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

	,						
The		Agency, (hereinafter referre	d to as Agency) places and is financially responsible for				
	(recipient) while placed at GM	FS/SC, 3619 SW 15th Aven	uc, Willmar, MN 56201, as of				
The Ago	ency and GMFS/SC agree to abide by the provisions outlined in this placemen	1 agreement					
Ĭ.	The Agency shall, by written communication, provide GMFS/SC with a splegal custody of the child.	ecific statement as to the le	- ·				
2.	GMFS/SC shall, within five (5) working days following the last day of eac name of child served; 2) number of days of service with daily rate (the unit cost of providing services.	h calendar month, submit a cost is \$201.99/day for day	n invoice to the Agency. The invoice shall contain: 1) is 1-7 and \$192,92/day for days 8 and after); and 3) tota				
3.	GMFS/SC for the total cost of services incurred by the resident. Any financial arrangements or obligations on the part of the recipient's parents will be between the recipient and the Agency and will not involve GMFS/SC. It is also our understanding, with prior written approval of the Agency, that vendor payments relative to the recipient's medical, psychological, psychiatric, dental, or optical care would be billed from the vendor to the Agency or recipient's medical insurance.						
4.	Insurance Company Co-pays for client's medical/medications will not be included as part of the unit cost for providing service to eligible clients. The Contractor shall, within ten (10) working days following the last day of each calendar month, submit on a standard invoice the cost for any client's medical/medication needs not covered by the client's Medical Insurance to the Agency. The Contractor shall, within ten (10) working days following the last day of each calendar month, submit on a standard invoice, the cost incurred by the Contractor for any client's medical/medication needs, when clients do not have Medical Insurance, to the Agency.						
5.	GMFS/SC shall inform the Agency within one (1) working day when the cl working day between GMFS/SC and the Agency as to how long the recipie the Agency within five (5) working days.	nt's bed shall be held. All v	erbal communications must be confirmed in writing by				
6.	GMFS/SC shall provide the Agency and the child's family with information	relative to the procedures a	at GMFS/SC.				
7.	The Agency must allow access to GMFS/SC the following information in v	vriting at the time of places	ment;				
	 a. Social history on child and family; b. Results of recent psychological and/or psychiatric evaluations; 						
	c. Results of physical examination which has been given within the last	year (if no recent phys. exa	am has been given, GMFS/SC will set up as necessary).				
	d. Medical health problems (including names of physician last seen, far	nily doctor, dentist, opticis	in, and specialist);				
	c. Educational data (IEP, achievement scores, and special programs);						
	f. Child health insurance information (medical assistance number/card g. Out-of-home placement plan;	, parent's health insuranc	e/policy number);				
	h. Court order or voluntary placement agreement.						
8. 1	At the time of placement, the Placing Worker shall complete admission face sl	neet, provided by GMFS/SC	. The parents shall be present at the time of placement				
!	to sign the necessary consent forms (if parents are unavailable, the child's gua	rdian/Placing Worker shall s	sign the consent forms)				
9. 1	If GMFS/SC is requested y the referring Agency to transport residents to staffi included in the per hour costs.	ngs, nearings, medicai/inera	apy appointments, or court appearances, they will be				
10. 1	the Agency agrees to pay full per diem costs to GMFS/SC in the event that a	child is given home visits. T	The Agency will not new nor diam costs to Charles				
	for respite visits or pre-placement visits to another facility. The child is considered	fered a resident of GMFS/S	C until date of official discharge as requested by the				
1	referring Agency.		and of others of our officers of the				
	GMFS/SC Representative	Date					
	O'M GOO TOP WOOMEN'S	Date					
	Placing Agency Representative	Date	And have been seen that the second and the second s				
н. 1	he Agency agrees to contract the following additional services: (The following	ra service fees are in additio	on to per diam charges and neumant				
	within thirty (30) calendar days of the date of receipt of the invoice, with payn	nents made directly to GMF	S/SC)				
		<u>Masters</u>	Doctorate				
	Psychological Evaluation	\$82.16/hr	\$96.00/hr				
	Family Based Assessments (Done in the home by a professional counselor)	\$82.16/hr					
		\$55.96/hr					
	Family Based Counseling Family Based Life Skills	\$42.36/hr					
	Transportation to and from placement by	*					
	Transportation to and from placement by practitioner Interpretative services (if available) One-one aide for high-risk youth	\$32.00/hr					
	Interpretative services (if available)	\$50.00/hr					
	One-on-one aide for high-risk youth Urine Analysis	\$21,22/hr \$45.00/UA					
	Urine Analysis Other county requests	\$40.00/QA					
	Rule 25 CD Assessments	\$130.00					
	GMFS/SC Representative	Date					
	Placing Agency Representative	Date					
12. T	he Agency does not wish to contract for additional services.						
į	GMFS/SC Representative	Date	····				
		-					
	Placing Agency Representative	Date					



Greater Minnesota Family Services

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

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 <u>NOT</u> 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.

physically stop a resident from running away from the Shaimmediate danger to himself/herself or others.	elter Care facility, unless the child is in
I,(Parent/Guardian)	, parent/guardian of
(Resident)	
acknowledge that the Greater Minnesota Family Services facility and will not be held responsible for the health and they were to run from the facility located at 3619 15 th Ave Shelter Care program is also not responsible for a child who program staff while on an off-site outing. This includes, but injured after running away from the facility and/or staff me type of unlawful act after running away from the facility at	welfare of the above named resident if SW, Willmar, MN 56201. The no chooses to run away from the ut is not limited to, a child becoming embers or the child committing some
Shelter Care program staff, at the time a runaway has been Kandiyohi County Sheriff's Department to inform them the be considered for discharged at that point and will not be a facility until he/she has been placed and observed in a seculours.	at a child is missing. The resident may allowed to return to the Shelter Care
Re-admittance into the Shelter Care program will be based re-admit or not.	on the Shelter Care team's decision to
Parent/Guardian	Date:
Referring Worker	Date:
Shelter Care staff	Date:



Application for Services

Greater Minnesota Family Services

Reason for Referral (check one): Prevent Placement of Children

Assessment Only

Legal Custody Status of Children: Both Parents or Name of Custodial Parent, Guardian, or Agency:

GMFS Staff Name Client Number Date Services Began Legal Name of Client: Address: Number/Street/Route Town/City State Zip TYPE OF SERVICE REQUESTED: County of Residence: (Initial & Date) Date of Birth: 1 Diagnostic Assessment SSN: _____ Male Female 2 Family Based Services 3 School Mental Health Telephone: Home:(_____) _____ 4 🔲 Early Childhood FBS __ ☐ HCBS __/__/_ Work: (_____) ____ 6 Day Treatment Cell: (_____) 7 Group Therapy Who Referred You to GMFS? 8 🗀 FGDM / / 1 Self 2 Pamily/Friend 9 Connections / 3 Other (Agency, Staff Person, and Phone): 10 Shelter Care Previous D.A. yes no if yes Agency Name 11 Shelter Care FBS 12 Psychiatric Services Party Responsible for Payment (PLEASE CHECK ONE): Client Authorization for Third Party/Other COUNTY OF RESIDENCE COUNTY: DIFFERENT THAN COUNTY OF RESIDENCE: Payment Claims: I request that payment for services received from Greater Minnesota Family Services (GMFS) be made directly to GMFS. I authorize GRANT/INSURANCE_____ GMFS to release to the aforementioned third party payor(s) diagno-PRIMARY INSURANCE ses, 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. # already disclosed data. POLICY/GROUP #_____ POLICY HOLDER____ _____ god____ Signature of Client or Legal Guardian Date ☐ SECONDARY INSURANCE COMPANY I, the Undersigned, Confirm that: PHONE # I am willing to receive these services. I have been offered a copy of MEMBER I.D. # the Notice of Privacy Practices, Client's Rights and Responsibilities. POLICY/GROUP #_____ and use of Email Policy POLICY HOLDER

Signature of Client or Legal Guardian

☐ Reunification

☐ Supportive Services

GMFS-01 8282013

Date

Other



For Office Use Only:
Date of Arrivel:
Time of Arrival:

Admissions Face Sheet

Resident's Name;	Last	Fire	······································	Middle	
Resident's Nicknames:					
Date of Birth:					
Address:		(Sity:	Sente:	Ζίφ:
Pareuts:			·····		
Address:			City:	State:	Zip:
Home Phone:	Work	Phone:		_ Cell Phone:	
Emergency Contact:				Phone:	
Severely Emotionally Dist	ubed diagnosis:			vice and a second of the secon	
Medications:	······································				
Social Security #:		Heath in	a, hlo:		
Physical Health Concerns:		**************************************			
Medications:		NAVIONALIA SI			
Prior Pincentente:		· · · · · · · · · · · · · · · · · · ·			
Resident's Place of Birth:					
Languages spoken/written:		- 			
Tribel Affiliation:			 		
Last Educational Setting:	School Name:				
	Address:				
	Phone:				
	Contact Person:				
Spiritual / Religion:	Resident:		Family:		
Physical Custody:	O Mother & Father	O Mother Only	(1) Father Only	D Other	
Logal Custady:	□ Mother & Father	D Moder Oaly	D'Fuster Only	[] Other	
Visitation Rights:	O Modier & Father	□ Modier Only	□ Father Only	O Other	***************************************
Upcoming Appointments: _				····	

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

all Greate	(Keside	nt's Ναισε)		(Date of l	3irth)
	r Minnesota Family Servi	ces staff and			G
	•		(Soc	ial Worker's Age	incy)
		•		•	
and who have the discould be the selection of the selecti	(Mailing Address)		(Phone)		(Fax)
	(Social Worker's	Name)			
To: _	Disclose	Obtain From	Exchan	ige With	
I	nsurance and Billing Information Psychological, Psychiatric I Reports and Consultations and Social History Creatment Plan, Discharge: Social Service Information	Evaluations/Reports; M	Academic/Schoot Coun/Probation In	Transcripts formation	
(I sendaretan	d that the information to be	ـــــــــــــــــــــــــــــــــــــ			
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	re this revocation shall not be a b	reach of confidentiality. I wa contest a claim water my poli	denstand that the revocation by:	i will not apply to in: ga this nuthorization.	nand thet any information released y insurance company when the lan- . I need not sign this authorization
before provide	ucive services unless the services losure to a third party (i.e. consult dervisued that I have due right to be dervisued that if the individual or o lations under Public Law #104-19	are court-ordered or are to butions). Appeal and receive placte copie rganization that receives the 11, 1996, the information des a about discineure of my hea authorization is as effective	e provided edely for the pu ≤ of health information dis information is not a health cribed in this authorization th information, I can conte	closed under this out care provider or beat may be re-closed on et Grenter Minnesot	herization. di plan covered by Ademi privacy d no longer protected by the same a Family Services' Privacy Office.
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beft prov 2. L w to re disa 3. L w 4. I w reg fede 5. A pl Ger Signatures:	derstand that authorizing the disci- ucive services unless the sorvices losure to a third party (i.e. consult derviand that I have die right to la derstand that I the individual or o lations under Public Law #104-1! rat regulations. If I have question lotocopy or facaimile copy of this inite as well as the United States	see court-ordered or are to butions). spect and receive pluote copic rganization that receives the 11, 1996, the information des a about disclosure of my hea sutborization is as effective. Pustal Service.	e provided edely for the pu es of health information dis information is not a health eribed in this authorization th information, I can conta is the original. I also give	closed under this out cure provider or beal may be re-closed in et Greater Mianesot my permission to exc	herization. di plan covered by Ademi privacy d no longer protected by the same a Family Services' Privacy Office.



