Our Home, Inc.
Caring for Kids and Families

Admission Packet

PRTF Parkston (All Female Facility)	PRTF Huron (All Male Facility)	PRTF Rediscovery (Co-ed Drug & Alcohol Facility)
Return to: **Brittany Dugger** 103 W. Maple St. Parkston, SD 57366 Phone: 605-928-7907 Extension 1418 Fax: 605-928-7910 bdugger@ourhomeinc.org	**Return to:** **Brittany Dugger** 40354 210th St. Huron, SD 57350 Phone: 605-928-7907 Extension 1418 Fax: 605-928-7910 bdugger@ourhomeinc.org	**Return to:** **Oran Williams** 40354 210th St. Huron, SD 57350 Phone: 605-353-1025 Extension 1205 Fax: 605-353-1061 owilliams@ourhomeinc.org

Required Admission Information & Documents

- ✓ **Social Security Card**
- ✓ **Title 19 (Medicaid) Card**
- ✓ **Birth Certificate**
- ✓ **Court Order** (if applicable)
- ✓ **Custody Order** (if applicable)
- ✓ **Interstate Compact** (if applicable)
- ✓ **Social History**
- ✓ **Psychological/Psychiatric Evaluation** (if available)
- ✓ **Drug & Alcohol Evaluation** (if applicable)
- ✓ **Immunizations**
- ✓ **School Transcript**
- ✓ **Individualized Education Plan/504 Plan copy** (if applicable)
- ✓ **Completed Admission Packet**
- ✓ **Signed Consents & Releases**
- ✓ **Allergy Information**
- ✓ **Authorization for Tuition Cost** (if applicable)
- ✓ **Insurance Card Copies**

Referred By:

Name: _____ Agency: _____

Address: _____

Phone: _____ Emergency Phone: _____ Fax: _____

Email: _____

Youth:

Name: _____ Sex: _____

Race: _____ Age: _____ Birthdate: _____

Social Security Number: _____ Medicaid Number: _____

Present Address: _____

Is youth living with parent? ☐ Yes ☐ No

If not, where and with whom? _____

Has the child received professional counseling? ☐ Yes ☐ No

If yes, by whom? _____

Family:

Parent 1: ☐ Has custody of youth ☐ Rights Terminated ☐ Other: _____

Name: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Has this parent received any type of counseling? ☐ Yes ☐ No

If yes, by whom? _____

Parent 2: ☐ Has custody of youth ☐ Rights Terminated ☐ Other: _____

Name: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Has this parent received any type of counseling? ☐ Yes ☐ No

If yes, by whom? _____

Marital Status of parents:
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Legal Guardian *(if other than parent)*: ☐ Custody of youth

Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Sibling Information:

	Name	Age	Living in home or elsewhere
1.			
2.			
3.			
4.			
5.			
6.			

List any persons who contact with might be damaging for youth: _____

_____

Describe any family problems affecting the youth: _____

_____

_____

Describe how youth gets along with his/her siblings: _____

_____

Health:

Describe the youth's general health: _____

_____

Describe any psychological or psychiatric problems youth has had: _____

_____

Has youth received psychological/psychiatric care for the problems above? ☐ Yes ☐ No

If yes, identify provider seen: _____

List current diagnoses: _____

_____

Does the youth have any physical limitations? ☐ Yes ☐ No

If yes, please describe: _____

Does the youth currently take any medications ☐ Yes ☐ No

If yes, list medications and dosage: _____

_____

_____

Prescribed by: _____ Date: _____

Has youth ever been on medication in the past that he/she is no longer taking? (i.e.: for depression, anxiety, mood stabilizer, etc.) ☐ Yes ☐ No

If yes, list medications: _____

_____

Name of youth's primary physician: _____

Address: _____ Phone: _____

Date of last physical exam: _____

Allergies and symptoms: _____

_____

Name of youth's dentist: _____

Address: _____Phone: _____

Date of last dental exam: _____

Name of youth's optometrist: _____

Address: _____Phone: _____

Date of last vision exam: _____

Education:

Last grade completed: _____ Current grade: _____

Last school attended: _____

Address: _____

Has youth obtained a GED? ☐ Yes ☐ No If yes, date completed: _____

Does youth have an Individualized Education Plan (IEP) or 504 Plan? ☐ Yes ☐ No

If yes, please provide a copy. Next review date: _____

Name of school who developed plan: _____

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

Has youth ever been suspended/expelled or given detention? ☐ Yes ☐ No

If yes, explain: _____

_____

Describe youth's attitude and performance towards school: _____

_____

Describe youth's relationship with peers and teachers: _____

_____

Legal History:

Describe youth's legal history (include arrests, charges, etc.): _____

_____

_____

Is youth on probation/DOC? ☐ Yes ☐ No

If yes, name of probation officer or JCA: _____ Phone: _____

Is youth court ordered to treatment? ☐ Yes ☐ No *If yes, please provide a copy of court order.*

Is youth required to register as a sex offender? ☐ Yes ☐ No

Placement History:

Please list all past placements (treatment centers, JDC, jail, behavioral health, etc.)

	Placement Name	Dates Attended	Completed Program?
1.	_____		☐ Yes ☐ No ☐ N/A
2.	_____		☐ Yes ☐ No ☐ N/A
3.	_____		☐ Yes ☐ No ☐ N/A
4.	_____		☐ Yes ☐ No ☐ N/A
5.	_____		☐ Yes ☐ No ☐ N/A

Substance Use History:

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

_____

_____

Describe, if possible, how much the youth uses in terms of quantity: _____

_____

Describe how the youth gets money and how much money the youth is accustomed to having in an average week: _____

If possible, describe any unsuccessful attempts the youth has made to cut down or stop using substances (for example, prior drug and alcohol counseling treatment, promising not to use anymore, etc.): _____

_____

Do you believe the youth has ever been intoxicated or high over the course of an entire day?

☐ Yes ☐ No If yes, describe the incident(s) of this that you can recall: _____

_____

Do you have any reason to believe the youth has had a blackout or loss of memory of events that took place while under the influence of substance? ☐ Yes ☐ No

If yes, describe: _____

_____

Does the youth's personality seem to have changed? ☐ Yes ☐ No

If yes, describe: _____

_____

Has the youth ever missed or had difficulties at school or work due to their substance use?

☐ Yes ☐ No If yes, describe: _____

_____

Describe any legal problems resulting from drug and alcohol use: _____

_____

Have any medical problems or injuries occurred because of substance use? ☐ Yes ☐ No

If yes, describe: _____

Describe any family arguments or difficulties because of youth's substance use: _____

_____

Describe any difficulties the youth may have with friends due to substance use: _____

_____

Do any other members of the youth's family have a history of drug and/or alcohol use?

☐ Yes ☐ No If yes, describe: _____

Has a Drug & Alcohol Evaluation been completed? ☐ Yes ☐ No

If yes, by whom: _____ *Please provide a copy of the evaluation.*

Religion:

Denomination: _____

Does religion play a ☐ *large*, ☐ *average*, ☐ *small* part in youth's life?

Additional Information:

Provide any additional information you feel is important to know about the youth:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Financial Responsibility for Medical Costs

As a parent/guardian of a youth 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.

☐ DSS ☐ DOC ☐ Private Guarantor Name: _____
Address: _____
Phone: _____

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

☐ Medicaid Number: _____

☐ Indian Health Services Location: _____

☐ Private Health Insurance *(copy of insurance card required)*

Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____

Policy Holder Name: _____

Address: _____

Phone Number: _____

Employer: _____

Social Security Number: _____

Date of Birth: _____

Medical Consent

As parent/guardian of _____, I authorize Our Home, Inc. to procure emergency medical treatment, surgery, hospitalization, and other routine medical care, including recommended vaccinations, determined necessary for the youth identified. Additionally, I authorize the administration of urinalysis for the detection of drugs and alcohol when deemed necessary.

I acknowledge that this authorization is given even though circumstances may not allow for proper notification, to you as parent/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 youth identified above is transferred to another Our Home, Inc. program.

Signed this _____day of _____, 20_____.

_____
Parent/Guardian Signature

_____
Print Parent/Guardian Name

_____
Referral Agent Signature

Janise Pischel, MSE
_____
Administrator of Our Home, Inc.

