INTAKE PACKET

HURON PRTF

40354 210TH STREET, HURON, SD 57350

PHONE (605) 352-9098 FAX (605) 352-0550

ADMISSION CRITERIA

Huron PRTF

1. Admission to the Our Home, Inc. (OHI) ASAP is restricted to adolescent males age 12 – 17 with histories of committing sexual offenses and sexual acting-out behaviors. The restriction to male admissions is in place, as OHI can't reasonable assure for sexual safety with a co-educational group in this special population. Applications for female sex offenders shall be referred to the OHI (Parkston) Treatment Program or other appropriate service facilities. Aside from a "male only" admission requirement, this OHI program shall not discriminate in admission practices in regard to race, color, religion, ancestry, national origin, disability or co-occurring disorder.
2. Applicants must have a history of sexual offenses and their offense history must not preclude their safe treatment in a non-secure and semi-community based environment.
3. Applicants must be reasonably expected to benefit from or halt further regression of their condition through the services provided.
4. Applicants must not present the threat of serious risk of physical or sexual harm to self or others within the context of the treatment environment provided.
5. Applicants must have sufficient intellectual capacities such that they can be reasonably expected to benefit from and participate in the therapeutic and educational services provided. Historical experience with admissions suggests that those applicants with a Full Scale IQ of 68 or below have had difficulty benefiting from the services provided.
6. Applicants with other diagnostic conditions (in addition to histories of sex offenses and sexually acting out) are welcomed as service participants. The program accepts applicants with such co-occurring diagnosis as conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, impulse control disorder, eating disorders and chemical abuse/dependency.
7. In the event of co-occurring chemical dependency, applicants shall not be in need of medical detoxification at the time of admission. Therefore, prior CD assessment is preferred.
8. All applications require the pre-arrangement of funding prior to admission approval.
9. Admissions for the purpose of evaluation (for appropriateness) will be considered on a case-by-case basis.

All applications must be submitted prior to admission to allow for Program Coordinator and Treatment Team review to determine admission eligibility and appropriateness.

As referrals are made to ASAP, the Program Coordinator first reviews any materials sent by the referral agency and consults with treatment team staff to determine appropriateness for placement. It is the Program Coordinator's responsibility to communicate with referral agencies on bed space and potential placement dates. As referrals are made, the Program Coordinator makes attempts to place residents on a first-come, first-served basis, as long as funding is in place, the necessary paperwork has been completed and bed space allows for an expedient placement. If a referral is put on a waiting list, the Program Coordinator will make continued efforts to place on a first come-first served basis. If ASAP is deemed as an inappropriate placement, it is the responsibility of the Program Coordinator to complete a denial for the referral worker within a reasonable time so alternative placement can be made.

HURON PRTF

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 youth.

- 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: The form may be necessary to receive information from previous placements, doctors, psychologist or other professionals
- Medical Consent Form: During a youth's stay at Our Home, Inc., it may be necessary for him 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 status of youth's work needed.

Additional Information Needed:

- Report of psychosexual, psychological and/or psychiatric evaluation completed within last 12 months
- Court Order, Police Reports, 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
- Interstate Compact with State of South Dakota
- Discharge Summaries form previous placements
- Victim statements, if available
- Previous Polygraph reports, if available
- Drug/alcohol use or evaluation, if available

OUR HOME, INC. - HURON PRTF

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HURON PRTF – ASAP TRACK PROGRAM PROCEDURES

For participants in the ASAP track 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 ASPA 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

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. Youth will be assessed to determine appropriateness of placement.
3. If the youth is determined to be inappropriate, the referral worker will be notified and arrangements will be made
4. Group Leader and assigned staff will provide orientation for youth within 24 hrs. of arrival

When a change in placement is required

When a substantial change in placement is required for an ASAP track 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 track participant is to be discharged

The treatment team will make decisions regarding discharge from Huron PRTF. 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.

OUR HOME, INC.
HURON PRTF
(5/23/21)
APPLICATION FOR ADMISSION

REFERRED BY:

NAME: _____

AGENCY: _____

ADDRESS: _____

PHONE: Work: _____

Home: _____

A. YOUTH

NAME: _____
First Middle Last

Date of Birth: _____ Age _____ (Attach Birth Certificate)

Sex _____ Race _____ Social Security Number_____

RID# _____ TITLE XIX_____

Present Address
_____

Is youth living with parent (s) Yes _____ No _____
If not, where
_____

With Whom
_____

B. CUSTODY

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

Social History (Attached) or
_____

_____

Has Child received professional counseling? Yes _____ No _____
If yes, by whom? _____

Does this resident need to register as a sex offender? Yes _____ No _____

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 is youth's life?

CHECKLIST OF POSITIVE PEER CULTURE PROBLEMS

(check all that apply to the youth)

(1/24/14)

Youth Name:_____

_____ Low self image: Poor opinion of self, often feels put down or of little worth.

_____Inconsiderate of others: Does things that are damaging to others.

_____Inconsiderate of self: Does things that are damaging to self.

_____Authority Problem: Does not want to be managed by anyone.

_____Misleads others: Draws others into negative behavior.

_____Aggravates others: Treats people in negative, hostile ways.

_____Easily angered: Is often irritated or provoked or has tantrums.

_____Stealing: Takes things that belong to others.

_____Alcohol or Drugs: Misuses substances that could hurt self.

_____Lying: Cannot be trusted to tell the truth.

_____Fronting: Puts on an act rather than being real.

_____Easily Mislead: Follows others into negative behavior.

COMMENTS:

HURON PRTF
CLOTHING REQUIREMENTS CHECKLIST

(Revised 06/05/19, 5/23/21)

Resident Name _____Date:_____

The following is a list of sufficient clothing needed at time of admission:

Underwear (7) _____

Socks (7) _____ (white only)

Jeans (6) _____ (NO Skinny jeans__No holes)

Shorts (Nylon / Denim) (6) _____

Pajamas (No strings) _____

Winter sweaters/shirts (5) _____

Winter coat _____

Jacket/sweatshirt _____

Summer shirts/tops (5) _____

Tennis shoes (2 pr)_____ 1pr snow boots/ winter months

Gloves _____ Hat _____

Other Supplies: <u>All Must Be New</u>

Toothbrush and paste _____

Deodorant _____

Comb/ brush _____

Shampoo _____

Razor/Electric only _____
Bar Soap or body wash _____ (No Axe or Old Spice Products)
Acne Wash (no pads) _____

_____
Child Care Coordinator Signature

OUR HOME, INC. – HURON PRTF

40354 210TH STREET, HURON, SD 57350, PHONE (605) 352-9098 FAX (605) 352-0550

(5/23/21)

MEDICAL CARE POLICIES AND PROCEDURES

Please acknowledge the following policies and procedures pertaining to the medical care of the youth 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" concerning 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. An individual that holds parental rights or legal guardianship must sign this consent form.

2. "Financial Responsibility for Medical Costs" from must also be provided prior to or at the time of admission. It is Our Home, Inc.'s 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 place 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. recognized that there will be situations wherein there is a potential for third party pay concerning 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 Manage 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 case without the prior authorization of the parent/guardian.

OUR HOME, INC.

