

OUR HOME, INC., Psychiatric Residential Treatment

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

Dear Parent/Guardian:

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

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

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

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

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

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

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

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

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

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

Sincerely,

A handwritten signature in cursive script that reads "Jade Hamilton".

Jade Hamilton
Program Coordinator

STAGES OF THE PARKSTON PROGRAM

(Revised 8/2/2021)

The Parkston program consists of four stages that you will be asked to work your way through. These stages will serve as a progress guide for you and your treatment team in your person centered treatment planning. These stages include the orientation stage, trust and accountability stage, exploration and disclosure stage and the re-socialization stage. Each stage is designed to give you new skills that will help you in your journey through the program. The amount of time it takes to progress forward through each stage will be individualized based on your areas of need. Since your treatment planning is individualized, you may be required to return to a previous stage to work on goals if you need additional help with identified problem areas. Your treatment team will instruct you at intake on how to progress through the stages of the program and what you need to do to begin working on the stages. Your treatment team will incorporate the work that you are doing into your individual treatment plan, which you will guide with your input as well as effort. Since it is your effort that guides the progress, the more effort you put in, the better the outcome...it is all up to you, and how you build your plan for success by putting your mind to work toward your goals each day. Some steps of progress are bigger than others, so remember each day to find a way to meet something on your treatment plan.

ORIENTATION STAGE

The orientation stage is used to help you and your treatment team determine your strengths, needs and ways to aid you in making healthy progress towards your identified treatment goals during your time in the program. The treatment team will utilize this time to work with you to better determine the forms of treatment that best fit your individual needs. The first two weeks of programming will be used as an adjustment period for you and your assigned group. This time will provide your group, the treatment team and yourself an opportunity to get to know each other better, as well as helping everyone in determining your basic needs. During this stage, an initial person centered treatment plan will be written by you with the assistance of your treatment team. This treatment plan will outline for you and your treatment team your identified areas of strengths, needs, treatment goals and expectations. Extra time may be necessary after 30 days to help your treatment team with gathering more information to better assist them in helping you with your goals and expectations throughout your stay at Our Home, Inc.

Goal:

1. To complete an individual assessment to determine the need for placement.
2. To become familiar with the program and group expectations while getting to know your treatment team and group.
3. To determine the appropriate individualized treatment for each youth based on assessments, history, and self-reported information.

The Responsibilities, Restrictions and Expectations are the same for the orientation stage as they are for the Trust and Accountability Stage.

You can advance to the next stage of the program by requesting to do so through Request RAP. Requests approved through Request RAP are then taken through to your group's treatment team meeting consisting of staff who are primarily assigned to work with your group. If approved in treatment team meeting you can then request to advance to the next stage of the program through a peer vote in your therapeutic group meeting. All decisions for stage advancement must go through Group Leaders Meeting for final decision. In order to not impede your program progression, Group Leaders Meeting may be held at various times through the request process timeline.

TRUST AND ACCOUNTABILITY- STAGE ONE

The trust and accountability stage focuses on developing a sense of trust and openness with your group and treatment team. Trust is not a feeling that happens automatically. It is a process or stage of growth as a person develops and grows healthier. Most people have fears of forming trusting relationships and for many people the process can be difficult and painful. However, trust is important when you need to cope successfully with yourself, your family, your group and the community. Trust is not all or nothing, you can start by giving your staff and group a little at a time. This way you take smaller risks and build up the trust so you can talk about what you need to.

Accountability is recognizing how your actions and words have affected your life and the life of others. Being accountable is how you show responsibility for your past actions. Taking accountability or responsibility for these actions will be determined by your demonstration of your skills through the process of helping and caring for others.

Goals:

1. Need to demonstrate trust in taking care of yourself in the following areas
 - a. Practice and maintain good personal hygiene.
 - b. Comply with nutritional requirements, eating three meals a day and practicing good manners.
 - c. Respect for other individual's personal space, privacy, belongings and problems.
 - d. Be involved and participate in therapeutic activities and encouraging others' participation.
 - e. Showing respect for other's personal property.
2. Show you can handle yourself in a respectful manner, increased ability to manage your emotions begin to learn and apply new coping skills, while working on your identified treatment needs.
3. Providing positive help and assistance to group members who need direction and positive feedback during rap sessions, school, group meetings and other times.
4. Starting to develop advanced skills on how to better manage anger, frustration and other feelings that may cause emotional or physical harm to yourself or others.
5. Begin to share with your group members and treatment team feelings, thoughts and events that cause you to struggle, without hurting yourself or others.
6. Acceptance is part of accountability and involves accepting ourselves, others, and situations. Acceptance is an attitude that influences our growth and ability to accomplish and meet our needs. This means being able to recognize what we can control and what we cannot control. It

means not giving up and it means facing and dealing effectively with positives and negatives in every part of our life and our past.