Immunization Consent

As the parent/legal guardian of _____,
Name of Youth

I agree to the administration of immunizations as recommended by the doctor including the seasonal Flu vaccine. 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.

Vaccination informational sheets are available at www.cdc.gov/vaccines

_____ _____
Parent/Guardian Signature Date

Our Home, Inc.
Caring for Kids and Families

Vaccination Exemption

We understand that personal preferences, experiences, and religious beliefs may affect healthcare decisions for youth and their families – most commonly being vaccinations. Please complete this form only if you prefer your youth opt out of receiving specific vaccinations.

As the parent/legal guardian of _____,
Name of Youth

I do **not** consent to the following vaccinations while at Our Home, Inc. :

☐ Influenza
☐ HPV
☐ Covid-19
☐ Other (Please list): _____

_____ _____
Parent/Guardian Signature Date

Media Consent

As the parent/legal guardian of _____,
Name of Youth

a resident of _____, _____, I ☐ **DO** or ☐ **DO NOT** consent to Our Home,
City State

Inc. to use, for the publication thereof, information relating to the residency and activities of said youth at Our Home, Inc. Consent includes, but is not limited to, the use of youth's name, photograph, stories concerning the youth's residency and activities at Our Home, Inc.

_____ _____
Parent/Guardian Signature Date

Ukeru Acknowledgement

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 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 Signature Date

Seclusion And Personal Restraint Consent

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

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

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

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

As the parent/legal guardian of _____, I hereby
Name of Youth

consent to the use of monitored seclusion and personal restraint by Our Home, Inc. for the purpose of personal safety.

_____ _____

Parent/Guardian Signature Date

Evacuation Acknowledgement

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.

Parents/guardians of residents will be notified immediately upon determination of a need to move residents to a secondary location. Parents/guardians have the option of approving the move to the secondary site or will need to make plans to immediately come and taky physical custody of the resident. If a parent/guardian 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.

As the parent/legal guardian of _____,
Name of Youth

I acknowledge that I have been informed of Our Home, Inc.'s procedures when a determination of need for evacuation to a secondary location has been made. I understand that 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.

_____ _____
Parent/Guardian Signature Date

Acknowledgement of Receipt & Notification of Selected Agency Policies

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

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

- Seclusion & 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 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
- Collections & Recording of Health Appraisal Data
- Medical Emergency Plan
- Immediate Medical Examination & 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.

By signing below, I acknowledge that I have been provided with and understand the listed policies.

_____ _____

Parent/Guardian Signature Date

_____

Resident Name

Our Home, Inc.
Caring for Kids and Families

Authorization to Release Information

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

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

_____
Name of Youth

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Youth

_____ _____
Address Phone Number

_____ _____
Police Officer's Name Badge No.

_____
Agency

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

_____ _____
Responsible Party Date

_____ _____
Referral Worker/Agency Date

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

As the parent/legal guardian of _____,
Name of Youth

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

_____ _____
Parent/Guardian Signature Date

Video Surveillance Acknowledgement

(5/10/2024)

Our Home, Inc. authorizes the use of video surveillance equipment on agency property to enhance the safety of youth, employees, and others on agency premises, as well as to deter inappropriate behavior and to be used for training enhancement. In dealing with surveillance of youth, employees, and others, Our Home, Inc. recognizes both its obligation to provide appropriate levels of supervision in the interest of safety and the privacy rights of youth, employees, and others who may enter Our Home, Inc. property. Video surveillance, like other forms of supervision, must be conducted in a manner that respects privacy rights.

Video surveillance will be used to record in public or common areas. Video surveillance cameras may be used to record in locations authorized by the Executive Director of Our Home, Inc. Video surveillance is not to be ordinarily used in locations where appropriate confidential or private activities/functions are routinely carried out. At no time will an exception be granted to utilize video surveillance in bathrooms or shower areas. Video surveillance cameras will be installed in plain sight. At no time will video surveillance cameras be hidden, or the use of hidden video cameras be permitted.