FINANCIAL RESPONSIBILITY FOR MEDICAL COSTS

(5/23/21)

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 # _____

Policy Holder Date of Birth: _____

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 circumstance 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 (Huron PRTF, Parkston PRTF, or Rediscovery).

Signed this _____ Day of _____, 20___.

_____ _____

Parent/Guardian Signature Please Print Parent/Guardian Name

_____ _____

Referral Agent Signature Administrator of Our Home, Inc.

INFLUENZA VACCINATION RECORD

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Primary Care Provider: _____

Primary Insurance: _____

Please answer the following questions so that we may determine your eligibility to be vaccinated today.

VACCINE ELIGIBILITY	YES	NO	N/A
Have you ever received the flu vaccine?	❑	❑	❑
Have you ever had a serious reaction to the flu vaccine?	❑	❑	❑
Do you feel sick today, or are you running a fever?	❑	❑	❑
Do you have an allergy to latex?	❑	❑	❑
Do you have an allergy to Thimerosal, a preservative?	❑	❑	❑
Do you have any severe or life-threatening allergies?	❑	❑	❑
Do you have or have you had Guillain-Barre Syndrome?	❑	❑	❑

RISKS AND POSSIBLE SIDE EFFECTS – Side effects of influenza vaccine are generally mild in adults and occur at low frequency. These reactions consist of tenderness at the injection site, fever, weakness, or muscle aches. Symptoms may last up to 48 hours. Allergic reactions may also occur.

FOR YOUR SAFETY, PLEASE WAIT 10 MINUTES AFTER RECEIVING THE SHOT IN CASE OF ALLERGIC REACTION.

I understand the benefits and risks of the influenza vaccine and request that it be given to me (or to the person named below for whom I am authorized to make this request). I hereby assume any risks related to receiving the influenza vaccine, and release the staff of the Huron Clinic from any and all liability related, directly or indirectly, which may arise from having been given the influenza vaccine. I understand that it is recommended to wait at the Clinic for 10 minutes after receiving the shot.

_____

Signature of Patient (or Legal Guardian) Relationship to Patient Date

MEDICARE / INSURANCE AUTHORIZATION: I hereby authorize direct payment for all medical benefits to the Huron Clinic for services provided by the clinic and its staff. I hereby authorize the release of all information acquired in the course of my treatment necessary for filing my insurance claims. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

PRIVACY NOTICE: In the interest of protecting your private health information, the Huron Clinic complies with the rules and regulations of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). A notice of our privacy practices is posted at the Clinic, and you may obtain a copy upon request. Note – employers who are paying for their employee's flu shots will be entitled to a listing of employees who were vaccinated.

FOR CLINIC USE ONLY

FLULAVAL® quadrivalent PFS by GlaxoSmithKline	Exp.	Lot #	❑ NON-STATE 6 mo. & older
FLULAVAL® quadrivalent PFS by GlaxoSmithKline	Exp.	Lot #	❑ STATE 6 mo. & older

Injection Site (Deltoid): Left or Right

Date Given: _____

Signature_____

Huron PRTF
40354 210th Street
Huron, SD 57350-7928
Phone (605) 352-9098
Fax (605) 352-0550

IMMUNIZATION CONSENT

(5/23/21)

_____, 20_____

I, _____, having legal guardianship/custody of

(Name of Guardian)

_____, agree to immunizations as recommended by the

(Name of Child in Care)

doctor,

Including the seasonal flu. 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.

Information sheets sent with consent Yes No

Informational sheets available for viewing at **www.cdc.gov/vaccines**

Signed,

_____ _____

Parent of Guardian Date

_____ _____

Referral Worker Date

Dakota Family Dentistry
Registration Form

Patient Information

First Name:	Last Name:	Middle Initial:
Date of Birth: Age:	Sex: ○ Male ○ Female	
Social Security #:	Address:	
Phone #:	Cell #:	
If Child: Parent/Guardian Name:	If Child: Parent/Guardian Social Security #:	
E-mail Address:		
Occupation:	Employer:	
Employer Address:	Employer Phone #:	
Spouse Name:	Spouse Social Security #:	
Spouse Employed By:	Employer Phone #:	
Who is Responsible for this account:	Method of Payment : (Circle One) Insurance Cash Credit card	
Other Family Members in this Practice:	Who may we thank for this referral:	

In Case of Emergency

Name of relative or friend (Not living at the same address):	Relationship to patient:
Phone #:	Cell #:

Insurance:

*Please bring insurance card and photo ID to your appointment

Dakota Family Dentistry
Acknowledgement of Privacy Notice Form

Section 1: Patient

First Name:	Last Name:	Middle Initial:
Date of Birth: Age:	E-Mail:	
Social Security #:	Address:	
Phone #:	Cell #:	

Section 2: Patient

I,_____, acknowledge that I have received a Notice of Privacy Practices from Dakota Family Dentistry.

Signature:_____ Date:_____
If a personal representative signs this authorization on behalf of the individual, complete the following:
Personal Representative:_____
Last First Middle Initial

Relationship to Patient:_____

Section 3: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form:_____

_____

Describe the reason why the individual would not sign this form:_____

_____

Section4: Signature

I CERTIFY THAT THE ABOVE INFORMATIONIS IS COMPLETE AND ACCURATE

SIGNATURE_____DATE_____

PRINT NAME:_____

Dakota Family Dentistry
Child Medical History Form

Patient's Name_____
Last First Initial Date of Birth

MEDICAL HISTORY- Circle the Appropriate Answer

1. Name of physician_____
2. Does your child have a health problem?----------YES NO
3. Is your child under care of a Physician?----------YES NO
   If yes, since when and why?_____
4. Is your child receiving any medication?----------YES NO
   If yes, what?_____
5. Has your child ever had surgery?----------YES NO
   If yes, what?_____
6. Has your child had any serious illness?----------YES NO
   If yes, when_____ what_____
7. Does your child have a heart murmur?----------YES NO
8. Is surgery contemplated?----------YES NO
9. Does your child experience severe or prolongated bleeding?----------YES NO
10. Does your child have AIDS or has he/she tested HIV positive?----------YES NO
11. Has your child tested positive for hepatitis?----------YES NO
12. Is your child subject to nervous disorders?----------YES NO
    _____Fainting _____Seizures _____Dizziness _____Behavioral/Learning problems
13. Does your child have frequent headaches?----------YES NO
14. Does your child have any allergies?----------YES NO
    _____Penicillin _____Latex/Metals _____Dental Anesthetics _____Aspirin _____Codeine
    Other_____
15. Has your child had history of: (Circle all appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