7. Complete all assignments you have been assigned, based on your own personal therapeutic needs and individual treatment plan.

Responsibilities:

1. Willingness to develop a sense of care and concern for yourself and your group.
2. Learning to assist others in the pursuit of recognizing inappropriate behavior by calling RAP. Calling RAP can occur anytime it is necessary. There are a few exceptions to this such as school, it does not always work, but you can work with staff to find a time that does work. There is no way to outline all the pieces and parts to RAP so that is something that will build throughout your stay. Appropriate use of RAP goes a long way in helping you succeed.
3. Completed life history in group meeting and to any new group members who come into your group.
4. Start making positive contributions towards helping others in the group.
5. Willingness to accept accountability for your own behavior by recognizing hurtful behavior and taking strides to intervene in appropriate ways.
6. Actively working on development of trusting and sharing with the entire group.
7. Active participation in development of academic improvement and setting long-term vocational and or educational goals.
8. Exhibit pride in your surroundings and your personal hygiene.
9. Portrays an attitude of trust and respect towards those in authority.
10. Developing an understanding of the resident handbook.
11. Actively participates in all groups and programming identified for your treatment needs.
12. Avoid breaking personal space with other youth.

Privileges / Limitations:

1. The first two weeks of placement is considered the adjustment period for all youth. Phone contact occurs after the first week of placement and on-campus Sunday visitation is considered after the first two weeks of placement.
2. After one week of placement, phone call time is designated according to each group and limited to two calls each week for 15 minutes apiece and limited to immediate family. Visitation upon approval is on Sundays for four hours with immediate family. Additional forms of contact such as Zoom and FaceTime calls with approved individuals can be set up through your assigned group leader after one week of placement.
3. You are limited to on-grounds visitation until granted treatment team approval.
4. Off-grounds visitation will be considered by the treatment team based on your treatment progress, attitude, identified areas of need and safety.
5. You are limited to in Parkston visitation during this stage.
6. You will be allowed to carry \$2.50 to be spent at your discretion. Any excess of \$2.50 needs to be placed in an envelope with your name and the amount, and then placed in the suggestion box and it will be deposited to your personal account.
7. You are limited to TV programming that does not include any provocative or sexual material.
8. Picture taking is limited to family or relatives.

9. You are limited to shaving in staff presence. (Unless authorized by treatment team)
10. You are limited to family pictures in their personal areas.
11. You are limited to attending Our Home self-contained classrooms. (Unless it is determined that public school classrooms are what is in the best interest of your treatment/education needs)
12. The use of radios is depending upon the overall position of the group. The group is limited to the use of radios during activities, free time, traveling, and up to staff discretion.
13. Some youth will not be allowed to attend functions in the community depending upon safety and behavior.

Expectations:

1. Conversation or whispering among group members without majority of the group or staff present is considered hurtful and harmful behavior.
2. You are expected to wear appropriate attire.
3. You will develop understanding of expectations of daily jobs and follow safety and sanitation expectations. (Etc. make bed, clean room, participate in daily jobs)
4. After any attempt to run away or successful runaway, you will comply with Our Home's procedures. You will be placed in flip flops for at least 48 hours and will remain in the building until such time you are considered safe to resume other activities.
5. You are expected to understand and comply with prohibited acts and sanctions.
6. If you should require utilization of the quiet room or seclusion room, you will be expected to clean the room prior to returning to your group.
7. You are expected to communicate to night staff when requiring assistance or needing to use the bathroom facilities.

EXPLORATION AND DISCLOSURE- STAGE TWO

Throughout this stage you will work on better understanding why you make the choices you do. Through contemplation and reflection, you will start to explore what causes your thoughts, feelings, behaviors and how it effects how you develop relationships. On this stage, we go over how you make decisions and what influences or causes your choices in life.

As part of learning to make better decisions, you must also learn self-disclosure. This is the process of revealing descriptive and evaluative personal information about oneself to others. It may include thoughts, feelings, aspirations, goals, failures, successes, fears and dreams as well as your likes, your dislikes, what you are good at and what you may need to work on.