_____ _____

Signature Date

Parkston PRTF Admissions Only

Complete the following forms:

- Internet & Electronic Mail Acceptable Use Policy

STUDENTS: INTERNET AND ELECTRONIC MAIL ACCEPTABLE USE POLICY

PARKSTON PUBLIC SCHOOL ACEPTABLE USE POLICY INTERNET AND ELECTRONIC MAIL PERMISSION FORM

Please read the following carefully before signing this document. This is a legally binding document.

The Internet is an electronic highway connecting thousands of computers all over the world and millions of individual subscribers. These guidelines are provided so that you are aware of the responsibilities you are about to acquire. In general, this requires efficient, ethical and legal utilizations of the network resources. If a Parkston Public School user violates any of these provisions, his or her current access will be terminated in the future and indicate the party (parties) who signed has (have) read the terms and conditions carefully and understand(s) their significance.

INTERNET – TERMS AND CONDITIONS

1. Acceptable Use – The purpose of providing Internet and Electronic Mail (E-Mail) through State K-12 E-Mail System is to enable students to explore thousands of libraries, databases and bulletin boards while exchanging messages with Internet users throughout the world.

The use of the Internet and E-Mail must be in support of education and research consistent with the educational objectives of the Parkston School District. Use of other organization's networks or computing resources must comply with the rules appropriate for that network. Transmission of any material in violation of an U.S., or state regulation is prohibited. This includes, but is not limited to: copyrighted material, threatening, obscene or lewd material, or material protected by trade secret. Use for product advertisement, commercial purposes, or political lobbying is also prohibited.

Students will not use any mass e-mailing lists created by district personnel to send out an e-mail unless the e-mail has been approved by the administration or tech personnel. Using this list without the prior consent of the administration or tech personnel will result in the loss of all computer privileges until further notice. This violation can also contain additional forms of punishment in the form of suspension.

2. Privileges – The use of Internet is a privilege, not a right, and inappropriate use will result in cancellation of those privileges. The Parkston Public School administration will deem what is inappropriate use and its decision is final. The administration, faculty, and staff of Parkston Public School may request the system administrator to deny, revoke, or suspend any specific Internet user's privilege.

3. Netiquette – You are expected to abide by the generally accepted rules of network etiquette. These include (but not limited to) the following:

a. Be polite. Do not get abusive in your message to others. Do not send or display offensive messages or pictures.
b. Use appropriate language. Do not swear, use vulgarities or any other inappropriate language. Do not harass, insult, or attack others. Illegal activities are strictly forbidden.
c. Do not reveal your personal address or phone numbers of students or colleagues.
d. Network storage areas will be treated like school lockers. Network and school administrators may review files and communications to maintain system integrity and insure that users are using the system responsibly. Users should not expect that files stored on district servers will be private. Trespassing on another's folders, work, or files is prohibited and will result in loss of privileges. Messages relating to or support of illegal activities will be reported to the authorities.
e. Do not use the network in such a way that you would disrupt the use of the network by other users (intentionally wasting limited resources).
f. All communications and information accessible via the network should be assumed to be private property.

4. No Warranties – The Parkston Public School District makes no warranties of any kind, whether expressed or implied, for the service it is providing. The Parkston Public School District will not be responsible for any damages you suffer. This includes loss of data resulting from delays, non-deliveries, or service interruptions caused by its own negligence on your errors or omissions. Use of any information obtained via the internet is at your own risk. The Parkston Public School District specifically denies any responsibility for the accuracy or quality of information obtained through its services. The Parkston Public School District cannot be responsible for inappropriate or offensive material you encounter on the internet. If offensive material would cause you personal embarrassment or other emotional or psychological damage you should not use the system.

5. **Security** – Security on any computer system is a high priority, especially when the system involves many users. If you feel you can identify a security problem on internet, you must notify a system administrator. Do not demonstrate the problem to other users. Do not use another individual's account without written permission from that individual. Attempts to login to internet as a system administrator will result in cancellation of user privileges. Any user identified as a security risk or having a history or problems with other computer systems may be denied access to the internet.

6. **Vandalism** – Vandalism will result in cancellation of privileges. Vandalism is defined as any malicious attempt to harm or destroy data of another user, internet or any of the above listed agencies or other networks that are connected to the state k-12 email system. This includes, but not limited to, the uploading, creation or intentional transition of computer viruses.

