

**OUR HOME INC. REDISCOVERY
Initial Referral Form**

RETURN TO: Blaise Tomczak
Chemical Dependency Services Coordinator
40354 210th Street
Huron, SD 57350
Ph. (605) 353-1025
Fax (605) 353-1061

REFERRED BY: Name _____
Agency _____
City _____ State _____
Email: _____
Zip _____ Telephone _____

A. Youth

Name _____
(First Name) (Middle name) (Last Name)

Social Security # _____ Title19/Ins# _____

Insurance Company: _____
(**** Our Home will need a copy of insurance card- front & back)

Sex _____ Race _____ Birthday _____ Age _____

Present Address _____

Cell Phone #: _____ Email address: _____

Is youth living with parent(s)? Yes _____ No _____

If not, who does this youth live with? _____

B. Family Members

Mother's information: check if has custody of youth

Name: _____ Age: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home) () _____ (work) () _____ (cell) () _____

Email Address: _____

Occupation: _____

Father's information:

check if has custody of youth

Name: _____ Age: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home) () _____ (work) () _____ (cell) () _____

Email Address: _____

Occupation: _____

Guardian's information:

check if has custody of youth

Name: _____ Age: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home) () _____ (work) () _____ (cell) () _____

Email Address: _____

Occupation: _____

Family Income (annual): _____

Marital status of parents: Married ___ Separated ___ Divorced ___ Widowed ___ Never married ___

Additional information regarding family: _____

Siblings

Age

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

C. Health

Describe the youth's health: _____

Does the youth have any physical limitations: Yes ___ No ___ Explain: _____

Is the youth on any medication: Yes ___ No ___

If Yes, List medication and dosage: _____

Has client ever been on medication in the past that he/she is no longer taking (for depression, anxiety, mood stabilizer, etc.): List medication(s): _____

Name of youth's physician (Primary Care Provider), address & Phone#: _____

Date of last physical examination: _____

Date of last dental exam: _____

Our Home, Inc. Rediscovery's medical director is Dr. Janice McKenney with Huron Clinic 111 4th St. SE Huron, SD 57350 (605) 352-8691.

D. School

*Circle the number of school years completed: (High School Graduation = 12)

1 2 3 4 5 6 7 8 9 10 11 12 13

Has the youth obtained a GED? Yes ___ No ___ Date completed: _____

What was the last school attended?

Name: _____ City _____

Is youth on an IEP (Individual Education Plan). Yes ___ No ___ If Yes, name of the school that did the IEP: _____ When is the next review: _____

(**** Our Home will need a copy of the IEP)

Explain youth's performance at school: _____

Explain youth's relationships with peers: _____

Explain youth's relationship with teachers: _____

Has client ever been suspended/expelled or put in detention: Explain: _____

E. Legal History

Describe client's legal history (include # of arrests, what arrested for, etc) _____

Is youth on probation/DOC: Yes ___ No ___ Explain: _____

Name of probation officer/JCA: _____ Phone # _____

Is youth Court Ordered to treatment: Yes ___ No ___

(**** If so, Our Home will need a copy of the Court Order)

Past placements (include tx centers, JDC, Jail, etc.)

| Placement | Dates | Completed Y/N |
|-----------|-------|---------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

F. Substance use

| <u>Substance used</u> | <u>Frequency</u> | <u>Age Started</u> |
|-----------------------|------------------|--------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

Problems as a result of substance use: _____

Has there been a Drug and Alcohol evaluation completed: Yes ___ No ___ If yes, evaluation

was completed by: _____

(**** Our Home will need a copy of the Drug and Alcohol evaluation)

**** Please fax this form back to Blaise Tomczak at (605) 353-1061****

10/7/10

OUR HOME, INC.

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 client or provide any mental health or medical information relating to a client's substance abuse treatment unless (i) the client 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

CLIENT'S NAME: _____

PARENTS/GUARDIAN NAME: _____

**Our Home, Inc. Rediscovery Program
Family Questionnaire**

The information requested in this packet must be provided by the youth's parents/guardian before a youth can be admitted to the Our Home, Inc. Rediscovery Program. Please respond to the items below.