AUTHORIZATION FOR RELEASE OF INFORMATION
Probation Officer
Greater Minnesota Family Services - Shelter Care
3619 SW 15⁴¹ Avenue, Willnur, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

T.			hereby authorize
(Re	sident's Name)		(Dute of Birth)
all Greater Minuesota Family S	ervices staff and		st
		(Probati	ion Officer's Agency)
(Mailing Address)		(Phone)	(Fax)
(Probation Office	er's Name)	and a	
To: Disclore	Obtain From	Exchange	With
x Insurance and Billing I Psychological, Psychia Reports and Consultati Family and Social Hist Treatment Plan, Discha Social Service Informa	tric Eveluations/Reports; Monts ory rge Summary	edical Reports Including Academic/School Tre Court/Probation Infor	anscripts rantion
(I understand that the information		Chemical Dependency I	uformation.)
when Greater Minnerota Family 1. I understand that this authorized to ATTN: Data Privacy Officer, befine this revocation shall not provides my insurer with the rig. 2. I understand that authorizing the to receive services unless the se disclosure to a third party (i.e. 3. I orderstand that I have the rig! 4. I understand that I have the rig! 5. I understand that I fave the right funderstand that if the individual regulations under Public Low #	of Care For The Client's Re ELEASE OF INFORMATI Services' services are ter four may be revoked at any time. Greater Minnerota Femily Servic the a becach of confidentiality. I a thin to contest a claim under my po a disclosure of this information is revices are court-ordered or are to rounsultations). a to inspect and receive photo cop al or organization that reactives th 104-191, 1996, the information de testions about disoluture of my he of this authorization is as offective	ON IS VALID UNTIL: a minerated, whichever not price to the subarization remains in e.e., EO. Bor, 1810, Wiltrar Madestand that the rovocation whiley, toluntary. I can refuse to sign be provided solely for the purpies of benith information diacter information is not a bealth can confided in this untorization with information. I can contact	first unless it is specifically revoked by written notice N 56201. I understand that say information colessed till not apply to any insurance company when the law this authorization. I need not sign this authorization one of creating protected health information for
Signatures:			
Resident			Date
Parcot/Guardian			Date 1



AUTHORIZATION FOR RELEASE OF INFORMATION

Medical Advisor

Greater Minnesona Family Services - Shelter Care
3619 SW 15th Avenue, Willmar, MN 56201

Phone: (320) 235-3664 Fax: (320) 235-1671

L		hereby authorize
(Resident's Name)	(Date of Buth)	
all Greater Minnesota Family Services staff and Family Practice Medical Center at	502 2nd St. SW, W	illman MN 5626X
Phone: 320-231-8888		
Fax: 320-231-8602		
Contact: All FPMC staff		
To: Disclose Obtain From Exchange W	1th	
x Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including H Reports and Consultations Family and Social History Academic/School Trans Treatment Plan, Discharge Summary Count/Probation Information Other		
Social Service Information Other		
(I understand that the information to be obtained may include Chemical Dependency Info	rmation.)	
The information requested/exchanged is needed for the following purpose(s): x		
THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: one when Greater Minnesota Family Services' services are terminated, whichever occur		
 I understand that this authorization may be revoked at any time. This authorization remains in effect to ATTN: Data Privacy Officer, Greater bitmesota Family Services, P.O. Box, 1810, Wilmar MN Schefore this revocation shall not be a breach of confidentiativy. I understand that the revocation will reprovides any locater with the right to contest a claim under my policy. I understand that authorizing the disclosure of this information is voluntary. I can orfuse to sign this to receive services unless the services are court-ordered or are to be provided society for the purpose disclosure to a third party (i.e. consultations). I understand that I have the right to inspect and receive photo copies of health information disclosed. I understand that if the individual or organization that receives the Information is not a health care pregulations under Public Law #104-191, 1906, the information described in this suthorization may be federal regulations. If I larve questions about disclosure of my health information, I can contact Green. A photocopy or facednile copy of this authorization is so effective as the original. I also give my perfaceinable as well as the United States Postal Service. 	tunions it is specifically or izot. I understand that an ant apply in my insurance suthorization. I need sol of creating protected healt under this authorization writer or health plan con or re-closed and no longer ater Minneson Family Se	evoked by written notice y information released company when the law sign this suthorization h information for cred by federal privacy protected by the same rvices' Privacy Officer.
Signatutes:		
Resident	Date	.11
Parent/Guardian	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

		dent's Name)		(Date of Birt	*-7
all Gr	eater Minnesota Family Ser	vices staff and		**************************************	
			(Presi	enbing Physician's Cli	n(c)
	(Mailing Address)		(Phone)		(Fux)
	(tamium Voquesa)		(rnone)		(rux)
	(Prescribing Physic	ian's Name)			
lo:	Disclose	Obtain From	Exch	ange With	
X	Insurance and Billing Inf Psychological, Psychiatri Reports and Consultation Family and Social Histor Treatment Plan, Discharg	c Evaluations/Reports; M s y e Summury	Academic/Schoo Court/Probation	ol Transcripts Information	
	Social Service Information	11	Other		
	Evaluation/Treatment Financial Billing Per Client Request UTHORIZATION FOR REI	ease of informati	ON IS VALID UNT	IL: one year from the	date of signature, or
HIS A	Sandar William and Thursday C			occurs ilest, lutilier	more:
HIS A chen G	I understand that this authorization to ATTM: Duta Privacy Officer, Or before this revocation shall not be provides my insurer with the right I understand that authorizing the disto receive services unless the servidisclosure to a third party (i.e. const understand that I have the right to understand that I have the right to understand that I have the right to cognitations under Public Low #104 federal regulations. If I have quest A photocopy or faceintile copy of I facrimile as well as the United Stat	may be revoked at any time. It could Minnesote Family Service a breach of confidentiality. I us to contest a claim under my polectionare of this information is a season or constructed or are to buildings). inspect and receive photo copie or organization that acceives the -191, 1996, the information does about disclosure of my kee his authorization is as effective his authorization is as effective	This nutherization remains. P.O. Box 1810, Wilms, addressing that the revocation, columns. I can refuse to be provided solely for the set of health information in not a beat matched in this sutherization, I can contain, I can contain.	is in effect tudens it is specific to the 36201. I understand from will ant apply to my fact sign this nutlentization. In purpose of creating protect this company to the third protect the ear provider on beating the man are provider of and no stact Carator Minuscole Fair	ically revoked by written notice that any information released urance company when the law end to sign this authorization of health information for eation, an covered by federal privacy longer protected by the same utily Services' Privacy Officer.
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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

(Reside	ail's Name)	(Date of	bereby authorize Birth)
	•	·	a c
nii Grenter Minnesota Family Servi	ICON KRII NIIG	(Resident's Primary Cl	inic)
			