DENTAL HISTORY- Circle the Appropriate Answer

1. Is this your child's first visit to a dentist?----------YES NO
   If no, how long since the last visit to the dentist_____
2. Were any x-rays or radiographs taken when your child previously visited the dentist?----------YES NO
3. Does your child eat between meals?----------YES NO
4. Does your child eat sweets, such as candy, soda pop, chewing gum?----------YES NO
5. When does your child brush his/her teeth? (check all that apply)
   _____Upon arising _____After eating any food _____Right after meals _____Before going to bed
6. How does your child receive Fluoride? (check all that apply)
   _____Community water-level_____ppm _____Well water-level_____ppm
   _____Fluoride drops or tablets _____Fluoride rinse or gel
7. Has your child had any cavities in the past----------YES NO
8. Does your child suck his/her thumb or fingers?----------YES NO
9. Where any teeth (baby or permanent) removed by extraction?----------YES NO
   Was it suggested that the space by maintained?----------YES NO
   Was an appliance placed?----------YES NO
10. Have there been any injuries to teeth, like falls, blows, chips, etc?----------YES NO
    If yes, describe_____
11. Has your child had any problem with dental treatment in the past?----------YES NO
12. Has anyone in the family, including parents, had orthodontics?----------YES NO
13. Has your child ever received local anesthetic?----------YES NO
14. Has your child ever had occlusal sealants?----------YES NO
15. Do you think there is anything wrong with his/her teeth?----------YES NO
    If yes, explain_____
16. Do you have other conditions/problems not coved above?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATENT'S / GUARDIAN'S SIGNATURE_____DATE_____

welcome

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 _____

Form No. T110R

REGISTRATION

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Telephone: (_____) _____–_____ Fax: (_____) _____–_____

Email: Address:

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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 .....❑ N ❑ Y	_____	Arthritis.....❑ N ❑ Y	_____	High Blood Press...❑ N ❑ Y	_____
Glaucoma .....❑ N ❑ Y	_____	Cancer .....❑ N ❑ Y	_____	Kidney Disease .....❑ N ❑ Y	_____
Macular Degeneration ....❑ N ❑ Y	_____	Diabetes.....❑ N ❑ Y	_____	Lupus.....❑ N ❑ Y	_____
Retinal Detach/Disease ...❑ N ❑ Y	_____	Heart Disease .....❑ N ❑ Y	_____	Thyroid Disease ....❑ N ❑ Y	_____
Cataract .....❑ N ❑ Y	_____	Crossed Eyes.....❑ N ❑ Y	_____	Other ❑ N ❑ 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**
Fever, Weight Loss / Gain	❑	❑
INTEGUMENTARY (Skin)	❑	❑
NEUROLOGICAL		
Headaches, Seizures	❑	❑
EYES		
Loss of Vision	❑	❑
Blurred Vision	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Redness	❑	❑
Burning	❑	❑
Excessive Tearing	❑	❑
Eye Pain	❑	❑
Eye or Eyelid Infections	❑	❑
Flashes / Floaters	❑	❑
ENDOCRINE		
Thyroid / Other Glands	❑	❑

EYES, NOSE, MOUTH, THROAT	**NO**	**YES**
Allergy / Hay Fever	❑	❑
Chronic Cough	❑	❑
Dry Mouth	❑	❑
RESPIRATORY (Lung Problems)	❑	❑
VASCULAR / CARDIOVASCULAR		
Diabetes	❑	❑
High Blood Pressure	❑	❑
Heart Failure	❑	❑
GASTROINTESTINAL		
Diarrhea / Constipation	❑	❑
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	❑	❑
Muscle / Joint Pain	❑	❑
LYMPHATIC / HEMATOLOGIC		
Anemia / Bleeding Problems	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑
PSYCHIATRIC	❑	❑

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*** _____

CREATIVE PRINTING · HURON, SD

Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Appointment Date _____

Patient's Name (please print) _____ Birth Date _____ M or F _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Emergency Contact _____ Phone Number _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.

❑ Gastrointestinal	❑ Nervous System	❑ Mental
❑ Ear/Nose/Throat	❑ Genitourinary	❑ Endocrine (Glands)
❑ Cardiovascular	❑ Musculoskeletal	❑ Blood/Lymph
❑ Respiratory	❑ Skin	❑ Allergic/Immunologic
❑ Headaches	❑ Surgeries (what type & when) _____	

Are you in good health? Yes ❑ No ❑

Any allergic reactions to medications or other substances? Yes ❑ No ❑

If yes, please list _____

Name of general physician _____

Please check Yes or No

Do you smoke? Yes ❑ No ❑ How much? _____

Do you drink alcohol? Yes ❑ No ❑ How much? _____

Do you take medications? Yes ❑ No ❑ Please list names & how often _____

_____

Do you use other substances? Yes ❑ No ❑

Do you have family history of any of the following? If Yes, please check box.

❑ Diabetes	❑ Glaucoma	❑ High blood pressure
❑ Macular Degen.	❑ Retinal Detachmt	❑ Cataracts

Please explain any boxes you have checked _____

_____

Do you have any of the following? If Yes, please check box.

❑ Dry Eyes	❑ Eye Surgeries	❑ Wear Glasses
❑ Blurred Vision	❑ Eye Injuries	❑ Wear Contacts

Any eye problems at this time? Please explain _____

Are you interested in laser vision correction? Yes ❑ No ❑

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____

OUR HOME, INC. – HURON PRTF
AUTHORIZATION FOR RELEASE OF INFORMATION

6/28/17 revised 5/23/21

There are times when Our Home, Inc. Huron PRTF 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. NOTE: The person with whom your information is being shared may not be required to ensure the confidentiality of your protected material.

I, _____ authorize Our Home, Inc.- Huron PRTF
(Resident Name)

☒ To disclose to: ☒ To receive from:

Dakota Family Dentistry 1010 Dakota Ave S, Huron, SD (605) 352-6999
(Name or title of person and organization)

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

- ☐ Family and Social History
- ☒ Medical History
- ☐ Treatment Plan/Progress
- ☐ Discharge Summary
- ☐ Diagnosis
- ☐ Education Records
- ☐ Psychological Information/Testing
- ☐ Substance Abuse Records
- ☐ Other, Specify:

_____
_____

The purpose of need for such disclosure:

- ☒ For Continuity of Services
- ☐ For the purpose of Quality Assurance
- ☐ For Supervision
- ☐ To Fulfill Requirement of Purchaser
- ☐ Other:

_____
_____

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. – HURON PRTF
AUTHORIZATION FOR RELEASE OF INFORMATION

6/28/17 revised 5/23/21

There are times when Our Home, Inc. Huron PRTF 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. NOTE: The person with whom your information is being shared may not be required to ensure the confidentiality of your protected material.

I, _____ authorize Our Home, Inc. – Huron PRTF
(Resident Name)

☒ To disclose to: ☒ To receive from:

Huron Eye Clinic 1288 Dakota Ave S. Ste # 3 Huron, SD 57350 (605) 352-4181

(Name or title of person and organization)

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

- ☐ Family and Social History
- ☒ Medical History
- ☐ Treatment Plan/Progress
- ☐ Discharge Summary
- ☐ Diagnosis
- ☐ Education Records
- ☐ Psychological Information/Testing
- ☐ Substance Abuse Records
- ☐ Other, Specify:

_____

_____

The purpose of need for such disclosure:

- ☒ For Continuity of Services
- ☐ For the purpose of Quality Assurance
- ☐ For Supervision
- ☐ To Fulfill Requirement of Purchaser
- ☐ Other:

_____

_____

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-HURON PRTF
AUTHORIZATION FOR RELEASE OF INFORMATION

6/28/17 revised 5/23/21

There are times when Our Home, Inc. Huron PRTF 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. NOTE: The person with whom your information is being shared may not be required to ensure the confidentiality of your protected material.