Substance use

1. Describe to the best of your ability the substances (including alcohol) you know your child has used and how long the child has been using:

Describe, if possible, how much your child uses in terms of quantity:

2. If possible, describe any unsuccessful attempts your child has made to control/cut down or stop excessive use of substances (For example, prior drug and alcohol counseling/treatment, promising not to use as much, promising not to use again, etc.):

3. Do you believe your child has ever been intoxicated or high over the course of an entire day? Yes ___ No ___. If so, describe the incident or incidents of this that you recall:

4. Do you have any reason to believe that your child has had a blackout or loss of memory or events that took place when under the influence of a substance? Yes ___ No ___. Describe incident:

5. Does your child's personality seem to have changed since use began? Yes ___ No ___. Describe the change:

6. Has your child ever missed or had difficulties at school or work (if applicable) due to substance use? Yes ___ No ___. Has your child been suspended from school as a result of use? Yes ___ No ___. Describe incidents:

7. Describe all legal problems that your child has had as a result of or involving drug and alcohol use:

8. Describe any family arguments or difficulties the family has had with the child because of substance use:

Mental and Physical Health

1. Describe any psychological or psychiatric problems your child has had:

2. Has your child received any psychological or psychiatric care for these problems? Yes ___ No ___. If yes, identify with whom and where:

3. Summarize any medical problems or injuries affecting your child:

Have any of these injuries been related to the use of substances? Yes ___ No ___. Explain:

Current medication use (specify medication):

Education

1. What school does your child attend:

Describe your child's attitude toward and performance in school:

2. Describe any special education needs your child may have:

Is your child on an IEP (Individual Education Plan)? Yes ___ No ___

Finances

1. Describe how your child gets money and how much money he or she is accustomed to having in an average week:

2. Describe how your child gets along with his peer group:

3. Describe any problems or difficulties your child may have had with friends, due to substance use:

Family

1. Describe any family problems affecting your child:

2. Describe how your child gets along with his or her siblings:

3. Do any other members of your child's family have a history of substance abuse/dependency? Yes ___
No ___. Identify:

Religion

1. What is your family's religious denomination?

2. Does religion play a large ___ average ___ or small ___ part in your family's life?

Additional information

1. Is there any additional information you feel that should be known about your child's substance use or about your child in general that may be helpful:

Clothing/Personal Items

PLEASE INSTRUCT THE YOUTH TO BRING ALONG THESE ITEMS:

Clothing: The clients are given 1 laundry day a week. Please send enough clothing to last between washes. This includes underwear, socks, bras, shirts and jeans. Please remember that excessively baggy or torn clothing is not allowed and will be placed in lock-up until the client leaves. We will issue sweat pants if we have to confiscate clothing. We also do not allow any cropped T-shirts, T-shirts with music/drug/alcohol logos or inappropriate symbols. Please keep in mind that during the colder months of the year, a winter coat, mittens, and a hat should also be sent.

Personal Hygiene Items: Toothpaste, toothbrush, deodorant, bar soap, comb, brush, razors, shampoo and conditioner. Also, if the client wears contact lenses, please be sure to send contact solution and a case for the contacts.

Piercing: Jewelry in facial piercings are not allowed. This includes (rings/studs) in the nose, brow or lip. Females are allowed modest stud earrings. No client is allowed to wear gauges. Tongue studs/bars will be evaluated upon admission and a decision will be made on whether or not allowed.

DO NOT SEND:

Mouthwash
Radio
Personal CD (I-pod) Player
Alcohol based Aftershave
Perfumes
Jewelry
Hair gels or mousses
Fingernail Polish
Any type of aerosol container (hairspray, etc)
Hair dryer
Curling iron
Cell phones

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

**Our Home, Inc. Alternative School
Academic (special education)**

45-day treatment: Our Home Alternative School, a part of the Huron Public School system, is designed to meet the client's educational needs while still enabling you to work on treatment issues. Clients are enrolled in the Our Home Alternative School. Please send us any special education IEP plan or 504 plan necessary for enrollment. Since this is a short term placement (45-60 days), enrollment will continue with your school district and the student will not be enrolled long enough at Our Home School for any necessary updates to be completed. Students will be attending classes for four hours each day following our curriculum in the areas of Social Studies, English, and Math. Students are expected to complete the work assigned at our school as part of their treatment program. Clients have the opportunity to earn a ¼ credit in Math, ¼ credit in Social Studies and a ¼ credit in English.

