

#300, PARK PLACE  
4825, 47 STREET  
RED DEER, ALBERTA  
T4N 1R3



PHONE 403.343.3422  
FAX 403.343.9293  
REFERRAL 1.888.505.3422  
HERITAGEFAMILYSERVICES.COM

### Consent for Service

\_\_\_\_\_  
Clients Name                      Child Welfare I.D. #                      Date of Birth                      C.W. Status

#### Terms of Agreement

I \_\_\_\_\_ (Caseworker) am aware the per diem for \_\_\_\_\_ is  
\$ \_\_\_\_\_ per child as of \_\_\_\_\_ (admission date), and agree to pay this  
amount until the client has been discharged from the program or I receive written notice of an  
increase.

Facility I.D. #: \_\_\_\_\_

Heritage Placement and Address: \_\_\_\_\_

\_\_\_\_\_  
Caseworker's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Program Coordinator's Signature

\_\_\_\_\_  
Date

**This agreement will be completed upon signature of the program coordinator.**

\_\_\_\_\_  
Date of Discharge

\_\_\_\_\_  
Last Day Billed

\_\_\_\_\_  
Program Coordinator's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Caseworker's Signature

\_\_\_\_\_  
Date

\* HFS OFFICE: Please send to Central Referral and referring office at both discharge and intake.

*Please File in Section 2 of Client File*

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### Consent to Release Information

Re: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Youth or Child Month/Day/Year

Children's Services #: \_\_\_\_\_

#### Request for Consent

We, **Heritage Family Services** want to:  Obtain  Release the following information about the child/youth named above.

Records  Other: \_\_\_\_\_

#### From/To:

Physician  Psychiatrist  Therapist  
 Psychologist  Probation Officer  School Principal

For the purpose of placement at \_\_\_\_\_ and to necessitate appropriate strategies.

|                       |       |       |
|-----------------------|-------|-------|
| _____                 | _____ | _____ |
| Requestor's Signature | Title | Date  |
| _____                 | _____ | _____ |
| Requestor's Signature | Title | Date  |

#### Consent

My name is: \_\_\_\_\_ I am the child above; or

My relationship to the child above is: \_\_\_\_\_ I give consent for:

Physician  Psychiatrist  Therapist  
 Psychologist  Probation Officer  School Principal

To release information to **Heritage Family Services**

The information may be release for the purpose of:

Placement  Assessment  Risk Assessment  
 Necessitate appropriate intervention strategies  
 AB Education Student Records

**This consent terminates 90 days from today.**

\_\_\_\_\_ Date  
Consenter's Signature

After receiving the release information, the receiving person shall sign below and fax back to sender.

\_\_\_\_\_ Date  
Signature

*Please File in Section 2 of Client File*

### Consent to Voluntary Participation

I \_\_\_\_\_ declare:

I have been given a copy of the Youth Orientation Manual which describes:

- The Rules and Routines
- Chores and Allowance
- The School Program
- House Expectations
- Behaviour Management and Discipline
- Use of photos for media, organizational events, portable records, research, or training
- Emergency Evacuation and Fire Procedure
- Important Phone Numbers
- My Rights
- Grievance and Appeal
- The Child and Youth Advocate
- Other creative work produced by you will be returned at discharge

Through reading of the Orientation Manual, my Services Agreement, and conversation with my Caregiver, the following statements are true:

- I understand my rights
- I will work toward achieving my goals
- I will participate in the program
- I understand grievance and appeal
- I will help set out goals
- I understand live feed monitoring may be done in the program for security purposes

\_\_\_\_\_  
Child/Youth's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Key/Support Worker's Signature

\_\_\_\_\_  
Date

I (Caseworker) \_\_\_\_\_ have received and reviewed the program's Child/Youth Orientation Manual, which reviewed programming, behaviour management, restrictive procedures, and the grievance and appeal process.

\_\_\_\_\_  
Caseworker's Signature

\_\_\_\_\_  
Date

|                                  |                |
|----------------------------------|----------------|
| <b>Review on a Monthly Basis</b> |                |
| Date: _____                      | Initial: _____ |
| Date: _____                      | Initial: _____ |
| Date: _____                      | Initial: _____ |

### Right to Access Cultural Resources

Name of Client: \_\_\_\_\_

Which cultural community do you identify with? \_\_\_\_\_

Do you wish to be connected with a cultural resource? \_\_\_ Yes \_\_\_ No

Name of Resource Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you wish to be connected with Heritage Family Services Cultural Resource Staff?

\_\_\_ Yes \_\_\_ No

What Cultural Resources would you like to access?

