KVC Missouri

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# SUPERVISED VISITATION REFERRAL FORM

***All consents must be SIGNED and sent with referral***

| REFERRAL DEMOGRAPHIC INFORMATION | | |
|---|---|---|
| Date of referral: | County of referral: | |
| Name: | Email: | |
| Agency: | Office Phone: | |
| Next court hearing: | Cell Phone: | |
| Guardian ad litem: | GAL Email address: | |
| Attorney for Petitioner: | Attorney Email address: | |
| Attorney for Respondent: | Attorney Email address: | |
| **NON-CUSTODIAL CAREGIVER DEMOGRAPHIC INFORMATION** | | |
| Name 1: | Name 1 DOB: | |
| Name 1 Gender: | Name 1 Race: | |
| Name 1 Address: | Name 1 Phone: | |
| | Name 1 Email: | |
| Name 2: | Name 2 DOB: | |
| Name 2 Gender: | Name 2 Race: | |
| Name 2 Address: | Name 2 Phone: | |
| | Name 2 Email: | |

**OTHER PARTICIPANTS DEMOGRAPHIC INFORMATION** (include here: any sibling not in CD custody, household members not considered non-custodial caregivers, grandparents who are part of the family dynamic, etc.)

| Participant Name | Participant Relationship to child(ren) |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| Comments: | |

| CHILD #1 DEMOGRAPHIC INFORMATION | | |
|---|---|---|
| **Name:** | | |
| **DOB:** | **Gender:** | **Race:** |
| **Relationship to Visiting Non-Custodial Caregiver(s):** | | |
| **1.** | | |
| **2.** | | |
| **Placement Name:** | **Placement Type:** | |
| **Placement Address:** | **Placement Phone:** | |
| | **Placement Email:** | |
| **Individuals Authorized To Transport Child To/From Visits:** | | |
| **1.** | **Relationship to child:** | |
| **2.** | **Relationship to child:** | |
| **3.** | **Relationship to child:** | |
| **Describe Transportation Arrangements To/From Visits:** | | |

| CHILD #2 DEMOGRAPHIC INFORMATION: | | |
|---|---|---|
| **Name:** | | |
| **DOB:** | **Gender:** | **Race:** |
| **Relationship to Visiting Non-Custodial Caregiver(s):** | | |
| **1.** | | |
| **2.** | | |
| **Placement Name:** | **Placement Type:** | |
| **Placement Address:** | **Placement Phone:** | |
| | **Placement Email:** | |
| **Individuals Authorized To Transport Child To/From Visits:** | | |
| **1.** | **Relationship to child:** | |
| **2.** | **Relationship to child:** | |
| **3.** | **Relationship to child:** | |
| **Describe Transportation Arrangements To/From Visits:** | | |

| CHILD #3 DEMOGRAPHIC INFORMATION: | | |
|---|---|---|
| Name: | | |
| DOB: | Gender: | Race: |
| Relationship to Visiting Non-Custodial Caregiver(s): | | |
| 1. | | |
| 2. | | |
| Placement Name: | Placement Type: | |
| Placement Address: | Placement Phone: | |
| | Placement Email: | |
| Individuals Authorized To Transport Child To/From Visits: | | |
| 1. | Relationship to child: | |
| 2. | Relationship to child: | |
| 3. | Relationship to child: | |
| Describe Transportation Arrangements To/From Visits: | | |

| CHILD #4 DEMOGRAPHIC INFORMATION: | | |
|---|---|---|
| Name: | | |
| DOB: | Gender: | Race: |
| Relationship to Visiting Non-Custodial Caregiver(s): | | |
| 1. | | |
| 2. | | |
| Placement Name: | Placement Type: | |
| Placement Address: | Placement Phone: | |
| | Placement Email: | |
| Individuals Authorized To Transport Child To/From Visits: | | |
| 1. | Relationship to child: | |
| 2. | Relationship to child: | |
| 3. | Relationship to child: | |

| |
|---|
| **Describe Transportation Arrangements To/From Visits:** |

| **CHILD #5 DEMOGRAPHIC INFORMATION:** | | |
|---|---|---|
| **Name:** | | |
| **DOB:** | **Gender:** | **Race:** |
| **Relationship to Visiting Non-Custodial Caregiver(s):** | | |
| **1.** | | |
| **2.** | | |

| | | |
|---|---|---|
| **Placement Name:** | **Placement Type:** | |
| **Placement Address:** | **Placement Phone:** | |
| | **Placement Email:** | |