As you explore this, it provides a foundation and opportunity to understand feelings, which you may have stuffed inside or you acted out on in the past and it may be causing you physical or emotional harm. Additionally, as you work through this stage you will get opportunities to practice the skills that you are developing.

Goals:

1. Consistently practice and demonstrate accountability and trust stage goals.
2. Learning who you are and how your decisions affect and hurt others.

3. Accept responsibility for your actions and how they affect other people's lives.
4. Call RAPs frequently. Talk to the group about past feelings that have influenced how you treat others and your personal relationships. Utilize the ABC's of problem solving, any fears, concerns, thoughts or problems that arise.
5. Continue to show care and concern to other people including your treatment team, group members, family and teachers.
6. Complete all assignments you have been assigned, based on your own personal therapeutic needs and individual treatment plan.
7. Explore and utilize healthy coping skills that will assist in handling all types of situations in the facility and in the community.
8. Continue to disclose any information that seems to affect how you or others treat yourself and others.

Responsibilities:

1. Practicing and utilizing all stage one requirements and assisting other group members to learn more appropriate coping skills.
2. Continue to develop care and concern for yourself and your group.
3. Consistently assists group members with inappropriate behaviors by calling RAPs.
4. Making positive contributions to the group by helping and showing care and respect to all treatment team members, group members and teachers.
5. Calling RAPs to discuss your feelings and thoughts on a more consistent basis.
6. Has developed trust with your group and group has developed trust in you.
7. Is beginning to make plans for transition into life after treatment.
8. Beginning to work with treatment team on identifying appropriate placement to live upon discharge from the program.
9. Utilizing appropriate coping skills to handle problems, feelings, and thoughts in an appropriate manner. Taking accountability for mistakes on a consistent basis.
10. Preparing rules and consequences for home visits.
11. Continues to carry journals and make entries according to individual's needs.

Privileges / Limitations:

1. Any youth needing in-patient chemical dependency treatment will be considered for such on this stage depending upon attitude and behavior. Any individual returning from in-patient chemical dependency treatment will continue where they left off upon return from treatment.
2. You will be allowed to carry up to \$5.00 to be spent at your discretion.
3. You are limited to TV programming that does not include any provocative or sexual material.
4. Picture taking is limited to family and friends.
5. Magazine and newspaper privileges may be considered with purpose and content.
6. Decorations in rooms will be considered after group recommendation and treatment team approval.
7. Attending public school and extracurricular activities will be considered upon appropriate request and will be based on attitude, academic performance, completion of drug and alcohol treatment and motivation within the group process.

8. You must attend public school to be in consideration for participation in extracurricular activities.
9. On occasion, you may have day visits or overnight visits in town prior to going to in-patient chemical dependency treatment if approved by group and treatment team.
10. You are allowed to have radios in your room and may be used upon approval from group and staff.
11. The first two home visits are limited to Friday, beginning after group meeting, to Sunday at a time determined by treatment team but no later than 4 pm. Home visits must be approved by group and treatment team. (Special considerations can be made for situations including, but not limited to holidays, funeral leave, or other special family occasions).
12. Day passes outside of city limits may be allowed if approved by treatment team.
13. Additional items may be kept in your room. (Ex. Books, cards, etc.)
14. Outside AA will be considered for youth that have completed in-patient treatment. Participation in Outside AA must be approved by group and treatment team.
15. Other privileges may be considered when you are progressing towards the end of stage 2 should these privileges be of benefit to your overall treatment.

Expectations:

1. You are expected to continue to follow Stage 1 expectations.
2. You are expected to continue role modeling appropriate behavior for other clients should this behavior not occur, you can be dropped to Stage 1.
3. You will be expected to teach new group members program responsibilities, stages, goals and expectations.
4. You are expected to show stage two competency prior to asking for Stage 3. You can show competency by demonstrating consistency, holding yourself and other equally accountable, meeting more treatment plan objectives, and using healthy coping skills instead of acting out.

RESOCIALIZATION- STAGE THREE

The final and last stage of the program is to help you in adjusting back into the community. You do this by becoming more aware of the outside issues, situations and relationships, which may lead to negative choices. This stage is to help you in developing better knowledge and abilities to meet your own basic needs without hurting yourself or others. In discovering ourselves, we are able to understand how to make realistic and healthy decisions and choices. Through this process of making decisions, you need to be able to look at what did work in your past combined with your new skills and move forward.

Goals:

1. Consistently practice and demonstrate goals from previous stages.
2. Demonstrate ability to control your behavior and impulses.
3. Apply your knowledge through increased opportunities to participate in community, family or social events.
4. Consistently show how you can use your new skills through your positive leadership within the group by helping and assisting other members with making better decisions.

5. Display assertiveness while still showing care and concern for your peers, staff, teachers and others.
6. Demonstrate consistently your readiness to transition on with your life in a healthy manner.

Responsibilities:

1. Continue to follow all responsibilities from Stage 2.
2. Develop aftercare plans for future placement, academic or vocational training.
3. Preparing for home visits through development of a Rules and Consequences Contract to go over with parent/guardian/custodian and sign.
4. Looking at potential options for continued counseling, seeking out venues to attend AA meetings in the community in which you are planning to reside.
5. Additional responsibilities will be considered as you demonstrate the ability to apply skills you have acquired through completion of stages.
6. Through consultation with your group and treatment team, you may request for your release.

Privileges / Limitations:

1. You should follow all other privileges and limitations from stage 2.
2. You will be allowed to carry up to \$10.00 to be spent at your discretion.
3. You may request outings with individuals in the community with authorization from treatment team.
4. Three (3) visits a month may be considered based on your individual treatment needs.
5. You may be considered to go for a twenty (20) minute off-ground walk, once per day.
6. You may request to go for a twenty (20) minute walk, twice per day on Saturday and Sunday, once per shift.
7. You may be considered to go to your bedroom or study unsupervised upon approval from group and treatment team.
8. You, upon request, will be considered on this stage to attend and walk to your church of choice or your scheduled appointments. (Ex. Dentist, haircut, etc.)
9. You may request to utilize thirty (30) minutes of TV/PS4 time in the visitation room once per week.
10. You will receive one extra ten (10) minute phone call per week.
11. You may request to bring homework up to sides to do during intervention times.

Expectations:

1. You are expected to continue to follow Stage 1 and 2 expectations.
2. Continue to demonstrate positive leadership qualities and coping skills. You will continue to share your knowledge in assisting other youth in learning appropriate ways to handle problems (mentoring and role modeling for other clients).

INFORMATION REQUIRED FOR ADMISSION CONSIDERATION

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

- **APPLICATION FOR ADMISSION:** please complete the application for admission including the names and telephone numbers required.
- **AUTHORIZATION FORM:** indicating approval or denial for photographs to be taken.
- **MEDICAL CONSENT FORM:** during a youth's stay at Our Home, Inc. It may be necessary for him/her to receive medical attention. We are, therefore; asking that you cooperate with us in reference to five important areas:
 1. We ask that each youth receive a physical examination prior to placement and that the examination form be completed and signed by a doctor unless otherwise arranged with the Program Coordinator.
 2. State law requires that students must be current with all immunizations. **Please furnish complete immunization records.**
 3. Medical consent form must be completed. If the youth is entitled to any medical assistance, include the appropriate Title XIX number for proper insurance information and forms.
 4. The referring agency must provide Our Home, Inc. with a copy of the youth's dental and eye examinations and current status of youth's work needed.
 5. Proof of second MMR immunization.

ADDITIONAL INFORMATION NEEDED:

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

OUR HOME, INC.
PRTF / PARKSTON

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

Referral Agent:

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

The below list should include:

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

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

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

Thanks for you cooperation!



Agency:

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

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

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

C. FAMILY

Mother's Information:

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Work # _____

Email Address _____

Mother's Occupation: _____

Father's Information:

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Work # _____

Email Address _____

Father's Occupation: _____

Children	Age	Living in home or elsewhere
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

List those persons with whom contact might be detrimental to youth: _____

Parent's Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____

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

Has child received professional counseling? Yes _____ No _____

By whom? _____

D. HEALTH

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

Name of medication _____

Prescribed by _____ Date _____

Name of youth's physician _____

Address _____ Phone _____

Date of last physical examination _____

Immunizations (**copy attached**) allergies _____

Name of youth's dentist _____

Address _____ Phone _____

Date of last dental examination _____

Date of last eye examination _____

E. EDUCATION

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

Last grade completed successfully _____ Date _____

Current grade placement _____ Last school attended _____

Address _____

What is youth's attitude toward school? _____

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

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

F. RELIGION

Denomination _____

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

CHECKLIST OF POSITIVE PEER CULTURE PROBLEMS

(Check those that apply to youth)

