SOLACE HOUSE
CONFIDENTIAL INTAKE

Intake Date: _____

Individual/Parent(s)/Guardian(s) Names(s): _____

Home Address: _____

City/State/Zip: _____ **County:**_____

How may we contact you? (check all that apply)

❑ **Home Phone:** _____ ❑ **Cell Phone:** _____

❑ **Work Phone:** _____ **Employer:** _____

❑ **Email:** _____

Emergency Contact: (Name) _____ **(Phone)** _____

Do you have insurance? ❑ **Yes** ❑ **No** **If yes, what carrier:** _____

Please list all family members that are currently residing in your household (include self):

First & Last Name	Age	Birthdate

Questions about the person(s) who died:

Full Name: _____ Age: _____ Birthdate: _____

Date of Death: _____ Location of Death: _____

Full Name: _____ Age: _____ Birthdate: _____

Date of Death: _____ Location of Death: _____

Causes/Circumstances of death(s): _____

_____

Did the deceased and/or your family receive services from a hospice organization? ❑ Yes ❑ No

If yes, where? ❑ Kansas City Hospice ❑ Other: _____

How was the deceased related to individual/parent(s)/guardian(s)? (as applicable) _____

How was the deceased related to the child(ren)/teen(s)? (as applicable) _____

Were you present when your loved one died? Adults: ❑ Yes ❑ No _____

Child(ren)/Teen(s) (as applicable) : ❑ Yes ❑ No _____

Please explain: _____

Questions about Individual(s) and family member(s):

Please answer the following questions for those in your immediate family who are seeking services today.

Who attended the funeral/memorial service(s)? Adults: ❑ Yes ❑ No _____

Child(ren)/Teen(s) (as applicable) : ❑ Yes ❑ No _____

How has the death been explained to the child(ren)/teen(s)? (as applicable) _____

_____

_____

Have there been any other significant deaths? ❑ Yes ❑ No If yes, please describe: _____

_____

_____

Have there been any other significant changes? (i.e. moved, job change, school change) ❑ Yes ❑ No If yes, please describe:

_____

_____

Is anyone *currently* receiving counseling services? ❑ Yes ❑ No

If yes, with whom? _____

For what reason? _____

Has anyone *previously* received any counseling services? ❑ Yes ❑ No

If yes, with whom? _____

For what reason? _____

Diagnosis: _____

Has anyone been on any medications? ❑ Yes ❑ No Prescriber: ❑ Primary Care Physician ❑ Psychiatrist

Medications: _____

Why was this medication(s) prescribed? _____

❑ Current ❑ Previous How long has this medication been taken?_____

Any medications prescribed since the death? ❑ Yes ❑ No Please list: _____

_____

Are you involved in any other services/systems? ❑ Yes ❑ No

- ❑ Court System For what reason? _____
- ❑ Family Community Services (SRS, DCFS) For what reason? _____
- ❑ Other: _____

Where have you received the most emotional support for your grief? (i.e. friends, church, family, school, work, neighbors) _____

_____

Problems/symptoms that adult(s) or child(ren)/teen(s) have experienced: (Check all that apply)

Behavioral:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Bed Wetting	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Aggression (Verbal & Physical)	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Excessively Avoids Reminders (People/Places/Situations)	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Cannot Function without the Deceased	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Decline in Grades	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Withdrawal/Isolation	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Emotional:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Depressed Mood or Intense Sorrow	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Feeling Hopeless/ Hard to Plan for Future	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Often Tearful	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Feelings of Self-Worthlessness	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Guilt	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Unable to Feel Positive Emotions	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Irritability, Bitterness, Anger or Temper Tantrums	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Easily Startled or Frightened	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Constant Yearning/Longing for Deceased	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Experiencing Disbelief/Emotional Numbness	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Issues Separating from Primary Caregiver(s)	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Physical:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Change in Diet (Increase/Decrease)	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑Fatigue or Loss of Energy	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Sleep Disturbance (Restless: Trouble Falling/Staying Asleep)	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Relational:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Parenting Issues/Not Responding to Discipline	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Difficult Peer/Family Relationships	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Problems at Work	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Not Feeling Connected to Others	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Hard to Trust Others	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Cognitive:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Inability to Concentrate/Make Decisions	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Repeated Distressing Dreams/Flashbacks	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Constant Thoughts Around the Event of the Death	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Unable to Accept the Reality of the Death	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Desire to Die to be with Deceased Loved One	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Less Interest/Pleasure in Activities	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Excessively Avoid Upsetting Thoughts/Memory/Feelings	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Challenges:

Name(s) of person experiencing symptom	When did this symptom begin?	Is this a current symptom?
_____ ❑ Use of Drugs	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Increased Use of Alcohol	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Harm to Self or Others	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Repeated Thoughts of Death/Suicide	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Suicide Attempt/Plan	❑ Before the death ❑ After	❑ Yes ❑ No
_____ ❑ Other:_____	❑ Before the death ❑ After	❑ Yes ❑ No

Adult(s) strengths: _____
Adult(s) interests/hobbies: _____

Child(ren)/teen(s) strengths: _____
Child(ren)/teen(s) interests/hobbies: _____

Is there anything else that we should know about you to help serve you better? (i.e. current concerns)

_____

_____

Goals

What do you hope to gain from services at Solace House: _____

_____

_____

_____

_____

Demographic Information:

PLEASE TAKE A MOMENT TO COMPLETE THIS PAGE. This information is confidential and is used for statistical and grant-funding purposes in order to meet grant requirements which keep our services at no cost to clients and participants.

How did you hear about Solace House?_____

Ethnicity (Please check the one race that you most closely identify or check some other race.)

❑ White ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Some Other Race: _____
❑ African American/Black ❑ American Indian/Alaska Native ❑ Hispanic/Latino

School District (SD) of Child(ren)/Teen(s) *(List for each child/teen)*: ❑ Not Applicable

Examples:	School	School District
	Lincoln Prep	KCMO School District
	Prairie Trail Junior High	Olathe School District
	Academie Lafayette	Charter
	St. Thomas Aquinas	Private

School	School District
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Combined Household Income (yearly)

STEP 1: Please *circle* the figure (in the chart below) that most closely matches your total household income.

$11,675	$19,800	$27,900	$36,000	$45,000	$50,000+	$100,000+
$15,725	$23,850	$32,000	$40,000	$50,000	$75,000+	$125,000+

STEP 2: How many people in your household depend on this income? _____

STEP 3: Do any children in your home qualify for free or reduced school lunch? ❑ Yes ❑ No

SOLACE HOUSE
INFORMED CONSENT

It is important that you, as the client, are fully informed about the therapeutic support services you will be receiving. Your signature below indicates that you have received, read, and understand the organization's policies in helping you make an informed decision about entering into this program.

I understand that Solace House is a program of Kansas City Hospice & Palliative Care.

I understand that I have certain rights as a client, such as client privilege and confidentiality, and those rights have been reviewed with me. I understand that Kansas and Missouri state law mandates Solace House to:

- Notify appropriate state agencies of any suspicion of child or elder abuse;
- Warn others of life-threatening concerns (harm to self or others); and
- Provide information in legal cases when court-ordered.

I understand exceptions to client confidentiality, and I agree to them.

I understand that Solace House staff may consult with one another and occasionally receive outside supervision.

I understand that if Solace House should ever wish to use quotes, stories, artwork, photos, or videos for educational or promotional purposes, I would be contacted and given the option to sign a consent form.

I understand that there are potential risks associated with receiving services, such as emotional exploration, and I have discussed these with my intake administrator.

I understand that Solace House does its best to provide services to those who have been impacted by the death of a loved one. If at any time it is determined that services at Solace House are no longer appropriate, Solace House will do its best to provide an appropriate community referral.

Solace House is a not-for-profit organization and welcomes donations. Some services may have a fee.

I understand that I have the right not to sign these forms. However, I also understand that doing so will make me ineligible to receive any program services at Solace House. By signing this form I show that I agree to the afore-mentioned statements in receiving services at Solace House.

Adult Signature	Date	Adult Signature	Date

SOLACE HOUSE
WAIVER OF MEDICAL AND PSYCHIATRIC CONSULTATION

Kansas law KSA 65-6404 (b) (3) states that Solace House staff are required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that s/he may have observed while working with me or my minor children (*under* age 18).

By signing below I am waiving the immediate medical consultation between the Solace House staff and my physician. Should the need arise for a medical consultation in the future, I will be asked to sign a *Release of Information* to allow for such consultation.

In the event that the Solace House staff addresses the need for further consultation, and I or my minor child(ren) do not currently have a primary care physician or psychiatrist, I acknowledge that the Solace House staff may recommended that I seek medical consultation or provide me with appropriate referrals.

I understand that I have the right not to sign this waiver and that doing so provides the Solace House staff the full requirement to make immediate consultation. I am also aware that this waiver will become part of my client record.

Please list name(s) of **adults** being treated:	Please list name(s) of **children** being treated:

To be signed by all legal adults.

Adult Signature	Date	Adult Signature	Date

SOLACE HOUSE
MINOR CONSENT

Please only complete if applicable.

