



3924 Perkins Ave.
Huron, Oh 44839
Phone: (419)625-2672
Fax: (419)625-3822
tara@kinshiphouse.com

Date Of Intake:

Name: _____ **Emergency Contact:** _____

Relationship: _____

Phone Number: (____)____-____ **Phone Number:** (____)____-____

Your Address: _____

City, State, Zip _____ **County:** _____

Your Gender At Birth:

- Male Female

Your Date Of Birth:(mm/dd/yyyy) ____/____/____

Your Email Address: _____

You Are:

- Custodial Non-Custodial Other: _____

Your Relation to Child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Mother(Biological or Adoptive) | <input type="checkbox"/> Sister | <input type="checkbox"/> Paternal Grandfather |
| <input type="checkbox"/> Father(Biological or Adoptive) | <input type="checkbox"/> Maternal Grandmother | <input type="checkbox"/> Foster Parent |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Maternal Grandfather | <input type="checkbox"/> Other Family Member(ie Aunt, Uncle, Cousin, etc) |
| <input type="checkbox"/> Stepfather | <input type="checkbox"/> Paternal Grandmother | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Brother | | |

Income:

- Less than 10,000
 10,000 - 19,999
 20,000 - 29,999
 30,000 - 39,999
 40,000 and above

Race:

- | | |
|---|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Native Hawaiiin | <input type="checkbox"/> Multi-Racial |

Income and Race is used for statistical purposes only and Kinship will not share this information with any third parties

Name of Other Involved Party: _____

Contact Information: _____

Relationship to Each Other:

- | | |
|---|--|
| <input type="checkbox"/> Married(Husband/Wife)
Date: ____/____/____ | <input type="checkbox"/> Engaged(Fiance/Fiancee)
Date: ____/____/____ |
| <input type="checkbox"/> Divorced(Exhusband/Exwife)
Date: ____/____/____ | <input type="checkbox"/> Unmarried(Boyfriend/Girlfriend) |
| | <input type="checkbox"/> N/A |

For Staff Use Only

Referring Agency:

County Court
County _____
Floor number _____

Children's Services
Case Worker: _____

Domestic Violence Agency
 Child Protection Agency
 Self
 Other: _____
CW Phone #: (____)____-_____

Is there a court order? Yes

No

Date Issued: _____

Do we have a copy? Yes

No

Recommended Length of Supervised Visitation:

1 Hour

2 Hours

How many times a week: _____

What is your mode of transportation? _____

Is it reliable? Yes

No

Description of Vehicle: _____

License #: _____

Reason For Referral: (Choose One)

Domestic Violence
 Child Witness to Domestic Violence
 Parental Substance Abuse
 Substance Exposed Infant(s)

Parental Mental Health Issues
 Child Physical Abuse
 Child Sexual Abuse
 Other: _____

Service Requested:

Supervised Visitation

Supervised Exchange

Date of last visit with child: _____

Do you or the child have jobs/activities that can/will conflict with Visit/Exchange times?

(ie sports, groups, religious gatherings, appointments, etc.)

Days and times available for Visits/Exchanges:

Monday _____ Wednesday _____ Friday _____

Tuesday _____ Thursday _____ Sunday _____

(Visits/Exchanges will be scheduled according to the days/times that Kinship is available/open and the days/times BOTH parties are available)

Child Information

CHILD #1

Name: _____

Preferred Name: _____

Gender of Child at Birth: Male

Female

Date of Birth: ____/____/____

Age: _____

Resides with:

Mom

Dad

Other: _____

CHILD #2

Name: _____

Preferred Name: _____

Gender of Child at Birth: Male

Female

Date of Birth: ____/____/____

Age: _____

Resides with:

Mom

Dad

Other: _____

CHILD #3

Name: _____

Preferred Name: _____

Gender of Child at Birth: Male

Female

Date of Birth: ____/____/____

Age: _____

Resides with:

Mom

Dad

Other: _____

CHILD #4

Name: _____

Preferred Name: _____

Gender of Child at Birth: Male

Female

Date of Birth: ____/____/____

Age: _____

Resides with:

Mom

Dad

Other: _____

Do you or your child(ren) have any illnesses, conditions, disabilities, allergies, or limitations? *(this should include any insect allergies, learning disabilities, behavioral problems, etc)*

Do they require any medication? _____
Any other children? (Please list names, ages, and where they reside)

Outdoor Visitations

Kinship offers supervised visits outdoors, in the parks, on the trails, etc. Please review the rules then check one of the following:

- YES - I agree to supervised outdoor visits**
- NO - I do not agree to supervised outdoor visits**

RULES

1. KinShip staff will walk the entire family – adults and children – across the street.
2. Outside visits will take place within set boundaries, as defined by KinShip staff.
3. If a child does not listen to the parent or staff, everyone will have to come back inside for the duration of the visitation time.
4. For the safety of the family, KinShip staff will carry cell phones during outside visits.
5. Appropriate dress is required for the weather, including sunscreen, bug spray, etc.
6. If one person member in your party goes outdoors, everyone must go.
7. KinShip staff has the right to deny outdoor visitations at any time.
8. Family must come in a half hour before it gets dark.
9. KinShip does not provide outdoor video surveillance of the visit.