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

COMMENTS:

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

Dear Parent/Guardian:

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

Telephone days and hours will be:

- a) Group Star has telephone calls on Mondays from 6:00 p.m. to 8:00 p.m., on Thursdays from 6:00 p.m. to 8:00 p.m., on Fridays from 6:00 p.m. to 8:00 p.m. and on Saturdays from 12:30 p.m. to 8:00 p.m. and Sundays from 12:30 p.m. to 8:00 p.m.
- b) Group Independence has telephone calls on Tuesdays from 6:00 p.m. to 8:00 p.m., on Thursdays from 6:00 p.m. to 8:00 p.m., on Fridays from 6:00 p.m. to 8:00 p.m. and on Saturdays from 12:30 p.m. to 8:00 p.m. and Sundays from 12:30 p.m. to 8:00 p.m.
- c) Group Phoenix has telephone calls on Mondays from 6:00 p.m. to 8:00 p.m., on Wednesdays from 6:00 p.m. to 8:00 p.m., on Thursdays from 6:00 p.m. to 8:00 p.m. and on Saturdays from 12:30 p.m. to 8:00 p.m. and Sundays from 12:30 p.m. to 8:00 p.m.

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

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

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

Respectfully,



Jade Hamilton
Program Coordinator

OUR HOME, INC.
FAMILY QUESTIONNAIRE

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

SUBSTANCE USE:

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

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

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

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

Describe: _____

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

Describe the change: _____

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

Describe incidents: _____

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

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

MENTAL AND PHYSICAL HEALTH

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

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

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

EDUCATION

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

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

FINANCES

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

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

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

FAMILY

1. Describe any family problems affecting the child: _____

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

3. Does any other members of the child's family have a history of substance abuse/dependence?

Yes _____ No _____ Describe: _____

RELIGION

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

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

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

Please instruct the youth to bring along these items:

CLOTHING: The clients are given 1 laundry day a week. Please send enough clothing to last between washes. This includes underwear, socks, bras, shirts and jeans. Please remember that excessively baggy clothing is not allowed and will be placed in lock up until the client leaves. We will issue sweat pants if we have to confiscate clothing. We do not allow any cropped T-shirts, T-shirts with logos or inappropriate symbols.

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

DO NOT SEND:

Mouthwash

Radio

Personal CD player

Alcohol based aftershave

Perfumes

Jewelry

Any type of aerosol container (hairspray, etc.)

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

SUFFICIENT CLOTHING LIST

Youth's Name: _____ Date: _____

The following are recommended items to bring at the time of admission:

(10) Underwear _____ (10) socks _____

(6) Bras _____ Regular _____ Sport _____

(5) Jeans/ Sweat pants _____

(1) Dress pant _____ (1) Dress Shirt _____

(5) Shorts/ Capris _____

(5) Long sleeve shirts _____ (7) summer tops _____

Pajamas/robe _____

Swimsuit _____ Summer jacket/sweat _____

Tennis shoes _____ school/dress shoes _____

Winter Coat _____ Gloves _____ Hat _____

Other supplies:

Toothbrush/paste _____

Deodorant _____

Comb/brush _____

Shampoo/Conditioner _____

Body Wash/Soap _____

OUR HOME, INC.
MEDICAL CARE POLICIES AND PROCEDURES

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

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

Sleep Aid Consent
(4/18/2023)

As the parent/legal guardian of _____, I hereby
Name of Youth
authorize him/her to receive Melatonin or Tylenol PM, or any authorized generic or store
brand equivalents of, as a sleep aid in accordance with Our Home, Inc.'s Standing Medical
Orders.

Signature

Date

OUR HOME, INC.

FINANCIAL RESPONSIBILITY FOR MEDICAL COSTS

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

_____ DSS _____ DOC _____ Private

_____ Guarantor's Name

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

_____ Medicaid # _____

_____ Indian Health Services
Location _____

_____ Private Health Insurance ***NEED** a copy of Insurance Card
Insurance Company Name _____

Company Address _____

Insurance Company Telephone # _____

Policy # _____ Employer _____

Policy Holder Name _____

Address and Phone # _____

Policy Holder Social Security # _____

Policy Holder Birthday _____

MEDICAL CONSENT

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

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

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

Signed this _____ day of _____, 20_____.

Parent/Guardian Signature

Please Print Parent/Guardian Name

Referral Agent Signature



Administrator of Our Home, Inc.

IHS MEDICAL INFORMATION

Client's Name: _____

Date of Birth: _____

Degree of Blood: _____

Tribe Enrolled With: _____

Enrollment Number: _____

Mother's Name (Maiden): _____


Mother's Place of Birth: _____

Father's Name: _____

Father's Place of Birth: _____

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

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

FROM: Jade Hamilton 
Program Coordinator

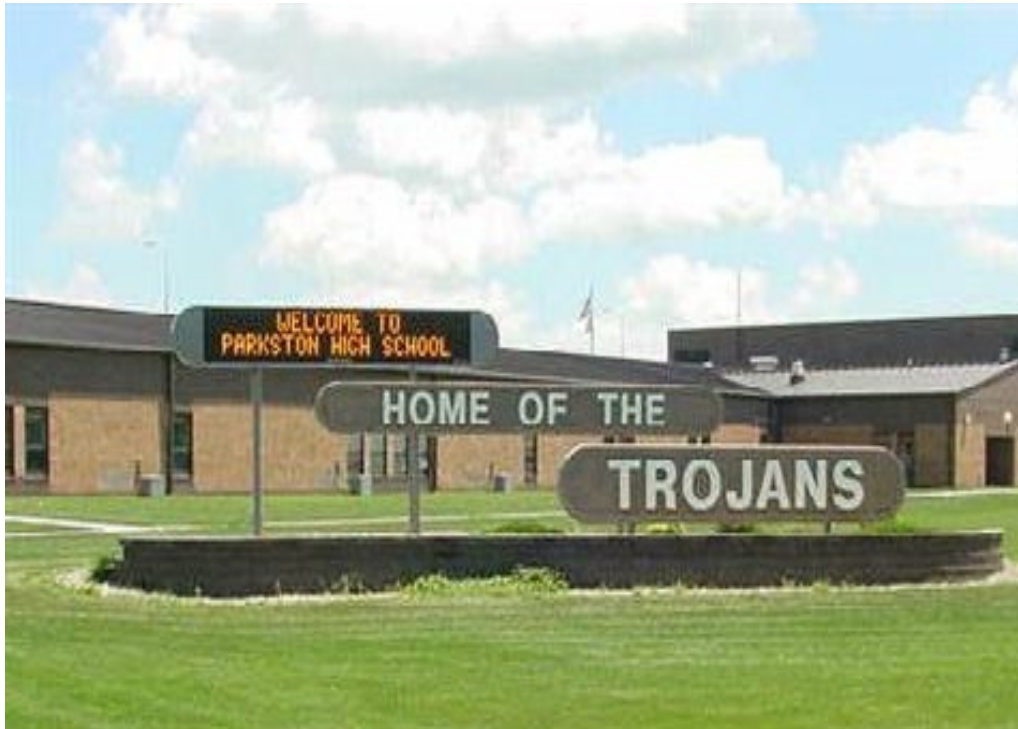
RE: School Records/Medical Records

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

ACCEPTED INTO THE PROGRAM WITHOUT THESE RECORDS.

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

I thank you in advance for your cooperation.



Parkston
School
District
Our Home
Inc. PRTF

Educational Responsibilities for Students Attending Our Home Inc. PRTF

Your child will be attending school at Our Home Inc. PRTF through the Parkston School District. The responsibilities below will provide more information regarding your child's educational program.

Parents

- complete necessary paperwork for enrollment
- inform resident district regarding current placement status
- attend parent teacher conferences (in person or by phone)
- attend annual IEP meeting
- contact resident district regarding IEP information and services
- contact Parkston School District teachers of current student progress

Resident District

- forward education records to Parkston School District

- maintain IEP paperwork while student is enrolled with Our Home Inc. PRTF
- pay tuition as applicable

Parkston School District

- communicate with resident district regarding student progress
- communicate with resident district regarding special education services
- assist resident district in maintaining IEP information by providing input for progress, goals and objectives
- maintain report card and other educational records
- notify resident district of applicable tuition rates

Our Home Inc. PRTF

- when allowed, share educational information with Parkston School District teachers
- provide educational support to students through study times in the residential setting