(Muiling Address)		(Phone)	(Fax)
(Frinary Physician's	Naore)	-	
	Obtain From	Exchange With	
Reports and Consultations Pamily and Social History Treatment Plan, Discharge	Evaluations/Reports; M	edical Reports Including History and Academic/School Transcripts Court/Probation Information Other	
Social Service Information (I understand that the information to b			
X To Effect a Continuum of C X Evaluation/Treatment	is needed for the follow Pare For The Client's Re		
To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request THIS AUTHORIZATION FOR RELI when Greater Minnesota Family Set I understand that this subborization at to ATTN: Data Privacy Officer, Gres before this revocation shalt not be at provides any insurer with the right to 2. I understand that authorizing the dise to receive services unless the service disclosure to a third party (i.e. costs 3. I understand that if the individual or regulations under Public Law #104- federal regulations. If I have question	Care For The Client's Re GASE OF INFORMATION releas' services are term say be revoked at any time. I ster Minnerota Family Service treentes a claim under my pol- closure of this information is to attentions). Inspect and receive photo copi organization that receives the 191, 1936, the information der ms about disclosure of my has is authorization is a reflective	COVERY ON IS VALID UNTIL: one year from minated, whichever occurs first, fur this audiorization remains in effect vales it is s. P.O. Bux 1810, Wilmer MR 56201. I unde identical that the revocation will not apply to a	rtherniore: specifically tenaked by written outces mund that any information observed my insurance company when the law m. I need not sign this authorization notested health information for otherization. otherization otherization for protected by the same otherization for protected by the same otherization for protected by the same
To Effect a Continuum of C X Evaluation/Treatment X Financial Billing Per Client Request THIS AUTHORIZATION FOR RELE when Greater Minnesota Family Set 1. I understand that this authorization at to ATTN: Data Privacy Officer, Grea before this revocation shall not be a provides any insurer with the right to 2. I understand that authorizing the dia to receive services unless the service disclosure to a third party (i.e. consu- disclosure to a	Care For The Client's Re GASE OF INFORMATION releas' services are term say be revoked at any time. I ster Minnerota Family Service treentes a claim under my pol- closure of this information is to attentions). Inspect and receive photo copi organization that receives the 191, 1936, the information der ms about disclosure of my has is authorization is a reflective	COVERY ON IS VALID UNTIL: one year from the audiorization remains in effect valear it is as a valuated, while he are necestra first, further start seed in the sevention will not apply to a decreased that the revention will not apply to a decreased that the revention will not apply to a decreased the are refuse to sign this outhorization provided solely for the purpose of creating prices of health information disclosed under this a information is not a health came provides or he accided in this outhorization may be re-closed to the information, I can content frequer Minnes.	rtherniore: specifically tenaked by written outces mund that any information observed my insurance company when the law m. I need not sign this authorization notested health information for otherization. otherization otherization for protected by the same otherization for protected by the same otherization for protected by the same
To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request THIS AUTHORIZATION FOR RELE when Greater Minnesota Family Set 1. I understand that this subsorization a to ATTN: Data Privacy Officer, Greateful of this revocation shall not be a provides my insurer with the right to 2. I understand that authorizing the disc to receive services unders the correct disclosure to a third party (i.e. consult 3. I understand that if the individual or regulations under Public Law #104- federal regulations. If I have question 5. A photocopy or facsimile copy of the facsimile as well as the United States	Care For The Client's Re GASE OF INFORMATION rylees' services are term say be revoked at any time. It ster Minnerota Family Service stere of confidentiality. I tu contest a claim under my pot florum of this information is a so are controded or are to b limitous). import and receive photo copi organization that receives the substitution of any heal is authorization is as effective s Postal Service.	ON IS VALID UNTIL: one year from the state of the sadiorization reasons in effect vales it is a sectorization reasons in effect vales it is seen to see that the revocation will not apply to a fer it is a sectorized that the revocation will not apply to a fer it is a sectorized when the revocation will not apply to a fer it is a sectorized solely for the purpose of creating present of the sectorized water this a information is not a health came provided or the section in this cuthorization may be re-closed afth information, I can contact Greater Minness as the original. I also give my permission to a	rtherniore: specifically terriked by written notice rated that my information coloused my insurance company when the law a. I need not sign this authorization rotected health information for otherization, with plan covered by federal privacy and no longer protected by the same the Family Services' Privacy Officer, sechange information by the of



AUTHORIZATION FOR RELEASE OF INFORMATION

Pharmacy

Greater Minnesona Family Services - Shelter Care

3619 SW 15th Avenue, Willmar, MN 56201

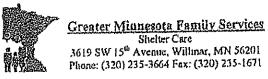
Phone: (320) 235-3664 Fax: (320) 235-1671

L			_ hereby authorize
	(Resident's Name)	(Dute of Birth)	
ull Great	cr Minnesota Family Sorvices staff and <u>Thrifty White I</u>	drug at 1600 First St. SW, Willman, Md	<u>1 56201</u>
Phone:	320-235-1930		
Fax:	320-235-7801		
Contact:	All Thristy White Drug staff		
To:	Disclose Obtain From	Exchange With	
	Treatment Plan, Discharge Summary Cou	Reports Including History and Physical identic/School Transcripts or VProbation Information er	
(I understa	nd that the information to be obtained may include Chemi	cal Dependency Information.)	
THIS AUT whom Gree 1. In to po 2. In to dia 3. (u	nation requested/exchanged is needed for the following put To Effect a Continuum of Care For The Client's Recovery Evaluation/Treatment Financial Billing Per Client Request HORIZATION FOR RELEASE OF INFORMATION IS after Minnesota Family Services' services are terminate understand that this authorization may be revoked at any time. This authority Data Privacy Officer, Greater Minnesota Family Services, P.O. B fore this revocation distill not be a breach of confidentability. I understand ovides my insurer with the right to contact a claim under my policy, anderstand that authorizing the disclosure of this information is voluntary receive services unless the services are court-ordered or are to be provided of out to a third party (i.e. consultations). Inderstand that I have the right to inspect and receive photo copies of hear addressed that I have the right to inspect and receive photo copies of hear addressed that if the individual or organization that receives the information and receives the informational contents.	VALID UNTIL: one year from the date d, whichever occurs first, furthermore: orization remains in effect unless it is specifically reloc 1810, Wilbrar MN 56201. I understand that my that the revection will not apply to my insurance of the relocation of the sutherization. I need not ed solely for the purpose of creating protected health this information disclosed under this authorization.	voked by written notice y information released company when the law righ this sutherization h information for
reg Iko 5. A j	gulations under Public Law \$104-191, 1996, the information described in leral regulations. If I have questions about disclusure of my bealth infor photocopy or assimila copy of this authorization is as effective as the or runile as well as the United States Pastal Service.	i this multiorization may be re-closed and no longer p mation, I can contact Greater Minneauta Family Ser	protected by the same vices' Privacy Office.
iguatures	·		
Resident _		Date	
'arent/Gu	ordian	. Date	.11