A failure to follow the rules will result in a loss of outdoor privileges

I have read, understand, and will comply with the rules for the outdoor visits:

Client's Signature _____ **Date** _____

Director's Signature _____ **Date** _____

Release Of Information

YOU ARE HEREBY GRANTED MY PERMISSION TO RELEASE INFORMATION TO AND/OR OBTAIN INFORMATION FROM:

(Please Initial In The Lines Provided)

_____ Kinship Inc. 3924 Perkins Ave. Huron, Oh 44839; (419) 625-2672
_____ Court: _____
_____ Attorney: _____
_____ CASA/GAL: _____
_____ Therapist: _____
_____ Children’s Services; County & Case Worker: _____

Please list all family members, including yourself, covered by this Authorization for Release of Information. Such information may be necessary to obtain/release information to the above stated parties.

FIRST NAME	MIDDLE INITIAL	LAST NAME

SUCH INFORMATION CAN BE RELEASED:

Monitor reports, need to knows, correspondence, case summary and sign-in sheet

This consent to disclose information may be revoked by me at any time except to the extent that action has been taken in reliance thereof, any revocation of the authorization shall be made only in writing and will only be effective when received by KinShip House, Inc, 3924 Perkins Avenue, Huron, Ohio 44839.

I have read, understand, and will comply with the above stated information:

Client’s Signature _____ **Date** _____

Director’s Signature _____ **Date** _____

Termination and Attendance

This policy is in regards to termination of services, attendance, no call/no shows and cancellations of visitations and exchanges at KinShip. Supervised Visitations and Exchanges may be terminated at the discretion of KinShip if this policy not adhered to by the undersigned parties.

Attendance:

Individuals participating in the supervised visitation/exchange program understand that their attendance is a necessity. KinShip staff will schedule appointments, days and times based upon KinShip's availability. Clients who use our facility understand that it is solely their responsibility to know when their visitation/exchanges are being held and arrive within the timeframes assigned. It is also the responsibility of clients to notify Kinship if anything occurs that would call for an alteration to be made to the schedule time. IF this occurs and an appointment is missed it will be documented which party could not attend and the reason given for the requested change. Please make every attempt to alter your own schedules around your assigned times.

Participating parties are also responsible for knowing their own Judgment Entries and requesting appropriate appointments that are assigned by the court in writing through Kinship's Need to Know Forms. Parties are encouraged to speak with their respective attorneys concerning any questions they may have in regard to visitation/exchanges as assigned in their Judgment Entries.

No Call/ No Show Policy:

A No call/No show occurs when either of the visiting party does not call KinShip to cancel their visitation/exchange or show up for the visitation/exchange that is scheduled.

- After the first offense a phone call on the following business day will be made to the violating party to document the reason for not attending. Kinship will remind the client of their visitation time and notify them that services could be terminated.
- After the second offense within 90 days, Kinship reserves the right to terminate future visitations.
- Please see payment agreement in regard to charges assessed for no call/no show.

Cancelation Policy:

A cancelation occurs when either party cancels a visitation/exchange due to illness, appointment, etc. Kinship does understand that emergency situations occur and may require the need to cancel a visitation/exchange.

- After the third cancelation within 90 days, a phone call will be made to all parties to notify them of the policy and document the situation in the party's permanent file. The parties will also be reminded that visitation /exchanges can be terminated.
- If there are two more cancelations within the same 90 days, Kinship reserves the right to terminate future visitations/exchanges.
- Please see the payment agreement in regard to charges assessed for cancelations.

I have read, understand, and will comply with Kinship's above stated policies and that my visits/exchanges can be terminated for any violations of these policies:

Client's Signature _____ **Date** _____

Director's Signature _____ **Date** _____

Contract Agreement for Services

I, _____, understand the policies of KinShip. I agree to comply with these policies and understand that failure to comply will result in termination of services.

The amount I agree to pay is _____ per visit / exchange. I understand this fee is due on the specified dates of service and that unless otherwise noted on a Judgment Entry or agreed upon by the other party that I am responsible for my own payments.

I agree to make payments as follows:

- I will make weekly payments of \$_____
 - Cash
 - Check
 - Card

- I will make monthly payments of \$_____
 - Cash
 - Check
 - Card

- I will pay for both my own Kinship fees as well as the other parties Kinship Fees and understand that I must notify Kinship in writing via Need To Know if this is to change.

- Children Services will pay for visits

Does client have paperwork that states this? Contact Person: _____

- Yes
- No

Date Issued: ___/___/___

Policy:

KinShip will add additional fees to the bill of the client that does not call at least three hours in advance to cancel a scheduled appointment. The fee will be the complete cost of the visitation or exchange. KinShip reserves the right to determine if something is an emergency and if fees will not be assessed for said emergency.

By signing this form you agree to the above terms and fully understand that each client’s bill is confidential and that KinShip’s staff will not disclose this information at any time to anyone other than the court or attorneys. It is also understood that nonpayment can result in contempt charges filled by the court and or loss of visiting privileges at The KinShip House.

I have read, understand, and will comply with the above stated information:

Client’s Signature _____ **Date** _____

Director’s Signature _____ **Date** _____

What are we waiting on to begin visits?

Call Log:

DATE	NAME	RELATION	REASON FOR CALLING

Staff Notes:

Medical Alerts:
