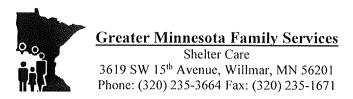
GREATER MINNESOTA FAMILY SERVICES - SHELTER CARE (GMFS/SC) AGREEMENT January 1, 2017 – December 31, 2018

	June 1, 2017	December 31, 2010	
The		Agency, (hereinafter referred	to as Agency) places and is financially responsible for
***************************************	(recipient) while placed at	GMFS/SC, 3619 SW 15th Avenu	e, Willmar, MN 56201, as of
The Ago	The state of the s	ment agreement. a specific statement as to the leg	al status of the child, and whom or which agency has
2.	legal custody of the child. GMFS/SC shall, within five (5) working days following the last day of name of child served; 2) number of days of service with daily rate (the	f each calendar month, submit an unit cost is \$201.99/day for days	invoice to the Agency. The invoice shall contain: 1) s 1-7 and \$192.92/day for days 8 and after); and 3) tota
3.	cost of providing services. The Agency shall, within thirty (30) calendar days of the date of receip GMFS/SC for the total cost of services incurred by the resident. Any f between the recipient and the Agency and will not involve GMFS/SC. payments relative to the recipient's medical, psychological, psychiatric medical insurance.	ot of the invoice, make payment of inancial arrangements or obligati	firect for services. The Agency is responsible to ions on the part of the recipient's parents will be
4.	Insurance Company Co-pays for client's medical/medications will not lead Contractor shall, within ten (10) working days following the last day of medical/medication needs not covered by the client's Medical Insurance day of each calendar month, submit on a standard invoice, the cost incubave Medical Insurance, to the Agency.	f each calendar month, submit on the to the Agency. The Contractor turred by the Contractor for any cl	a standard invoice the cost for any client's shall, within ten (10) working days following the last lient's medical/medication needs, when clients do not
5.	GMFS/SC shall inform the Agency within one (1) working day when the working day between GMFS/SC and the Agency as to how long the recthe Agency within five (5) working days.	he child is absent from GMFS/SC cipient's bed shall be held. All ve	C. Mutual agreement shall be reached within one (1) orbal communications must be confirmed in writing by
6. 7.	GMFS/SC shall provide the Agency and the child's family with information. The Agency must allow access to GMFS/SC the following information a. Social history on child and family; b. Results of recent psychological and/or psychiatric evaluations:	in writing at the time of placen	nent:
9. 10.	c. Results of physical examination which has been given within the d. Medical health problems (including names of physician last seen e. Educational data (IEP, achievement scores, and special program f. Child health insurance information (medical assistance number/og. Out-of-home placement plan; h. Court order or voluntary placement agreement. At the time of placement, the Placing Worker shall complete admission fast to sign the necessary consent forms (if parents are unavailable, the child's If GMFS/SC is requested y the referring Agency to transport residents to sincluded in the per hour costs. The Agency agrees to pay full per diem costs to GMFS/SC in the event the for respite visits or pre-placement visits to another facility. The child is correferring Agency.	t, family doctor, dentist, opticial (s); card, parent's health insurance ce sheet, provided by GMFS/SC. guardian/Placing Worker shall sistaffings, hearings, medical/theral (at a child is given home visits.)	n, and specialist); //policy number); The parents shall be present at the time of placement ign the consent forms). py appointments, or court appearances, they will be the Agency will not pay per diem costs to CMES/SC
	GMFS/SC Representative	Date	
	Placing Agency Representative	Date	CONTRACTOR OF SECTION AS A SECT
H. 7	The Agency agrees to contract the following additional services: (The foll within thirty (30) calendar days of the date of receipt of the invoice, with part of the invoice of the in	lowing service fees are in addition payments made directly to GMFS Masters	n to per diem charges and payment must be received 5/SC) Doctorate
	Psychological Evaluation	\$82.16/hr	\$96.00/hr
	Family Based Assessments (Done in the home by a professional counselor)	\$82.16/hr	
	Family Based Counseling	\$55.96/hr	
	Family Based Life Skills	\$42.36/hr	
	Family Based Counseling Family Based Life Skills Transportation to and from placement by		
	practitioner	\$32.00/hr	
	Interpretative services (if available) One-on-one aide for high-risk youth	\$50.00/hr	
	Urine Analysis	\$21.22/hr \$45.00/UA	
	Other county requests	\$43.00/OA	
	practitioner Interpretative services (if available) One-on-one aide for high-risk youth Urine Analysis Other county requests Rule 25 CD Assessments	\$130.00	
	GMFS/SC Representative	Date	
	Placing Agency Representative	Date	***************************************
12. T	The Agency does not wish to contract for additional services.		
	GMFS/SC Representative	Date	
	Placing Agency Representative	Date	The state of the s



Shelter Care Runaway Disclaimer

It should be understood that the Greater Minnesota Shelter Care Facility located at 3619 15th Ave. SW, Willmar, MN 56201 is **NOT** a locked facility nor are its staff members authorized to physically stop a resident from running away from the Shelter Care facility, unless the child is in immediate danger to himself/herself or others

infinediate danger to infinsent fiersen of others.	
I,(Parent/Guardian)	, parent/guardian of
(Parent/Guardian)	
(Resident)	
acknowledge that the Greater Minnesota Family Service facility and will not be held responsible for the health at they were to run from the facility located at 3619 15 th . Shelter Care program is also not responsible for a child program staff while on an off-site outing. This includes injured after running away from the facility and/or staff type of unlawful act after running away from the facility	and welfare of the above named resident if Ave. SW, Willmar, MN 56201. The I who chooses to run away from the s, but is not limited to, a child becoming I members or the child committing some
Shelter Care program staff, at the time a runaway has be Kandiyohi County Sheriff's Department to inform there be considered for discharged at that point and will not facility until he/she has been placed and observed in a shours.	n that a child is missing. The resident may be allowed to return to the Shelter Care
Re-admittance into the Shelter Care program will be be re-admit or not.	ased on the Shelter Care team's decision to
Parent/Guardian	Date:
Referring Worker	
Shelter Care staff	Date:

Date:



Greater Minnesota Family Services

Greater Minnesota Family Services	Application for Services
Client Number Date Services Began	GMFS Staff Name
Legal Name of Client: Last First	Race:
Address: Number/Street/Route T	own/City State Zip
County of Residence:	TYPE OF SERVICE REQUESTED:
Date of Birth:	(Initial & Date)
SSN: Male _ Female Telephone: Home:()	1 Diagnostic Assessment / / 2 Family Based Services / / 3 School Mental Health / / 4 Early Childhood FBS / /
Work: ()	5 HCBS / /
Cell: ()	6
Who Referred You to GMFS? Self 2 Family/Friend	8 FGDM / / 9 Connections / / 10 Shelter Care / / 11 Shelter Care FBS / / 12 Psychiatric Services
Party Responsible for Payment (PLEASE CHECK ONE):	
COUNTY OF RESIDENCE	Client Authorization for Third Party/Other
COUNTY: DIFFERENT THAN COUNTY OF RESIDENCE:	Payment Claims: I request that payment for services received from Greater Minnesota
GRANT/INSURANCE	Family Services (GMFS) be made directly to GMFS. I authorize GMFS to release to the aforementioned third party payor(s) diagno-
☐ PRIMARY INSURANCE	scs, dates, type and provider of service(s) regarding myself and/or
COMPANY	my dependents for the purposes of processing a claim. This authori-
PHONE #	zation expires one year from the date signed. I understand that I may revoke my consent at any time except to the extent that GMFS has
MEMBER I.D. # POLICY/GROUP #	already disclosed data.
POLICY HOLDER DOB	
SECONDARY INSURANCE	Signature of Client or Legal Guardian Date
COMPANY	
PHONE #	I, the Undersigned, Confirm that:
MEMBER I.D. #	I am willing to receive these services. I have been offered a copy of the Notice of Privacy Practices, Client's Rights and Responsibilities,
POLICY/GROUP#	and use of Email Policy
POLICY HOLDERDOB	
	Signature of Client or Legal Guardian Date
Reason for Referral (check one): Prevent Placement of Chi	ildren Supportive Services Other Reunification
Legal Custody Status of Children: Both Parents or Name of Cus	



Greater Minnesota Family Services
Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

For Office Use C	Only:
Date of Arrival:	**********
Time of Arrival:	****************

Admissions Face Sheet

Resident's Name;	Last	First	pot programa A vilgos Annocessos	Middle	uniter describe de grande apprise de la colonia de la colo
Resident's Nicknames:	بالمراجع والمراجع	در د	ndy allendrichten, wer der der deprinante der selb ander delpe deutsche der senten der selber der der der der	aphys desperandythensissery with	
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Home Phone:	Work	Phone:		Cell Phone:	and the state of t
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Medications:	************************************	Antonio de Perentanto de La Julius			
Prior Placements:	native and an account of the control	******************************	-		
Resident's Place of Birth:					
Languages spoken/written:		industrial promitting and the control of the contro			
Tribal Affiliation:		المعارضة والمعارضة و	may the form of the form of the square property.		
Last Educational Setting:	School Name:		·····		
	Address:				
	Phone:				
	Contact Person:				
Spiritual / Religion:	Resident:	gið í deinfresti í fleið þríði dir elleri fresti en	Family:	Annual transport and the property and the state of the st	······································
Physical Custody:	O Mother & Father	□ Mother Only	[] Father Only	Other	
Legal Custody:	D Mother & Father	D Mother Only	D'Father Only	D Other	
Visitation Rights:	□ Mother & Father	☐ Modier Only	□ Father Only	Other	
Upcoming Appointments: _					k and all replace of a little in the control of the



AUTHORIZATION FOR RELEASE OF INFORMATION
Social Worker
Circular Minnesola Family Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

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all Gr	eater Minnesota Family Serv	ices staff and	(Social Worker	a
	•		(Sovial Worker	's Agency)
		& de andre in the second and seco		
*********	(Mailing Address)		(Phone)	(Fax)
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waretarkele	(Social Worker's	Name)	-	
o:	Disclose	Obtain From	Exchange With	
X_	Insurance and Billing Info Psychological, Psychiatric Reports and Consultations	Evaluations/Reports; M	edical Reports Including History	and Physical
	_ Family and Social History		_ Academic/School Transcripts	
*****	Treatment Plan, Discharge Social Service Information	Summary	Court/Probation Information Other	
	-	Vianary physical		
unac	isianu mat me imornation to t	e opiainea may monude	Chemical Dependency Informati	ion.)
	To Effect a Continuum of (Evaluation/Treatment Financial Billing	Care For The Client's Re	covery	
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X X HIS A	Evaluation/Treatment Financial Billing Per Client Request UTHORIZATION FOR RELIGIONARY Lunderstand that this authorization to ATTN: Data Privacy Officer, Greekfire this revocation shall not be a provides my insurer with the right to Lunderstand than authorizing the distoractive services unless the service disclosure to a third party (i.e. consult understand that I have the right to I understand that I have the right to I	EASE OF INFORMATION TO THE PROPERTY OF THE PRO	ON IS VALID UNTIL: one year ninated, whichever occurs first his authorization remains in effect unless 5, P.O. Box 1810, Willmar MN 56201. 1 denstand that the revocation will not applicate. Oluntary, I can refuse to sign this author of provided solely for the purpose of creates of freath information disclosed under:	furthermore: It is specifically revoked by written notice understand that any information refersed by to my insurance company when the land ization. I need not sign this nutherizationing protected health information for this outherization.
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AUTHORIZATION FOR RELEASE OF INFORMATION
Probatton Officer
Greater Minnesota Fentily Services - Shelter Care
3619 SW 15th Avenue, William, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

I,			the state of the s		hereby authorize
	(Reside	nt's Name)		(Date of Birth)	
all Grea	der Minucsota Family Servi	ces staff and			st
			(Probatio	on Officer's Agency)	
	a adaman ya anang 18 amin'a kataman danan kataman kataman kataman kataman kataman kataman kataman kataman kata man	markater en la faction de la company			
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	(Probation Officer's	r (vaine)			
To:	Disclose	Obtain From	Exchange	With	
*	Insurance and Billing Infor Psychological, Psychiatric Reports and Consultations Family and Social History Treatment Plan, Discharge Social Service Information	Evaluations/Reports; Me	dical Reports Including Academic/School Trac Count/Probation Information Other	nscripts mation	
(I unders	stand that the information to b	e obtained may include C	hemical Dependency li	nformation.)	
THIS At whon Gi	To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request ITHORIZATION FOR RELI reater Minnesota Family Se I understand that this authorization at to ATTN: Data Privacy Officer, Gre- before this revocation shall not be a provides my insurer with the right to to receive services unless the service diedocure to a third party (i.e. consu- I conderstand that I have the right to I understand that I have the right to I unde	EASE OF INFORMATIO rvices' services are term may be revoked at any time. Thater Minnesota Family Services breach of confidentiality. I undo contest a claim under my policelosure of this information is we are court-ordered or are to be situations). Inspect and receive photo copie organization that reactives the in 191, 1996, the information descents about disclusive of my heal is authorization is as effective as	N IS VALID UNTIL: o littated, whichever occurs authorization remains in eff. P.O. Box 1810, Wilmar MN erstand that the revocation winy. I can refuse to sign to provided solely for the purpose of health information disclosuformation is not a health can this authorization and thinformation. I can contact of	urs first, furthermore feet unless it is specifically in \$620). I understand that as il not apply to my insurance his outhorization. Unced no see of orating protected heal and under this authorization, provider or health plan control by the re-closed and no longer freater Minnesots Family S.	evoked by written notice by information released company when the law t sign this authorization the information for reced by federal privacy or protected by the same crylecs! Privacy Officer.
Signatur	.6a;				
Residen	t			Date	_1
	was represented the state of the contract of the state of				
Parent/C	Guardian			Date	



AUTHORIZATION FOR RELEASE OF INFORMATION
Medical Advisor
Greater Minneson Family Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

Ц			hereby author	rize
	(Resident's Name) (Date	e of Birth)		
all Great	er Mianesota Family Services staff and <u>Family Practice Medical Center</u> at <u>502 2</u>	nd St. SW. Wi	llmar MN 562	OL
Phone:	320-231-8888			
Fax:	320-231-8602			
Contact:	All FPMC staff			
To:	Disclose Obtain From Exchange With			
	Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History Reports and Consultations Family and Social History Academic/School Transcripts Treatment Plan, Discharge Summary Court/Probation Information Social Service Information Other			
(I underst	and that the information to be obtained may include Chemical Dependency Information	on.)		
_ <u>x</u>	nation requested/exchanged is needed for the following purpose(s): To Effect a Continuum of Care For The Client's Recovery Evaluation/Treatment Financial Billing Per Client Request THORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: one year to	from the dute	of signature, or	•
when Gre	ater Minnesota Family Services' services are terminated, whichever occurs first,	furthermore:	!	
to be properties of the proper	understand that this authorization may be revoked at any time. This authorization remains in effect unless in ATTN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Willmar MN 56201. It after this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply avides my insurer with the right to contest a claim under my policy. I can refuse to sign this authorizing the disclosure of this information is voluntary. I can refuse to sign this authorize receive services unless the services are count-ordered or are to be provided solely for the purpose of creating solecute to a third party (i.e. consultations). Independent to a third party (i.e. consultations). Independent to third party (i.e. consultations). Independent to third party (i.e. consultations). Independent to the individual or organization that receives the information is not a health care provider of guilations under Public Law #104-191, 1996, the information described in this authorization may be re-clost detail regulations. If I have questions about disclosure of my health information, I can contact Greater Min photocopy or the simile copy of this authorization is as effective as the original. I also give my permitsion estimile as well as the United States Postal Service.	understand that any to my insurance of zation. Inced not ing protected health als authorization. or health plan cover sed and no longer panesota Family Ser mesota Family Ser	y information release company when the le sign this authorization information for ared by federal priva- protected by the sam vices' Privacy Office	od atv on cy
Signature	ız en			
Resident		Date	.	~~~
Parent/Gu	ardian	Date	.11	**********



AUTHORIZATION FOR RELEASE OF INFORMATION
Prescribing Physician
Greater Minnesota Family Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

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all Gre	nter Minnesota Family Ser	vices staff and			
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<u> </u>	mation requested/exchanged To Effect a Continuum of (Care For The Client's Re	covery		
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AUTHORIZATION FOR RELEASE OF INFORMATION
Primary Clinic
Greater Minnesota Family Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

(Primary Physician's Name)	Fax)
(Mailing Address) (Phone) (I (Primary Physician's Name) To: Disclose Obtain From Exchange With x Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History and Physical Reports and Consultations Pamily and Social History Academic/School Transcripts	
(I'rimary Physician's Name) To: Disclose Obtain From Exchange With k Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History and Physical Reports and Consultations Pamily and Social History Academic/School Transcripts	Fax)
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Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History and Physical Reports and Consultations Pamily and Social History Academic/School Transcripts	
Social Service Information Other	
(I understand that the information to be obtained may include Chemical Dependency Information.)	mages
Financial Billing Per Client Request THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: one year from the date when Greater Minnesota Family Services' services are terminated, whichever occurs first, furthermost to ATIN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Wilbuar MN 56201. I understand that before this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply to my insurant provides my insurer with the right to contest a claim under my policy. 2. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this outhorization. I need a to receive services unless the services are const-ordered or are to be provided solely for the purpose of creating protected be disclosure to a third party (i.e. consultations). 3. I understand that I have the right to inspect and receive photo copies of health information disclosed under this authorization 4. I understand that if the individual or organization that receives the information is not a health care provider or health plan or regulations under Public Law #104-191, 1996, the information described in this authorization may be re-closed and no long federal regulations. If have questions about disclosure of my health information, I can contact Greater Minnesota Family 5. A photocopy or fuestmile copy of this authorization is as effective as the original. I sloo give my permission to exchange in facsimile as well as the United States Postal Service.	re; y revaked by written notice any information rolessed are company when the law are sign this authorization with information for an avered by federal privacy ger protected by the same Services' Privacy Officer.
Signatures:	
Resident Date	
Parent/Guardian Date	



AUTHORIZATION FOR RELEASE OF INFORMATION
Pharmacy
Greater Minnesona Femily Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

L		·	_ hereby authori	ize
	(Resident's Name) (D	ute of Birth)		
ull Great	er Minnesota Family Sorvices stuff and <u>Thrifty White Drug</u> at <u>1600 First St. S</u>	W. Willmar, MI	<u> 56201</u>	
Phone:	320-235-1930			
Fax:	320-235-7801			
Contact:	All Thrifty White Drug staff			
To:	Disclose Obtain From Exchange With			
***************************************	Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including Histor Reports and Consultations Family and Social History Treatment Plan, Discharge Summary Social Service Information Other	is Y		
(I underst	and that the information to be obtained may include Chemical Dependency Informa			
THIS AUT	nation requested/exchanged is needed for the following purpose(s): To Effect a Continuum of Care For The Client's Recovery Evaluation/Treatment Financial Billing Per Client Request THORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: one yea atter Minnesota Family Services' services are terminated, whichever occurs fire	r from the date st, furthermore	of signature, or	
10 be pro 2. It is	anderstand that this authorization may be revoked at any time. This authorization remains in effect unle ATTM: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Willmar MN 56201, force this revocation shall not be a breach of confidentiality. I understand that the revocation will not approvides my insurer with the right to contest a claim under my policy, moderstand that authorizing the disclosure of this information is volumary. I can refuse to sign this authorized that authorizing the disclosure of this information is volumary. I can refuse to sign this authorized that party (i.e. consultations), anderstand that I have the right to inspect and receive photo copies of health information disclosed understand that if the Individual or organization that receives the information is not a health care provide galations under Public, Law #104-191, 1996, the information described in this authorization may be received regulations. If I have questions about disclosure of any health information, I can contact Grenter be photocopy or fleximile copy of this authorization is as effective as the original. I also give my permissioning as well as the United States Postal Service.	I understand that an ply to my insurance orization. I need not caling proteoted healt a this authorization. or or health plan coveries and no longer finnesots Family Ser	y information released company when the law sign this authorization information for ered by federal privacy protected by the same rvices' Privacy Office	i n y
Siguatures	K.			
Resident		_ Date		
Parent/Gu	ardian	Dute	.	



