

OUR HOME, INC. ASAP

INTAKE PACKET

CONTAINING CONSENTS, POLICIES, ETC.

MALE ASAP ADMISSION CRITERIA

The Our Home, Inc. Male ASAP program will accept individuals based upon the following admission criteria:

- Applicants must be between 12 and 18 years of age.
- Payment arrangements must be established prior to admission.
- It is preferable that applicants be evaluated by a Certified Chemical Dependency Counselor prior to admission. Other admissions will be admitted on an understanding that all applicants will be to evaluation.
- Applicants shall not require detoxification services.
- A State Application or a General Application created by Our Home, Inc. will be submitted prior to admission to allow the Program Coordinator and the treatment team to review resident eligibility based upon available date. Determination will be made as to appropriateness of placement.
- The programs do not discriminate in admission practices in regard to race, color, religion, sex, ancestry or national origin.
- Applicants with past sexual offences or sexually acting out behaviors.
- Applicants must have a Full Scale IQ of at least 69 or above.
- Will accept applicants with diagnosis of Conduct Disorder, Oppositional Deviant Disorder, Attention Deficit Hyperactivity Disorder, Post-traumatic Stress Disorder, Impulse Control Disorder and eating disorders. Other diagnoses will be considered upon review with treatment team.

ADOLESCENT SEXUAL ADJUSTMENT PROGRAM

INFORMATION REQUIRED FOR ADMISSION CONSIDERATION

It is extremely important for our pre-placement process that we receive the required information from parents and the referring agency. **Intake forms must be completed prior to placement.** It is essential that Our Home, Inc. have this information in order to meet State Regulations and to expedite assessment of the resident.

- Application for Admission: The Our Home, Inc. or the Department of Corrections Group/Residential Referral Application. Please fully complete the application for admission: If areas are not fully complete, it may slow down the process for admission.
- Authorization Forms: Media Consent indicating approval or denial for photographs to be taken.
- Release of Information: This form may be necessary to receive information from previous placements, doctors, psychologists or other professionals.
- Medical Consent Form: During a youth's stay at Our Home, Inc., it may be necessary for him/her to receive medical attention. We are, therefore, asking that you cooperate with us in reference to four important areas.
 1. We ask that each youth receive a physical examination prior to placement, if possible, and that the examination form be completed and signed by a doctor unless otherwise arranged with the Program Coordinator.
 2. State law requires that students must be current with all immunizations. Please furnish complete immunization records.
 3. Medical consent form must be completed. If the youth is entitled to any medical assistance, include the appropriate Title XIX number for proper insurance information and forms.
 4. The reference agency must provide Our Home, Inc. with a copy of the youth's dental and eye examinations and current status of youth's work needed.

Additional Information Needed:

- Report of psychosexual, psychological and/or psychiatric evaluation completed within last 12 months.
- Court Order/if available
- Social History

- Birth Certificate
- Social Security Number
- Clothing requirements checklist completed
- Billing address and appropriate person to whom billing is submitted
- Complete school records/IEP records
- Emergency numbers to notify in case of emergency.
- Any allergies, (i.e. insect stings, medications, detergents, etc)
- Interstate Compact with State of South Dakota (out-of-state placements)
- Police reports
- Discharge Summaries from previous placements
- Victim statements if available
- Previous Polygraph reports/if available
- Drug/alcohol use or evaluation

OUR HOME, INC., ASAP

40354 210th Street, Huron, SD 57350, Phone (605) 352-9098, Fax (605) 352-0550

ADOLESCENT SEXUAL ADJUSTMENT PROGRAM PROCEDURES

For participants in the ASAP program who are residents of Our Home, Inc. treatment team for each participant will include staff members from Our Home, Inc., parents/guardians, and any school or agency personnel involved with a particular child. Decisions that may affect the safety of the public in general, students or other residents of Our Home, Inc. will be made involving as many of the treatment team members as needed to ensure the safety of those individuals an ASAP participant may come in contact with.

WHEN A REFERRAL FOR ASAP IS RECEIVED

In order to determine the appropriateness of a particular referral, certain information is required at the time of referral to adequately consider the child for possible placement:

1. Any previous social services/police reports
2. Any medical and psychological reports
3. Previous treatment summaries
4. Drug/Alcohol use or abuse history
5. Educational history

WHEN ADEQUATE DATA IS RECEIVED

Staff from Our Home, Inc will consult to determine if referral is appropriate. The referral source will be notified regarding the conditions of acceptance or reasons for refusal.

PLACEMENT

If placement is continued, the treatment team develops a treatment plan that will include the goals and objectives for the child's long term treatment. The referral source will be provided with a copy of the treatment plan and a "Progress to Date" report.

WHEN A CHILD HAS COMPLETED THE 90 DAY EVALUATION

At the end of the 90 day evaluation period, the treatment team will consult to determine the appropriateness of continued placement. Our Home, Inc. will recommend alternative placements, if placement is discontinued at Our Home, Inc.

WHEN PLACEMENT IS CONTINUED PER 90 DAY EVALUATION

If placement is continued, the treatment team develops a treatment plan that will include the goals and objectives for the child's long term treatment. The referral source will be provided with a copy of the treatment plan and a "Progress to Date" report.

WHEN A REFERRAL IS ACCEPTED FOR PLACEMENT

A date and time for admission will be established with the referral worker. Upon admission, the following procedures will occur:

1. Group Leader will review with referral worker intake information and determine any immediate medical, psychological or family issues needing attention.
2. Resident will be assessed to determine appropriateness of placement.
3. If the resident is determined to be inappropriate the referral worker will be notified and arrangements will be made.
4. Group Leaders will notify via telephone and in writing the resident's data and time of arrival for a federal resident placements.
5. Group Leader and assigned staff will provide orientation for residents within 24 hours of arrival.

WHEN A CHANGE IN PLACEMENT IS REQUIRED

When a substantial change in placement is required for an ASAP participant, such as changing school, the treatment team will consult as to what is in the best interest of the youth regarding change in placement.

WHEN AN ASAP PARTICIPANT IS TO BE DISCHARGED

Decisions regarding discharge from ASAP will be made by the treatment team. A treatment summary report will be completed by the treatment team and will include any conditions or stipulations regarding the discharge and follow-up treatment needed.

DOCUMENTATION

All procedures, changes in placement, evaluations, etc will be documented by the various agencies involved in the treatment team.

Clothing Requirements For Admission

(Revised 3/27/09)

The following list of clothing needs is required for admission into the Our Home, Adolescent Sexual Adjustment Program. Should these requirements not be met, the referral worker will be notified within two weeks of placement in order to make arrangements to purchase these required clothing.

Please instruct the youth to bring along these items:

1. (4) Pairs of jeans or pants, that fit and is not full of holes. Dress Code requires that any pants that are wider than 12 inches across, more than 2 inches big in the waist, or drag on the floor will be confiscated. Pants cannot have anything printed on the zipper. Should the youth enter the program with pants that do not follow these conditions, will be confiscated and considered to be contraband. (Pants should fit. No baggy pants are allowed)
2. (9) Shirts – winter and summer shirts pending season. NO alcohol, cigarettes, music or drug logos. Not cropped shirts
3. (7) Pair of socks.
4. (7) Underwear
5. (4) Shorts (summer) without strings. If your son has any history of harm to self
6. (2) Pair of pajamas without strings.
7. Swimming trunks
8. Winter coat, gloves, and hat - mandatory
9. Belt
10. Also if the youth wears contacts, be sure to send contact solution and a case for the contacts.

OHI will furnish (Do not send the following):

1. Toothbrush and Tooth Paste
2. Deodorant
3. Comb/brush
4. Shampoo / Conditioner
5. Razor
6. Hair Dryer
7. Nail Clipper
8. Bar Soap
9. Mouthwash
10. Radio
11. Personal CD Player / CD's unless they are spiritual in nature
12. Perfumes
13. Jewelry
14. Hair gel or mousses
15. Any type of aerosol container (hairspray, etc.)

Cigarettes, lighters, chewing tobacco are considered contraband and will be destroyed.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Effective date of this Notice and policy is January 9, 2008

1. PURPOSE: Our Home, Inc. and its professional staff and employees follow the privacy practices described in this Notice. Our Home, Inc. keeps your health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS?

Your treatment includes sharing information among health care providers who are involved in your treatment. For example, if you are seeing both a physician and a psychologist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Agency operations. Staff members designated for Quality of Care may access clinical records periodically to verify that Agency standards are met.

3. HOW WILL OUR HOME, INC. USE MY PROTECTED HEALTH INFORMATION?

Your personal health records will be retained by Our Home, Inc. for approximately seven (7) years after your discharge. After that time has elapsed, your records will be erased, shredded, burned or otherwise destroyed in a way that protects your privacy. Copies of health records that have been distributed to other entities may continue to exist and are managed by their policies.

Until the records are destroyed they may be used for the following purposes unless you request restrictions on a specific use or disclosure.

- As may be required by law;
- For public health purposes such as reporting of child abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law);
- Health oversight inspections, e.g., Licensing/accreditation surveys, audits, inspections or investigations of administration and management of Our Home, Inc.;
- Lawsuits and disputes;
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred in the practice; when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out treatment and health care operations functions through transcription and billing services;
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority;

National security and intelligence activities;

- Alcohol and drug abuse information has special privacy protections. Our Home, Inc. will not disclose any information identifying an individual as being a resident or provide any mental health or medical information relating to a resident's substance abuse treatment unless (i) the resident consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES.

Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

You have the following rights regarding your health information.

- You have the right to look at a copy and obtain a copy of your medical information as maintained by Our Home, Inc. The request must be made in writing. You may not look at or copy information that is subject to law that prohibits access to medical information.
- You have the right to receive a list of certain disclosures we have made of your protected health information. These disclosures, if any, were made for purposes other than treatment, payment, healthcare operations, or other special exceptions.
- You have the right to request Our Home, Inc. to amend your medical information. The request must be made in writing. Your request may be denied if the changes apply to records Our Home, Inc. did not create, or for certain other reasons.
- You have the right to request restrictions of the use and disclosure of your restricted health information. Your request must be made in writing, and must state specific restrictions requested and to whom the restrictions should apply. We are not required to agree to these additional restrictions.

