

OUR HOME, INC.

Residential Treatment

103 W Maple Street • Parkston, SD 57366-2048 • Phone (605) 928-7907 • Fax (605) 928-7910

Referral Agent:

As you begin to fill out the intake paperwork would you please develop a list of agencies/contacts that would be helpful in us writing the most comprehensive treatment plan possible.

The below list should include:

- former placements
- former mental health agencies utilized for both psychological evaluations and psychiatric
- Physician Records: Significant medical records (e.g. surgery history, head injury history etc)
- Other information you may feel valuable

Once the list below is complete you will be sent Releases of Information filled out for each of the referenced agencies for signature:

We believe this will expediate the obtaining of records and save various calls from us after the placement has been done.

Thanks for you cooperation!



Agency:

Administrative Office
334 3rd St SW
Huron, SD 57350-2418
Phone (605) 352-4368
Fax (605) 352-4976

**Rediscovery Drug &
Alcohol Treatment Center**
40354 210th St
Huron, SD 57350-7928
Phone (605) 353-1025
Fax (605) 353-1061

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

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 client.

- **APPLICATION FOR ADMISSION:** please complete the application for admission including the names and telephone numbers required
- **AUTHORIZATION FORM:** indicating approval or denial for photographs to be taken
- **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 five important areas:
 1. We ask that each youth receive a physical examination prior to placement 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 referring 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
 5. Proof of second MMR immunization.

ADDITIONAL INFORMATION NEEDED:

- Report of psychological and/or psychiatric evaluation completed within the last twelve months
- Court order
- Social history
- Birth certificate
- Medicaid card
- Social security number
- Clothing requirements checklist completed
- Billing address and appropriate person to whom billing is submitted
- Authorization for tuition costs
- Complete school records
- Worker's home telephone number
- Any allergies, i.e., insect stings, medications, detergents, etc.
- Interstate compact with state of South Dakota (out-of-state placements)

**OUR HOME, INC. PARKSTON, SD 57366
REQUIRED INFORMATION FOR ADMISSION**

RETURN TO: Jenise Pischel, MSE
Program Coordinator
Our Home, Inc.
103 W. Maple Street
Parkston, SD 57366
Office: 605-928-7907

Fax: 605-928-7910

REFERRED BY: Name _____

Agency _____

Address _____

Phone _____ Home Phone _____

A. YOUTH

Name _____

First

Middle

Last

CID _____ Title XIX _____

Social Security _____ Sex _____

Race _____ Birthdate _____ Age _____

Present Address _____

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

If not, where _____

B. CUSTODY

Court Order (copy attached, **must** be forwarded prior to placement)

Social History (attached) or _____

Name of youth's physician _____

Address _____ Phone _____

Date of last physical examination _____

Immunizations (**copy attached**) allergies _____

Name of youth's dentist _____

Address _____ Phone _____

Date of last dental examination _____

Date of last eye examination _____

E. EDUCATION

Complete transcript of grades and immunization records (**attached**)

Last grade completed successfully _____ Date _____

Current grade placement _____ 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? (attached) Yes _____ No _____

F. RELIGION

Denomination _____

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

CHECKLIST OF POSITIVE PEER CULTURE PROBLEMS

(Check those that apply to youth)

- _____ 1) Low self-image: poor opinion of self; often feels put down or of little worth
- _____ 2) Inconsiderate of others: does things that are damaging to others
- _____ 3) Inconsiderate of self: does things that are damaging to self
- _____ 4) Authority problem: does not want to be managed by anyone
- _____ 5) Misleads others: draws others into negative behavior
- _____ 6) Easily misled: is drawn into negative behavior by others
- _____ 7) Aggravates others: treats people in negative, hostile ways
- _____ 8) Easily angered: is often irritated or provoked or has tantrums
- _____ 9) Stealing: takes things that belong to others
- _____ 10) Alcohol or drugs: misuses substances that could hurt self
- _____ 11) Lying: can not be trusted to tell the truth
- _____ 12) Fronting: puts on an act rather than being real

COMMENTS:

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 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 do not allow any cropped T-shirts, T-shirts with logos or inappropriate symbols.

PERSONAL HYGIENE ITEMS: toothpaste, toothbrush, deodorant, bar soap, comb, brush, razors, hair dryer, curling iron, shampoo and conditioner. Also, if the client wears contact lenses, please be sure to send contact solution and a case for the contacts.

DO NOT SEND:

Mouthwash

Radio

Personal CD player

Alcohol based aftershave

Perfumes

Jewelry

Any type of aerosol container (hairspray, etc.)

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

SUFFICIENT CLOTHING LIST

Youth's Name: _____ Date: _____

Sufficient clothing or arrangements to purchase clothing is needed at time of admission:

(7) underwear _____ (7) socks _____ (2) bras _____

(3) jeans _____ (2) slacks _____ (4) shorts _____

church wear _____ pajamas/robe _____

(5) winter sweaters/shirts _____ (5) summer tops _____

winter coat _____ summer jacket/sweat _____

tennis shoes _____ boots _____ school/dress shoes _____

swimsuit _____ gloves _____ hat _____

Other supplies:

Toothbrush/paste _____

Deodorant _____

Comb/brush _____

Shampoo _____

Razor _____

Hair dryer _____

Nail clipper _____

OUR HOME, INC.
FAMILY QUESTIONNAIRE

The information requested in this packet must be provided by the youth's parent/guardian before a youth can be admitted to the Our Home program.

SUBSTANCE USE:

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

2. If possible, describe any unsuccessful attempts your child has made to cut down or stop using substances (i.e., prior drug and alcohol counseling treatment, promising not to use anymore, promising not to use again): _____

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 can recall: _____

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

Describe: _____

5. Does your child's personality seem to have changed? Yes _____ No _____

Describe the change: _____

6. Has your child ever missed or have difficulties at school or work (if applicable) due to substance use? Yes _____ No _____

Describe incidents: _____

7. Describe all legal problems that your child has had as a result of/or involving drugs 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/psychiatric care for these problems? Yes _____ No _____
If yes, identify with whom and where:

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

EDUCATION

1. Describe your child's attitude and performance in school: _____

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

FINANCES

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

2. Describe how your child gets along with his/her peers: _____

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

FAMILY

1. Describe any family problems affecting the child: _____

2. Describe how the child gets along with his/her siblings: _____

3. Does any other members of the child's family have a history of substance abuse/dependence?
Yes _____ No _____ Describe: _____

RELIGION

1. What is your family's religious denomination? _____

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

Any additional information you feel should be know about your child's substance use or about your child in general that may be helpful:

**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 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.

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 and 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, Rediscovery or Residential Treatment).

Signed this _____ day of _____, 20_____.

Parent/Guardian Signature

Please Print Parent/Guardian Name

Referral Agent Signature



Administrator of Our Home, Inc

IHS MEDICAL INFORMATION

Client's Name: _____

Date of Birth: _____

Degree of Blood: _____

Tribe Enrolled With: _____

Enrollment Number: _____

Mother's Name (Maiden): _____

Mother's Place of Birth: _____

Father's Name: _____

Father's Place of Birth: _____

OUR HOME, INC., Psychiatric Residential Treatment
103 W Maple Street, Parkston, SD 57366, Phone (605) 928-7907, Fax (605) 928-7910

TO: Referral agencies of youth placed at Our Home, Inc.

FROM: Jenise Pischel, MSE
Program Coordinator



RE: School Records/Medical Records

It is imperative that we receive current school records, current Individualized Education Plan (IEP) (if applicable) and a list of all schools child has attended prior to placement at Our Home, Inc. **CHILD WILL NOT BE**

ACCEPTED INTO THE PROGRAM WITHOUT THESE RECORDS.

It is also imperative that we receive any medical, dental and optometry records that the youth has incurred before being placed at Our Home, Inc., along with the youth's Medicaid card. This is a licensing requirement for our program. If you have any questions, please contact me (605) 928-7907.

I thank you in advance for your cooperation.

Parkston School District #33-3

102C South Chapman Drive
Parkston, South Dakota 57366-2017
TELEPHONE: (605) 928-3368
FAX: (605) 928-7284

SUPERINTENDENT: SHAYNE MCINTOSH
BUSINESS MANAGER: CRAIG BRUENING

SECONDARY PRINCIPAL: JOE KOLLMANN
ELEMENTARY PRINCIPAL: ROBERT I. MONSON

CONSENT FOR MEDICAL TREATMENT

I am the _____ (Mother, Father, Legal Guardian) of
_____ who participates in extra-curricular activities for
Parkston High School. I hereby consent to any medical services that
may be required while said child is under the supervision of an employee of
Parkston School District while on a school-sponsored activity and hereby
appoint said employee to act on behalf in securing necessary medical services from any duly
licensed medical provider.

Dated this _____ day of _____, 20__

Parent's Signature

CONSENT OF CHILD

I, _____, have read the above Consent form signed by
my _____ (Mother, Father, Legal Guardian) and join with
_____ (him, her) in the consent.

Dated this _____ day of _____, 20__

Student's Signature

INTERNET PERMISSION FORM:

I understand and will abide by the Terms and Conditions for use of the Internet as stated in the handbook. I further understand that any violation of the regulations as stated in the handbook are unethical and may constitute a criminal offence. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken and/or appropriate legal action.

USER'S FULL NAME (PLEASE PRINT) _____

USER'S SIGNATURE: _____

DATE _____

HOME ADDRESS _____

HOME PHONE _____

GRADE IN SCHOOL _____

PARENT OR GUARDIAN: (if the student is under the age of 18, a parent or guardian must also read and sign this agreement)

As the parent or guardian of this student, I have read the Terms and Conditions for Internet access. I understand that this is designated for educational purposes and The Parkston Public School District has taken available precautions to eliminate controversial material. However, I also recognize it is impossible for Parkston Public Schools to restrict access to the network. Further, I accept full responsibility for supervision if and when my child's use is not in a school setting. I hereby give permission for my child to access the Internet and E-Mail and certify that the information contained on this form is correct.

PARENT OR GUARDIAN NAME (PLEASE PRINT) _____

PARENT OR GUARDIAN SIGNATURE _____

DATE _____

SECLUSION AND PERSONAL RESTRAINT

(7/1/07) (revised 9/18/07, 1/11/08)

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. Use shall be selected only when other less restrictive measures have been ineffective.
- II. Our Home, Inc. shall be dedicated to creating an environment that strives to prevent, reduce, and eliminate the use of seclusion and restraint.
- III. 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.
- IV. Seclusion and restraint shall be provided under physician supervision/oversight.
- V. An order for seclusion or restraint shall not be written as a standing order.
- VI. 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.
- VII. Seclusion and restraint shall not be used at the same time.
- VIII. 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).
- IX. Staff will be solely responsible for conducting seclusion and restraint. Residents will not be used or allowed to control other residents.
- X. Only staff who have completed and demonstrated competency in required trainings may participate in an emergency safety intervention.
- XI. 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.

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 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 8 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 and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the program.

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. Application of Time Out

In the event a resident needs an opportunity to regain self-control, staff may implement the procedures for time out. Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity of other residents (inclusionary). Staff shall determine the best area for time out based on the resident's behavior and their location.

A staff member shall monitor the resident while he or she is in time out and ensure that the resident is never physically prevented from leaving the time out area, visual and verbal contact is made at least every 15 minutes, and resident personal needs are met. The staff member shall interact with the resident in an effort to solve problems and to determine a time to end time out. The time out shall end when the resident has regained self-control.

X. Law Enforcement Emergency Intervention

In a life- or safety-threatening situation when de-escalation has failed or is not possible and agency staff is unable to safely manage resident behavior, appropriate law enforcement personnel shall be notified for assistance. If possible, staff may implement a personal hold on the resident if the hold is only used as a time-limited emergency measure until law enforcement personnel arrive on site.

XI. Treatment Plan Review

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

XII. 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.

XIII. Room Requirements

Rooms designated for the use of seclusion or restraint shall be free of potentially hazardous conditions and have adequate air flow, an emergency exit plan, access to bathroom facilities, sufficient lighting, and observation availability that allows staff full view of the resident in all areas of the room.

XIV. Performance Improvement

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

XV. 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 -

Mark Leonard
Deputy Division Director
DSS Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Phone: 605-773-3495
Fax: 605-773-5246
Email: mark.leonard@state.sd.us

State-designated Protection Organization

Cara Beers
Regional Manager
DSS – Child Protection Services – Brookings
1310 Main Ave S., Suite 101
Brookings, SD 57006-3893
Phone: 605-688-4330
Fax: 605-688-4339

- or -

Arlene Kathan
Regional Manager
DSS – Child Protection Services – Yankton
3113 N. Spruce St., Suite 200
Yankton, SD 57078-5320
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

(7/1/07) (revised 8/23/07, 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., Parkston\PRTF

103 W Maple Street, Parkston, SD 57366, Phone (605) 928-7907, Fax (605) 928-7910

TO: Referral Agencies and the Parent/Guardian

FROM: Jenise Pischel, MSE
Program Coordinator



RE: Release of Information Form

As a parent/guardian of a child receiving treatment services at Our Home, Inc., please sign the attached release of information in the event of a possible runaway attempt.

Thank you for your cooperation.

OUR HOME, INC., Psychiatric Residential Treatment

103 W Maple Street, Parkston, SD 57366, Phone (605) 928-7907, Fax (605) 928-7910

TO: Referral Agencies and the parent/guardian

FROM: Steve Gubbrud, Executive Director

RE: Consent Form

As per the licensing study done at this facility, we are required to have this form completed and kept on file. For the sake of convenience and the reassurance of its return, the referring worker should get the parent's/guardian's signature before returning the form.

Thank you for your cooperation.

CONSENT

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

_____ (Name of Youth in Full)

and being resident of the city of _____

in the state of _____ Do hereby give my (our) permission

and consent to Our Home, Inc., to use, for the purpose of publication thereof, information relating to

the residency and activities of said youth, at Our Home, Inc., which permission and consent includes,

but is not limited to the use of said youth's full name and photograph and stories concerning his/her

residency and activities at Our Home, Inc

Signed this _____ day of _____, 20 _____

Parent/Guardian

Referral Agency Representative

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

Date

Or

If privately placed –Parent/Guardian

OUR HOME, INC., Psychiatric Residential Treatment

103 W Maple Street, Parkston, SD 57366, Phone (605) 928-7907, Fax (605) 928-7910

Dear Parent/Guardian:

This letter is not only to inform you that your son/daughter has been placed at Our Home, Inc , but also to let you know what is involved with your child's placement here. We are a co-educational residential treatment facility for minors, ages twelve to eighteen. The length of time a client stays with us varies from individual to individual, but an average is nine to ten months.

We use a group treatment program called Positive Peer Culture. This program has received national acclaim and was considered to be the best in the country in 1971 by the President's Committee on crime and delinquency. One of the basic elements of our program is the belief that people do not change much in a positive direction unless they feel a part of the change process. So, when you visit your son/daughter you will find that, under adult supervision, the students have a significant role and voice in what takes place at the residential treatment facility.

We believe that people have a universal desire to be of service to others; people derive a deep sense of satisfaction and develop a strong feeling of self-worth and purpose from helping others. In general, you may expect your son/daughter to receive help from his/her group members in any area in which they have trouble. It is their job to talk with your child when he/she is unhappy and to keep them safe and out of trouble. In return, we would expect them to help out in any way they can.

The students attend the Parkston Public School. Our close working relationship with the school personnel allows both the school and the residential treatment facility to closely monitor and assist your child to provide the maximum educational opportunities for them. Medical care is provided by Avera Dakota Family Practice and Avera St Benedict Hospital.

Other principles we believe in are: (1) that people are influenced more by their peers than anyone else, (2) that punishment has no place in good treatment, it only suppresses rather than change bad behavior and (3) that people tend to act responsible when treated in a responsible manner. With this in mind, we train our group to help their own group members. Five afternoons a week, the group has an hour and a half meeting, again under the supervision of an adult group leader, to discuss problems group members may have had during the day.

Students may bring personal items such as radios and athletic equipment. Personal hygiene supplies are furnished by the residential treatment facility, but we encourage parents to provide the necessities upon first being placed here. Pens, pencils, notebooks, stamps and combs may be purchased as needed. Other personal items may be purchased with their allowance.

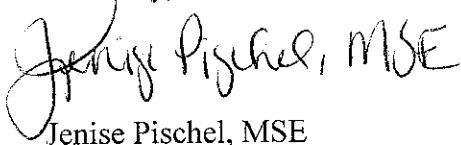
Each month your son/daughter's worker, judge and parent/guardian will receive a report evaluating the progress they have made over the past month. When a group feels your son/daughter has progressed enough to be able to avoid further trouble at home, they will recommend their release to our staff. The staff, after communicating with you and the social worker or court worker, will decide about the release recommendation

You are cordially invited to visit your child on Sundays between 1:00 p.m. and 5:00 p.m., which are visiting hours. We recommend visiting twice monthly. If need be, other visiting times can be arranged. We would appreciate it; however, if you would give us three days advance notice of your visit. Our group is often participating on community service projects or recreational activities or are at a stage in their problem solving progress where a visit may not be advantageous for their progress or the progress of your child. If you will call or write in advance, we will make sure your son/daughter is free.

This is basically our program: teaching in a non-secretarian way that man is his brother's keeper and that people are responsible for their own behavior. One thing we believe is that places must exist where parents may send their children for help without fear for their child's physical and emotional well being. Our staff has worked hard to develop this therapeutic setting and we believe this is a place we would send our own children, should the need rise.

If you have any further questions about our program or about your son/daughter, please feel free to contact me

Sincerely,

A handwritten signature in cursive script that reads "Jenise Pischel, MSE". The signature is written in black ink and is positioned above the typed name.

Jenise Pischel, MSE
Program Coordinator

OUR HOME, INC., Psychiatric Residential Treatment

103 W Maple Street, Parkston, SD 57366, Phone (605) 928-7907, Fax (605) 928-7910

Dear Parent/Guardian:

This is to inform you of the hours that your child may receive telephone calls and visits while involved in the program here at Our Home, Inc.

Telephone days and hours will be:

- a) Group Star has telephone calls on Mondays from 7:30 p.m. to 8:30 p.m., on Thursdays from 7:30 p.m. to 8:30 p.m., on Fridays from 7:30 p.m. to 8:30 p.m. and on Saturdays from 12:30 p.m. to 9:30 p.m. and Sundays from 12:30 p.m. to 8:30 p.m.
- b) Group Independence has telephone calls on Tuesdays from 7:30 p.m. to 8:30 p.m., on Wednesdays from 7:30 p.m. to 8:30 p.m., on Fridays from 7:30 p.m. to 8:30 p.m. and on Saturdays from 12:30 p.m. to 9:30 p.m. and Sundays from 12:30 p.m. to 8:30 p.m.
- c) Group Phoenix has telephone calls on Mondays from 7:30 p.m. to 8:30 p.m., on Tuesdays from 7:30 p.m. to 8:30 p.m., on Wednesdays from 7:30 p.m. to 8:30 p.m. and on Saturdays from 12:30 p.m. to 9:30 p.m. and Sundays from 12:30 p.m. to 8:30 p.m.

Sunday is visiting day. Church attendance is an integral part of our program; therefore visiting hours on Sunday are from 1:00 p.m. to 5:00 p.m. Sunday visits are to be arranged during a telephone call made during the week. Since there is an adjustment period when a child is admitted to Our Home, Inc., please note that the first week the child is here, there will be no telephone calls made or received. For the first two weeks there will be no Sunday visits.

It is mandatory that you visit with staff both before and after a family visit. This allows us the chance to get to know each other better and can only aid us in our mutual concern for doing all we can for your child.

Please feel free to contact me if you should have any questions.

Respectfully,



Jenise Pischel, MSE
Program Coordinator

OUR HOME, INC.

Residential Treatment

103 W Maple Street • Parkston, SD 57366-2048 • Phone (605) 928-7907 • Fax (605) 928-7910

To whom it may concern:

Each year as part of a teaching tool for the youth whom reside at Our Home, Our Home Inc. has participated in the Adopt-a-Highway program.

This year the State of South Dakota is requiring that waivers be signed before anyone participates. Enclosed you will find a waiver of liability form. We would appreciate completion of this paperwork, so that we can continue to teach about giving to the community and world in which we live in

Sincerely,



Jerise Pischel, MSE
Program Coordinator
Our Home Inc./Parkston-PRTF

Enclosure

Administrative Office
334 3rd St SW
Huron, SD 57350-2418
Phone (605) 352-4368
Fax (605) 352-4976

**Rediscovery Drug &
Alcohol Treatment Center**
40354 210th St
Huron, SD 57350-7928
Phone (605) 353-1025
Fax (605) 353-1061

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

Attachment 2

**PARENTS OR GUARDIANS RELEASE AND WAIVER OF LIABILITY,
ASSUMPTION OF THE RISK
AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL
TREATMENT**

(For use by adults and minors, if the participant is under 18 years of age.)

By our signatures below, we acknowledge that we are aware of, appreciate the character of, and voluntarily assume the risks involved in participating in **the Adopt-a-Highway Litter Control Program**.

By our signatures below, on behalf of ourselves, our heirs, next of kin, successors in interest, assigns, personal representatives, and agents, we hereby:

1. Waive any claim or cause of action against and release from liability the State of South Dakota, its officers, employees, and agents for any liability for injuries to person or property resulting from participation in the activity listed above.
2. Agree to indemnify and hold the State of South Dakota, its officers, agents and employees, harmless from and against any and all actions, suits, damages, liability or other proceedings that may arise as the result of performing the activity listed above ;
3. Consent to receive any medical treatment deemed advisable during participation in the activity listed above;
4. Acknowledge that we are signing below as a minor child and as the parent or legal guardian of the minor child named below.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF THE RISK AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL TREATMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE TO ME AND INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Minor's Name _____ Date of Birth _____

Signature _____ Date _____

Address _____

Guardian's Name _____ Date of Birth _____

Signature _____ Date _____

Address _____