Easily distracted by internal stimuli
    xi. Memory: Intact to gross testing both long & short term, Other: (*text box*)
    xii. Speech: Articulation problem, Fast, Slow, Good articulation, Loud, Soft, Pressured, Spontaneous speech, No spontaneous speech, Other: (*text box*)
    xiii. Mood: Described by as: Frustrated, Happy, Angry, Sad, Other: (*text box*)
12. Medical Issues & Follow-up: (*text box*)
13. AIMS Test: (*title subsection*) – Instructions:
    - Either before or after completing the examination procedure, observe the patient unobtrusively at rest (i.e. waiting room)

7. Assessment/Plan: (*text box*)
8. User Name with credentials signature, Date

Nursing Progress Note

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Date: (*calendar control*), Time (*time control*): (*text box)(multi-row capability*)

Emergency Treatment Team Meeting

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Date: (*calendar control*), Time: (*time control*)
3. Location: (*text box*)
4. Reasons for the Meeting: (*text box*)
5. Safety Plans (*title subsection*)(*set hyperlink to safety plans to open & review; if opened, populated date reviewed to each safety plan*)
6. CIPOC (*title subsection)(set hyperlink to CIPOC to open & review; if opened, populated date reviewed)*
7. Physical Hold (*title subsection*)(*set hyperlink to physical hold to open & review; if opened, populated date reviewed to each physical hold*)
8. Direct/Shift Notes (*title subsection*)(*set hyperlink to shift notes (last 7-days) to open & review; if opened, populated date reviewed to each shift note*)
9. Medication Management (*title subsection)(set hyperlink to medication management to open & review; if opened, populated date reviewed)*
10. Antecedents, Precipitants, Contextual Factors Associated with Problem Behaviors and Symptoms: (*text box*)
11. Discharge Plan discussed: (*checkbox*) *(if marked, pop-up text box*)
12. Was an Individualized Behavioral Contingency Plan (IBCP) Developed? Yes/No (*radio buttons*)(*if Yes, pop-up:* "IBCP Reviewed?" Yes/No *(radio buttons*)(*If No, pop-up:* "Treatment Recommendations/Interventions Designed to Diminish Target Behaviors and Symptoms if no IBCP was Developed:" (*text box*))
13. Suggested Participants (*title subsection)(auto-populate from Intake Admissions*)
    i. Participant's Name, Title, Agency Name, Relationship to Child, Type of Support, Phone Work, Phone Cell, E-mail: Add as participant, Delete (*link/button)(if 'Add as participant', populate in Attended Participant list*)
14. Attended Participants (*title subsection)(grid adding participants*)
    i. Participant's Name: (*text box*), Title: (*text box*), Agency Name: (*text box*), Relationship to Child: (*text box*), Type of Support: (*drop-down*), Phone Work: (*numeric*), Phone Cell: (*numeric*), E-mail: (*text box*); Save/Cancel (*link/button*)
15. Guardian Name (*text box*), signature, Date, Time
16. Youth Name (if 12-year old or over) (*pre-populate, text box*), signature,
    - The chair to be used in the examination should be a hard, firm one without arms
    - After observing the patient, rate him or her on a scale of 0-4 according to the severity of symptoms: 0 (none), 1 (minimal), 2 (mild), 3 (moderate), 4 (severe)
    - Ask the patient whether there is anything in his or her mouth (i.e. gum, candy, etc.) and if so to remove it
    - Ask the patient about the current condition if his or her teeth. Ask patient if he or she wears dentures. Do teeth bother patient now?
    - Ask patient whether he or she notices any movement in mouth, face, hands or feet. If yes, ask patient to describe the indicate to what extent they currently bother patient or interfere with his or her activities
14. Have patient sit in chair with hands on knees legs slightly apart and feet flat on the floor. (look at entire body for movements while in this position) (*scale 0-4*)
15. Ask patient to sit with hands hanging unsupported. If male, between legs; if female & wearing a dress, hanging over knees. (observe hands and other body areas) (*scale 0-4*)
16. Ask patient to open mouth (observer tongue at rest within mouth) do this twice.
17. Ask the patient to tab thumb, with each finger, as rapidly as possible for 10-15 seconds; separately with right hand then with left hand. (observe facial & leg movements)
18. Flex and extend patient's left and right arms (one at a time)
19. Ask patient to stand-up. (observe profile – observe all body areas again, hips included)
20. Ask patient to extend both arms outstretched in front with palms down. (observe trunk, legs and mouth)
21. Have patient walk a few paces, turn and walk back to chair (observe hands and gait), do this twice.
22. AIMS total: (*numeric total*)
23. Assessment: (*title subsection*) (*3 column grid, 6 rows*)
24. DSM V Code (*text box, code search look-up*), ICD-10-CM (*text box, code search look*-up), Diagnosis Description (*auto-populate based on code*)
25. Explanation of diagnostic changes: (*text box*)
26. Plan: (*text box*)
27. User Name with credentials signature, Date, Time