Date: _____

This is to certify that I/we, _____, have legal custody or guardianship of the following child(ren) and have the legal right to authorize the care, treatment and counsel of this/these child(ren):

Name of Child	Date of Birth

and give consent for him/her/them to receive counseling and/or to participate in support groups at Solace House.

Legal Custodial Parent/Guardian Signature	Date	Legal Custodial Parent/Guardian Signature	Date

SOLACE HOUSE
GROUP PARTICIPATION AGREEMENT

I understand that support group programs at Solace House are based upon acceptance into the program and that in order to participate in groups, one must first be accepted. Acceptance is based not only on services being appropriate to meet your needs, but also on availability of services.

I understand that Solace House provides emotional support to children, individuals, and families while working through the natural grieving process in a group setting. These groups are not therapy groups. They are led by trained volunteer facilitators. I understand that the cause of death for the loved ones of group participants may be varied and may include, for example: illness, sudden loss, suicide, homicide, or unknown causes.

I understand that support group programs run in 8-session cycles and that my family or I should only plan to leave the program at the end of a cycle. Furthermore, any individual may participate in as many 8-session cycles as are beneficial, for as long as they are deemed appropriate. I will give notice to Solace House staff when any individual, child, or family member feels that services provided by Solace House are no longer needed. I agree to attend support groups regularly and will call in advance if any individual is unable to attend. I understand that my absence from the first two nights of group or any two consecutive missed groups will result in my withdrawal from the program.

If I am bringing children, I understand that a parent or guardian must accompany children to each support group meeting. I further understand that I am responsible for my child's behavior while at Solace House. If the parent(s) or guardian(s) of any child, under the age of 18, will not be participating in the support groups, it is required that the parent(s) or guardian(s) will still accompany the child to groups. They will be asked to wait in the waiting area. If this is applicable to me, then I agree to this statement. Parents are not allowed to remain inside the children's group during the group session hour. I understand that Solace House does not provide babysitting services during support groups. Parent(s) and guardian(s) will be responsible for providing childcare outside of Solace House for any child not participating in groups. Parents/guardians of any child(ren) who require help using the restroom, will be asked to assist their child during support group sessions.

I understand that myself and/or my family members are not allowed to bring friends or family to support groups who have not first initiated services for themselves, completed an intake interview, and been accepted to the Solace House program. This also helps to ensure confidentiality and a consistent support group.

I also understand that Solace House reserves the right to withdraw any participant from the program if at any time participation in support groups is no longer appropriate.

There are no fees for support group participation. Donations are always welcome and appreciated.

I give permission for myself and/or my child(ren), listed below, permission to participate in the Solace House grief support group programs.

I understand that not following these guidelines, once signed and agreed to, may result in dismissal from our support group programs. I have the right not to sign this agreement. However, doing so will result in non-acceptance to our grief support programs at Solace House.

This must be signed by all legal adults.

Minor Child (please print)	Minor Child (please print)	Minor Child (please print)
Minor Child (please print)	Minor Child (please print)	Minor Child (please print)

Adult Signature	Date	Adult Signature	Date

SOLACE HOUSE
SUGGESTED DONATION SCALE

A Program of Kansas City Hospice

Solace House is a non-profit 501 (c) (3) charity organization; therefore, we rely heavily on donations and grants to help fund our program. As a participant we ask for your financial support. There is a moderate fee of $40 per grief counseling session. There is no fee required for participation in grief support groups, however Solace House welcomes donations.

Should you choose to make a donation each time you receive a service at Solace House, you may wish to utilize the following suggested donation sliding scale to help determine what might be an appropriate donation amount, based upon your family income and family size. Donations are made voluntarily.

We appreciate your commitment and financial support of the Solace House program through which you are receiving services.

SUGGESTED DONATION SLIDING SCALE
Please circle applicable level.

Total Family Income	Family Size 1-2	Family Size 3-4	Family Size 5+
Less than $15,000	$15.00	$10.00	$5.00
$15,000 - $29,000	$25.00	$20.00	$15.00
$30,000 - $49,000	$30.00	$25.00	$20.00
$50,000 - $69,000	$35.00	$30.00	$25.00
$70,000 – and up	$40.00	$35.00	$30.00

Making a donation while at Solace House:

1. Place your donation inside the provided envelope. (Checks encouraged.)
2. Complete the requested information on the envelope.
3. Seal the envelope.
4. Deposit donation envelope into the birdhouse. (Located throughout Solace House.)

Thank You!

Donations are voluntary. Solace House is exempt under 501 (c) (3) as a non-profit organization. Gifts to Solace House are deductible for income tax purposes. Consult your tax advisor for more information.