I, _____authorize Our Home, Inc.- Huron PRTF
(Resident Name)

☒ To disclose to: ☒ To receive from:

Huron Clinic 111 4th St SE Huron, SD 57350 (605)352-8691
(Name or title of person and organization)

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

- ☐ Family and Social History
- ☒ Medical History
- ☐ Treatment Plan/Progress
- ☐ Discharge Summary
- ☐ Diagnosis
- ☐ Education Records
- ☐ Psychological Information/Testing
- ☐ Substance Abuse Records
- ☐ Other, Specify: _____ _____

The purpose of need for such disclosure:

- ☒ For Continuity of Services
- ☐ For the purpose of Quality Assurance
- ☐ For Supervision
- ☐ To Fulfill Requirement of Purchaser
- ☐ Other: _____ _____

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 Youth 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

Parent/Guardian Responsibility for

Removal of Youth from the Treatment Facility

In cases where a private placement resident demonstrates serious and/or high-risk assaultive behavior that presents a high level of danger to themselves or others, the Program Coordinator of the Our Home, Inc. treatment facility may need to have the resident removed from the facility as a behavioral intervention. Removal of a resident from the treatment facility will only be considered after other behavioral interventions have been unsuccessful and will at no time be initiated as punishment for the resident.

Parent/Guardian Responsibility

When removal from the treatment facility is chosen as a behavioral intervention, the parents/guardians of a privately placed resident are responsible for the transport of the youth from the treatment facility. Arrangements for transport will be made in consultation with the Program Coordinator of the Our Home, Inc. treatment facility.

Parent/Guardian Acknowledgement of Responsibility

By signing my name below, I, being the parent/legal guardian of _____,
Full Name of Resident

acknowledge that I have been informed of my transporting responsibility in the event removal from the treatment facility as a behavioral intervention is needed during my youth's stay at Our Home, Inc. and I agree to honor that responsibility.

Signed this _____ day of _____, 20_____.

_____ _____

Parent/Guardian Signature

Please Print Parent/Guardian Name

ACKNOWLEDGEMENT OF RECEIPT & NOTIFICATION OF SELECTED AGENCY POLICIES

(3/31/14)

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 who 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 our facilities or on Our Home, Inc. 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

Questions, Concerns, or Complaints: Our Home, Inc. uses a collaborative team and person-centered approach to treatment. If you have any questions, concerns, or complaints, please contact the resident's assigned Counselor/Group Leader.

Parent/Guardian Acknowledgement

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

_____ _____

Parent(s) or Legal Guardian(s) Signature | Date

_____ _____

Resident Name | Resident ID #

SECLUSION AND PERSONAL RESTRAINT

(3/18/2019 Revised 4/29/2021)

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 Our Home, Inc. written permission and the use of seclusion or personal restraint has been incorporated into the resident's treatment plan. If the resident has been placed in Our Home, Inc. by the resident's parent or guardian, the parent or guardian must provide the written permission for the use of seclusion or personal restraint.

II. The use of seclusion and personal restraint shall be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others. All attempts shall be made to de-escalate crises and use seclusion and personal restraint only as a safety intervention of last resort. Appropriate interaction with staff shall occur as an effort to de-escalate threatening situations and manage behavior.

III. Our Home, Inc. shall be dedicated to creating an environment and an organizational approach that strives to prevent, reduce, and eliminate the use of seclusion and personal restraint.

IV. Our Home, Inc. shall immediately assess contributing environmental factors that may promote maladaptive behaviors and shall act to minimize those factors.

V. Our Home, Inc. personnel 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 by personnel in lieu of adequate programming or as compensation for lack of staff presence or competency.

VI. Seclusion and personal restraint shall be provided under the supervision and/or oversight of a licensed physician.

VII. An order for seclusion or personal restraint shall not be written as a standing order or on an as-needed basis.

VIII. Seclusion or personal restraint shall be implemented in a manner to avoid harm or injury to the resident and must be used only to ensure the safety of the resident or others during an emergency safety situation and until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the seclusion or personal restraint order has not expired.

IX. Seclusion and personal restraint shall not be used simultaneously.

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 safe, 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 the exercise of seclusion and personal restraint. Residents will not be used or allowed to control other residents.

XIII. Only staff who have completed and demonstrated competency in the required trainings as described in this policy may participate in an emergency safety intervention.

XIV. Pursuant to Statement of Work requirements, videotaping of calculated personal restraint incidents is required on all U.S. Probation and Custody residents.

Definitions

For the purposes of this policy, the following definitions apply:

Emergency Safety Intervention: the use of seclusion or personal restraint as an immediate response to an emergency safety situation.

Emergency Safety Situation: unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Personal Restraint or Restraint: the application of physical force without the use of any device for the purpose of restraining the free movement of a resident's body. The term does not include briefly holding a resident without undue force in order to calm or comfort them or holding a resident's hand for purposes of safely escorting the resident from one area to another.

Seclusion: the involuntary confinement of a resident in a room or an area from which the resident is physically prevented from leaving, including the use of a locked room.

Serious Injury: any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Time-out: the use of an area or unlocked room from which a resident is not physically prevented from leaving, to allow the resident time to calm down or regain control of their behaviors.

Primary Staff: Staff who provide direct supervision to residents as part of their job duties and are trained in Nonviolent Crisis Intervention and engage in resolving crisis in non-violent ways through the use of restraint and seclusion.

Secondary Staff: "Auxiliary Team" – Staff for whom direct supervision of residents is not part of their job duties and are not counted as part of the staff to child ratio. Secondary staff are trained in Nonviolent Crisis Intervention to assist when needed in resolving crisis in non-violent ways to include acting on written professional orders for the purpose of seclusion and restraint.

Tertiary Staff: Staff for whom direct supervision of residents is not part of their job duties and are not counted as part of staff to child ratio. Tertiary staff are trained in Non Violent Crisis Intervention for the role of observing. Individuals serving as Tertiary Staff will not physically engage in restraint and seclusion through the placing of hands on a resident.

Procedures

I. Notification of program policies and reporting requirements.

At admission, a copy of the program's Seclusion and Personal Restraint policy shall be provided to the incoming resident and the resident's parent(s) or legal guardian(s). The resident and the resident's parent(s) or legal guardian(s) shall be informed of the program's policy regarding the use of seclusion or personal restraint and provided contact information, including the phone number and mailing address for the State Protection and Advocacy organizations. In addition, the resident and parent(s) or legal guardian(s) shall be provided a copy of the Notice of Privacy Practices and notified of specific agency policies and reporting requirements identified on the Acknowledgement of Receipt and Notification of Selected Agency Policies form.

A. The assigned Group Leader/Counselor/Community and Family Service Coordinator shall provide the resident and the resident's parent(s) or legal guardian(s) a copy of the Resident Handbook and Notice of Privacy Practices form and explain and discuss the Seclusion and Personal Restraint policy, contact information, privacy practices notice, notification of policies, and reporting requirements in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility shall provide interpreters or translators.