| | |
|---|---|
| **Individuals Authorized To Transport Child To/From Visits:** | |
| **1.** | **Relationship to child:** |
| **2.** | **Relationship to child:** |
| **3.** | **Relationship to child:** |
| **Describe Transportation Arrangements To/From Visits:** | |

| **REASON FOR SUPERVISED VISITATION (include reason for children's placement and any safety concerns)** |
|---|
| |

| **CURRENT VISITATION PLAN (# of hours per week, who can be present at visit, etc.)** |
|---|
| |

| |
|---|
| |
| **DISCUSS SPECIAL CONSIDERATIONS REGARDING VISITATION RULES** |
| |
| **GOALS FOR THE CHILD/FAMILY THROUGH SUPERVISED VISITATIONS** |
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |
| **ADDITIONAL INFORMATION/COMMENTS/RECOMMENDATIONS:** |
| |

*****All consents must be SIGNED and sent with referral*****

Referring Individual Signature

Date

Referring Individual Supervisor Signature

Date

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I, _____ hereby authorize and request
(NAME OF INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE)

that _____ release or disclose
(NAME OF ENTITY, AGENCY OR INDIVIDUAL HOLDING THE RECORDS)

to _____ the below
(NAME OF ENTITY, AGENCY, INDIVIDUAL OR CLASS INTENDED TO RECEIVE THE INFORMATION)

information specified that relates to the following individual:

| NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

**THE SPECIFIC INFORMATION TO BE DISCLOSED**

- ☐ Disenrollment Summary/Instructions
- ☐ Entire medical record/or summary
- ☐ Social and Behavioral Information
- ☐ Other_____
- ☐ Education Information
- ☐ Family History and Background Information
- ☐ Medical Information

**PURPOSE OF REQUEST FOR DISCLOSURE:**

This consent is subject to revocation at any time except in those cases in which KVC has acted with the understanding that the consent will continue to be in effect until the stated purpose has been accomplished. However, any consent given with respect to substance abuse records shall have duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

Without expressed revocation, this consent expires one year subsequent to signing, or on the date set forth below, or for the following specified reasons.

| DATE: | EVENT: |
|---|---|
| | |

**CONDITION:**

**NOTE: A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

| | |
|---|---|
| _____ Signature of Client/Legal Representative | _____ Signature of Witness |
| _____ Date Signed | _____ Date Witnessed |

| | |
|---|---|
| _____<br>Relationship to client if not signed by client | **Indicate why client is unable to sign:**<br><br>□ **Minor** □ **Other**_____ |

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Dear Family,

KVC welcomes the opportunity to serve your family through our Supervised Visitation Program. We understand how difficult it may be for your family to be in a situation possibly requiring outside assistance, but we want to assure you that our goal is to help your family grow in the most successful ways possible.

We have partnered with the 13th Circuit Juvenile Court to provide yours and many other families supervised visitation by a provisionally or fully licensed clinical social worker or professional counselor. The therapist will play a role in your family support team meetings if requested. The therapist will also provide feedback to the treatment team, court and you to focus on strengths and needs of your relationship with your child to help reduce the amount of time your child spends away from you.

At KVC, we focus on family's strengths to help them realize they have the capabilities to change themselves. Through constructive interactions with the therapist, we show families how their unique strengths can help them in the difficult or trying situations they are facing. It is our sincere hope that this process will in turn lead to the development of trusting relationships among family members, where parents and children find belief in each other.

Working collaboratively with you and your treatment team, below are a few examples of services your KVC therapist may offer:

- Develop a family visitation plan
- Provide education regarding basic child development, and basic childcare needs
- Employ treatment approaches to complement family therapy such as role-modeling, role-playing, problem-solving techniques, effective communication styles, and appropriate discipline techniques.
- Observation of your ability to apply strategies learned or discussed with the therapist.
- Observe and record your interaction with your child(ren)
- Remain non-judgmental

At the end of the supervised visitation hours, we would greatly appreciate you filling out the evaluation form we will give you. Your input helps us to provide quality services; I look forward to working with you.

KVC
Supervised Visitation Therapist

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# SUPERVISED VISITATION PROGRAM – FINANCIAL POLICY

- Proof of Income and Residency: Proof of income for non-custodial parents participating in the supervised visitation program is required prior to visits being scheduled.

