Intake Agenda and Checklist

We foster environments where building trust, fostering bonds, and engaging safely takes place.

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1. Please fax or email the following items for the Intake Meeting

☐ All Intake Forms in this packet

☐ Copy of Photo ID of yourself and anyone you would like to be able to pick up or drop off your children

☐ Court Order, Stipulations, or Legal documents that pertain to Visitation, time-sharing, or exchanges, you are welcome to email or fax these documents

☐ Recent individual photos of your children who will participate in the visitation

☐ Your attorney's contact information Name _____ Phone _____
Email _____

☐ Any additional information you believe would be helpful to The Therapeutic Solution staff in order to provide safe and effective visitation

2. Review Case History and needs with parents: This includes discussions of why services are needed, what services we can provide, and the family dynamics that are important for us to know.

3. Review forms and policies: THE THERAPEUTIC SOLUTION staff will review each form explaining and elaborating on the meaning that needs to be signed and completed by the parent. Please have your forms completed when you arrive to expedite the process.

Forms: Intake Packet, Release of Information, Fee Agreement, Child Information Papers, Court Papers, Emergency Procedures, Child Health and Allergies, Personal History and Policies and Procedures.

4. Establish a time-sharing plan: A plan for the first appointment is discussed and scheduled that includes the date and time for the visitation, persons permitted at the visit, and any possible activities planned at the visit

5. Your child is welcome to attend a separate meeting to become introduced to the location and staff where they will participate in visitation. The intake meeting is not appropriate for your children to participate. **If a family member would like to bring them at the end of the meeting for the last 5 -10 minutes that is also an option.**

Intake Application

Supervised Visitation And Exchange

Case Name _____

Name _____ DOB _____ SSN_____

I am the _____ Custodial Parent _____Visiting Parent _____

I am the _____ Father _____ Mother _____ Family Member _____ Guardian_____

Phone _____ Cell _____ Homework _____

The best number to reach me at? Work _____ Cell Number _____

Is it ok to leave a message _____Yes _____ No Home Number_____

Leave a message _____ Yes _____ No Work Number _____

Leave a message _____ Yes _____ No Address _____

City _____ State _____ Zip _____

Mailing Address: _____

City _____ State _____ Zip _____

Email Address _____ Employer _____ Job _____

Work address _____

City _____ State _____ Zip_____

Work schedule and hours

Mon. _____Tues. _____Wed. _____Thurs. _____Fri. _____Sat. _____Sun._____

Supervised Visitation and Exchange

Name of other parties involved _____

Do you have contact with this person _____Yes _____ No _____

Indicate the statute of your relationship with your children's guardian or visiting parent:
☐ Divorce ☐ Separated ☐ Never Married No Relationship

Guardian Date of Marriage _____ Date of Separation _____

Date filed for Divorce _____ Date of Divorce _____

Is there a Step-Parent or Significant other living in the house? ○ Yes ○ No

Name of Step-Parent of Significant other _____

Address (if not in same household)_____

City _____State _____Zip _____

Employer _____

Work Number _____ Leave a message ○ Yes ○ No

Cell Number _____ Leave a message ○ Yes ○ No

Are there Step-Siblings living in the household? ○ Yes ○ No

Name _____ Gender_____DOB _____ Age _____

_____

_____

_____

_____

Supervised Visitation and Exchange

Court Information

Judge Name _____

Your Attorney _____

Address _____ Phone _____

Other's Attorney _____

Address _____ Phone _____

Children listed in order for Visitation

Name _____ Gender_____DOB _____ Age _____

_____

_____

_____

Additional Information

_____

_____

_____

_____

_____

_____

_____

_____

_____

Legal Information

1. Estimate how many times you have been to Court concerning visitation disagreements

_____

2. Is there a protective order preventing you and the other party from having direct contact with each other?

☐ Yes ☐ No **Please supply a copy**

3. How many times have the police been contacted to enforce the restraining order? _____

4. Have you and/ or the other party ever been convicted of a felony or misdemeanor?

Me: ☐ Yes ☐ No **Other Party:** ☐ Yes ☐ No

Describe

_____

_____

5. Is there any history of abuse by the other party toward you? ☐ Yes ☐ No

Type of Abuse

Physical (slapping, kicking, burning, destroying and/or throwing objects) ☐ Yes ☐ No

Sexual (raping, forcing, threatening sex, sex in the presence of others) ☐ Yes ☐ No

Emotional (humiliating, how often does this happen and describe)

_____

_____

6. Have there ever been charges filed against you or the other party for physical abuse?

Me: ☐ Yes ☐ No **Other Party:** ☐ Yes ☐ No

7. Do you or the other party own any weapons?

Me: ☐ Yes ☐ No **Other Party:** ☐ Yes ☐ No

Have the children witnessed the abuse? ☐ Yes ☐ No

Which child and what did they see or experience?