B. The assigned Group Leader/Counselor/Community and Family Service Coordinator shall obtain a signed acknowledgement from the resident and the resident's parent(s) or legal guardian(s) that they have been informed of the items listed above in A. The acknowledgements shall be maintained in the chart of the resident.

1. The resident shall complete the orientation checklist at the back of the Resident Handbook and a Notice of Privacy Practices form.

2. The parent(s) or legal guardian(s) shall complete the Acknowledgement of Receipt and Notification of Selected Agency Policies form. If the parent(s) or legal guardian(s) are unable to attend admission, the staff member designated by the Program Coordinator shall either obtain a signed acknowledgement form from the parent(s) or legal guardian(s) or call to inform them of the Seclusion and Personal Restraint policy, contact information, privacy practices notice, notification of policies, and reporting requirements that have been previously provided via certified mailing. The call shall be documented on a Parent/Legal Guardian Notification form.

II. Admission Assessment for Potential Seclusion or Personal Restraint

The Medical Director, Clinical Psychologist, Registered Nurse, and Group Leader/Counselor shall obtain information about the resident to help minimize use of seclusion or personal restraint.

A. To determine whether seclusion or personal restraint can be administered without risk to the resident's health and safety, the Medical Director and Registered Nurse shall review the medical history of the resident. The Medical Director shall conduct the review during the initial physical examination and record findings on the Assessment Summary for Potential Seclusion or Personal Restraint form. If appropriate for residents with special needs, the Medical Director shall also document protocols for the use of specific interventions. The Registered Nurse shall conduct a secondary review during the initial health screening and record findings on the Nursing Care Evaluation form.

B. The Clinical Psychologist or his designee shall review the behavioral health history of the resident for identification of prior trauma including any history of physical, sexual, or emotional abuse, neglect, or exposure to violence that would place the resident at greater psychological risk during seclusion or personal restraint. The review shall be documented on the Assessment Summary for Potential Seclusion or Personal Restraint form.

C. The Group Leader/Counselor and Registered Nurse shall consult with the resident regarding alternatives the resident prefers prior to the use of seclusion or personal restraint and the effectiveness of prior use of seclusion or restraint on the resident. These consultations shall be documented on the Assessment Summary for Potential Seclusion or Personal Restraint form.

D. Pertinent information shall be included in the resident's treatment plan.

III. Determining the Need for and Implementing Seclusion or Personal Restraint

A. 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. If the on-duty RN or staff member designated on the schedule by the Childcare Coordinator is not present at this time, one shall be summoned to lead the response to the emergency safety situation and assign duties as needed.

B. When determining the use of seclusion or personal restraint, staff shall take into consideration the information documented on the resident's Assessment Summary for Potential Seclusion or Personal Restraint form and the current situation. When less restrictive intervention techniques have been attempted, staff shall determine if an emergency safety situation exists and if seclusion or personal restraint is needed. An emergency safety situation exists when unanticipated resident behavior places the resident or others at serious threat of violence or injury if no intervention occurs and calls for the use of seclusion or personal restraint. Seclusion or personal restraint may occur without attempting less restrictive techniques.

C. In assessing the need to use seclusion or personal restraint, the potential for any negative impact on the resident shall be considered.

D. In determining the most appropriate intervention for use in an emergency safety situation which may warrant the use of seclusion or personal restraint, any alternatives the resident prefers shall be considered.

E. 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. To summon law enforcement personnel, the response leader, in consultation with the assigned Group Leader/Counselor or on-call staff member (and Program Coordinator, when possible) shall call the appropriate local agency as indicated below. Phone numbers for the agencies are listed on each program's emergency telephone lists.

Huron PRTF/Rediscovery – Sheriff Dept. Residential Treatment – Police Dept.

F. In instances involving calculated personal restraint on all U.S. Probation and Custody residents, staff shall ensure that the calculated personal restraint is videotaped following the *Videotaping of Personal Restraint* policy.

G. Staff shall obtain a written or verbal order for seclusion or personal restraint. The order must be for the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. The order shall be time limited and may not exceed **1 hour**.

- A written order can be obtained in-person, via fax, via email with electronic signature, or picked up from the office of a licensed practitioner. The on-duty RN or designated staff member shall call for the order. If such staff is not available, any direct care staff may place the call. When the order must be picked up from the practitioner's office, the staff who called for the order and the on-call staff member shall coordinate the pickup.

- A verbal order can only be received by a registered nurse or a licensed practitioner including a physician, a licensed physician's assistant, a certified nurse practitioner, a licensed psychologist, a licensed professional counselor, a licensed social worker, or a qualified mental health professional who meets the requirements of SDCL 27A-1-3.

1. If the Medical Director is available, staff shall obtain the order to initiate seclusion or personal restraint from him/her.

2. If the Medical Director is not available, the order can be obtained from another licensed practitioner including a physician, a licensed physician's assistant, a certified nurse practitioner, a licensed psychologist, a licensed professional counselor, a licensed social worker, or a qualified mental health professional who meets the requirements of SDCL 27A-1-3.

3. When the Medical Director or a licensed practitioner is not available, staff may initiate seclusion or personal restraint before obtaining an order. The order shall be received while the seclusion or personal restraint is being initiated or immediately after the seclusion or personal restraint ends.

4. The Medical Director or licensed practitioner who provides the order must be available to staff for consultation, at least by telephone, throughout the period of the seclusion or personal restraint.

5. The order shall be recorded on the Seclusion/Personal Restraint Order form. Written orders shall be recorded by the Medical Director or licensed practitioner giving the order and the staff member receiving the order. Verbal orders shall be recorded by the registered nurse or licensed practitioner receiving the order.

6. The Medical Director or licensed practitioner who issued the order must sign the Seclusion/Personal Restraint Order form. Written orders shall be signed when issued. Verbal orders shall be signed as soon as possible, but not to exceed 48 hours from the time the order was issued.

7. If another licensed practitioner ordered the use of seclusion or personal restraint, that person must consult with the Medical Director or acting Medical Director as soon as possible and inform the Medical Director of the emergency safety situation that required the resident to be restrained or placed in seclusion. The licensed practitioner or the Medical Director shall document the date and time of the consultation on the Seclusion/Personal Restraint Order form.

8. When completed, the Seclusion/Personal Restraint Order form shall be filed in the chart of the resident.

H. Staff shall implement the order for seclusion or personal restraint following the subsequent steps:

1. Seclusion

a) Staff may place the resident in a seclusion room or other designated area from which the resident is physically prevented from leaving, up to and including the use of a lock. For instances in which a lock is used, staff shall enable the seclusion room's locking mechanism.

b) Staff shall ensure that the resident does not inflict self-injury. If the resident begins to inflict self-injury, staff may initiate procedures to enact personal restraint.