Our Home Inc. PRTF

Jade Hamilton, Program Coordinator
jhamilton@ourhomeinc.org
 103 W Maple Street
 Parkston SD 57366
 Phone (605) 928-7907
 FAX (605) 928-7910
<http://www.ourhomeinc.org/>

Parkston School District 33-3

Cole Knippling, High School Principal
Cole.Knippling@k12.sd.us
 Kay Weber, Special Education Teacher at Our Home Inc. PRTF
Kay.Weber@k12.sd.us
 102 A South Chapman Drive
 Parkston SD 57366
 Phone (605) 928-3368
 FAX: 605) 928-4032
www.parkston.k12.sd.us

Parkston School District #33-3

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

SUPERINTENDENT: PAT MIKKONEN
BUSINESS MANAGER: CRAIG BRUENING

PRINCIPAL: ERIC NORDEN

CONSENT FOR MEDICAL TREATMENT

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

Dated this _____ day of _____, 20__ .

Parent's Signature

CONSENT OF CHILD

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

Dated this _____ day of _____, 20__ .

Student's Signature

**STUDENTS: INTERNET AND ELECTRONIC MAIL ACCEPTABLE USE
POLICY**

**PARKSTON PUBLIC SCHOOL ACCEPTABLE 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 _____

SECLUSION AND PERSONAL RESTRAINT

(revised 5/23/17)

Policy

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

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

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

Procedures

I. Notification of program policy.

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

II. Admission Assessment for Potential Seclusion or Restraint

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

III. Determining the Need for and Implementing Seclusion or Restraint

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

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

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

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

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

V. Medical Treatment for Injuries Resulting from Seclusion or Restraint

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

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

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

VI. Facility Reporting

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

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

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

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

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

VIII. Post Intervention Debriefings

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

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

IX. Treatment Plan Review

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

X. Education and Training

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

XI. Room Requirements

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

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

XII. Performance Improvement

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

XIII. Plan to Minimize Use of Seclusion and Personal Restraint

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

XIV. Annual Review

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

Contact Information

State Medicaid Agency

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

- or -

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

State-designated Protection Organization

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
South Dakota Advocacy Services
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: 303-844-7048

SECLUSION AND PERSONAL RESTRAINT CONSENT FORM

(7/1/07) (revised 8/23/07, 1/11/08)

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

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

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

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

CONSENT

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

(Full Name of Resident)

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

Parent/Guardian

Date

Placement Agency Representative

Date

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

TO: Referral Agencies and the parent/guardian

FROM: Jade Hamilton, Program Coordinator 

RE: Consent Form

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

Thank you for your cooperation.

CONSENT

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

_____ (Name of Youth in Full)

and being resident of the city of _____

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

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

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

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

residency and activities at Our Home, Inc.

Signed this _____ day of _____, 20 _____


Parent/Guardian

Referral Agency Representative

OUR HOME, INC., Parkston\PRTF

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

TO: Referral Agencies and the Parent/Guardian

FROM: Jade Hamilton 
Program Coordinator

RE: Release of Information Form

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

Thank you for your cooperation.

**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

CONSENT FORM FOR DRUG AND ALCOHOL URINALYSIS

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

(Full Name of Juvenile)