7. **Exception of Terms and Conditions** – All terms and conditions as stated in this document are applicable to the Parkston Public School District. These terms and conditions shall be governed and interpreted in accordance with policies of the Parkston Public School Board, the laws of the state of South Dakota and the United States of America.

PERMISSION FORM

I understand and will abide by the above terms and conditions for internet. I further understand that any violation of the regulations above is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken and/or appropriate legal action.

USER'S FULL NAME (PLEASE PRINT)_____

USER'S SIGNATURE_____

DATE_____

HOME ADDRESS_____

HOME PHONE_____ **GRADE IN SCHOOL**_____

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

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

PARENT OR GUARDIAN NAME (Please Print) _____

PARENT OR GUARDIAN SIGNATURE_____

DATE _____

Huron PRTF Admissions Only

Complete the following forms:

- Request of Grade Transcript
- Huron PD Runaway/Missing Person and Authorization Form

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: _____

Our Home, Inc.
Caring for Kids and Families

Request of Grade Transcript

The youth whose name is listed below has enrolled in the Our Home Alternative School and indicated former attendance in your school. Please forward a transcript of grades and any other information that may be available regarding this student's school progress, as well as health and immunization records. When the transfer is during the school year, please include transfer grades for the present term.

Records can be faxed to 605-352-0550 or emailed to edliaison@ourhomeinc.org

Name of Student: _____

Grade: _____ Date of Birth: _____

Date of Withdrawal (if available): _____

_____ _____

Parent/Guardian Signature Date

Rediscovery Admissions Only

Complete the following forms:

- Alternative School Academic (Special Education) Agreement
- Division of Behavioral Health Substance Use Disorder Outcome Tool – Family

Alternative School Academic (Special Education) Agreement

Youth at the Rediscovery program become dually enrolled (enrolled at both Our Home Alternative School and the youth's home school). Our Home Alternative School, a part of the Huron Public School system, is designed to meet the youth's educational needs while still enabling them to work on treatment issues. **It is the responsibility of the parent/guardian to inform the home school of the length of time that their child will be out of school** and dually enrolled at Our Home Alternative School. **If the student has an Individualized Education Plan (IEP) or 504 Plan, please provide a copy of the plan.** Since this is a short-term placement, the youth will not be enrolled long enough at Our Home Alternative School for any updates to IEP or 504 plans to be completed but youth will be available for a phone conference if their home school district needs to update the IEP or 504 Plan.

There are five options available for the youth during their treatment stay. They will be spending four hours per day in the classroom. The available options are outlined below.

Option 1: Lessons at the Alternative School focus on reading and math skills.

Option 2: Youth are offered the option to bring work from their home school. Because of shortened school days, youth are limited to bringing to no more than two subjects. The home school would be responsible for getting assignments to the youth (through mail, staff email, or fax). For this option to be successful, the home school needs to be consistent with sending assignments and required books or materials. Youth are only allowed access to their own email if it is required as part of the class and approved by Our Home teachers. If the home school fails to provide assignments, the youth will move to Option 1. Youth that are waiting for work from their home school will start out with Option 1 and when the schoolwork arrives, will switch to Option 2. Youth that elect Option 2 and fail to abide by what is outlined above, or experience complications that disrupt learning, will be put into Option 1.

Option 3: This option is offered to youth who are already enrolled in a virtual/cyber school and have their own computer. Our Home is not responsible for any damage caused to the youth's computer. Wi-Fi is available at both the Alternative School and Rediscovery; however, work would need to be completed at the unit since log-in passwords for the school server are not provided to short-term youth. Youth that elect Option 3 and fail to abide by what is outlined above, or experience complications that disrupt learning, will be put into Option 1.

Short Term Track: Youth that are in the Short-Term Relapse Program (18-day program) can continue their education. Youth coming into treatment need to notify their home school prior to coming to get an excused absence and advanced make up assignments. Youth do have the availability of a fax machine if assignments need to be faxed back and forth from their home school. Short term youth on an IEP will be required to attend classes at the Our Home Alternative School.

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

Alternative School Academic (Special Education) Agreement (cont.)