2. Personal Restraint

a) Staff shall carefully lower the resident to the floor, preferably on a carpeted surface and away from any furniture or other obstacles.

b) The resident shall be placed on his or her back. - NO EXCEPTIONS- Staff shall provide continuous visual supervision to monitor the

resident's respiration and circulation, allow for communication between the resident and staff, and ensure for the resident's safety.

c) Staff shall place themselves on the floor around the resident. Staff shall hold the resident's arms above and below the elbow joint and the legs above and below the knee joint. The arms and the legs must be positioned comfortably away from the body. Only enough force necessary to control the resident shall be used.

d) If the resident begins to bang his or her head on the floor, a staff member may need to place a cushion or pillow underneath the resident's head. To secure the pillow or cushion in place, the staff member should place his or her knees against the sides of the pillow or cushion.

e) If the resident begins to spit at the staff facilitating the personal restraint, the staff may need to hold a cloth or napkin 10 to 12 inches above the resident's mouth to avoid being spit on. Do not place anything directly on the resident's mouth or nose. Doing so could hinder the resident's ability to breathe or communicate with staff.

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

A. The response leader must be physically present at the emergency safety intervention. For seclusions, this includes being outside the room or in the room when necessary to assure the safety of the resident. The response leader shall continually observe, assess, and monitor the resident to evaluate the physical and psychological well-being of the resident and the safe use of seclusion or restraint throughout the duration of the emergency safety intervention. Attention to vital signs, the need for meals, liquids, bathing, use of restroom, and other personal needs shall be given throughout the intervention. For restraints, attention to the resident's skin integrity and circulation shall also be given.

Staff shall attempt appropriate interaction with the resident as an effort to de-escalate the crisis and continually re-evaluate the resident to determine whether the threat of harm is no longer imminent. The interaction shall include staff communicating to the resident their intention to keep them and others safe, and how the specific intervention being used will keep them and others safe. The re-evaluation shall include monitoring the resident for tension reduction (a decrease of physical and emotional energy following a crisis) to determine if the threat of harm is no longer imminent. Behavioral examples of tension reduction include deep breathing, crying, answering questions, relaxed muscles, and being apologetic.

For restraints, the attention and re-evaluations shall be documented and signed by the response leader at least every 5 minutes on the Restraint Observer Monitoring form. For seclusions, the attention and re-evaluations shall be documented and signed by the response leader on the Seclusion Monitoring form at least every 5 minutes when at least two staff are present or at the end of the seclusion when one staff is present.

B. Within 1 hour of the initiation of the seclusion or personal restraint, the Medical Director, another physician, a licensed physician's assistant, a certified nurse practitioner, a licensed psychologist, a licensed professional counselor, a licensed social worker, a qualified mental health professional, or registered nurse trained in the use of emergency safety interventions 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 personal restraint is necessary and appropriate and also allows the medical status of the resident to be evaluated.

    1. As soon as possible after receiving the order or initiating the seclusion or personal restraint, the response leader shall contact a qualified on-duty individual to conduct the face-to-face assessment. If no qualified individual is on-duty, the response leader shall consult the Assessment On-call List and contact the appropriate staff member. The staff member shall ensure the contacted individual is informed of the time the intervention was initiated.

    2. The individual conducting the face-to-face assessment shall use a Resident Face-to-Face Assessment Form to record the evaluation criteria. The report of the assessment must be completed and signed by the end of the shift in which the procedure ends. The assessment form shall be filed in the chart of the resident.

    3. The individual conducting the face-to-face assessment shall also complete an Order Note form and enter it into the chart of the resident. The form shall be completed and entered into the resident's chart as soon as possible, but no more than 2 hours after implementation of the order.

C. If it appears the emergency safety situation will persist beyond the time limit of the order for the use of seclusion or personal restraint, staff must contact the ordering physician or licensed practitioner prior to the expiration of the original order. Staff shall report the results of the face-to-face assessment and obtain further instruction. The staff shall document the contact, and if a new order is given, record the order on a new Seclusion/Personal Restraint Order form.

D. If the face-to-face assessment due within 1 hour of initiation of seclusion or personal restraint was conducted prior to the resident's release, a second face-to-face assessment to evaluate the resident's well-being must be conducted immediately after the seclusion ends or the personal restraint is removed. This second assessment shall be conducted following the same procedures as the initial assessment.

V. Medical Treatment for Injuries Resulting from Seclusion or Personal Restraint

A. All staff shall be alert for any resident or staff injuries following a seclusion or personal restraint incident. Specifically, staff shall observe and question all persons involved regarding their current health status immediately following the seclusion or personal restraint to determine in any injuries occurred.

- If injuries appear to have occurred, staff shall follow the *Medical Emergency Plan* to immediately obtain medical examination and treatment from qualified health care personnel.

- If no injuries appear to have occurred following a personal restraint, staff shall follow the *Medical Examination and Treatment* policy to ensure the resident is provided a medical examination and, if necessary, treatment from qualified health care personnel. This examination is not necessary if the face-to-face assessment completed immediately after the resident is removed from restraint is conducted by a physician, a licensed physician's assistant, a certified nurse practitioner, or a registered nurse.

- Staff shall report injuries to their supervisor as soon as possible.

B. Our Home, Inc. shall maintain written service agreements with local hospitals that reasonably ensure that:

- A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care.

- Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting.

- Services are available to each resident 24 hours a day, 7 days a week, including emergent care.

C. Staff shall document in the chart of the resident, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

- Resident injuries shall be documented on a Resident Injury Report form and then attached to the Restraint Report or Seclusion Report form.

- Staff injuries shall be documented on an Accident / Illness Report form by the staff's supervisor as soon as possible, but no later than the end of the next business day. Attach a copy to the Restraint Report or Seclusion Report form and forward original to the Accounting Assistant in Huron or the Office Manager in Parkston.

VI. Facility Reporting

1. An incident report shall be completed following the use of seclusion or restraint. The report shall include description of the less restrictive intervention techniques used prior to the use of seclusion or restraint. The staff in charge of the intervention shall prepare the Seclusion Incident Report or Restraint Incident Report and the Seclusion Narrative or Restraint Narrative, and submit both documents and the completed Seclusion/Personal Restraint Order form and Seclusion Monitoring or Restraint Monitoring form to the Program Coordinator.

The Program Coordinator shall then forward the documents to the Associate Director for review and signature. The Associate Director's review and signature shall take place after every occurrence of the use of seclusion or restraint and shall be completed prior to the resident's treatment plan review to determine conformance with applicable polices/procedures.

2. A report via email shall also be submitted to the RRM within 24 hours of the restraint for all U.S. Probation and Custody residents. The staff in charge of the intervention shall prepare the report and present it to the Program Coordinator for approval and submittal to the RRM.

3. Attestation of facility compliance. The Executive Director shall provide a completed Attestation – Psych Under 21 Rule form for each Our Home, Inc. psychiatric residential treatment facility (PRTF) to attest that each facility is in compliance with CMS's standards governing the use of restraint and seclusion.

   The attestation(s) shall be submitted to the State Medicaid Agency:

   - At the time the residential facility achieves PRTF status.
   - On an annual basis, by July 21st.
   - In the event of a new Executive Director

4. Reporting of serious occurrences. The facility must report each serious occurrence to the State Medicaid Agency and the State-designated Protection and Advocacy Organizations. Serious occurrences that must be reported include a resident's death, a resident's suicide attempt, and a serious injury to a resident as defined in this policy. The reporting of such events shall be conducted following the Reporting of Serious Occurrences policy.