6. REQUIREMENTS REGARDING THIS NOTICE.

Our Home, Inc. is required to provide you with this Notice that governs our privacy practices. Our Home, Inc. may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for health information we have about you as well as any information we receive in the future. You may ask for and receive the Privacy Notice that is in effect at the time.

7. QUESTIONS AND COMPLAINTS.

If you have any questions regarding this notice, please ask to speak with our Business Manager.

If you believe we have violated your privacy rights, please contact our Business Manager. We will not retaliate against you for filing a complaint. You may also submit a written complaint to the U.S. Department of Health and Human Services at the following address:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
Or
Phone: 1-202-619-0257
Toll-Free: 1-877-696-6775

Notification of Agency Policies

We are also required to let you know of policies established by Our Home, Inc. to ensure for the health, safety, and care of each resident. Copies of these policies are available upon request.

- * Admission
- * Written Treatment Plan
- Intervention
 - * Scope of Services
 - * Case Management
 - * Counseling
 - * Discharge
 - * Resident Discipline
- * Confidentiality of Information
- * In-house Abuse and/or Neglect Prevention &
- * Access to Health Care
- * Collection and Recording of Health Appraisal Data
- * Medical Emergency Plan
- * Immediate Medical Examination and Treatment

Reporting Requirements

Regarding the policies listed above, we are required to advise you of our reporting obligations. Reports must be made to the following individuals or agencies as required on a monthly and/or quarterly basis or if a specific event occurs:

- * Placement Agency/Worker
- * State Certification Team
- * Department of Social Services Office of Child Protection Services
- * Department of Social Services Division of Medical Services
- * South Dakota Advocacy Services
- * Centers for Medicare & Medicaid Services – Regional Office

SECLUSION AND PERSONAL RESTRAINT

(revised 10/13/10)

Policy

It is the policy of Our Home, Inc. to limit the use of seclusion and personal restraint to situations in which unanticipated resident behavior places the resident or others at serious threat of violence or injury if no intervention occurs.

Seclusion and personal restraint will be performed under the following guidelines:

- I. A resident shall not be placed in seclusion or personal restraint unless the placement agency has given written permission and the use has been incorporated into the resident's treatment plan. If the resident has been placed by their parent or guardian, the parent or guardian must provide the written permission.
- II. Use shall be selected only when other less restrictive measures have been ineffective. All attempts shall be made to de-escalate crises and use seclusion and personal restraint as a safety intervention of last resort.
- III. Our Home, Inc. shall be dedicated to creating an environment that strives to prevent, reduce, and eliminate the use of seclusion and restraint.
- IV. Contributing environmental factors that may promote maladaptive behaviors shall be immediately assessed with action taken to minimize those factors.
- V. Staff shall recognize that each resident has the right to be free from seclusion or restraint, of any form, used as a means of coercion, discipline, convenience, punishment, and retaliation.
- VI. Seclusion and restraint shall be provided under physician supervision/oversight.
- VII. An order for seclusion or restraint shall not be written as a standing order.
- VIII. Seclusion or restraint shall be implemented in a manner to avoid harm or injury and must be used only until the situation has ceased and the resident's safety and the safety of others can be ensured.
- IX. Seclusion and restraint shall not be used at the same time.
- X. The physical plant of each agency treatment facility shall be planned to safely and humanely accommodate the practice of seclusion or restraint.
- XI. An emergency safety intervention must be performed in a manner that is proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
- XII. Staff will be solely responsible for conducting seclusion and restraint. Residents will not be used or allowed to control other residents.
- XIII. Only staff who have completed and demonstrated competency in required trainings may participate in an emergency safety intervention.
- XIV. Videotaping of calculated restraint incidents is required on all U.S. Probation and Custody residents.

Procedures

I. Notification of program policy.

At admission, the incoming resident and the resident's parent(s) or legal guardian(s) shall be provided a copy of this document and have it reviewed with them in a language that is understandable. Contact information shall be provided, including the phone number and mailing address for the State Protection and Advocacy organizations.

II. Admission Assessment for Potential Seclusion or Restraint

Staff shall obtain information about the resident to help minimize use of seclusion or restraint. This information includes: the medical history, a physical examination, behavioral health history for identification of prior trauma, alternatives the resident prefers, and the effectiveness of prior use of seclusion or restraint.

III. Determining the Need for and Implementing Seclusion or Restraint

Staff members shall implement Nonviolent Crisis Intervention techniques designed to help provide for the best possible care and welfare of residents exhibiting threatening or harmful behavior. When determining the use of seclusion or restraint, staff shall take into consideration admission assessment information and the current situation. When less restrictive intervention techniques have been attempted, staff shall determine if seclusion or restraint is needed. Seclusion or restraint may occur without attempting less restrictive techniques.

Staff shall obtain a written or verbal order from the Medical Director or another licensed practitioner for seclusion or restraint. The order may not exceed 1 hour. When the Medical Director or licensed practitioner is not available, staff may initiate seclusion or restraint before obtaining an order.

IV. Monitoring of the Resident In and Immediately After Seclusion or Restraint

The response leader must be physically present, continually observing, assessing, and monitoring the resident to evaluate the physical and psychological well-being of the resident and the safe use of restraint or seclusion throughout the duration of the intervention. Attention to vital signs and resident needs, as well as skin integrity and circulation for restraints, shall be given throughout the intervention. Staff shall attempt appropriate interaction with the resident as an effort to de-escalate the crisis.