Date, Time

17. Name of Witness (*text box*), signature, Date, Time

Exhibit 6 – Optional Forms

The following current forms of client gathered data are used at the Village. These optional forms need to be priced out separately in the proposal cost section. Below illustrates the collected data for each optional form.

Therapeutic Pass Request

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Person requesting: (*text box*)
3. Relationship to child: (*drop-down*)
4. Contact information: (*text box*)
5. Length of Pass (*title section*)
6. Date(s) (*calendar control*), Time of pick-up (*time control*), Duration (*radio buttons:* 2-hours, 4-hours, 8-hours, 1-overnight stay, 2-overnight stay, Other: (*text box*))(*3 columns & 3 rows*)
7. Goal of Pass: (*text box*)
8. Attestation (I am responsible for the care of named child until returning to Childhelp) (*title section*)
9. Print Name: (*text box*), Signature: _____, Date: (*calendar control*)
10. Physician Order (*title section*)
11. Per MD orders, child may have an off grounds visit with: (*text box*) (parent/guardian).
12. The visit will start on: (*calendar/time controls*) (departure from Childhelp date/time) and will end on: (*calendar/time controls*) (arrival back to Childhelp date/time).
13. The visit is to include a pre-visit and post-visit body check. (*label statement*)
14. User Name with credentials signature, Date
15. Approved, Modified, Denied (*radio buttons*)
16. Reason: (*text box*)
17. Name with credentials signature, Date
18. Name with credentials signature, Date
19. Name with credentials signature, Date
20. Name with credentials signature, Date

TB Risk Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. History of prior Bacillus Calmette-Guerin (BCG) vaccine? Yes/No/Unknown (*radio buttons*) (*if Yes, pop-up:* Specify year: (*numeric*))
3. Drug allergies: (*text box*)
4. History of TB Skin Test and TB Treatment (*title subsection*)
5. Prior Mantoux Tuberculin Skin Test (TST)? Yes/No/Unknown

Therapeutic Pass Success Form *(completed after Therapeutic Pass Request)*

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Name of person taking child on pass: *(text box*), Date: (calendar control)
3. Length of Pass: (*radio buttons:* 2-hours, 4-hours, 8-hours, 1-overnight stay, 2-overnight stay, Other: (*text box*))
4. What was the goal that was worked on? (*text box*)
5. Please give an example of something that happened during the visit that best describes how the goal was achieved or not achieved: (*text box*)
6. Name with credentials signature, Date

Physical Examination - Sick & Acute Care Form

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Physical Exam, Sick/Acute Care (*checkboxes*)
3. Vital Signs (*title section*)
4. Allergies: (*text box*)
5. Temp: (*numeric*), Heart Rate: *(numeric*), Resp: (*text box*), Blood Pressure: (*numeric*)/(*numeric*) (*trigger warning if Systolic ages 6-12 is <85 or >120, ages 13-18 is <95 or >140, or if Diastolic ages 6-12 is <50 or >80, ages 13-18 is <60 or >90*), Pulse-ox %: (*numeric*), HT: (*numeric*) ft (*numeric*) in, WT: (*numeric*) lbs
6. Immunizations: (text box), Last PPD Date Placed: (*calendar contro*l), Result: (*text box*)
7. Current Meds: (*text box*)
8. Past Medical History: (*text box*)
9. Family Medical History: (*text box*)
10. Treatments tried: *(text box*)
11. Anticipatory guidance provided (*checkbox*)
12. Early & Periodic Screening, Diagnostic, & Treatment (EPSDT) Screen (required for Head Start): Results: (*text box*), Date: (*calendar control*), Blood Lead: (*text box*), Hct/Hgb: (*text box*)
13. General appearance: (*text box*)
14. Chief complaint and History of Present Illness: (*text box*)
15. Focused Systems Assessment (*title section*)
16. HEENT Exam: (*title subsection*), PERRLA, EOM's intact, TM's WNL, Pharynx-WNL, Fundoscopic exam-WNL, Conjunctiva-WNL, External auditory canals-WNL, Nares-WNL, Sclera-white, No facial droop/sagging, Oral-teeth intact, Hearing-WNL, Visual Acuity (Snellen) (checkboxes), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)),