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 emergency safety intervention. For U.S. Probation and Custody residents, the notification to the RRM must be made immediately by telephone or fax following a restraint.

A. The assigned Group Leader/Counselor shall attempt to contact the parent(s) or legal guardian(s) within the required timeframe. If the Group Leader/Counselor is not on duty, the on-call shall be responsible to make the notification.

B. The notification to the parent(s) or legal guardian(s) shall include the following information:

   - Current medical status
   - Reason for action taken
   - Injuries, if any

C. The facility must document in the resident's chart that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the

date and time of notification and the name of the staff providing the notification. If staff is unable to successfully contact the parent(s) or legal guardian(s), they shall document their attempts on the Restraint Incident Report or Seclusion Incident Report.

D. If emergency contact information for the resident indicates that the parent(s) or legal guardian(s) do not want to be contacted, staff shall document this fact on the Restraint Incident Report or Seclusion Incident Report.

VIII. Post Intervention Debriefings

A. Within 24 hours after the use of seclusion or personal restraint, staff involved in the emergency safety intervention and the resident must have a face-to-face discussion for the purpose of: (1) hearing from the resident what they experienced and/or their perspective; (2) informing the resident as to why the seclusion/restraint was used; and (3) returning control to the resident.

- 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. The Program Coordinator, Childcare Coordinator, Registered Nurse or other designated staff member shall organize, lead, and document the debriefing.
- Other staff and others observing the incident may participate in the discussion when it is deemed appropriate by the program.
- Others (family/guardian/significant others) requested by the resident may participate in the discussion, unless clinically contraindicated. During parent notification of the seclusion or restraint, the assigned Group Leader or on-call shall inform the parent(s) or legal guardian(s) that they may be asked to participate.
- The program must conduct such discussion in a language that is understood by the others requested and approved to participate. The leader of the debriefing shall note any communication barriers on the Resident Debriefing form, and if so, how the barriers were accommodated.
- The discussion shall be documented on the Resident Debriefing form and then filed in the chart of the resident. A copy of the form shall be forwarded to the Associate Director.

B. Within 24 hours after the use of seclusion or personal restraint, staff involved in the resident debriefing, and appropriate supervisory and administrative staff, must conduct a debriefing session. The Program Coordinator, Childcare Coordinator, Registered Nurse or other designated staff member shall organize, lead, and document the debriefing. The debriefing shall include, at a minimum, a review and discussion of:

- The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.

- Description of the implementation of the intervention
- Resident's response to the intervention
- Alternative techniques that might have prevented the use of seclusion or personal restraint.
- The procedures, if any, that staff are to implement to prevent any recurrence of the use of seclusion or personal restraint.
- The outcome of the intervention, including any injuries that may have resulted from the use of seclusion or personal restraint.
- If the emergency safety intervention resulted in an injury to a resident or staff, the debriefing shall also include an evaluation of the circumstances that caused the injury and the development of a plan to prevent future injuries. The plan shall be implemented through distribution of written documentation, verbal discussions with individual staff or in small groups, or staff training.

The debriefing shall be documented on a Team Debriefing form and then filed in the chart of the resident. A copy of the form shall be forwarded to the Associate Director.

IX. Treatment Plan Review

All uses of seclusion or personal restraint shall result in a review and, as appropriate, revision of the resident's treatment plan. The review shall occur within 30 days following the seclusion or personal restraint and shall incorporate recommendations from any debriefings.

X. Education and Training

A. All staff shall have ongoing education when applicable, training, and demonstrated knowledge of:

1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations.
2. The use of a continuum of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, verbal and observational methods, engagement, one-to-one attention, meditation, self-protection, time out, re-direction, personal bedrooms, or prompting to prevent emergency safety situations.
3. The correct application of time out and how to monitor a resident in time out.
4. The safe application and use of personal restraint and the safe application and use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.
5. Certification in CPR and First Aid, including periodic recertification.

6. The contributing factors or causes of threatening behavior, including training on recovery and trauma-informed services and the use of personal safety plans.
7. The ability to recognize precursors that may lead to aggressive behavior.
8. Medical conditions that may contribute to aggressive behavior.
9. How interpersonal interactions, including how personnel interact with each other and with the residents, may impact the behaviors of the residents.
10. The prevention of threatening behaviors.
11. Recovery/wellness oriented relationships and practices.
12. How to handle a crisis without restraints, in a supportive and respectful manner.
13. When and how to restrain or seclude while minimizing risk.
14. The risks of seclusion or restraint to the residents or personnel, including medical risks and psychological risks.
15. How to monitor and continually assess for the earliest release.
16. The practice of intervention done by a team.
17. The practice of intervention done by an individual.

B. The training shall include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

C. Staff shall be trained and demonstrate competency before participating in an emergency safety intervention.

D. Staff shall demonstrate their competencies for items 1. – 4. on a semiannual basis and items 5. – 17. on an annual basis.

E. Only Individuals who are qualified by education, training, and experience shall provide this staff training.

F. Documentation that the training and demonstration of competency were successfully completed shall be maintained in the staff personnel files.

G. The training programs and materials used by the facility shall be maintained on file with the Training Specialist and made available for review by CMS, the State Medicaid agency, and the State survey agency.

XI. Room Requirements

A room designated for the use of seclusion or restraint shall have the following:

- A focus on the comfort of the resident, including adequate air flow, a comfortable temperature, and a safe, comfortable seating and/or lying arrangement

- An identified plan for emergency exit
- Access to bathroom facilities
- Sufficient lighting
- Observation availability that allows staff full view of the resident in all areas of the room
- A location that promotes the privacy and dignity of the resident

In addition, a room used exclusively for seclusion shall be free of potentially hazardous conditions and have the following:

- Not less than 54 square feet of floor space
- A ceiling height of not less than 8 feet
- A lighting fixture, equipped with a minimum of a 75-watt bulb, screened or designed and installed to prevent tampering
- A locking mechanism, if used, must be designed to be fail-safe and tied into the fire alarm system to release when the alarm is activated or when there is loss of power to the fire alarm panel

XII. Performance Improvement

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

A. Each incident of seclusion and restraint goes through an initial review for the purpose of performance improvement. This review, at minimum, is conducted by Child Care Coordinator, Program Coordinator, Clinical Psychologist, and Associate Director.

B. Quality Assurance/Performance Improvement is conducted on a quarterly basis for each occurrence of seclusion or restraint. Findings are brought forward to the administrative team for trend analysis and performance improvement implementation.

XIII. Plan to Minimize Use of Seclusion and Personal Restraint

In order to minimize or eliminate the use of seclusion and personal restraint in its treatment programs, Our Home, Inc. administrative staff shall implement an agency-wide plan that includes at least the following:

- Identification of the role of leadership
- Use of data to inform practice
- Development of workforce attitudes, skills, and practices that support recovery
- Identification of specific strategies to prevent crisis
- Identification of timelines to reduce the use of seclusion and restraint
- Identification of roles for residents and advocates in determining if crisis procedures and practices are implemented in a positive and proactive fashion
- A review of the role of the debriefing process in supporting the reduction of the use of seclusion or restraint

On an annual basis, a written status report shall be prepared on the plan for minimization or elimination of the use of seclusion and personal restraint. The status report shall include:

- Goals and timelines
- Progress made
- Areas needing improvement
- Factors impeding elimination of the use of seclusion and restraint

XIV. Annual Review

The Clinical Psychologists and Medical Directors shall document their individual review and approval of this policy and related procedures on an annual basis to ensure that proper protocols are in place. The documented reviews and approvals shall be maintained on file with the Licensing and Accreditation Manager.