_____

_____

_____

Have your children intervened? ☐ Yes ☐ No

Describe

_____

_____

8. Have your children been abused (hit, hurt, or threatened)? ☐ Yes ☐ No

   What type of Abuse did they experience? ☐ Physical ☐ Sexual ☐ Emotional

   Describe which child experienced what type of abuse

   _____

   _____

9. Have you ever been involved with Child Protective Services (CPS)? ☐ Yes ☐ No

   Describe

   _____

   _____

Medical Information Form

This form is to be completed when children need medication or have a special dietary requirement that might arise during visitation. **Please complete a separate form for each child.**

Child's Name _____ DOB _____

☐ This child has no Known Medical or Special Dietary Needs.

Medical Information

☐ Asthma	☐ Peanut/Nut Aller	☐ Breathing Problems	☐ Blood clotting problems
☐ Fainting	☐ Allergic to Dogs	☐ Wetting Pants	☐ Vomiting
☐ Stomach Upset	☐ Anxiety/Panic	☐ Nose Bleeds	☐ Contagious Disorde
☐ Diabetic	☐ Mrsa Infection	☐ Bee / Wasp Stings	☐ Separation / Fears

☐ Other _____

Condition _____

Medication or Treatment _____ Medication or Treatment _____

Medication Name _____ Medication Name _____

Medication Name _____ Dosages _____

Frequency and Time to administer _____

Please write additional medications on a separate sheet

Food Allergies and Special Dietary Needs

Food Allergies _____

Treatment of the Allergies _____

Additional Information _____

You (Custodial Parent) are required to bring any EPI pen or other antidotes to visitation sessions and leave it with us for the duration of the visit for the safety of your child. Forgetting the EPI pen or antidote will result in canceling the visit and the fee will be charged in full to the Custodial parent.

Weather permitting, we may have supervised visits outside, please provide, hat, sunscreen, bug repellant is you wish them used during the visit

Pediatrician's Name _____ Phone _____

☐ I authorize **THE THERAPEUTIC SOLUTION** to call for emergency medical care for any child since we cannot transport and attempt to notify me at the following number as soon as possible.

During Supervised Visits, bottle-fed children will be provided at least one prepared bottle for the visit by the Custodial parent.

Parents Name _____ Signature _____ Date _____

Additional Information & Agreement

Health Information

1. Do you personally have any medical conditions that **THE THERAPEUTIC SOLUTION** staff should be aware of? Yes____ No ____ Describe _____

2. Do your children have any medical conditions/needs **THE THERAPEUTIC SOLUTION** should know about?
Yes _____No_____ Describe _____

Is your child also seeing a therapist/counselor or prescriber? ☐ Yes ☐ No
RX _____ ☐ Yes ☐ No Type _____ Allergies _____ ☐ Yes ☐ No

3. Substance Abuse History by either party
History of drinking alcoholic beverages
By you: ☐ Yes ☐ No **By the other party ☐ Yes ☐ No ☐ I don't know**

History of non-prescription street drugs
By you: ☐ Yes ☐ No **By the other party ☐ No ☐ I don't know**

Drug of choice and quantity _____
History of prescription drugs
By you: ☐ Yes ☐ No **By the other party ☐ Yes ☐ No ☐ I don't know**

RX _____

Do you believe that there is a problem currently with drugs or alcohol?
By you: ☐ Yes ☐ No **By the other party ☐ Yes ☐ No ☐ I don't know**

Behaviors experienced or observed while under the influence: _____
_____
Treatment History _____ Sobriety _____

4. Mental Health History/Condition _____

5. Other Condition or impairment _____

Custody and Visitation Arrangement

1. Who presently has legal custody of the children?

☐ Guardian ☐ Father ☐ Mother ☐ Joint ☐ CPS ☐ not determined at this time

2. Who presently has physical custody of the children?

☐ Guardian ☐ Father ☐ Mother ☐ Joint ☐ CPS ☐ not determined at this time

If there are different arrangements for each child please give specifics

_____

3. Until today what arrangements were in place between you and the other party for contact/visitation with the children? _____

4. How frequent have the visits been with the children? _____

5. How long have the visits lasted? _____

6. Where have the visits taken place? _____

7. The decision for visitation arrangements was made by or with assistance from

☐ Counselor or Mediator ☐ You and your ex-spouse/partner ☐ Attorney's ☐ Judge/Court

8. When was the date of the last contact between the visiting parent and the children? _____

_____ Who was present? _____

9. What is the understanding of the reason why you were referred to

The Therapeutic Solution (mark all that apply)

☐ Domestic violence Allegations or History of violence

☐ Children witnessed abuse

☐ Child Abuse allegations

☐ Sexual Abuse allegation

☐ Lack or Access/ Alienation of the children

☐ Abduction Risk (threatened or attempted

☐ Substance Abuse History

☐ Mental Health History or Instability

☐ Neglectful or Threatening

☐ Inconsistent or Unreliable

☐ Poor Parenting Skills

☐ Other

10. Have you informed your children of the court order and why you are coming to TTS? ☐ Yes ☐ No

11. What do you anticipate your children's response to coming to TTS? (happy, sad, scared, angry, shy)

_____ explain _____

12. What can we do to make this a good experience for them? _____

_____

13. We currently only have English-speaking staff. If you speak another

language, if available, you may request an interpreter or you will need to provide an interpreter at your own cost. Will you provide an interpreter? ☐Yes ☐No