(*radio buttons*) (*If Yes, pop-up*: Date (*calendar control*)), Induration: (*numeric*) mm

6. Prior TB treatment? Yes/No/Unknown (*radio buttons*) (*If yes, pop-up*: LTBI, TB Disease (*checkboxes*), Year of Treatment: *(numeric*), Treatment duration: (*text box*), TB medication taken: (*text box*), Location of treatment: (*text box*)
7. I. Screen for TB Symptoms (*title subsection*)(*checkboxes*)
8. None (*if marked skip to II. TB Infection Risk*), Cough for > 3 weeks *(if marked, pop-up:* Productive? Yes/No (*radio buttons*), Hemoptysis? Yes/No (*radio buttons*)), 'Fever, unexplained', Hemoptysis, Unexplained weight loss, Poor appetite *(if marked, pop-up warning:* "Evaluate symptom"), Night sweats, Fatigue (*if marked, pop-up warning:* "Evaluate symptom")
9. Pediatric child (<= 6 years of age): Wheezing, Failure to thrive, 'Decreased activity, playfulness and/or energy', Lymph node swelling, Personality changes (*checkboxes*)
10. II. Screen for TB Infection Risk (*title subsection*), "Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized."
    i. Assess Risk for Acquiring LTBI (*checkboxes*)
        - Person is a <u>current</u> close contact of a person known or suspected to have TB disease. Name of source case: (text box)
        - Person has lived in a country – for 3 months or more – where TB is common, and has been in the US for 5 or fewer years
        - Person is a resident or an employee of a high TB risk congregate setting
        - Person is a health care worker who serves high-risk clients
        - Person is medically underserved
        - Person has been homeless within the last two years
        - Person is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
        - Person injects illicit drugs or uses crack cocaine
        - Person is a member of a group identified by the local health department to be at an increased risk for TB infection
        - Person needs baseline/annual screening approved by health department

    ii. Assess Risk for Developing TB Disease if Infected (*checkboxes*)
        - Person is HIV <u>positive</u>
        - Person <u>has risk for HIV infection, but HIV status is unknown</u>
        - Person was recently infected with Mycobacterium tuberculosis

Notes/Abnormal findings: *(text box*)

17. Neck: (*title subsection*), WNL, No Bruit/JVD, No lymphadenopathy-R/L, No thyromegaly/nodules, Trachea mid-line (*checkboxes*), Note Abnormal findings: (*text box*)
18. Respiratory/Chest/Lungs *(title subsection*), Breath sounds-WNL, No distress, No cough, No Tachypnea, No wheezing, Cap ref<3sec, Pink mucous membranes, No adventitious breath sounds, Good bilateral aeration, No use of accessory muscles or nasal flaring, Percussion resonate in all fields, symmetrical movement on inspiration/expiration (*checkboxes*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
19. Lymphatic (*title subsection*), No lymph gland enlargement to neck, axilla, epitrochlear and supraclavicular area, or groin (*checkbox*), Notes/Abnormal findings: (*text box*)
20. Cardiac/Heart (*title subsection*), RRR, No Brady/tachycardia, No murmurs, S1/S2, No gallops (*checkboxes*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
21. Abdomen (title subsection), No tenderness to palpation, BS present x 4 quads, No rebound tenderness, No masses, No scarring or pulsation, No HSM, No distention, Soft and flat, No CVA tenderness, No Hernias (checkboxes), Last BM: (text box), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
22. GU/Rectal (*title subsection*), Genitals WNL, No Hernias, No masses, Anus intact, Circumcised, Testes descended-R?, No Vesicles or ulcerations, Femoral pulse-bilat, No discharge vaginal/penile, 'Denies dysuria, burning, urgency, or frequency' *(checkboxes*), Tanner stage: (*text box*), Last menstrual period: (*text box*), Notes/Abnormal findings: (*text box*)
23. Back (*title subsection*), Non-tender, ROM WNL, No flank pain, Hips in alignment, Shoulders in alignment, Normal curvature of the spine (*checkboxes*), Notes/Abnormal findings: (*text box*)
24. Breast (*title subsection*), Inspection WNL, No masses/tenderness, Symmetrical, No discharge, dimpling, wrinkling, or discoloration of the skin, Tanner stage: (*text box*), Notes/Abnormal findings: (*text box*)
25. Extremities (*title subsection*), ROM-WNL, NVI x4 distally, No hip clicks, No cyanosis/clubbing, No deformities, No-tender x4, Strong musculature x4, No joint pain/edema, No gallops (*checkboxes*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
26. Skin/Hair (*title subsection*), No lesions, No rashes, No pediculosis, Warm/moist to touch, Normal distribution/color, 'No tinea capitus, corporis, pedis, cruris' (*checkboxes*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
27. Visual Acuity (Snellen Chart) (*title subsection*), Both: (*text box*), R: (*text box*), L: (*text box*), Notes/Abnormal findings: (*text box*)
28. Neurological (*title subsection*), Balance/gait intact, CNs II-XII-WNL, No