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

	(vea)	deut's Name)		(Date o	f Birth)	
all Greater M	lianesots Pamily Ser	rvices stall and	·····	Organizatioo)		
			(C	Ngamzanoo)		
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To;	Disclore	Obtain From	Ercl	iange With		
Psyc Rep Fatt Tres	rance and Billing Inf chological, Psychintri orts and Consultation ally and Social Histor atment Plan, Discharg ial Service Informatic	c Evaluations/Reports; M s y e Summury	edical Reports Incl Academic/Scho Count/Probation Other	ol Transcripts		
		be obtained may include				-
Fina	Client Request					
HIS AUTHOR Sen Greater F. I under to ATT before to provide 2. I under to receive disclose 3. I under 4. I unders regulation	Client Request RIZATION FOR REI Minusosta Family S tand that this authorization is Data Privacy Officer, or bits revocation shall not be a my insures with the right tand that othorizing the d ive services unless the servi- are to a third party (i.e. con- tand that I have the right to could that I have the right to the under Public Law #104 regulations. If I have quest	s inspect and receive photo copi or organization that receives the i-191, 1996, the information de- ions about disclosure of my her	minated, whicheve his authorization remains, P.O. Box 1810, Willinderstand that the revocaticy, rotherapy, I can refuse to a provided solely for the color for for the color for for the color for the color for the color for the color for the	er occurs first, further in in effect unless it is not MN 56201. I und then will not apply to o sign this sutherization purpose of creating purpose of creating purpose of the rith care provider or this interest with care provider or the sum may be re-closed under Greater Munres	rthermore specifically erstand that a my insurance on. I need no protocled tien suthorization suthorization and no longe ots Family S	revoked by written as my historication release company when the lot sign this authorized the information for record by federal privier protected by the energioes' Privacy Officery Privacy Privacy Officery Privacy Officery Privacy Privacy Privacy Privacy Officery Privacy Priv
Per Greater J. Lunders to ATTS frefore it provide Lunders to receive disclosur J. Lunders to receive disclosur J. Lunders regulation federal (Client Request RIZATION FOR REI Minusosta Family S tand that this authorization is Data Privacy Officer, or bits revocation shall not be a my insures with the right tand that othorizing the d ive services unless the servi- are to a third party (i.e. con- tand that I have the right to could that I have the right to the under Public Law #104 regulations. If I have quest	ervices' services are ter- may be revoked at any time. I enter Minnesota Family Service a breach of confidentiality. I us to contest a claim under my pol- isolosure of this information is a con-are count-ordered or are to b solutions). Inspect and receive photo copi ar erganization that receives the ions about disclosure of my bee his authorization is a effective	minated, whicheve his authorization remains, P.O. Box 1810, Willinderstand that the revocaticy, rotherapy, I can refuse to a provided solely for the color for for the color for for the color for the color for the color for the color for the	er occurs first, further in in effect unless it is not MN 56201. I und then will not apply to o sign this sutherization purpose of creating purpose of creating purpose of the rith care provider or this interest with care provider or the sum may be re-closed under Greater Munres	rthermore specifically erstand that a my insurance on. I need no protocled tien suthorization suthorization and no longe ots Family S	revoked by written as my historication release company when the lot sign this authorized the information for record by federal privier protected by the energioes' Privacy Officery Privacy Privacy Officery Privacy Officery Privacy Privacy Privacy Privacy Officery Privacy Priv
Fer Greater J. I unders to ATTS before to provide to receive discloss 3. I unders regularic federal 5. A photo factional	Client Request RIZATION FOR REI Mintesota Family S tand that this authorization is Data Privory Officer, Gr this revocation shall not be my insurer with the right tand that authorizing the di te services unless the servi- te to a third party (i.e. com- te to a third party (i.e. com- te to a third party (i.e. com- te to a third party in the tested that if the individual one under Public Law #104 regulations. If I have quest copy of fresimile copy of	ervices' services are ter- may be revoked at any time. I enter Minnesota Family Service a breach of confidentiality. I us to contest a claim under my pol- isolosure of this information is a con-are count-ordered or are to b solutions). Inspect and receive photo copi ar erganization that receives the ions about disclosure of my bee his authorization is a effective	minated, whicheve his authorization remains, P.O. Box 1810, Willinderstand that the revocaticy, rotherapy, I can refuse to a provided solely for the color for for the color for for the color for the color for the color for the color for the	er occurs first, further in in effect unless it is not MN 56201. I und then will not apply to o sign this sutherization purpose of creating purpose of creating purpose of the rith care provider or this interest with care provider or the sum may be re-closed under Greater Munres	rthermore specifically erstand that a my insurance on. I need no protocled tien suthorization suthorization and no longe ots Family S	revoked by written as my historication release company when the lot sign this authorized the information for record by federal privier protected by the energioes' Privacy Officery Privacy Privacy Officery Privacy Officery Privacy Privacy Privacy Privacy Officery Privacy Priv
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Per de la	Client Request RIZATION FOR REI Mintresota Family S und that this authorization is Data Privery Officer, Or tisk revocation shall not be o my insucet with the right tand that outhorizing the di- re services unless the servi- ze to a third perty (i.e. com- act to a third perty (i.e. com- tand that have the right to test dots if the individual cost under Public Law #104 regulations. If I have quest copy of resimile copy of c as well as the United State	ervices' services are ter- may be revoked at any time. I enter Minnesota Family Service a breach of confidentiality. I us to contest a claim under my pol- isolocute of this information is - cost are const-entered or are to be solutiones. Inspect and receive photo copi or originization that receives the i-191, 1996, the information de- ions about disclosure of my bee this authorization is as effective tes Postal Service.	minated, whicheve his authorization remains, P.O. Box 1810, With decision of the time revocation restaurant that the revocation of the provided solely for the confinence of health information information in sole a beautiful information, I can exact the distribution, I can exact the originat. I also give	er occurs first, fur mar MN 56201. I und dion will not apply to o sign this authorization purpose of creating disclosed under this a tith care provider or hith care provider or hith care provider or hith care may be re-closed author Greater Minnes ive my permission to	rthermore specifically critical dist a my insurance on. I need no rectorfed ten sutherization, salth plan co- and so longe out Family S exchange info	revoked by written as my historiation release company when the string this audionized bit information for protected by federal privar protected by the care cryices! Privacy Officentiation by use of