Within 1 hour of the initiation of the seclusion or restraint, the Medical Director, another licensed practitioner, or registered nurse must conduct a face-to-face assessment of the physical, emotional, and psychological well being of the resident. The assessment ensures the resident's rights, assures the seclusion or restraint is necessary and appropriate and also allows for resident medical status evaluation. If the assessment is conducted prior to the resident's release, a second assessment must be conducted after the seclusion or restraint ends.

V. Medical Treatment for Injuries Resulting from Seclusion or Restraint

All staff shall be alert for any resident or staff injuries following seclusion or restraint. Specifically, staff shall observe and question all persons involved regarding their current health status immediately following the seclusion or restraint to determine if any injuries occurred. As necessary, staff shall follow medical emergency or medical examination policies to ensure for resident care.

Written service agreements with local hospitals shall be maintained to reasonably ensure a resident will be transferred to a hospital and admitted in a timely manner when medically

necessary, information needed for care will be exchanged in accordance with State medical privacy law, and services are available 24 hours a day, 7 days a week, including emergent care.

VI. Facility Reporting

An incident report shall be completed following the use of seclusion or restraint. A report shall also be submitted to the CCM within 24 hours of the restraint for all U.S. Probation and Custody residents.

Attestation of facility compliance. A completed attestation form shall be submitted to the state to attest that each facility is in compliance with CMS's standards governing the use of restraint and seclusion.

Reporting of serious occurrences. Each serious occurrence shall be reported to both the State Medicaid Agency and the State-designated Protection and Advocacy organizations. Serious occurrences that must be reported include a resident's death, suicide attempt, or serious injury. Additionally, the resident's parent(s) or legal guardian(s) must be notified as soon as possible, and in no case later than 24 hours after the serious occurrence.

VII. Notification of Parent(s) or Legal Guardian(s)

The parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion must be notified as soon as possible but at least within 10 hours after the initiation of each intervention. For U.S. Probation and Custody residents, the notification to the CCM must be made immediately by telephone or fax following a restraint.

VIII. Post Intervention Debriefings

Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion in a language that is understood by all participants. This discussion must include the intervention's response leader, primary responder, secondary responder(s), and the resident. A required staff can be excused when their presence may jeopardize the well being of the resident. Other staff may participate in the discussion when it is deemed appropriate by the program. Family/Guardian/Significant others requested by the resident may participate in the discussion, unless clinically inadvisable.

Within 24 hours after the use of restraint or seclusion, staff involved in the resident debriefing, and appropriate supervisory and administrative staff, must conduct a debriefing session.

IX. Treatment Plan Review

All uses of seclusion or restraint shall result in a review and, as appropriate, revision of the resident's treatment plan.

X. Education and Training

Staff shall receive specific training for managing emergency safety situations and take part in exercises that allow for successful demonstration of the techniques they have learned.

XI. Room Requirements

Rooms designated for the use of seclusion or restraint shall be free of potentially hazardous conditions and have a focus on the comfort of the resident, an emergency exit plan, access to bathroom facilities, sufficient lighting, observation availability that allows

staff full view of the resident in all areas of the room, and a location that promotes privacy and dignity of the resident.

XII. Performance Improvement

Our Home, Inc. shall collect seclusion and personal restraint data to monitor and improve its performance of emergency safety interventions.

XIII. Plan to Minimize Use of Seclusion and Personal Restraint

To minimize or eliminate the use of seclusion and restraint in its treatment programs, Our Home, Inc. shall implement an agency-wide plan that is monitored and updated annually.

XIV. Annual Review

This policy and related procedures shall be reviewed by medical and mental health professionals on an annual basis to ensure that proper protocols are in place.

Contact Information

State Medicaid Agency

Nicki Bartel RN, RHIT
Nurse Consultant
DSS Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Phone: 605-773-3495
Fax: 605-773-5246
Email: nicole.bartel@state.sd.us

- or -

Revi Warne
DSS Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Phone: 605-773-3495
Fax: 605-773-5246
Email: revi.warne@state.sd.us

State-designated Protection Organization

Huron Programs:

Michelle Bretsch
Intake Specialist
DSS – Child Protection Services – Aberdeen
3401 10th Ave SE
Aberdeen, SD 57401-8000
Toll Free: 1-866-858-3204
Phone: 605-626-3160
Fax: 605-626-2610

- or -

Parkston Program:

Coreen Odens (ext. 228) or Kathy Boysen (ext. 225)
Intake Specialists
DSS – Child Protection Services – Yankton
3113 N. Spruce St., Suite 200
Yankton, SD 57078-5320
Toll Free: 1-866-847-7338
Phone: 605-668-3030
Fax: 605-668-3014

State-designated Advocacy Organization

Robert Kean, Executive Director
South Dakota Advocacy Services
221 South Central Avenue
Pierre, SD 57501
Phone: 605-224-8294 Voice/TDD \ 800-658-4782
Fax: 605-224-5125
E-mail: keanr@sdadvocacy.com

Centers for Medicare & Medicaid Services (CMS)

Michael K. Bishop
Centers for Medicare and Medicaid Services
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967
Phone: 303-844-7032
Fax: 303-860-5897
Email: Michael.Bishop1@cms.hhs.gov

C. FAMILY

Parents/Guardians Age Address Education
Father _____

Occupation _____ Address _____

Home Phone _____ Work Phone _____

Mother _____

Occupation _____ Address _____

Home Phone _____ Work Phone _____

Marital status of parents:

Married _____ Separated _____ Divorced _____ Widowed _____

Has either parent received any type of counseling? Yes _____ No _____

Mother _____ Father _____ If so, by whom? _____

Children Age Living in home or elsewhere

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

List those persons with whom might be detrimental to youth:

D. HEALTH

Does youth receive any medication at present? Yes _____ No _____

Name of medication _____

Prescribed by _____ Date _____

Name of Youth's physician _____

Address _____

Date of last physical examination _____

Immunizations (copy attached) _____

Name of youth's dentist _____

Address _____

Date of last examination _____

Allergies _____

E. SCHOOL

Complete transcript of grades (attached)

Last grade completed successfully _____ Date _____ Current Grade _____

Last School attended _____

Address _____

What is youth's attitude toward school? _____

Is youth presently in school? Yes _____ No _____ If not, why? _____

Is youth certified for special education? Yes _____ No _____ (attached)

F. RELIGION

Denomination _____

Has religion played a large _____ average _____ small _____ part in youth's life?

ACKNOWLEDGEMENT OF RECEIPT AND NOTIFICATION OF SELECTED AGENCY POLICIES

(Revised 3/18/11)

It is the responsibility of Our Home, Inc. to provide you, the parent or guardian of a resident in our care, copies or notification of specific agency policies and a listing of agencies to whom required reports must be made.

Provision of Agency Policies

We are required to provide you copies of some agency policies. Those policies listed below are being provided for your review:

- * Seclusion and Personal Restraint
- * Notice of Privacy Practices

Notification of Agency Policies

We are also required to let you know of policies established by Our Home, Inc. to ensure for the health, safety, and care of each resident. Copies of these policies are available upon request.

- * Admission
- * Written Treatment Plan
- * Scope of Services
- * Case Management
- * Counseling
- * Discharge
- * Resident Discipline
- * Confidentiality of Information
- * In-house Abuse and/or Neglect Prevention and Intervention
- * Access to Health Care
- * Collection and Recording of Health Appraisal Data
- * Medical Emergency Plan
- * Immediate Medical Examination and Treatment

Prohibition of firearms or other dangerous weapons: Our Home, Inc. prohibits the presence of firearms or other dangerous weapons (knives, CD gas, Chemical agents, etc.) in the facility or on Our Home property.

Reporting Requirements

Regarding the policies listed above, we are required to advise you of our reporting obligations. Reports must be made to the following individuals or agencies as required on a monthly and/or quarterly basis or if a specific event occurs:

- * Placement Agency/Worker
- * Department of Social Services Office of Child Protection Services
- * Department of Social Services Division of Medical Services
- * South Dakota Advocacy Services
- * Centers for Medicare & Medicaid Services – Regional Office
- * State Certification Team

Parent/Guardian Acknowledgement

By signing my name below, I acknowledge that I have been provided the listed policies and informed of the additional policies as well as individuals or agencies to whom required reports must be made.

Parent(s) or Legal Guardian(s) Signature

Date

SECLUSION AND PERSONAL RESTRAINT CONSENT FORM

(1/11/08)

Our Home, Inc. maintains a Seclusion and Personal Restraint policy that includes procedures for the implementation of seclusion and personal restraint interventions. These interventions are only used as a last resort to unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs. At admission, parents/guardians are provided a copy of the policy and informed of its contents.

Safety measures of the policy include, but are not limited to:

- Continuous observation, assessment, and monitoring to evaluate the well-being of the resident.
- Staff interaction and support as an effort to de-escalate the situation.
- Time limited order not to exceed 1 hour.
- Face-to-face assessment conducted by a physician, licensed practitioner or registered nurse within 1 hour of the initiation of the seclusion or personal restraint.

In order to place a resident in seclusion or personal restraint, Our Home, Inc. must have written permission from the resident's placement agency. If the resident is placed by the parent or guardian, the parent or guardian must approve the use. If you have no questions regarding the use or procedures of seclusion or personal restraint, please sign the consent below. The placement worker's signature or the parent/guardian signature is required. If you have any questions or concerns regarding this matter, please contact the Program Coordinator at the Our Home, Inc. program to which your child is being referred.

CONSENT

I/We, being the parent(s)/legal guardian of :

(Full Name of Resident)

do hereby give my (our) permission to Our Home, Inc., to use, for the purpose of personal safety, monitored seclusion and personal restraint, at Our Home, Inc.