AUTHORIZATION FOR RELEASE OF INFORMATION General

Greater Minnesota Family Services - Shelter Care 3619 SW 15th Avenue, Willmar, MN 56201 Phone: (320) 235-3664 Fax: (320) 235-1671

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		terest and the contract of	(Organization)	***************************************
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îo:	Disclose	Obtala From	Exchange With	
X_	_ Insurance and Billing Info	rmation		
	Psychological, Psychiatric	Evaluations/Reports; M	edical Reports Including History as	id Physical
	Reports and Consultations Family and Social History		Academic/School Transcripts	
	Treatment Plan, Discharge	Summary	Court/Probation Information	
***************************************	Social Service Information	***************************************	Other	***************************************
onder	stand that the information to I	se obtained may include	Chemical Dependency Information	
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	mustion requested/exchanged			
	To Effect a Continuum of t	Care For The Client's Re	covery	
-X-	Evaluation/Treatment Financial Billing			
	Per Client Request			
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IA SIF	ITHORIZATION FOR RELI	LASE OF INFORMATION	ON IS VALID UNTIL: one year fr	om the date of signature, or
nen G	reater Minnesota Family Se	rvices' services are terr	ninated, whichever occurs first, f	urthermore:
	I understand that this authorization i	may be revoked at any time. T	his authorization remains in effect unless it	is specifically revoked by written notic
3 .		itee Minnesota Family Service	s, P.O. Box 1810, Willmar MN 56201, Jun	derstand that my information released
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	before this revocation thall not be a provides my insuce with the right to	contest a claim under my poli	cv.	
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Greater Minnesota Family Services
Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

Activity Waiver
(Informed Consent and General Waiver)

I hereby authorize	to participate in any trips,
(Resident)	
events, community service and skills learning groups, and/o GMFS team. These include, but are not limited to: cleaning recreational activities; and events which require travel in an	g and maintenance; water, letsure and
l,(Purent/Quardian)	agree for participant, myself, my heirs,
executors, administrators, successors and assigns that neither nor any of its officers, members, agents, representatives, no implied or otherwise, or any personal injury, or death, or proor loss suffered or sustained by me/participant named above activities of GMFS or sponsored or supervised by GMFS.	r employees shall be those for any negligence
Further, for participant/myself, my heirs, executors, administration assume all risk whatsoever of personal injury or death or proinconnection with any or all activities engaged in by me/pa supervised by GMFS and I absolve and release GMFS, its cand/or employees from all liability and covenant and agree GMFS on account of any personal injury or death or proper express intention and purpose to waive any potential claim from any activity sponsored, supervised or participated in b and purpose to bind participant/myself, my heirs, executors waiver and assumption of risk.	operty damage, medical expense or other loss cricipant named above and sponsored or officers, members, agents, representatives, not to sue or prosecute any claim against ty damage or loss of any kind. It is my for any liability arising or claimed to arise by GMFS and it is further my express intent
Not withstanding any expiration date of any other consent of with this waiver or otherwise, this waiver is intended to be specifically revoked.	or waiver which may be signed concurrently permanent and shall remain in offect unless
If signing as a parent, natural guardian, appointed guardian represent and warrant that I possess the full legal authority ward, conservatee, or other person.	, or in any other representative capacity, I to enter this agreement on behalf of my child,
Parent/Guardian	Date:
Resident	Date:
Shelter Care staff	Date:



Greater Minnesota Family Services
Shelter Care
3619 SW 15th Ayenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

Consent to Monitor Incoming & Outgoing Communications

I,, parent/guardi	an of
(Rosident)	
hereby authorize Greater Minnesota Family Services Shelter Care staff m incoming and outgoing correspondence of said minor, under the laws of t	
This authorization shall remain in effect so long as the said minor is in the care, and control of Greater Minnesota Family Services Shelter Care prog	
Parent/Guardian	Date:
Shelter Care staff	Date:



Greater Minnesota Family Services
Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

Information Needed Prior To Admission

Resident's Na	me:	White Probability's Halo Resu	A deret from the property of the second of t
Gender:	M	F	
Race:		······································	-
Height:	***************************************		-
Weight:	***************************************		-
Eye Color:		- The Strick country of the principle of the spine of the	-
Tattoos:		Phy Charles are are a surprised again	
Piercings:	***************************************		
Date of Last Pl	hysical	Exam:	
Primary Physic			
Primary Clinic	:	**************************************	
Address:		dayah da da da bayas a	

Phone:		-	
Fax:		************	
والإنجاب والمعارض وا	and other families	The product and production in	1887年 1887年 1888年 18884 18884 18884 18884 18884 18884 18884 18884 18884 18884 18884 18884 18884
Prescribing Phy	/sician	•	
Clinic:			
Address:			
Phone:			
Fax:			
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Greater Minnesota Family Services
Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

## Consent for Medical Treatment

I,		, parent/guardian of						
	(Parent/Guardian)	k V						
	(Resident)	(Date of Birth)						
Minnesota Fa anesthetic, or under the gen	amily Services Shelter Care staff mer surgical diagnosis; for treatment and	t for said minor. I hereby authorize Greater obers to consent to any x-ray examination; I hospital care, to be rendered to said minor advice of a physician or surgeon duly						
minors referri from Greater to release to t	I also authorize GMFS to provide whatever therapy or psychological testing requested by said minors referring agent at the time of admission. I request that payment for all services received from Greater Minnesota Family Services (GMFS) be made directly to GMFS. I authorize GMFS to release to third party payor(s) diagnoses, dates, type and provider of service(s) regarding myself and/or my dependents for the purposes of processing a claim.							
	I also authorize GMFS Shelter Care staff to administer medication to the said minor as directed and prescribed by a duly licensed physician or surgeon.							
I am willing b	I am willing to receive these services. I have received a copy of the Notice of Privacy Practices.							
	ation expires one-year from the date of time except to the extent that GMF	signed. I understand that I may revoke my S has already disclosed data.						
Parent/Guardi	an	Date:						
Shelter Care s	taff	Date:						
Primary Insur	ance:	Secondary Insurance:						
Company Phone Member ID Policy/Group Policy Holder Date of Birth		Company Phone Member ID Policy/Group Policy Holder Date of Birth						