  Items that can be used to provide proof of income include the following:
  - ✓ **Recent check from employer**
  - ✓ **SSI check**
  - ✓ **Last year's income tax forms**

- Based on the information provided, a sliding scale fee chart will determine the amount owed by the non-custodial parent for each supervised session. **Payment will be required prior to the visit occurring. It is CASH only.**

- Failure to follow this policy will be reported to the court system as non-compliant due to non-payment.

_____Initial receipt of this information
_____Date

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# 13th CIRCUIT SUPERVISED VISITATION PROGRAM

## PRIVATE PAY SLIDING SCALE FEE

| | | Number of persons in household | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Gross Family Income** | **Level** | **1** | **2** | **3** | **4** | **5** | **6** | **7+** |
| Less than $8,000 | A | $8 | $8 | $7 | $7 | $6 | $5 | $4 |
| $8,100-$16,000 | B | $9 | $9 | $8 | $8 | $7 | $6 | $5 |
| $16,100-$20,000 | C | $10 | $10 | $11 | $11 | $10 | $9 | $8 |
| $20,100-$24,00 | D | $11 | $11 | $10 | $10 | $9 | $8 | $7 |
| $24,100-$28,000 | E | $13 | $13 | $12 | $12 | $11 | $10 | $9 |
| 28,100-$32,000 | F | $15 | $15 | $14 | $14 | $13 | $12 | $11 |
| $32,100-$36,000 | G | $20 | $20 | $19 | $19 | $18 | $17 | $16 |
| $36,100-$40,000 | H | $25 | $25 | $24 | $24 | $23 | $22 | $21 |
| $40,100-$44,000 | I | $30 | $30 | $29 | $29 | $28 | $27 | $26 |
| $44,100-$48,000 | J | $35 | $35 | $34 | $34 | $33 | $32 | $31 |
| $48,100-$52,000 | K | $40 | $40 | $39 | $39 | $38 | $37 | $36 |
| $52,100-$58,000 | L | $48 | $48 | $47 | $47 | $46 | $45 | $44 |
| $58,100- Plus | M | $58 | $58 | $57 | $57 | $56 | $55 | $54 |

*Each amount represents the amount per session.

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# NOTICE OF COST - FOR USE IN SUPERVISED VISITATION PROGRAM

The charges and cost for _____, a client of **KVC**, receiving therapeutic supervised visitation has been established at the following amount:

$_____, per session for hourly visitation effective _____/_____/_____.

Reviewed by: _____

Forms used to determine cost: _____

We are committed to the principle that all persons who need assistance should receive high quality services regardless of ability to pay.

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# STATEMENT OF AGREEMENT/CONSENT

I/We have received the ***Supervised Visitation Family Packet***. The material of this handbook includes the Welcome Letter, Client's Rights and Responsibilities, Code of Ethics, Grievance Process, and the Notice of Cost Form. This information has been reviewed with me/us and I/we understand that I/we may contact my/our Supervised Visitation Therapist with any questions regarding the content.

_____ _____

**Parent/Guardian** **Date**

_____ _____

**Parent/Guardian** **Date**

_____ _____

**Supervised Visitation Therapist** **Date**

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# CLIENT'S RIGHTS AND RESPONSIBILITIES

Rights:

1. To have access to all services without discrimination based on race, religion, gender, sexual orientation, ethnicity, age or disability.
2. To be informed about issues that may limit your access to services and decide if your family will participate in the program.
3. To be treated with respect for your personal values and beliefs.
4. To be informed of rules and policies relating to the service being provided.
5. To participate in decisions about your treatment (including your right to refuse treatment except when legally authorized) and in developing a treatment plan.
6. To have your needs met in a respectful manner.
7. To receive services in the least restrictive environment possible.
8. To have a treatment plan designed specifically for your family
9. To have a treatment team working with you that is sufficient in qualifications and numbers to carry out the treatment plan and to know who they are and what they do.
10. To raise concerns about the services you are receiving and participate in developing solutions. You also have access to a grievance process and information on filing a grievance will be provided.
11. To have information about your treatment be kept confidential, except when legal permission is given otherwise.
12. Parents/guardians may review the client record upon request. The record must be reviewed with a representative of the agency.
13. To receive a written copy of these rights and have them explained to you.