\_\_\_ Ceremonies/Traditional activities

\_\_\_ Cultural Resource Staff to help you develop your Case Plan/Service Plan

\_\_\_ Cultural Information, and educational resources

\_\_\_ Other: \_\_\_\_\_

Heritage Family Services accommodates clients who are of Aboriginal origin by:

- Training to staff and parents regarding Cultural Awareness Issues to strengthen Cultural Competence.
- Providing on-going access and encouragement to participate in traditional ceremonies for staff, parents, and children.
- Providing Cultural Resource Staff for every program.
- Providing Cultural Resource Staff to review each child's complex needs to ensure the youth's heritage is respected and promoted.

**I understand the resources specifically relating to my culture which are available.**

\_\_\_\_\_  
Child's Signature (12+)

\_\_\_\_\_  
Month/Day/Year

\_\_\_\_\_  
Cultural Resource Staff

\_\_\_\_\_  
Month/Day/Year

**I have explained to my client the resource which are available to him/her regarding his/her culture. I believe he/she understand at a level which is appropriate to their age.**

\_\_\_\_\_  
Caseworker's Signature (11 & under)

\_\_\_\_\_  
Month/Day/Year

# **RESIDENT / GRIEVANCE PROCEDURE**

If you have a concern or issue that involves your care and complex needs, follow the steps in the diagram below:



|   |                                  |
|---|----------------------------------|
| <b>Discuss your issue/concern with the person you have an issue with.</b> | <b>RESPONSE TIME</b><br>Same day |
|---|----------------------------------|



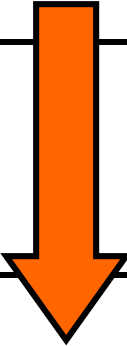
|   |                                  |
|---|----------------------------------|
| <b>If the issue/concern is not being addressed then try to work it out with your Key Worker</b><br><br>_____ (Name) | <b>RESPONSE TIME</b><br>Same Day |
|---|----------------------------------|



If the issue/concern is not being addressed then ask for a meeting with the Program Coordinator:

\_\_\_\_\_  
(Name)

**RESPONSE TIME**  
Within 5 days of not being satisfied with Key Worker response

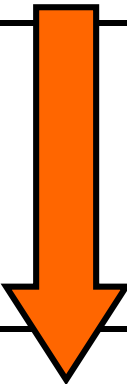


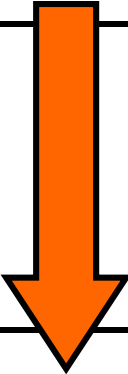
If the issue/concern is not being addressed then ask for a meeting with the Manager Community Service:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Phone #)

**RESPONSE TIME**  
Within 5 days of not being satisfied with Program Coordinator response



|  |   |
|--|---|
| <p><b>If the issue/concern is still not being addressed then ask for a meeting with the Company Director:</b></p> <p>_____</p> <p style="text-align: center;">(Name)</p> <p>_____</p> <p style="text-align: center;">(Phone #)</p> | <p><b>RESPONSE TIME</b></p> <p><b>Within 5 days of not being satisfied with the Manager Community Service</b></p> |
|   |   |
| <p><b>TOTAL: 15 Days</b></p>   |   |

These are the people who can advocate for you. You can also talk to your Social Worker \_\_\_\_\_ or the Children's Advocate \_\_\_\_\_

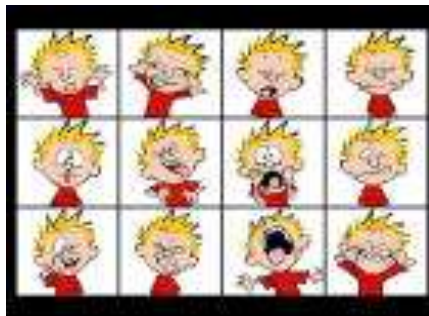
(Name) (Name)

If you feel that your needs are not being met, or you are not being treated fairly, you can talk to a Children's Advocate and share your concerns him/her. Your Social Worker, Key Worker, or Parent may approach this person for you.

|  |
|--|
| <p><b>Office of the Children's Advocate</b></p> <p><b>Phone:</b> _____</p> <p><b>Name:</b> _____</p> |
|--|

**Youth/Guardian Signature** \_\_\_\_\_

Date:



## Personal/Miscellaneous Items

|  |  |
|--|--|
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I \_\_\_\_\_, understand that my clothing and personal items are solely my responsibility. Heritage Family Services is not responsible for lost, damaged, or stolen items.

I understand that it is my responsibility to retrieve any personal belongings left behind after my discharge. I also understand that if I do not retrieve my belongings within 30 days of my discharge date, they may be disposed of (i.e. Salvation Army, Women`s Shelter).

\_\_\_\_\_  
Client

\_\_\_\_\_  
Caseworker`s Signature

\_\_\_\_\_  
Admitting Staff

\_\_\_\_\_  
Date