			DHS-4258 (1-0:
Informed Consent	INDIVIDUAL		10
Form for Psychotropic	DATE (MM/D	D/YYI	CONSENT EXPIRATION (MM/DO/YY)
Medication(s)	BHAZICIVM	to provide the transport of the related to a recommendation of a provide students of which a commen	CASE MANAGER
Psychotropic(s)	t	e the second	mendikan di dengan mengan mengapan pengan pengan pengan pengan bang bang bang bang bang bang bang
Current Proposed Generic name:		Generic name:	Proposed
Trade name:  Dose:		Trade name: Dose:	and the same statement of the same statement
Maximum dose:	mg/day mg/day		mg/day
Roure:	- •	Route:	
Current Proposed Generic name:	awah-mangang untung planapapapahan Al		
Trade name:			tarkaniyanda kiya da malanda ya da da qayayaya aya aya aya da maatanda ya ahkanda aya da aya hari aya da aya d
Dose:  Maximum dose:			
Route:			
Oral Communication  No, could not reach Yes:	1 1	side-effects(	mation including possible  The control of the contr
☐ Telephone on ☐ Meeting on	_//_	Not provide	
Person to contact for questions or co			rinesia (TD)(*)
NAME		Present	☐ Not present
ADDRESS			hle to the psychotropic and case
			sact side-effects and/or TD forms
CITY STATE Z	QP	provided:	
TELEPHONE			
( )			
The following information has been listed and written information has be 1. The reasons for the medication(s)	explaine een provi	d about the psychological ded about:	otrapic medication(s)
<ol> <li>A description of the behavior/condition in</li> <li>The rate and intensity of the behavior/cond</li> <li>The benefits of the medication(s)</li> <li>The alternative therapies available</li> </ol>	specific obs dition	servable and measurable	e terins
6. The risks including possible side-effects and 7. Specific aspects of the medication(s) such a 8. The fact that I may refuse consent, or, if give 9. The fact that my consent expires in one year.	is name, dos ve, that I m	se, maximum dose, rou ay change my mind at	
10. The names, addresses, and phone numbers			risc.
Based upon the above (Check one):	·	Comments:	
I approve the use of the psychotropic(s) list I do not approve the use of the psychotropi I only approve as follows (specify in comm	ic(s) listed.		
SIGNATURE DA	VE		
verse		*** ***********************************	

# Greater Minnesota Family Services - Shelter Care

3619 SW 15th Ave. Willmar, MN 56201 Phone: 320-235-3664 Fax: 320-235-1671

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		intake / Di	scharge	Medicat	Intake / Discharge Medication Inventory				
	Resident		D.O.B.				and the second s		
Rx Number	Prescribing Physician	Medication Name	Size	Dosage	Times Given	Form	Container Type	Intake Amount	Intake Amount Discharge Amount
					- Service of the serv	Manufactor de La Constitución de L			
							·		
	Intake Responsible Party:		Time:	·			Date:		
Intake She	Intake Shelter Care Staff Member:		Time:	,			Date:		
Disch	Discharge Responsible Party:		Time:				Date:		
Discharge She	Discharge Shelter Care Staff Member:		Time:				Date:		
l acknowledge the consistent and sy child.	acknowledge the above containers and their content of medication that I am providing to Shelter Care for my child at the time of their intake e consistent and accurate with what is printed on the labels. I give permission to Shelter Care staff to administer the above medications to y child.	eir content of medication ted on the labels. I give	n that I ar e permissi	n providir on to She	ng to Shelter Care	e for my c administe	thild at the time of the rabove medication	eir intake ons to	
acknowledge th	l acknowledge that my child has no medications at the time of their intake.	tions at the time of thei	r intake.						
give GMFS She	l give GMFS Shelter Care staff permission to administer Acetaminophen 325mg caplets (1-2 caplets) to my child, as needed.	to administer Acetamin	ophen 32	5mg capl	ets (1-2 caplets) t	o my chil	d, as needed.		
arent / Guardian signature:	n signature:						Date:		