- Person has certain clinical conditions, placing them at higher risk for TB disease
- Person injects illicit drugs (determine HIV status)
- Person has a history of inadequately treated TB
- Person is > 10% below ideal body weight
- Person is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as Humira Remicaid, etc.)

11. III. Finding(s) (*checkboxes*)
    i. Previous Treatment for LTBI and/or TB disease
    ii. No risk factors for TB infection
    iii. Risk(s) for infection and/or progression to disease
    iv. Possible TB suspect
    v. Previous positive TST, no prior treatment
12. IV. Action(s) (*checkboxes*)
    i. Issued screening letter
    ii. Issued sputum containers
    iii. Referred for CXR
    iv. Referred for medical evaluation
    v. Other: (*text box*)
    vi. Administered the Mantoux TB Skin Test *(if marked, pop-up:* TST #1: Arm: Right/Left *(checkboxes*), Date Given: *(calendar control*), Time Given: (*time control*), Date Read: *(calendar control)*, Time Read: *(time control*), Induration: (*text box*) mm, Positive/Negative (*radio buttons*); TST #1: Arm: Right/Left (*checkboxes*), Date Given: (*calendar control*), Time Given: (*time control*), Date Read: (*calendar control*), Time Read: (*time control),* Induration: (*text box*) mm, Positive/Negative *(radio buttons*))
13. Comments: (*text box*)
14. Name with credentials signature, Date, Phone number

Acuity Monitoring Sheet

1. Client information (*auto-populate:* ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Responsible Staff(s): (*title subsection*)
    i. Hours (From: (*drop-down*), To: (*drop-down*), (*text box*)
    ii. Hours (From: (*drop-down*), To: (*drop-down*), (*text box*)
    iii. Hours (From: (*drop-down*), To: (*drop-down*), (*text box*)
    iv. Hours (From: (*drop-down*), To: (*drop-down*), (*text box*)
    v. Hours (From: *(drop-down*), To: (*drop-down*), (*text box*)
    vi. Hours (From: (*drop-down*), To: (*drop-down*), (*text box*)
3. Level of Supervision (describe Doctor's Order): (*title subsection*)
    i. Medical Staff (Acuity sheet order completed by): (*drop-down*)
    ii. Acute: (*text box*)
    iii. Other: (*text box*)
4. Time (*start range at 6:00 AM with 30-miniute incremental rows for* weakness/extremities x4 (*checkboxes*), Level of Consciousness: Alert & oriented x3, Drowsy, Stupor Coma (*checkboxes*), Handedness: Right, Left, Ambidextrous (*checkboxes*), Knowledge: 'able to answer age appropriate questions regarding, education, cultural background, life experience, etc.' (*checkbox*), Speech and Language: Clear Articulation, No slurring, No stuttering, 'No difficulty sending, receiving, interpreting verbal, written, or gestural messages' (*checkboxes*), Deep Reflexes: 0=Absent 1=Diminished 2=Normal 3=Increased 4=Hyperactive 5=Hyperactive Clonus (*scale/slider/button control*) –
    i. Biceps: Right:, Left:
    ii. Triceps: Right, Left:
    iii. Radial: Right:, Left:
    iv. Patellar: Right:, Left:
    v. Achilles: Right:, Left:

    (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
29. Cranial Nerves Exam (*title subsection*), Olfactory I: Smells coffee or alcohol swab (*checkbox*), Optical II: Visual field full, no deficits (*checkbox*), Oculomotor III, Trochlear IV, and Abducens VI: Movement of eyes smooth through all six fields of gaze (*checkbox*), Trigem V: Distinguish 1 from 2 point touch symmetrically on forehead, cheek, chin; clinch teeth symmetrically (*checkbox*), Facial VII: 'Upper; frowns symmetrically', 'Lower; smiles symmetrically' (*checkboxes*), Acoustic VIII: Hears finger rubbing or snapping equally in both ears (*checkbox*), Glosso-Pharyngeal IX: Has gag reflex (*checkbox*), Vagus Nerves X: Can make guttural sounds (*checkbox*), Accessory XI: 'Shrugs shoulders symmetrically; normal strength and symmetry on turning head and elevation of shoulders' (*checkbox*), Hypoglosal XII: 'Tongue protrudes in midline with absence of fasciculation, tremors, or atrophy, normal muscle strength of tongue, normal lingual speech' (*checkbox*), Cerebellar: No abnormalities of gait (tandem and heel-toe), 'Able to touch finger to nose and heel to shin and visa-versa rapidly and accurately; able to perform rapid alternating movements (supination and pronation of forearms (quickly and symmetrically) (*checkboxes*)
30. Motor Functions (*title subsection*), 'Muscle tone and mass symmetrical on inspection, good tone without spasticity or rigidity; no contractures or hypotonus, no atrophy', Adequate and symmetrical muscle strength muscle strength of resistance to opposing force, 'Absence of tremors, twitches, tics', 'Full range of motion with no restrictions in upper and lower extremities, spine' (*checkboxes*)
31. Genital (*title subsection*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
32. Urinary (*title subsection*), (*scale:*1=Within normal, 2=Abnormal finding, 3=Referred for evaluation or treatment (*radio buttons*)), Notes/Abnormal findings: (*text box*)
33. Lab ordered/results: (*title subsection*) (*text box*)
34. Sensory System (*title subsection*), Normal and symmetrical response to touch

24-hours), Description of Child's Behaviors and Activities and Staff Interventions (*text box*), Staff Initials (*column grid, subsection*)
5. General Comments: *(text box*)
6. Final review by Director of Residential Services: Signature, Date

Occupational Therapy Screening

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, IEP, User Name & Credentials)
2. Fine Motor (*title subsection*)
   i. Shoe tie: Yes/No (*radio buttons*), Comments: (*text box*)
   ii. Adequate cutting: Yes/No (*radio buttons*), Comments: (*text box*)
   iii. Finger opposition: Yes/No (*radio buttons*), Comments (both feet): (*text box*)
3. Pencil grip: Comments: (*text box*)
4. Gross Motor (*title subsection*)
   i. Jumping Jacks x5: Yes/No (*radio buttons*), Comments: (*text box*)
   ii. Stride jumps x5: Yes/No (*radio buttons*), Comments: (*text box*)
   iii. Ball catch x5: Yes/No (*radio buttons*), Comments: (*text box*)
   iv. Balance one foot (10 seconds): Yes/No (*radio buttons*), Comments (both feet): (*text box*)
5. Visual Motor (*title subsection*)
   i. Tracking Horizontal: Yes/No (*radio buttons*), Comments: (*text box*)
   ii. Tracking Vertical: Yes/No (*radio buttons*), Comments: (*text box*)
6. Sensory (Teach/IA Input) (title subsection)
   i. Seeks movement: Yes/No (*radio buttons*), Comments: (*text box*)
   ii. Easily distracted: Yes/No (*radio buttons*), Comments: (*text box*)
   iii. Seeks oral input: Yes/No (*radio buttons*), Comments: (*text box*)
   iv. Avoids input: Yes/No (*radio buttons*), Comments: (*text box*)
7. Evaluation recommended (*checkbox*)
8. Name with credentials signature, Date

Occupational Therapy Assessment

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Referral and Psychosocial Overview (*title subsection*)
   i. Referral Source: (*text box*)
   ii. Brief Psychosocial Overview: (*text box*)
3. Observations (*title subsection*)
   and pin prick (*checkbox*)
35. Other Review of Systems (*title subsection*) (*text boxes*)
   i. General
   ii. Integumentary
   iii. Gynecological
   iv. Musculoskeletal
   v. Hematologic
36. Diagnosis (*title subsection*), F/U: (*text box*), Yes, No, PRN (*radio buttons*)
37. Other Reflexes and Signs: (*title subsection*), Babinski-Absent (great toes down going on right and/or left), Babiski-Present (great toes up going on right and/or left), Non-reactive (*checkboxes*), Pain Assessment: Yes/No (*radio buttons*) (*If 'Yes', pop-up* "Refer to Pain Assessment"), Follow-up: Yes/No/PRN (*radio buttons*), History and Physical Exam Impressions: (*text box*), Order/Plan: (*text box*)
38. Developmental Screen (*title subsection*)(*5 columns:* Assessed for, Assessment Method, Within normal, Concern Identified, Referred for Evaluation; *5 rows: under Assessed for*: Emotional/Social, Problem Solving, Language/Communication, Fine Motor Skills, Gross Motor Skills; *under Assessment Methods (text boxes); Within normal (radio buttons); Concern Identified (text boxes); Referred for Evaluation (text boxes)*)
39. Hearing Screen (*title subsection*)
   i. Screened at 20dB: (*checkbox*), Indicate Pass (P) or Refer (R); Screen, 1000, 2000, 4000 (*column title grid*); (*2 rows:* R, L (*under Screen*), (*text boxes, can be* 'P' or 'R' *under 1000, 2000, 4000*)
   ii. Screened by OAE (Otoacoustic Emissions): Pass/Refer (*radio button*)
   iii. Referred to Audiologist/ENT, Permanent Hearing Loss Previously identified (Left), Permanent Hearing Loss Previously identified (Right), Hearing aid or other assistive device, Unable to test – needs rescreen (*checkboxes*)
40. Vision Screen (*title subsection*)
41. With Corrective Lenses (*checkbox*)
   i. Stereopsis: Pass/Fail/Not tested (*radio buttons*)
   ii. Distance: Both: 20/(*numeric*), Right: 20/(*numeric*), Left: 20/(*numeric*), Test used: (*text box*)
42. Pass/Referred to eye doctor, Unable to text – needs rescreen (*checkboxes*)
43. Dental Screen (*title subsection*)
   i. Problem Identified: Referred for treatment, No Problems: Referred for prevention, No Referral: Already receiving dental care (*checkboxes*)
44. Recommendations to (Pre) School, Child Care, or Early Intervention Personnel (*title subsection*)
45. Summary of Findings: (*radio buttons*)
   i. Well child; no conditions identified of concern to school program activities
   ii. Conditions identified that are important to schooling or physical activity (if marked, expand)
      - Complete sections below and/or explain: (t*ext box*)
      - Allergy: (*checkbox*), Food: (*text box*), Insect: *(text box*), Medicine: *(text box*), Other: (text box) (*checkboxes*); Type of allergic reaction:

i. Physical Appearance: (*text box*)
ii. Relatedness (*text box*)
iii. Affect: (*text box*)
iv. Mood: (*text box*)
v. Motor Behavior: (*text box*)
vi. Activity: (*text box*)
vii. Speech: (*text box*)
viii. Reality Orientation: (*text box*)
ix. Thought Process: (*text box*)
x. Frustration Tolerance: (*text box*)
xi. Attention Span: (*text box*)
xii. Impulse Control: (*text box*)
xiii. Selection of Materials: (*text box*)
xiv. Approach to Tasks: (*text box*)

4. Drawing Developmental Level (*title subsection*)
   i. Stage of current drawing developmental level as defined by Lowenfeld: (*text box*)
   ii. As evidenced and indicated by the artwork: (*text box*)
5. Projective Drawing Tasks (*title subsection*)(*2 columns:* "Tasks", "Title (per child)")
   i. Projective Scribble Drawing (PSD): (*text box*)
   ii. Favorite Weather Drawing (FWD): (*text box*)
   iii. Human Figure Drawing (HFD): (*text box*)
   iv. Kinetic Family Drawing (KFD): (*text box*)
   v. Reason for Being Here Drawing (RBHD): (*text box*)
   vi. Free Choice Drawing (FCD): (*text box*)
6. Challenges and Strengths (*title subsection*)(*2 different columns:* "Challenges", "May be evidenced and indicated by the following: art indicators, behavioral observations and verbalizations"; "Strengths", "May be evidenced and indicated by the following: art indicators, behavioral observations and verbalizations")
7. Diagnostic Impression, DSM-5 (*title subsection*)(*3 columns:* "DSM-V Code", "ICD-10-CM", "Diagnosis Description")(*3 rows*)(*Lookup table*)
8. Rule Out due to possible historical report (*title subsection*) (*3 columns:* "DSM-V Code", "ICD-10-CM", "Diagnosis Description")(*3 rows*)(*Lookup table*)
9. By History (*title subsection*) (*3 columns:* "DSM-V Code", "ICD-10-CM", "Diagnosis Description")(*3 rows*)(*Lookup table*)
10. Recommendations: (*text box*)
11. Name with credentials signature, Date
12. Name with credentials signature, Date

anaphylaxis, local reaction, Response required: None, epi pen, other (*text box*)(*radio buttons*)
- Individualized health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc.)(*checkbox*)
- Restricted Activity, specify: (*text box*)(*checkbox*)
- Developmental Evaluation: (*checkbox*), Has IEP, Further evaluation needed for: (*text box*)(*checkboxes*)
- Medication (child takes medicine for specific health condition(s)): (*checkbox*), Medication must be given and/or available at school (*checkbox*)
- Special Diet, specify: (text box)(*checkbox*)
- Special Needs, specify: (*text box*)(*checkbox*)

46. Other Comments: (*text box*)
47. Name with credentials signature, Date
48. Name with credentials signature, Date
49. Practice/Clinic Name: Alice C. Tyler Village of Childhelp, 23164 Dragoon Rd, Lignum, VA 22726, Phone: 540-399-1926, Fax: 540-423-1732 (*label*)

Comprehensive Physical Examination Report

1. Client information (*auto-populate*: ClientID, Name, DOB, Gender, Date, Date of Admission, Admission #, User Name & Credentials)
2. Current Grade: (*drop-down*)
3. State or County of Birth: (*text box*)
4. Main Language Spoken: (*drop-down, auto-populate*)
5. Address/City/State/Zip Code (*text boxes, auto-populate*)
6. Name of Mother or Legal Guardian: (*text box, auto-populate*)
   i. Home Phone: (*numeric*), Work Phone: (*numeric*), Cell Phone: *(numeric*) (*auto-populate*)
7. Name of Father or Legal Guardian: (*text box, auto-populate*)
8. Home Phone: (*numeric*), Work Phone: (*numeric*), Cell Phone: (*numeric*) (*auto-populate*)
9. Emergency Contact: (*text box*)
10. Condition (*label*), Yes/No (*radio boxes*), Comments (*text box*) (*3 column titles*)
    i. Allergies (food, insects, drugs, latex)
    ii. Allergies (seasonal)
    iii. Asthma or breathing problems
    iv. Attention-Deficit/Hyperactivity Disorder
    v. Behavioral problems
    vi. Developmental problems
    vii. Bladder problem
    viii. Bleeding problem
    ix. Bowel problem
    x. Cerebral Palsy
    xi. Cystic fibrosis
    xii. Dental problems
    xiii. Diabetes
    xiv. Head injury, concussions

xv. Hearing problems or deafness
xvi. Heart problems
xvii. Lead poisoning
xviii. Muscle problems
xix. Seizures
xx. Sickle Cell Disease (not trait)
xxi. Speech problems
xxii. Spinal injury
xxiii. Surgery
xxiv. Vision problems

11. Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.): (*text box*)
12. List all prescription, over-the-counter, and herbal medications your child takes regularly: (*text box*)
13. Check here if you want to discuss confidential information with the school nurse or other school authority: Yes/No (*checkboxes*)
14. Visit (*label*), Name (*text box*), Phone (*numeric*), Date of Last Appointment (*calendar control*) (*4 columns with titles*)
    i. Pediatrician/primary care provider
    ii. Specialist
    iii. Dentist
    iv. Case Worker (if applicable)
15. Child's Health Insurance: None, FAMIS Plus (Medicaid), FAMIS, Private/Commercial/Employer sponsored (*checkboxes*)
16. "I, (*text box*) (do (*radio button*)) (do not (*radio button*)) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of disclosure is maintained in your child's health or scholastic record."
    i. Signature of Parent or Legal Guardian: _____, Date: ____/____/_____
17. Name with credentials signature, Date
18. Name with credentials signature, Date