I, _____, the parent/guardian of
Parent/Guardian

_____, have contacted _____
Youth's Name Home School District

regarding my child and choose the following option:

☐ Option 1

☐ Option 2

☐ Option 3

☐ Short Term Track

☐ GED

**If no option is marked, the youth will be placed in Option 1.*

My child ☐ **IS** or ☐ **IS NOT** on an Individualized Education Plan (IEP) or 504 Plan.
Our Home, Inc. will need a copy of any IEP or 504 Plan. Please include the most recent evaluations and eligibility documentation.

_____ _____
Parent/Guardian Signature Date

_____ _____
Youth Signature Date

Client STARS ID:

Date:

Tool Type:

Family should answer for how they feel their child is doing for the services.

☐ Initial ☐ Family

☐ Level of Care Transfer

☐ Discharge

1. Would you say that in general your child's mental health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please answer the following questions based on the <u>past 30 days:</u>

a. Has your child been arrested?	☐Yes ☐No ☐Refused
b. Did you have enough money to meet your child's needs?	☐Yes ☐No ☐Refused
c. Have you been satisfied with the conditions of your child's living space?	☐Yes ☐No ☐Refused
d. Has your child spent time in a facility for:	
i. Detoxification/Inpatient or Residential Substance Use Disorder Treatment?	☐Yes ☐No ☐Refused
ii. Mental Health Care?	☐Yes ☐No ☐Refused
iii. Any illness, injury, or surgery to the human body?	☐Yes ☐No ☐Refused
e. Has your child spent time in a correctional facility including jail/prison/detention (because of an arrest, parole, or probation violation)?	☐Yes ☐No ☐Refused
f. Has your child had suicidal thoughts?	☐Yes ☐No ☐Refused
g. In the past 30 days, has your child felt…	
i. Nervous?	☐Yes ☐No ☐Refused
ii. Hopeless?	☐Yes ☐No ☐Refused
iii. Restless or fidgety?	☐Yes ☐No ☐Refused
iv. So depressed that nothing could cheer your child up?	☐Yes ☐No ☐Refused
v. That everything is an effort?	☐Yes ☐No ☐Refused
vi. Worthless?	☐Yes ☐No ☐Refused
vii. Bothered by psychological or emotional problems?	☐Yes ☐No ☐Refused

2. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion for your child over the <u>past 30 days</u>.	Response Options						
	Strongly disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**Not Applicable**	**Refused**
Domain: Social Connectedness Questions a-g							
a. My child is happy with the friendships they have, their friends will listen and understand them when talking.	☐	☐	☐	☐	☐	☐	☐
b. My child has people with whom they can do enjoyable things.	☐	☐	☐	☐	☐	☐	☐
c. I feel my child belongs in the community.	☐	☐	☐	☐	☐	☐	☐
d. In a crisis, my child would have the support they need from family or friends.	☐	☐	☐	☐	☐	☐	☐
e. My child has people that they are comfortable talking with.	☐	☐	☐	☐	☐	☐	☐
f. My child has family or friends that are supportive of their recovery.	☐	☐	☐	☐	☐	☐	☐
g. My child generally accomplishes what they set out to do.	☐	☐	☐	☐	☐	☐	☐
Domain: Functioning Questions h-q							
h. My child does things that are more meaningful to them.	☐	☐	☐	☐	☐	☐	☐
i. My child can take care of their needs.	☐	☐	☐	☐	☐	☐	☐
j. My child can handle things when they go wrong.	☐	☐	☐	☐	☐	☐	☐
k. My child can do things that they want to do.	☐	☐	☐	☐	☐	☐	☐
l. My child gets along with family, friends, and other people.	☐	☐	☐	☐	☐	☐	☐
m. My child can deal with crisis.	☐	☐	☐	☐	☐	☐	☐
n. My child does well in social situations.	☐	☐	☐	☐	☐	☐	☐
o. My child does well in school and/or work.	☐	☐	☐	☐	☐	☐	☐
p. My child's symptoms are not bothering them as much.	☐	☐	☐	☐	☐	☐	☐
q. My child's housing situation is a safe place to live.	☐	☐	☐	☐	☐	☐	☐