Parent/Guardian

Date

Placement Agency Representative

Date

OUR HOME, INC., ASAP
40354 210th Street, Huron, SD 57350, Phone (605) 352-9098, Fax (605) 352-0550.
(4/26/11)

MEDIA CONSENT FORM

I/WE BEING THE PARENT(S) LEGAL GUARDIAN OF:

(Full name of youth)

**AND BEING RESIDENTS OF THE CITY OF _____ IN THE STATE
OF _____, DO DO NOT GIVE (OUR) PERMISSION AND CONSENT TO
OUR HOME, INC., ADOLESCENT SEXUAL ADJUSTMENT PROGRAM TO USE, FOR THE
PURPOSE OF PUBLICATION INFORMATION RELATING TO THE RESIDENCY AND
ACTIVITIES OF SAID YOUTH AT OUR HOME, INC. PERMISSION AND CONSENT
INCLUDES, BUT IS NOT LIMITED TO, USE OF SAID YOUTH'S FULL NAME AND
PHOTOGRAPH AND STORIES CONCERNING HIS RESIDENCY AND ACTIVITIES AT OUR
HOME, INC.**

SIGNED THIS _____ DAY OF _____, 20_____

PARENT/GUARDIAN

REFERRAL AGENCY REP

OUR HOME, INC.

Adolescent Sexual Adjustment Program

40354 210th St.

Huron, SD 57350-7928

Phone (605) 352-9098

Fax (605) 352-0550

REQUEST OF GRADE TRANSCRIPT

Dear _____;

The pupil whose name is listed below has enrolled in the Our Home, Alternative School and indicated former attendance in your school.

Please forward to us a transcript of grades and any other information that may be available regarding this student's school progress. Also send us health and immunization records.

When transfer is during the school year, please include transfer grades for the present term.

Name of Student _____

Grade _____ Date of Birth _____

Date of withdrawal (if available) _____

A prompt reply will be appreciated.

Parent/Guardian Signature

Date

AUTHORIZATION TO RELEASE INFORMATION

I certify that I am the parent or guardian of the person described in this report, and that my right to the custody of said person has not been terminated or limited by the order or decree of any court of law. I hereby authorize my local law enforcement agency and any other criminal justice agency to collect and/or disseminate the information/provided by me; including photographs, dental and medical information; to any person or organization engaged directly or indirectly in any effort to assist in the location of missing persons.

I certify the information I have provided is true and correct to the best of my knowledge.

Time report filed _____ AM/PM

This _____ day of _____, 20_____.

Resident's Name _____ Resident's Number _____

Referral Worker's Signature _____ Relationship _____

Address _____ Phone No. _____

Police Officer's Name _____ Badge No. _____

Agency _____

*Please note that Our Home, Inc. is not responsible for the cost if the above resident is placed at a detention center. Please identify who would be the responsible party for payment.

Responsible Party Date

Referral Worker/ Agency Date

**OUR HOME, INC.
FINANCIAL RESPONSIBILITY FOR MEDICAL COSTS**

As a parent/guardian of a child receiving treatment services at Our Home, Inc. programs, I acknowledge that I have been provided with a copy of the Our Home, Inc. Medical Care Policies and Procedures. I also acknowledge that the costs of medical care are my responsibility as a parent or guardian.

If a third party is to be used for expense incurred, please identify below with the information needed:

_____ Title 19 # _____

_____ Indian Health Services
Location _____

Address & Phone # _____

_____ Private Health Insurance
Insurance Company Name _____

Company Address _____

Insurance Company Telephone # _____

Policy # _____ Employer _____

Policy Holder Name _____

Policy Holder Social Security # _____

MEDICAL CONSENT

As a parent/guardian of _____, I authorize Our Home, Inc. Programs to procure EMERGENCY MEDICAL TREATMENT, SURGERY, HOSPITALIZATION and other medical care determined to be necessary in the care of the child identified.

I acknowledge that this authorization is given even though circumstances may not allow for proper notification, to you as parent or guardian, of the need for the procurement of emergency medical care.

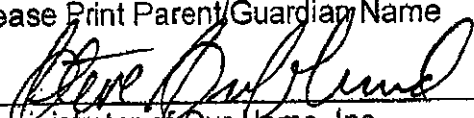
I further acknowledge that this consent form is valid in the event that the child identified above is transferred to another Our Home, Inc. Program (ASAP, Residential Treatment Care or Rediscovery)

Signed this _____ Day of _____, 20____.

Parent/Guardian Signature

Referral Agent Signature

Please Print Parent/Guardian Name



Administrator of Our Home, Inc.

OUR HOME, INC., ASAP

40354 210th Street, Huron, SD 57350, Phone (605) 352-9098, Fax (605) 352-0550

MEDICAL CARE POLICIES AND PROCEDURES

Please acknowledge the following policies and procedures pertaining to the medical care of young people in the Our Home, Inc. programs. It is imperative that you provide documented consent authorizing Our Home, Inc. to secure emergency medical care so that we can assure for the safety of your child. Our Home, Inc. wants to acknowledge "your need to know" in regard to matters involving the medical care. Therefore, the following policies are maintained:

1. Consent for the purpose of securing Emergency Medical Care **must** be signed and provided to the Our Home, Inc. program prior to or at the time of admission. This consent form must be signed by an individual that holds parental rights or legal guardianship.
2. "Financial Responsibility for Medical Costs" form must also be provided prior to or at the time of admission. It is Our Home, Inc. program policy **that all medial costs are the responsibility of the parents or guardians.** This policy applies to Admission Physical Examination costs as well as those medical and medication costs incurred during the treatment process. Exceptions to this policy apply to those youth placed in the Our Home, Inc. Rediscovery program under the contract with the State of South Dakota and with Indian Health Services. In this exception, the Rediscovery Program pays the Physical Examination costs. **THIS EXCEPTION APPLIES ONLY TO PHYSICAL EXAMINATION COSTS.** It does not apply to incidental costs. All youth must have an admission physical by the Our Home, Inc. Medical Director as mandated by accreditation rules.
3. Our Home, Inc. recognizes that there will be situations wherein there is a potential for third party pay in regard to medical costs. If you wish the attending physician to bill the insurance company for any medical costs, it is **your responsibility to inform our Office Manager and furnish her with ALL necessary information.** Another option would be to have the attending physician send you the itemized bill, which you can send along with your insurance form to the insurance company.
4. Our Home, Inc. will make and document reasonable efforts to contact parents/guardians or third party pay if necessary in any event of a medical emergency. This is done to assure that significant others are advised of the emergency situation and to advise such party that it was necessary to incur an unexpected medical expense.
5. Our Home, Inc. will not obtain any routine medical care or incur any medical expense for ordinary care without the prior authorization or the parent/guardian.

OUR HOME, INC/ASAP
AUTHORIZATION FOR RELEASE OF INFORMATION

7/1/09

There are times when Our Home, Inc. ASAP Program will be asked to share or receive information with other people or agencies in order to best help you. Please complete this form that will serve as your authorization for sharing of this information. This authorization will continue to guarantee that your privacy of information remains confidential.

I, _____ authorize Our Home, Inc./ASAP
(Resident Name)

To disclose to: _____ To receive from:
Huron Clinic, Huron Vision Care, Dakota Family Dentistry, Community Counseling – Dr. Christopherson, Tschetter-Hohm Clinic, Sanford Lab

The following protected health information from my records (Specify extent or nature of information to be disclosed.)

- | | |
|---|--|
| <input type="checkbox"/> Family and Social History | <input type="checkbox"/> Education Records |
| <input checked="" type="checkbox"/> Medical History | <input type="checkbox"/> Psychological Information/Testing |
| <input type="checkbox"/> Treatment Plan/Progress | <input type="checkbox"/> Substance Abuse Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other, Specify:
_____ |
| <input type="checkbox"/> Diagnosis | _____ |

The purpose of need for such disclosure:

- | | |
|--|--|
| <input checked="" type="checkbox"/> For Continuity of Services | <input type="checkbox"/> To Fulfill Requirement of Purchaser |
| <input type="checkbox"/> For the purpose of Quality Assurance | <input type="checkbox"/> Other:
_____ |
| <input type="checkbox"/> For Supervision | _____ |

I have been informed that I have the right to withhold my consent concerning release of confidential material related to me or to the person named above.

This consent (unless expressly revoked earlier) expires upon: _____
(Specify date, event, or condition consent will expire)

Signature of Resident _____ Date _____

Signature of Parent, Guardian or Person Authorizing Disclosure (If a minor) _____ Date _____

Signature of Legal Representative or Person Authorizing Disclosure (If a minor) _____ Date _____

Resident Date of Birth _____

Resident Social Security Number _____

OUR HOME, INC.

Adolescent Sexual Adjustment Program
40354 210th St.
Huron, SD 57350-7928
Phone (605) 352-9098
Fax (605) 352-0550

Immunization Consent

_____, 2 _____

I, _____, having legal guardianship/custody of
(Name of guardian)

_____, agree to immunizations as
(Name of child in care)

recommended by the doctor, including the seasonal flu and H1N1. I have discussed the purpose of the immunizations with the nurse or group leader employed by Our Home, Inc., and feel the immunizations in question are appropriate and helpful to the above named. If at any time, I believe the immunizations are not helpful, I may visit with the nurse or group leader to have this consent revoked and discuss other options.

Informational sheets sent with consent yes no
Informational sheets available for viewing at www.cdc.gov/vaccines/

Signed,

Parent or Guardian

Date

Referral Worker

Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
STATE OF SOUTH DAKOTA DEPARTMENT OF HEALTH**

I, (Print Name) _____,
acknowledge and agree that I have received a copy of the Notice of Privacy
Practices, Version I dated 04/14/2003 from the South Dakota Department of
Health.

Signature of Participant

Date

Signature of Participant's Legal Representative (if applicable)

Date

Printed Name of Legal Representative (if applicable)

Relationship to Participant

Witness

Date

THIS SECTION FOR STAFF USE ONLY

*****Fill out only if program participant refuses or is unable to sign*****

The South Dakota Department of Health has made the following good faith effort
to obtain the above-referenced individual's written acknowledgement of receipt of
its Notice of Privacy Practices:

- Participant refused to sign.
- Participant unable to sign.
- Legal Representative refused to sign.
- Legal representative unavailable to sign.
- Other _____

Witness

Date

_____|_____|_____|_____|_____|_____|_____|_____|

PATIENT NUMBER



Age _____ Date _____

Patient's Name _____ Date of Birth _____ Male Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single Married Separated Divorced Widowed Minor

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance Cash Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