Based on results of the K-TEA administered at the beginning of the client's stay and results of the Plato Assessments, the youth may have a chance to work on basic reading, math, and language arts skills through the Plato Fasttrack Program and under the guidance of the Title I teacher.

A letter grade for each class will be given at the end of the youth's stay. In addition, the number of hours that the youth attended school will also be placed on transcript with the grades that they have earned. It is up to the home school to determine how these hours may be used toward earning high school credit. These grades will be forwarded to the client's home school.

It is important to note that they youth will have a chance to pick up some skills that they may have missed in the past due to drug/alcohol issues or a number of other issues. The teachers are aware of the problems that these youth endure and are willing to help in those areas needing remediation.

Short Term Relapse Program: Clients that are in the Short Term Relapse program (18-day program) have the opportunity to continue their education. A client coming to treatment needs to notify their home school prior to coming in order to get an excused absence and advanced make up assignments. Clients will be allowed 4 hours a day back at the unit to work on school work. If needed, Clients do have the availability of a fax machine in the event that assignments need to be faxed back and forth from their home school. Clients fail to get an excused absence and advanced make up assignments, will be enrolled and attend the Our Home, Inc. Alternative School.

Clients that are on an IEP (Individual Education Plan) will be required to attend classes at the Our Home, Inc. Alternative School. Our Home, Inc. needs a copy of the IEP (this can be faxed to 605-353-1061 Attention: Blaise Tomczak). Our Home, Inc. Alternative school will not be updating IEP plans that have lapsed due to the short time period that the clients attend school here.

Internet access is not available at the program for school work assignments.

GED: Clients that are pursuing their GED need to be responsible for obtaining records from the agency that they are currently attending. If individuals are currently studying for pre or post testing, please bring all study guides, materials or books that are needed. If an individual tests during their stay at Our Home, they are responsible for the costs of all testing. Testing schedules are on a six week rotation at Cornerstone Career Center, Huron, SD.

*****Those youth on an IEP (Individual Education Plans) or 504 plan, Our Home will need a copy (this can be faxed to 605-353-1061 Attention: Blaise Tomczak). Our Home, Inc. Alternative school will not be updating IEP plans that have lapsed due to the short time period that the clients attend school here.

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

(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 in 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:

Michele 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

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.g

SECLUSION AND PERSONAL RESTRAINT CONSENT FORM

(revised 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.
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 medical 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 payer 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 of the parent/guardian.

**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.

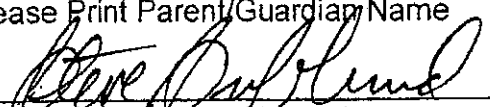
I further acknowledge that this consent form is valid in the event that the child identified above is transferred to another Our Home, Inc. Program (ASAP, Residential Treatment Care or Rediscovery)

Signed this _____ Day of _____, 20____.

Parent/Guardian Signature

Referral Agent Signature

Please Print Parent/Guardian Name



Administrator of Our Home, Inc.

EMERGENCY CONTACT LIST

In case of an emergency, we will make every attempt to notify the parents/guardians immediately. Please complete the following to assist us.

Parent/Guardian: Father (Home #) _____

(Work #) _____

Mother (Home #) _____

(Work #) _____

Extended Family (grandparents, aunts/uncles, brothers/sisters)

| | | |
|------|---------|--------------|
| Name | Phone # | Relationship |
|------|---------|--------------|

| | | |
|------|---------|--------------|
| Name | Phone # | Relationship |
|------|---------|--------------|

| | | |
|------|---------|--------------|
| Name | Phone # | Relationship |
|------|---------|--------------|

If we would be unable to contact any of the family members listed above, is there anyone else you would feel comfortable with us calling, (neighbor, friend.) If so, please list them.

| | | |
|------|---------|--------------|
| Name | Phone # | Relationship |
|------|---------|--------------|

| | | |
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| Name | Phone # | Relationship |
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