Activity Waiver (Informed Consent and General Waiver)

I hereby authorize	to participate in any trips,					
(Perident)						
events, community service and skills learning groups, and GMFS team. These include, but are not limited to: cleani recreational activities; and events which require travel in	ng and maintenance, water, terrory and					
l, (Purent/Guardian)	, agree for participant, myself, my heirs,					
•						
executors, administrators, successors and assigns that neit nor any of its officers, members, agents, representatives, a implied or otherwise, or any personal injury, or death, or p or loss suffered or sustained by me/participant named abo activities of GMFS or sponsored or supervised by GMFS.	property loss, medical expense or other damage we in connections with or arising from any					
Further, for participant/myself, my heirs, executors, admin assume all risk whatsoever of personal injury or death or in connection with any or all activities engaged in by me/ supervised by GMFS and I absolve and release GMFS, its and/or employees from all liability and covenant and agre GMFS on account of any personal injury or death or prop express intention and purpose to waive any potential clair from any activity sponsored, supervised or participated in and purpose to bind participant/myself, my heirs, executo waiver and assumption of risk.	property damage, medical expense of other loss participant named above and sponsored or sofficers, members, agents, representatives, see not to sue or prosecute any claim against serry damage or loss of any kind. It is my in 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 consen- with this waiver or otherwise, this waiver is intended to b specifically revoked.	nt or waiver which may be signed concurrently be permanent and shall remain in offect unless					
If signing as a parent, natural guardian, appointed guardian, or in any other representative capacity, I represent and warrant that I possess the full legal authority to enter this agreement on behalf of my child, ward, conservatee, or other person.						
Parent/Guardian	Date:					
4 249 makes, on the fort for 140 and						
Resident	Date:					
Shelter Care staff	Date:					



Consent to Monitor Incoming & Outgoing Communications

I, (Parent/Ouardian)	, parent/guardian of
(Rosident)	THE PARTY OF THE P
	rvices Shelter Care staff members to monitor the minor, under the laws of the State of Minnesota.
This authorization shall remain in effect so long are, and control of Greater Minnesota Family	
Parent/Guardian	Date:
belter Care staff	Date:



Information Needed Prior To Admission

Resident's Na	me:		 	
Gender:	M	F		
Race:				
Height:		P		
Weight:				
Eye Color:				
Tattoos:			 	
Piercings:			 ····	
Date of Last P	hysical I	Exam:	 	
Date of Last D	ental Vi	sit:		كالمستعمد ويتجارب والمراج كالمستعمد والمستعمد والمستعم والمستعمد والمستعمد والمستعد والمستعمد والمستعمد والمستعمد والمستعمد والمستعمد والمستعمد وا
Primary Physic	cian:			NAA CARE BASTERIA
Primary Clinic	: .		 	onetono en
Address:	•		 	
Phone:	_	·	 -	
Fax:	_		-	
along the second se	· · · · · · · · · · · · · · · · · · ·		 	
Prescribing Pb	ysician:			
Olinic:				
Address:	-	-		
	-			
Phone:	-			
Fax:	-		-	



Consent for Medical Treatment

[, (Parint/Guardian)	, paren	t/guardian of
(Residont)		(Date of Birth)
have the authority to consent for medical the Minnesota Family Services Shelter Care stanesthetic, or surgical diagnosis; for treath under the general or special supervision and licensed under the law of the State of Minnesote the law of the Minnesote the law of the Minnesote the law of the Minnesote the law of	taff members to consent nept and hospital care, t and on the advice of a ph	t to any x-ray examination; to be rendered to said minor
l also authorize GMFS to provide whateve minors referring agent at the time of admis from Greater Minnesota Family Services (on the control of the party payor (s) diagnoses myself and/or my dependents for the purpo	sion. I request that pay GMFS) be made directly, dates, type and provid	ment for all services received by to GMFS. I authorize GMFS or of service(s) regarding
		n to the said minor as directed
and prescribed by a duly licensed physician	n or surgeon.	
and prescribed by a duly licensed physician am willing to receive these services. I hat This authorization expires one-year from the	n or surgeon. ve received a copy of th ne date signed. I unders	ne Notice of Privacy Practices.
also authorize GMFS Shelter Care staff to and prescribed by a duly licensed physician am willing to receive these services. I have the sauthorization expires one-year from the consent at any time except to the extent that are arrested on the extent that are the same are the same at any time except to the extent that are the same at any time except to the extent that are the same	n or surgeon. ve received a copy of the ne date signed. I unders at GMFS has already dis	ne Notice of Privacy Practices. stand that I may revoke my sclosed data.
and prescribed by a duly licensed physician am willing to receive these services. I have his authorization expires one-year from the consent at any time except to the extent that are areas of the extent that the extent tha	n or surgeon. ve received a copy of the ne date signed. I unders nt GMPS has already dis	ne Notice of Privacy Practices. stand that I may revoke my sclosed data. Date:
and prescribed by a duly licensed physician am willing to receive these services. I hat This authorization expires one-year from the	n or surgeon. ve received a copy of the ne date signed. I unders nt GMPS has already dis	ne Notice of Privacy Practices. Stand that I may revoke my sclosed data. Date: Date:

			DHS-4398 11-0s
Informed Consent	IHOIVIOUAL		IO IO
Form for Psychotropic	DATE (MM/D	DWAI	CONSENT EXPRATION (MM/CO/YY)
Medication(s)	PHYSICIAN		CASE MANAGER
Psychotropic(s)	L	niya manamiy ya sarasar pakkan kik na kamilanin kiki kiki dalahir	
Generic name:		Current Generic name:	☐ Proposed
Trade name:		Trade name:	
Dose:	_mg/day	Dose:	mg/day
Maximum dose:	_mg/day	Maximum dose:	mg/day
Route:		Route:	
Generic name:			
77 . 3			
Maximum dose:			
Route:			
Oral Communication		Written infor	mation including possible
☐ No, could not reach ☐ Yes:		side-effects(*	
	1 1	Given at me	eting Sent with this form
☐ Telephone on ☐ Meeting on	//_	. O Not provide	d
Person to contact for questions or cor		Tardive Dysk	inesia (TD)(*)
NAME		Present	
		l	nle to the psychotropic and case
ADDRESS			act side-effects and/or TD forms
CRY STATE ZE	,	provided:	
TELEHRONE			
()			
The following information has been e listed and written information has be	en provi	d about the psycho ded about:	otropic medication(s)
1. The reasons for the medication(s)			
2. A description of the behavior/condition in s		ervable and measurable	eterms
 The rate and intensity of the behavior/cond The benefits of the medication(s) 	ition		
i. The alternative therapies available			
6. The risks including possible side-effects and	their treat	ment	
Specific aspects of the medication(s) such as	name, dos	re, maximum dose, rou	
S. The fact that I may refuse consent, or, if give			any time
9. The fact that my consent expires in one year			-i
10. The names, addresses, and phone numbers of Based upon the above (Check one):	at beobie t	Comments:	115 C.
I approve the use of the psychotropic(s) liste	d.		
I do not approve the use of the psychotropic			
I only approve as follows (specify in comme			
SIGNATURE DATE]	

Greater Minnesota Family Services - Shelter Care

Σ	Resident	Intake / Discharge Medication Inventory D.O.B.	scharge D.O.B.	Medica	Intake / Discharge Medication Inventory D.O.B.		1071		
Rx Number P	Prescribing Physician	Medication Name	Size	Dosage	Dosage Times Given	Form	Container Type	Intake Amount	Intake Amount Discharge Amount
						-			
				·					
Inta	Intake Responsible Party:		Time:				Date:		
Intake Shelte	Intake Shelter Care Staff Member:		Time:				Date:		
Dischar Discharge Shelte	Discharge Responsible Party: Discharge Shelter Care Staff Member:		Time: Time:				Date:		
I acknowledge the a are consistent and ac my child.	bove containers and th	I 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 are consistent and accurate with what is printed on the labels. I give permission to Shelter Care staff to administer the above medications to my child.	n that I a	m providii ion to She	ng to Shelter Car lter Care staff to	e for my administe	child at the time of ther the above medicati	eir intake	
I acknowledge that	my child has no medica	I acknowledge that my child has no medications at the time of their intake.	r intake.						
I give GMFS Shelte	r Care staff permission	l give GMFS Shelter Care staff permission to administer Acetaminophen 325mg caplets (1-2 caplets) to my child, as needed.	10phen 32	25mg capl	ets (1-2 caplets)	to my chí	ld, as needed.		
Parent / Guardian signature:	signature:						Date:		

SHELTER CARE PROGRAM 3619 SW 15TH STREET WILLMAR MN 56201

PHYSICIANS CONSENT TO ADMINISTER ROUTINE STANDING ORDERS

The following clien	t of yours		1 1
will be admitted to	Greater Minnesota Family Services' Sh	elter Care Program. Plea	se verify that the following
over the counter me	dications can be administered PRN as	Standing Orders.	
	ROUTINE STAND	ING ORDERS	
over the counter medical	SHELTER CARE PROGRAM RN must be not tion. Also the client's physician will be contacted client's condition changes significantly. Any of the physician.	ted if the following orders do	not result in relief of symptoms
1. Ointment for trea	tment	8. HC Cream 0.	5%
Triple Antibiotic	Ointment TID PRN	Up to TID PR	
A & D	TID PRN	- F	
Vicks	TID PRN	9. Debrox/Muris	ne
	•		affected ears B ID X 4 day
2. Analgesics		**	
Tylenol 325 mg Ibuprofen 200 r	1-2 tabs q 4-6 hours PRN for relief of ng 1-2 tabs q 4-6 hours PRN for relief	emporary pain. 10. Mof temporary pain	Iultiple Vitamins
3. Anti-diarrheal		11. May substitu	te liquid meds for tabs
Pepto-Bismol 2	Tbsp q. 2-3 hours PRN		eds if dosage allowed
Kaopectate Cond	c. 1-2 Tbsp q 4 hours PRN		s may be used unless
		Specified by	
4. Laxative			rs 1 gtt QID PRN
MOM 15-20 cc da	aily PRN for 1-2 days		0 2 - 22
Dulcolax Supp 10	mg daily PRN	12. Basic Skin C	are
May hold laxative	if loose stools, evaluate daily	May use OTO Dry sk	Clotions/ointments for
5. Antitussives & Ex	rpectorants	Skin Tears: c	leanse with sterile
Cough Drops, Cor	ugh Syrup with out Alcohol base		pply ointment,
			telfa pad & tape
6. Antacid			cleanse with sterile
Maalox 1-2 tsp TI	D PRN		solution, apply ointment,
Antacid Tablet 1-2	2 tabs QID PRN	cover	with band aid/telfa
	•	Transparent D	Pressing QID PRN
7. RID Head Lice 7	Preatment	for-skin-break	down/nurse-
I give permission for (the client named above to receive these S	Standing Orders.	
Parent/Guardian:			1 1
********		····	

SHELTER CARE PROGRAM GREATER MINNESOTA FAMILY SERVICES 3619 15TH AVE SW, WILLMAR MN 56201 320-235-3664 (PHONE) 320-235-1671 (FAX)

PHARMACY ORDERS TO ADMINISTER MEDICATIONS UNTIL PHYSICIAN'S ORDER CAN BE OBTAINED

The following	ng client of yours				<u>/</u> /
	(Reside	nt)			(DOB)
has been adn	nitted to our Shelter Care.	Please verify that the fo	llowing are m	edications	that you have doctor's
orders for an	d have been recently filled	for this resident by faxi	ng the medica	tion infor	mation she ets for the
medications	listed on this form.				
(Parent/Guard	lian)		(1	Date)	give permission for
(Pharmacy)		(Address)		
to release the	information to Shelter Car	e Program. ALLERO	GIES:		
X Number	Prescribing Physician	Medication / Strength	Dose	Times Given	Symptom s/Reason

	-				
	X THIS FORM BACK V ONS THE RESIEDENT I			MATION	SHEETS FOR THE
If this informa	ntion is correct, please sign hank you.	below. Please contact	320-235-3664	if there ar	re questions or
(Pharmacist	Signature)				// (Date)

FORM 23005

Greater Minnesota Family Bervices 513 SW 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.