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

Referral Agency Representative

Date

Or

If privately placed –Parent/Guardian

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

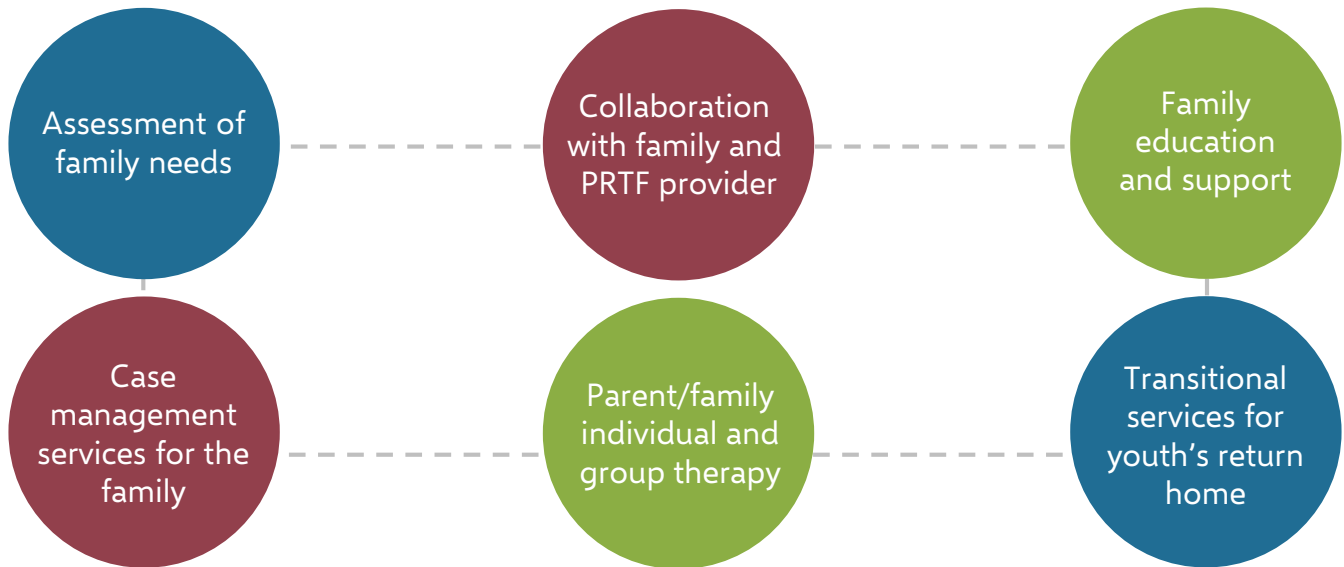
Please Print Parent/Guardian Name

INTENSIVE FAMILY SERVICES

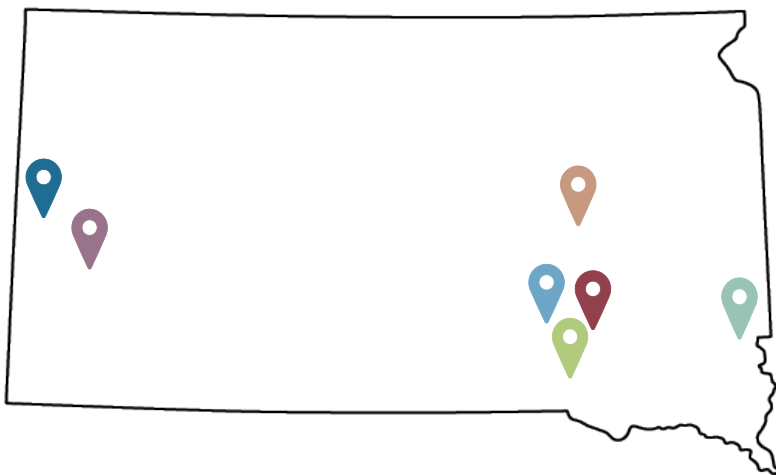
Primary goals of Intensive Family Services:

- Support parents and families of youth in residential placement
- Support successful reunification of the youth into their family
- Reduce the likelihood of youth returning to a residential placement

Services include:



Residential Locations:



- 📍 Abbott House, Inc.
Mitchell, SD (female only)
- 📍 Aurora Plains Academy
Plankinton, SD
- 📍 Children's Home Society of South Dakota-Black Hills
Rapid City, SD
- 📍 Canyon Hills Center
Spearfish, SD
- 📍 Our Home, Inc.
Parkston, SD
- 📍 Our Home, Inc.
Huron, SD (male only)
- 📍 Summit Oaks Center
Sioux Falls, SD
- 📍 Children's Home Society of South Dakota-Sioux Falls
Sioux Falls, SD

Community Mental Health Centers (CMHCs):

Behavior Management Systems
Rapid City, SD
(605) 343-7262

Brookings Behavioral Health and Wellness
Brookings, SD
(605) 697-2850

Capital Area Counseling Services, Inc.
Pierre, SD
(605) 224-5811

Community Counseling Services
Huron, SD
(605) 352-8596

Dakota Counseling Institute
Mitchell, SD
(605) 996-9686

Human Service Agency
Watertown, SD
(605) 886-0123

Lewis & Clark Behavioral Health Services
Yankton, SD
(605) 665-4606

Northeastern Mental Health Center
Aberdeen, SD
(605) 225-1010

Southeastern Behavioral HealthCare
Sioux Falls, SD
(605) 336-0510

Southern Plains Behavioral Health Services
Winner, SD
(605) 842-1465

Three Rivers Mental Health and Chemical Dependency Center
Lemmon, SD
(605) 374-3862