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

DSS – Child Protection Services
Intake Specialist:
Toll Free Hotline: 1-877-244-0864

State-designated Protection Organization

Huron Programs:
DSS – Child Protection Services –Huron
110 3rd Street SW Ste 200
Huron, SD 57350
Phone: 605-353-7105
Fax: 605-353-7103

Parkston Program:
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

Rod Raschke, Intake Specialist
Disability Rights South Dakota
221 South Central Avenue
Pierre, SD 57501
Phone: 605-224-8294 Voice/TDD \ 800-658-4782

Centers for Medicare & Medicaid Services (CMS)

Helen Jewell
Centers for Medicare and Medicaid Services
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967
Phone: 303-844-7032

SECLUSION AND PERSONAL RESTRAINT CONSENT FORM

(1/11/08 revised 5/23/21)

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 youth behavior that places the youth 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 youth.
- 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 youth in seclusion or personal restraint, Our Home, Inc. must have written permission from the youth's placement agency. If the youth 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 youth is being referred.

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

_____

(Full Name of Youth)

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 Rep Date

Use of Ukeru
(6/23/2021)

It is Our Home, Inc's objective to create an environment where staff have a proven prevention alternative to the use of restraint and or seclusion to de-escalate youth safely and effectively that is safer for both staff and youth, thus creating an environment where the youth can remain forward focused on their treatment planning.

Using its own experience as a model, Grafton developed Ukeru®(Japanese for "receive"), the first crisis-training program to offer a physical alternative to restraints and seclusion. Today, Ukeru is used in 36 states and Canada, and in more than 251 private day and residential programs, private and public schools, psychiatric hospitals and forensic units.

Through trauma informed training, Ukeru helps providers explore and understand the effects of trauma on behavior and functioning. Participants will learn how to assess the impact of trauma and grow a greater understanding of trauma symptoms.

- Introduces the importance of creating a trauma-Informed treatment environment.
- Explores the effects of trauma on the brain and subsequent behavioral, emotional, and adaptive functioning.
- Provides a better understanding of why individuals may exhibit behaviors that are considered "maladaptive" but may actually be quite "adaptive" in protecting the individual from real or perceived threat.
- Presents cultural and environmental factors associated with "trauma-informed" and "trauma-uninformed" settings,
- Reviews specific information to consider when assessing the impact of trauma and developing a support plan to minimize traumatic stress in the future.

Physical techniques are taught by practicing effective use of protective equipment and soft, cushioned blocking materials — custom made specifically for use with the Ukeru model— that keep both the employee and client safe. These techniques include:

- Physical release techniques
- Physical re-direction
- Blocking techniques

By signing below, I acknowledge that I have read and understand the use of Ukeru as an alternative to seclusion and restraint used within Our Home, Inc.'s treatment facilities:

Parent/Guardian/Worker Signature

Date

OUR HOME, INC.

HURON PRTF
40354 210th St.
Huron, SD 57350-7928
Phone (605) 352-9098
Fax (605) 352-0550
edliaison@ourhomeinc.org

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

Parent/Guardian/Custodian Evacuation Acknowledgement

(4/4/2019)

Our Home, Inc. developed an Emergency Preparedness Plan as a comprehensive approach to meeting the health and safety needs of the residents served in the event of a disaster/emergency situation. In the event of a disaster/emergency situation, the Executive Director will make a determination based on structural and operating integrity of the campus with safety and well-being serving as top priority to determine if a move to an alternate site is needed.

Parent/Guardian/Custodian Notification

Parent/Guardian/Custodians of residents will be notified immediately upon determination of a need to move residents to a secondary location. Parent/Guardian/Custodians have the option of approving the move to the secondary site or will need to make plans to immediately come and take physical custody of the resident. If a Parent/Guardian/Custodian is unable to be reached the resident will remain in the care of Our Home, Inc. and will be transported to the secondary location by Our Home, Inc. staff.

Parent/Guardian Acknowledgement

By signing my name below, I, being the parent/guardian of _____,

Full Name of Resident

Acknowledge that I have been informed of Our Home, Inc. procedures when a determination of need for evacuation to a secondary location. I understand in the event of an evacuation to a secondary site that I will need to make plans to immediately come and take physical custody or the resident will remain in the care of Our Home, Inc. and will be transported to a secondary location.

Signed this _____ day of _____, 20____.

_____ _____

Parent/Guardian Signature Please Print Parent/Guardian Name

OUR HOME, INC., HURON PRTF
40354 210th Street, Huron, SD 57350, Phone (605) 352-9098, Fax (605) 352-0550.
(5/23/21)

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

CONSENT FORM FOR DRUG AND ALCOHOL URINALYSIS

(4/26/11 revised 5/23/21)

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

_____.
(Full Name of Youth)

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

Huron Police Department

Runaway/Missing Person and Authorization Form

State Case #:
Incident #:
Office Use Only

First Name:	
Middle Name:	
Last Name:	
Sex: Male: ☐ Female : ☐	
Race: American Indian: ☐ Asian: ☐ Black: ☐ White: ☐	
Height:	**Weight:**
Hair Color:	
Hair Length/Style:	
Eye Color:	
Skin Tone: Fair : ☐ Black: ☐ Dark Brown: ☐ Medium Brown: ☐ Light Brown: ☐	
Date of Birth:	**Age:**
Year Runaway will turn 21:	
Ethnicity: Hispanic: ☐ Not Hispanic: ☐	
List location and description of any scars, marks and/or tattoos:	
Social Security Number:	
Driver's License Number:	**State:**
Date/Time and Location of last contact:	
Cell Phone Number:	
Social Media Accounts:	
Names/Addresses/Phone Numbers of individuals he/she may be in contact with:	
List any mental and/or physical conditions:	

Huron Police Department
Runaway/Missing Person and Authorization Form

State Case #:
Incident #:
Office Use Only

Vehicle Type [Make, Model, Year, Color and License Plate Number]:

_____

_____

Type of hangouts frequented:

_____

_____

Are Dental and Medical records available upon request?

Yes: ☐ No: ☐

List any other information not addressed above:

_____

_____

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 decree of any court of law. I hereby authorize the Huron Police Department and any other law enforcement agency to collect and/or disseminate the information, photographs and/or any other records provided by me, to any person or organization engaged directly or indirectly in the effort to assist in the location of the missing person.

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

_____ ____/____/20____ ____:____

Signature **Date** **Time**

_____ (____) _____-_____

Printed Name **Phone Number**

Relationship to missing person: _____

Address: _____

_____

Officer's Name: _____

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 REQURED 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
* Scope of Services
* Case Management
* Counseling
* Discharge
* Resident Discipline
* Confidentiality of Information
* In-house Abuse and/or Neglect Prevention & Intervention
* 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

Signature:_____ **Date:**_____