Responsibilities:

1. To participate in treatment to the best of your ability. Families are expected to actively participate in the services.
2. Families are expected to provide necessary information for determining an appropriate course for the intervention and to participate in the development of the Service Plan.
3. To respect the personal dignity of others by keeping appointments, as well as, canceling appointments in advance in case of an emergency.
4. To respect the personal values and beliefs of others and, when asked as a part of treatment, to examine your beliefs and values.
5. To be honest in your statements and to express your ideas in an appropriate manner.
6. To listen to others' ideas and respond in an appropriate manner.
7. To use services so that you can develop ways and resources to meet your family's needs.
8. To behave in a safe manner towards yourself, your family and others.
9. To share information with your treatment team so that they can individualize the plan and the review.
10. To use the time and resources of the team to work on your problem areas.
11. To be truthful in expressing concerns and reasonable in looking for solutions.
12. To use the services appropriately.
13. To sign and agree to pay the sliding scale fee as noted on the Notice of Cost Form. Payment must be made prior to a visit occurring by way of check, money order and in some cases credit cards.
14. Non-custodial parents will be expected to pay for this program only.

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# CODE OF ETHICS

Our primary responsibility is to the children and families we serve.

We will carefully consider the client's needs before agreeing to provide services.

We will respect and promote the right of clients to self-determination and will assist them in their efforts to identify and clarify their goals.

We will obtain informed consent for treatment services delivered to clients and will educate children and families about the range of services available to meet their needs.

We will provide services only within the boundaries of our competence and will strive to broaden and strengthen competency within the organization.

We will strive to ensure that documentation in our records is accurate and reflective of the services provided.

We will respect clients' right to privacy and protect the confidentiality of information unless compelling professional or legal reasons demand otherwise.

We will make efforts to ensure continuity of care from previous treatment, while in our treatment programs, and upon termination of our services.

We will take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

We will be alert to and avoid conflicts of interest that interfere with the exercise of impartial judgment and sound business practices.

We will not participate in, condone, or be associated with dishonesty, fraud, or deception.

We will accurately represent the official and authorized services and positions of the organization.

We will ensure that fees are fair, reasonable, and commensurate with services performed, and to the extent feasible, will consider the clients' ability to pay.

We will establish and maintain billing practices that accurately reflect the nature and extent of services provided, and specifically by whom the service was provided.

We will advocate for adequate resources to meet clients' needs.

We will not practice, condone, facilitate, or collaborate with any form of discrimination of the basis of race, ethnicity, national origin, color, age, religion, sex, sexual orientation, political belief, or mental or physical disability.
We will promote the general welfare of society and will engage in social and political action to ensure that all persons have equal access to treatment services needed.

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# GRIEVANCE PROCESS

Protecting the rights of clients and conducting activities in an ethical manner is the responsibility of all persons associated with KVC. The person charged with overseeing policies and procedures which protect client rights is the Director of Community Based Services.

All inquiries and formal complaints by clients are forwarded via the Inquiry or Complaint sections of the *Inquiry/Complaints/Grievances/Appeals* form available to the Director of Community Based Services. This person will determine the most appropriate administrator to further investigate the inquiry or complaint. Administrators who supervise the area where the complaint is being made will gather information, investigate the complaint, and make recommendations for resolution. If resolution is not deemed satisfactory by the client, agency, or guardian making the complaint, or an administrative review is deemed necessary by the investigating administrator, the complaint will be elevated to a grievance, and the grievance will be forwarded to the VP of Community Based Services.

The VP of Community Based Services will review the grievance and make further recommendations for resolution. These recommendations may include individual resolution procedures, a review of policy/procedure, a request for a task force committee or review by the risk management committee, a review by the Executive Team, or other recommendations as deemed appropriate to ensure the safety and well-being of clients.

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# NON-CUSTODIAL PARENT VISITATION EVALUATION FORM

**Thank you for participating in this program. We strive to maintain the highest quality of services for you and your children. To help us provide quality services, please complete this survey by discussing your experience with us through this program.**

| | | | |
|---|---|---|---|
| **Date:** | | **Location of Visits:** | |
| **# of Visits you have Received:** | | **County (Boone, Callaway):** | |

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Were the visits scheduled at a time that was convenient for you? | | | | | |
| Was the location of the visits convenient for you? | | | | | |
| Did you have difficulty getting to the visits? | | | | | |
| Were you satisfied with your visits? | | | | | |
| Were you treated with respect during your visits? | | | | | |
| During the visits did you learn something new about caring for your child? | | | | | |
| If Strongly Agree or Agree, what? | | | | | |
| Did you have the opportunity to practice something new you learned about caring for your child? | | | | | |
| If Strongly Agree or Agree, what? | | | | | |

| |
|---|
| What do you feel went well during your visits? |
| |
| What do you feel did not go well during your visits? |
| |
| How do you feel this could be improved for future participants? |
| |