## SHELTER CARE PROGRAM 3619 SW 15TH STREET WILLMAR MN 56201

## PHYSICIANS CONSENT TO ADMINISTER ROUTINE STANDING ORDERS

over the counter med	dications can be administered PRN as	nelter Care Program. Please verify that the following Standing Orders.
	ROUTINE STAND	ING ORDERS
over the counter medicat	tion. Also the client's physician will be contact client's condition changes significantly. Any	otified before or 24 hours after the administration of any PRN cted if the following orders do not result in relief of symptoms a standing order that is used regularly for over 5 clays will be
1. Ointment for treat	tment	8. HC Cream 0.5%
Triple Antibiotic (	Dintment TID PRN	Up to TID PRN for itch
A & D	TID PRN	op to the real tool
Vicks	TID PRN	9. Debrox/Murine
	•	3-4 drops to affected ears B ID X 4 day
2. Analgesics	1 · · · · · · · · · · · · · · · · · · ·	The second of th
	1-2 tabs q 4-6 hours PRN for relief of	
Ibuprofen 200 n	ng 1-2 tabs q 4-6 hours PRN for relief	of temporary pain
	ng 1-2 tabs q 4-6 hours PRN for relief	
3. Anti-diarrheal		11. May substitute liquid meds for tabs
3. Anti-diarrheal Pepto-Bismol 2	Tbsp q. 2-3 hours PRN	11. May substitute liquid meds for tabs  May crush meds if dosage allowed
3. Anti-diarrheal Pepto-Bismol 2		11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless
3. Anti-diarrheal Pepto-Bismol 2 7 Kaopectate Cond	Tbsp q. 2-3 hours PRN	11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD
<ol> <li>Anti-diarrheal Pepto-Bismol 2 7 Kaopectate Conc</li> <li>Laxative</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN	11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless
<ul> <li>3. Anti-diarrheal Pepto-Bismol 27 Kaopectate Cond</li> <li>4. Laxative MOM 15-20 cc da</li> </ul>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days	11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN
<ul> <li>3. Anti-diarrheal Pepto-Bismol 27 Kaopectate Conc</li> <li>4. Laxative MOM 15-20 cc da Dulcolax Supp 10</li> </ul>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care</li> </ul>
<ul> <li>3. Anti-diarrheal Pepto-Bismol 27 Kaopectate Conc</li> <li>4. Laxative MOM 15-20 cc da Dulcolax Supp 10</li> </ul>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Cond</li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN nily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Conc     </li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Conc     </li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN nily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment,</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Conc     </li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Conc     </li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex         Cough Drops, Cou     </li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily spectorants ugh Syrup with out Alcohol base	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape Small Ulcer: cleanse with sterile</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2         Kaopectate Cond</li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex         Cough Drops, Cou</li> <li>Antacid</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily spectorants ugh Syrup with out Alcohol base	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape Small Ulcer: cleanse with sterile saline solution, apply ointment,</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2 7         Kaopectate Cond</li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex         Cough Drops, Could</li> <li>Antacid         Maalox 1-2 tsp TI</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily spectorants ugh Syrup with out Alcohol base	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape Small Ulcer: cleanse with sterile saline solution, apply ointment, cover with band aid/telfa</li> </ul>
<ol> <li>Anti-diarrheal         Pepto-Bismol 2 7         Kaopectate Cond</li> <li>Laxative         MOM 15-20 cc da         Dulcolax Supp 10         May hold laxative</li> <li>Antitussives &amp; Ex         Cough Drops, Coud     </li> <li>Antacid         Maalox 1-2 tsp TI         Antacid Tablet 1-2</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily spectorants ugh Syrup with out Alcohol base	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape Small Ulcer: cleanse with sterile saline solution, apply ointment, cover with band aid/telfa Transparent Dressing QID PRN</li> </ul>
<ol> <li>Anti-diarrheal Pepto-Bismol 27 Kaopectate Conc</li> <li>Laxative MOM 15-20 cc da Dulcolax Supp 10 May hold laxative</li> <li>Antitussives &amp; Ex Cough Drops, Cou</li> <li>Antacid Maalox 1-2 tsp TI Antacid Tablet 1-2</li> <li>RID-Head-Lice T</li> </ol>	Tbsp q. 2-3 hours PRN c. 1-2 Tbsp q 4 hours PRN aily PRN for 1-2 days mg daily PRN if loose stools, evaluate daily spectorants agh Syrup with out Alcohol base D PRN 2 tabs QID PRN	<ul> <li>11. May substitute liquid meds for tabs May crush meds if dosage allowed Generic drugs may be used unless Specified by MD Artificial Tears 1 gtt QID PRN</li> <li>12. Basic Skin Care May use OTC lotions/ointments for Dry skin Skin Tears: cleanse with sterile solution, apply ointment, Band aid, telfa pad &amp; tape Small Ulcer: cleanse with sterile saline solution, apply ointment, cover with band aid/telfa Transparent Dressing QID PRN for-skin-breakdown/nurse</li> </ul>

### FORM 23005

### Greater Minnesota Family Services 513 GW 5TH Street, Willmar MN 56201 Minnesota Provider Notice of Privacy Practices EFFECTIVE DATE OF THIS NOTICE: 04/14/2003

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge And Legal Duty To Protect Health Information About You.

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information, including:

We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.

We must notify you about how we protect your health information.

- We must explain how, when and why we use or disclose your health information.
- " We may only use or disclose your health information as we have described in this Notice.

We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices, make copies available to you upon request and post the revised Notice on our website.

### USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

There are a number of purposes for which it may be necessary for us to use or disclose your health information. For some of these purposes, we are required to obtain your consent. In other specific instances, we may be required to obtain your individual authorization. And in a limited number of circumstances, we will be authorized by Law to disclose your health information without your consent or authorization. Following is a description of these uses and disclosures.

- A. Uses and Disclosures of Your Health Information for Purposes of Treatment, Payment and Health Care Operations.
  - Health Care Treatment. We may use or disclose health information about you to provide and manage your health care. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use or disclose health information about you when you need a prescription, lab work, an x-ray, or other health care services.

Appointment Reminders and Other Contacts. We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.

Payment. We may use or disclose your health information to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The Information on, or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

- Health Care Operations. We may use or disclose health information about you to allow us to perform business functions. For example, we may use your health information to help us train new staff and conduct quality improvement activities. We may also disclose your information to consultants and
- other business associates who help us with these functions (for example, billing, computer support and transcription services).

### Minnesota Patient Consent for Disclosures.

For some of the disclosures of health information described above, we are required by Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law.

B. Uses and Disclosures of Your Health Information that Require Your Opportunity to Agree or Object.

In the following instances we will provide you with the opportunity to agree or object to our use or disclosure of your health information:

Persons Involved in Your Care. We may, using our best judgment, disclose to a family member, other relative, close personal friend or any other person identified by you, health information relevant to that person's involvement in your care or payment related to your care.

Notification to Others. We may, in some instances, disclose health information about you to a family member, a personal representative, or another person responsible for your care, in order to notify such person about your current location or general condition.

### Uses and Disclosures Authorized by Law.

Under certain circumstances we are authorized by Law to use or disclose your health information without obtaining a consent or authorization from you. These may include when the use or disclosure is:

- Required by Law. We will disclose your health information when such disclosure is required by federal, state or local laws.
- * Necessary for public health activities. For example, when reporting to public health authorities the exposure to certain communicable diseases or risks of contracting or spreading a disease or condition.
- Related to victims of abuse and neglect. For example, when reporting suspected victims of abuse or neglect.
- For health oversight activities. For example, when disclosing health information to a state or federal health oversight agency so that they can appropriately monitor the health care system.
- For Judicial and administrative proceedings. For example, when responding to a request for health information contained in a court order.
- For law enforcement purposes. For example, when complying with laws that require the reporting of certain types of wounds or injuries.
- To a Coroner of Medical Examiner. To allow them to carry out their duties.
- To avert a serious threat to health or safety. For example, when disclosing health information that will help prevent a serious threat to the health or safety of you or another person of the public.
- Related to specialized government functions. For example, we may disclose health information about you if it relates to military and veterans' activities or national security.
- Related to Workers' Compensation. For example, when reporting health information to entities that
  provide benefits for work-related injuries and illness.
- · Related to correctional institutions. And in other custody situations.
- D. Uses and Disclosures of Your Health Information that Require Your Authorization.

  Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

### YOUR INDIVIDUAL RIGHTS

Right to Access and Copy Your Health Information.

You have the right to access and receive a copy or a summary of your health information contained in clinical, billing and other records that we maintain and use to make decisions about you. We ask that your request be made in writing. We may charge a reasonable fee. There might be limited situations in which we may deny your request. Under these situations, we will respond to you in writing, stating why we cannot grant your request and describing your rights to request a review of our denial.