14. The visiting room may not handicapped accessible, will that be an issue for you? ☐Yes ☐No
15. The custodial parent entrance may not be handicapped accessible if this applies to you, will this be an issue? ☐Yes ☐No
16. We ask that all weapons be left at home, do you agree? ☐Yes ☐No
17. We ask that no gum is in use during the visit and that there are no smoke breaks ☐Yes ☐No
18. I am agreeing to supervised visitation and all of the rules and policies. ☐Yes ☐No
19. I agree to use THE THERAPEUTIC SOLUTION for supervised visitation. ☐Yes ☐No
20. I have the following concerns _____

_____

I agree to participate in supervised visitation which includes following policies and rules to create a safe environment for parent–child interaction. I will follow these rules and if I am not certain of a rule I will seek clarification before acting upon it. I recognize that all interactions are written down and reported to the Court, these are observations of my behavior without judgment or prejudice.

I certify that the information given above is true and complete and I understand that misrepresentation and/or withholding of information will result in the rejection of this application or my dismissal as a client if discovered after service begins. I understand the court will be notified of this dismissal and that this may affect the visitation or custody of my children.

I understand that **THE THERAPEUTIC SOLUTION** can make no promises or guarantees relating to visitation or court matters, my client status may be suspended any time that I or any part of my family/friends become unsafe for the facilities and/or staff **The Therapeutic Solution**. I understand that any termination as a client will be documented and that this documentation may be presented to the court.

Printed Name _____ Signature _____ Date _____

_____

Staff Signature _____

Fees and Fee Agreement

Program Fees

Intake	$ 80
Supervised Visitation 1 – 2 Children - Up to two hours 3 – 4 Children - Up to two hours	 $ 60 $ 70
Therapeutic Visitation	$ 100
Notes	$10 per request
Reports	$50 an hour to prepare
No Show	Entire cost of Service/Visit
Less than 48 hours Cancellation	Entire cost of Service/Visit
Monitored Exchange – per exchange	$45
Late Fee	5 minutes or less $ 5 6 – 10 minutes $ 10 11 – 16 minutes $ 15

More than 17 minutes late $ 35, with no further visits scheduled until the case is referred back to court. The fees above are based on communication that is EMAIL; phone communications are charged at the full fee and not the discounted email fee. You will need to add a $10 per visit for phone-based communications if you choose to not use the email communications.

Payment Responsibility

Court-ordered families are assigned payment responsibility by the court. Other referring agencies may indicate in writing who will be responsible for payment. If the referring agency does not indicate who will be responsible for payment, **THE THERAPEUTIC SOLUTION** will assign financial responsibility. Service will not be provided until a fee agreement is signed by both parties and the initial payment is received.

Cancellations

All cancellations must be made at least 48 hours in advance of a scheduled appointment or visitation. Parents are not charged if proper notice is given this is expected during business or supervision hours. The party who cancels outside of the time frame will be charged the full visitation fee, regardless of which parent is responsible for visitation costs.

No Show

A party who fails to arrive for an appointment and has not notified the Center will be charged the entire amount of the service. Rescheduling of visits will depend on the Center's availability and cannot be guaranteed. Two cancellations without notification will result in termination of services and notice will be sent to the referring agency. Services may be suspended or terminated due to non-payment.

Court Testimony

A retainer fee of $1000 is required in advance to the party issuing the subpoena, with an additional $200 per hour fee for preparation, with a minimum of two hours of preparation for court. It is understood that no further information is generally available or useful outside of the Observation Monitoring Sheets which are prepared and submitted to the Court, creating no need for court testimony since **THE THERAPEUTIC SOLUTION** makes neither recommendations nor interpretations of the visit.

All fees will be paid by cash (via cashapp), cashier's check, money order, or Visa/MasterCard. Payments are paid in advance of the next visit. Payment for the next visit is made at the time of the current visitation/exchange. Any charge cards being used will need to be in your possession and a separate form filled out for ongoing use for the card for regular billing.

Payment for Visits

All fees are required one week in advance of the visit. We believe this is thoughtful to the children and the other parents in scheduling. It also provides both parents with the advance planning necessary to save money and also to plan the visit. I am showing my commitment to visiting with my children by consistently paying for my visits in advance to regularly and routinely have contact with them.

My Financial Obligation

I agree to make all payments for all services rendered and all services I default on by being late to visitation, late cancellation, no-shows, penalty fees, or requests for documents. I am liable for all additional court costs, attorney fees, and interest charged at the rate of 35% annually for balances due to **THE THERAPEUTIC SOLUTION** for these services. I will be terminated from service for non-payment and I will only be able to resume visits once I am paid in full. This also may necessitate a larger payment for future visits on my part paying for 2 or more visits instead of one in advance.

My signature indicates I understand the fees on these pages and agree to pay them.

I may withdraw from services with **THE THERAPEUTIC SOLUTION** at any point by giving written notice that I no longer wish to participate in supervised visitation and am formally canceling my visits and withdrawing from their services. Until I do this I am obligated for all services I have arranged and agreed upon.

Parent Signature _____

Date _____

Staff Signature _____

Date _____