**DENTAL INSURANCE
1ST COVERAGE**

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

**DENTAL INSURANCE
2ND COVERAGE**

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE _____

REGISTRATION

Date _____ **REGISTRATION & MEDICAL HISTORY** **HURON EYE CLINIC, P.C.**

Name _____ Spouse _____ Sex: Male Female
 Address _____ City _____ ST _____ Zip _____
 Age _____ Birthdate _____ Employer _____ Occupation _____
 Home Phone _____ Work Phone _____
 Medical Doctor _____ Were You Referred? _____
 Responsible Party _____
 Medicaid # _____ Medicare # _____ Social Security # _____ - _____ - _____

CURRENT MEDICATIONS: _____

Are you pregnant or nursing? No Yes
 Do you wear glasses? No Yes
 Do you wear contact lenses? No Yes
 Contact lens type: Rigid Soft Extended Wear
 How old is your eyeglass prescription? _____

MEDICATION ALLERGIES: _____

Have you been diagnosed with or had -
 Glaucoma No Yes
 Macular Degeneration No Yes
 Retinal Disease No Yes
 Cataracts No Yes
 Drooping Eyelid No Yes
 Eye Injury No Yes
 Eye Surgery No Yes

FAMILY MEDICAL HISTORY		WHO			WHO			WHO
Blindness <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Arthritis <input type="checkbox"/> N <input type="checkbox"/> Y	_____	High Blood Press... <input type="checkbox"/> N <input type="checkbox"/> Y	_____
Glaucoma <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Cancer <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Kidney Disease <input type="checkbox"/> N <input type="checkbox"/> Y	_____
Macular Degeneration <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Diabetes <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Lupus <input type="checkbox"/> N <input type="checkbox"/> Y	_____
Retinal Detach/Disease <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Heart Disease <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Thyroid Disease <input type="checkbox"/> N <input type="checkbox"/> Y	_____
Cataract <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Crossed Eyes <input type="checkbox"/> N <input type="checkbox"/> Y	_____	Other	<input type="checkbox"/> N <input type="checkbox"/> Y	_____

SOCIAL HISTORY

Do you drive? N Y If yes, do you have vision difficulty driving? N Y _____
 Do you use tobacco products? N Y If yes, type / amount / how long? _____
 Do you drink alcohol? N Y If yes, type / amount / how long? _____
 Have you been exposed to or infected with: HIV Hepatitis TB

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL	NO	YES	EYES, NOSE, MOUTH, THROAT	NO	YES
Fever, Weight Loss / Gain <input type="checkbox"/> <input type="checkbox"/>	Allergy / Hay Fever <input type="checkbox"/> <input type="checkbox"/>
INTEGUMENTARY (Skin) <input type="checkbox"/> <input type="checkbox"/>	Chronic Cough <input type="checkbox"/> <input type="checkbox"/>
NEUROLOGICAL			Dry Mouth <input type="checkbox"/> <input type="checkbox"/>
Headaches, Seizures <input type="checkbox"/> <input type="checkbox"/>	RESPIRATORY (Lung Problems) <input type="checkbox"/> <input type="checkbox"/>
EYES			VASCULAR / CARDIOVASCULAR		
Loss of Vision <input type="checkbox"/> <input type="checkbox"/>	Diabetes <input type="checkbox"/> <input type="checkbox"/>
Blurred Vision <input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/> <input type="checkbox"/>
Double Vision <input type="checkbox"/> <input type="checkbox"/>	Heart Failure <input type="checkbox"/> <input type="checkbox"/>
Dryness <input type="checkbox"/> <input type="checkbox"/>	GASTROINTESTINAL		
Redness <input type="checkbox"/> <input type="checkbox"/>	Diarrhea / Constipation <input type="checkbox"/> <input type="checkbox"/>
Burning <input type="checkbox"/> <input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Excessive Tearing <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid Arthritis <input type="checkbox"/> <input type="checkbox"/>
Eye Pain <input type="checkbox"/> <input type="checkbox"/>	Muscle / Joint Pain <input type="checkbox"/> <input type="checkbox"/>
Eye or Eyelid Infections <input type="checkbox"/> <input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Flashes / Floaters <input type="checkbox"/> <input type="checkbox"/>	Anemia / Bleeding Problems <input type="checkbox"/> <input type="checkbox"/>
ENDOCRINE			ALLERGIC / IMMUNOLOGIC <input type="checkbox"/> <input type="checkbox"/>
Thyroid / Other Glands <input type="checkbox"/> <input type="checkbox"/>	PSYCHIATRIC <input type="checkbox"/> <input type="checkbox"/>

IF YOU ANSWERED YES TO ANY OF THE ABOVE, OR HAVE A CONDITION NOT LISTED, PLEASE EXPLAIN AND LIST MEDICATIONS:

HIPPA Privacy Practices Notice Received

Patient's Signature _____

Dr's. Signature _____

OUR HOME, INC., ASAP

40354 210th Street, Huron, SD 57350, Phone (605) 352-9098, Fax (605) 352-0550.
(Do not need if DOC, USPO or BOP intake)

CONSENT FORM FOR DRUG AND ALCOHOL URINALYSIS

I authorize Our Home, Inc. to conduct urinalysis for the detection of drugs and alcohol on

(Full Name of Juvenile)

The urinalyses will be conducted on a random and selective basis following the policy and procedure established by Our Home, Inc.

Referral Agency Representative/Probation Officer

Or

If privately placed – Parent/Guardian

Date