- B. Right to Request an Amendment of Your Health Information.
- You have the right to request amendments to the health information about you that we maintain and use to make decisions about you. We ask that your request be made in writing and must explain, in as much detail as possible, your reason(s) for the amendment and, when appropriate, provide supporting documentation. Under limited circumstances we may deny your request. If we deny your request, we will respond to you in writing stating the reasons for the denial. You may file a statement of disagreement with us. You may also ask that any future disclosures of the health information under dispute include your requested amendment and our denial to your request.
- C. Right to Request Restrictions on Uses and Disclosures of Your Health Information.
  You have the right to request that we restrict our use or disclosure of your health information. We ask that your request be made in writing. We are not required to agree to your request for a restriction, and we will notify you of our decision. However, if we do agree, we will comply with our agreement, unless there is an emergency or we are otherwise required to use or disclose the information.
- Right to Request Confidential Communications.

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you in a specific way or at a specific location. For example, you may request that we contact you at your work address or phone number or by email. We ask that your request be made in writing. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests.

Right to Request and Accounting of Disclosures of Health Information.

You have the right to request a listing of certain disclosures we have made of your health information. We ask that your request be made in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). We will provide you one accounting in any 12-month period free of charge.

F. Right to Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time. We will make this Notice available in electronic form and post it in our web site.

If you have any questions about these rights or to exercise any of them please contact our Privacy Office listed below.

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If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Office. If you are concerned that your privacy rights have been violated, you may file a complaint with our Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.										
Contact information for Privacy I	Official:									
Greater Minnesota Family Se										
ATTN: Data Privacy Office										
513 SW 5 th Street										
Willmar MN 56201										
Phone: 320-214-9692 ext 101	Fax: 320-214-9924	e-mail: gmfs@greaterminnesota.org								

### Form 23005 Greater Minnesota Family Services 513 5th Street SW, Willmar, MN 56201

# Acknowledgment of Receipt of "Notice of Privacy Practice"

Resident's Name:
This is to acknowledge receipt of a copy of Greater Minnesota Family Services' "Notice of Privacy Practice" with an effective date of 04/14/03.
Resident's Name (printed):
Resident's Name (signed):
Date:
Legal Representative's Name (printed):
Legal Representative's Name (signed):
Date:
Capacity or Authority of Legal Representative*:
*May be requested to provide verification of representative status.
For Office Use Only
We made the following efforts to obtain written acknowledgment of receipt of the "Notice of Privacy Practices":
However, acknowledgment could not be obtained because:  Individual refused to sign Communication barriers prohibited obtaining the acknowledgment An emergency situation prevented us from obtaining acknowledgment Other (please specify):



Greater Minnesota Family Services
Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

## **Approved Contacts**

	Reside	nt's Na	me		*********************		
Namer				Phoue:			Relationship to Rosident:
	O Phone	C Mai	On-site Visite	Otf-site Visits	C Home	Visits	The same of the sa
	ii Yes	E) No	Must have worker	approval prior to visit	⊕ Yes	D No	Must have parenuguardian approval prior to visit.
aule:	~			Phonet			Relationship to Residents
	□ Phone	🗓 Moi	I I On-site Visits	COAssite Visits	O Home	Visit	
	⊕ Ү⇔	(† No	Must have worker a	aproval prior to visit	D Yes	i) No	Must have parent/guardian approval prior to visit.
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me:	7 64	m e e =		Phone:			Relationship to Resident:
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w:	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			Phone:			Relationship to Resident:
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ne:				Phone:			Relationship to Resident:
ŗ	Phone	C Maû	On-site Visits	COM-site Visits	C'Home V	/isitu	
f	3 Yes	C No	Must have worker op	proval prior to visit	3 Yes	II No	Must have parent/guardian approval prior to visit.
		l am gi	ving pennission	for the above peo	ple to ha	ve conti	oct with my child and Shelter Care staff.
		Parent/	Guardian				Date:

# New Discoveries Montessori Academy

1000 Fifth Avenue SE Hutchinson, MN 55350 320.234.6362 (phone) 320.234.6300 (fax) info@newdiscoveries.org * www.newdiscoveries.org



For Students age 9-12 o		APPLICATION	D. G.	rade ontacted	Enrolled Waiting List In itials
Student Name					
Last		First			Middle
AddressStreet		City	S	tate	Zip Code
SCHOOL most recently attended	d (date) & GRADE			•	
Name(s) of previous school(s) a					
Parent/Guardian Informa					
I. Name			Phone		
Last	First		***************************************		
AddressStreet		City	St	ate	Zip Code
Email Address	· · · · · · · · · · · · · · · · · · ·	_ Other Conta	ict Numbers	S	
Occupation	Location	W	ork Phone		
I. Name			Phone		
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Street		City	St	ate	Zip Code
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Occupation	Location	W	ork Phone		
Sibling(s)					
***************************************	School Attending _	***************************************		(	Grade
	School Attending _			(	Grade
	School Attending _			(	Grade
Other:					
Parent/Guardian Signature					

Date

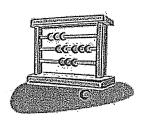
# New Discoveries Montessori Academy 1000 5th Ave SE

Hutchinson, MN 55350

Ph: 320-234-6362 Fax: 320-234-6300

www.newdiscoveries.org Executive Director: David Conrad MARSS: Tara Erickson

For Students age 9-12 only



## Request for Student Records

I authorize		Former School		
		City, State and Zip Code		
	Phone		Fax	Andrew Control of the
	vard all information including imm S I.D. number and Early Childhoo			nfo, Special Education
Student Nan	ne	Grade	Birthdate	
Student Nan	ne	Grade	Birthdate	Andre to a terrorismon abusaya
Student Nan	ne	Grade	Birthdate	NACONAL CONTROL CONTRO
I understan child(ren).	d that this information will be use Thank you.	ed in a confidential and profess	ional manner in the bes	t interest of the
	Signature of Parent of	Guardian	Date '	



# Home Language Questionnaire ED-01336-08E

The following is to be completed by School District Personnel:

STUDENT IDENTIFICA	ATION INFORMATION
Student's Full Name	Section 1 and 1110 and 112 and 122 and 123 and 124 and 125 and
_Date Of Birth Age	Grade Level
	The state of the s
	ERIFICATION INFORMATION
School name New Discoveries Montessori	Academy District number 461-07
and the second s	
I hereby verify that the above information is true a	nd accurate to the best of my knowledge and belief,
David L. Co	phrad
Name (	
Dunat Course	Executive Diversor
Signature – Responsible Authority	Title Date
The following is to be comp	COLUMN TO THE ADMINISTRATION OF THE STREET STREET, THE STREET STREET, THE STRE
STUDENT LANGUA	GE INFORMATION
Dear Parents and Guardians: In order to help your child learn, your child's teachers need Please respond to the questions below by checking the ap	
1. Which language did your child learn first?	☐ English ☐ Other (specify)
<ol> <li>Which language did your child learn first?</li> <li>Which language is most often spoken in your home</li> </ol>	
3. Which language does your child usually speak?	☐ English ☐ Other (specify):
1	
	A Company of the Comp
PARENT/GUARDIA	AN INFORMATION
The second secon	
I hereby verify that the above information is true a	nd correct to the best of my knowledge and belief.
a a	
Name (I	Printed)
Classic Paral (C.	dian Dul
Signature – Parent/Guar	dian Date

# New Century Academy

1000 5th Ave SE

Hutchinson, MN 55350

Phone:

(320) 234-3660

Fax:

(320) 234-3668

www.newcenturyacademy.com info@newcenturyacademy.com



Date
Grade
For Office Use



For Students age 13-17 only	STUDENT	APPLICATION

Student Name	Last First Middle
Street	
City, State, Zip	
	Home Phone
email	

NAME of last school attended	
DATE last attended	
GRADE and SCHOOL YEAR you are applying for to enter NCA	

	Parent / Guardian Information	
Parent/ Guardian Name (1)	Last First	
	EdSt FillSt	Relationship
Street		
City, State, Zip		
E-mail		
Home Phone	Cell Phone	
Employer		
Occupation	Work Phone	
Parent / Guardian		
Name (2)	Last First	Relationship
Street	and in the control of	en e
City, State, Zip		
E-mail		
Home Phone	Cell(Phone)	
Employer		
Occupation	Work Phone	

Student	Parent/Guardian
Signature	Signature

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For Students age 13-17 only				
REQUE	EST FOR RELEASE OF ST	UDENT RECOR	RDS	
Date:				
To:	,			
	Name of former school y	our child attended	<u> </u>	
Address of School:				
	Street	City	State	Zip
This student has an IEP?	Yes	No		
	Please release all student r	ecorde for		
	r rouse rerease an statement	ecords for.		
	Student First/Last N	ame		
Who ha	as registered to attend New	Century Academ	ıy	
Incl	ude the following information	on and send to:		
New Century	y Academy, 1000 5 th Ave SE	, Hutchinson, MN	<u> 1 55350</u>	
<ul> <li>ALL School Infor</li> </ul>				
<ul> <li>State MARSS Ide</li> </ul>	entification Number			

- Extra-Curricular Eligibility Status
- Attendance Records
- Health Records
- Standardized Test Results
- Psychological Services Reports
- Special Education Records (if applicable)

Thank you!

Parent / Guardian Name (Please Print)

Parent / Guardian Signature

New Century: A school that creates an inclusive community working together to support student achievement and a strong sense of self-worth.

New Century: Where students engage in critical thinking and teamwork, which empowers them toward life-long learning and global citizenship

# Minnesota Department of

# Educati@n

## Home Language Questionnaire ED-01336-08E

For Students age 13-17 only

The following is to be completed by School District Personnel:

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# RACE / ETHNICITY

Student Name:
RACE/ETHNICITY is used in federal and state civil rights and statistical reports. This is a nonscientific racial/ethnic designation as defined by the U.S. Department of Education. The manner of collection is described as follows in Minn. R. 3535.0120, Duties of District.
In order for New Century Academy to report the race/ethnicity of our students, please answer the following two questions:
Is the student Hispanic/Latino? (Choose only one with an "X")
No, not Hispanic/Latino
Yes, <b>Hispanic/Latino</b> (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)
The above part of the question is about ethnicity, <u>not race</u> . No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.
What is the student's race? (Choose one or more with an "X")
American Indian or Alaska Native (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment).
Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)
Black or African American (A person having origins in any of the black racial groups of Africa).
Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)
White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa.)
Parent/Guardian Date

# Computer Use Policy, 2015-2016

In order to use school computers and network resources, students must understand and agree to the conditions in this policy. Students and their parent(s)/guardian(s) must sign this form to acknowledge that they accept these terms before they will be allowed to use New Century computers. The use of computers and the Internet is a privilege, not a right. Any misuse or abuse of the conditions listed below will result in the loss of privileges.

- Computers are for academic purposes only. Any other activity is not allowed, including games, playing music, internet messaging, email, etc.
- Students may access the network only through their assigned student account.
   Students are not allowed to give out their passwords or allow others to use their account.
- Students are only allowed to print materials related to their class work or project work, and must receive permission from an advisor or educator before printing.
- Students must take proper care of the computers while they are using them. When
  finished, students must log off and leave the area in the same condition as when
  they arrived.
- Students are not allowed to download files or programs from the Internet.
- Students are not allowed to use the school computers unsupervised.
- Food and drinks are not allowed near any school computers or electronic equipment.
- Any form of vandalism is not allowed. This includes any malicious attempt to physically deface, disable, destroy, or 'hack' into computers or the network, or to harm or destroy data of another user.

Students who do not comply with the above conditions will have their privileges revoked for a time period determined by administration on a case by case basis. In cases of vandalism, students and their families will be responsible for any charges necessary for repair or replacement of the item, and there might also be legal consequences.

## **Acceptance of Computer Use Policy:**

I have read the Computer Use Policy. I understand the conditions listed in the policy, as well as the consequences for not following the policy. I agree to use the school laptops and computer network in a responsible, respectful manner.

Student Name (Please Print):	Grade:
Student Signature:	Date:
Parent/Guardian Signature:	Date:

Computer Use form 06/15



# MEDIA RELEASE & PERMISSION



I grant media release and permission to use my child's name and reproduction of physical likeness for the purpose of publicizing the program through pamphlets, video, newspaper, periodicals, etc. I also grant permission to use photos but not names on the school's web site.

I agree to let my child participate in the activities described.	
Name of Student	
Parent / Guardian	Date
FIELD TRIP RELEASE & PERMISSI	ON
I grant permission for my child to participate in local field trips (mavan/bus).	ay involve walking or riding
I understand that I will be informed in advance about each planned	trip.
Name of Student	
Name of Student  Parent / Guardian	Date
	Date
	Date
Parent / Guardian	not hesitate to seek proper
Parent / Guardian  MEDICAL EMERGENCY  In the event of an accident or sudden onset of illness, the school will care for any child. I understand that the school will attempt to contact and that the school may transport.	not hesitate to seek proper
Parent / Guardian  MEDICAL EMERGENCY  In the event of an accident or sudden onset of illness, the school will care for any child. I understand that the school will attempt to contact and that the school may transport my child to the nearest hospital of the school my permission to provide an authorize emergency medical	not hesitate to seek proper