- 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 Lews to obtain a written consent from you, unless the disclosure is authorized by Law.

 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.

C. 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 disks 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 evert 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' Compansation. For example, when reporting health information to entities that
 provide benefits for work-related inluries 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 INDIVIOUAL RIGHTS

A. 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.
- D. 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.

E. 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.

BURGEST	MN	9 🗂	26) CIRCON	DYIMA

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 compleint 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 retailate 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 Official:

Greater Minnesota Family Services

ATTN: Data Privacy Office

513 SW 5th Street

Willmar MN 56201

Phone: 320-214-9692 ext 101

Fax: 320-214-9924

e-mail: gmfs@greaterminnesota.org

Form 23005 Greater Minnesom Pamily 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):



Approved Contacts

	Reside	nt's No	inic	***************************************			
Names				Phone:			Balaidan okko sa Starlidania
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nic:	C. T.	634 ::		Phone:			Relationship to Residents
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194":	- Di	Maa 5		Phone:			Reintiouship to Resident:
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£,	3 Yes	C No	Must have worker ap	sproval prior to visit	J Yes	D No	Must have parent/guardian approval prior to vivit,
		l am gi	ving pennission	for the above peop	ple to hav	re conta	nct with my child and Shelter Care staff,
		Parent/	Guardian				Date:



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

	OTHE CALL	ADDITION		F		
Student Information	STUDENT	APPLICATION		Date	D (En rolled
				Contacted	For Office Use	als
Ctudent Name			l			
Student NameLast		First			Middl	<u> </u>
Address					Wilde	5
Street	***************************************	City		State		Zip Code
SCHOOL most recently attended	(date) & GRADE					-
Name(s) of previous school(s) atte						
		Vertex to the second se				
Parent/Guardian Informat	ion					
						
I. Name			Phone			
Last	First		1110110			· · · · · · · · · · · · · · · · · · ·
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Email Address		Work Phone	!			•
Other Contact Numbers						
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Other:						
arent/Guardian Signature				•		
-			· · · · · · · · · · · · · · · · · · ·		Date	

New Discoveries Montessori Academy

1000 5th Ave SE Hutchinson, MN 55350

Phone: 320-234-6362 Fax: 320-234-6300

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



Request for Student Records

l authorize		
	Former School	100 V
		,
**************************************	City, State and Zip Code	
Phone		Fax
		ιαχ
itudent Name	Grade	Birthdate
tudent Name		
tudent Name	Grade	Birthdate
understand that this information will be us hild(ren). Thank you.	sed in a confidential and professional man	ner in the best interest of the
Signature of Parent of	f Guardian	Date

Philipposistic Department of

Education

Home Language Questionnaire ED-01336-08E

The following is to be completed by School District Personnel:

	STUDENT IDENTIFICAT	ION INFORMATION	
Student's Full Name			
Date Of Birth	Age	Gra	nde Level
	DISTRICT INFORMATION/VER	IFICATION INFORMA	ATION
School name New Disc	overles Montessori Ac	cademy I	District number 4/6/-07
	above information is true and		
_	David L. Cor	rad	
Duu Signature –	Name (Pri	inted) <i>Executive Divecto</i> Title	Date
	· •		Juic
Dear Parents and Guardian In order to help your child le	he following is to be comple STUDENT LANGUAGE s: parn, your child's teachers need to lons below by checking the appro	INFORMATION determine which lang	
1. Which language did yo	our child learn first?	☐ English ☐ Other	Compated
	est often spoken in your home?	☐ English ☐ Other	(specify):
	your child usually speak?	☐ English ☐ Other	(specify):
I hereby verify that the	PARENT/GUARDIAN above information is true and		f my knowledge and belief.
	Name (Prir	nted)	
	Signature – Parent/Guardia	n	Date

New Discoveries Montessori Academy STUDENT RELEASE FORM

Student's Name	**************************************	Grade
	<u>at</u> information <u>each year</u> . Ple the office with any changes s	ease read and fill out carefully. so we can remain current.
Please help us with the follo	owing information:	
	om we are authorized to releastionship to your child, and cor	se your child to. Please include tact information.
Person's name	Relationship	Phone
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	n particular who is NOT allo etc.), please indicate below.	
Please circle your child'	's ethnicity (This is required	for state reporting):
	White, not of Hispanic ori Hispanic American Indian Asian or Pacific Islander Black, not of Hispanic ori	gin
	to stop at the office to sign his greatly appreciated.	efore the end of the school day, m/her out and get a student pass.
	Parent Cell Ph Parent Work #	none #

Enriching Community through Montessori Excellence



COMPUTER USE & INTERNET SAFETY POLICY

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 Discoveries Montessori Academy* computers. The use of New Discoveries Montessori Academy 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 are only allowed to print materials related to their class work or project work; and must receive permission from a staff member before printing.
- Students are not allowed to download files or programs from the Internet that are not related to classwork.
- Students are not allowed to use the Internet unsupervised.
- ❖ Students must take proper care of the computers while they are using them. 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 privileges revoked. On the first offense, the student will lose privileges for 2 weeks. For the second offense, the student will lose privileges for 1 month. On the third offense, Students and their parent(s)/guardian(s) will have a conference with instructional staff to determine the next step. In cases of vandalism, students and their families will be responsible for any reasonable cost necessary for repair or replacement of the item, as well as potential legal consequences.

Student Name (please print)	Grade:
Student signature	Date:
Parent/Guardian Name (please print)	
Parent/Guardian signature	Date:

New Discoveries Montessori Academy GENERAL PERMISSION FORM

In order to streamline the school's paperwork, New Discoveries Montessori Academy is requesting signed releases as part of the registration process.

and that I have legal authority to give permission for the activities described below. All

By my signature(s) below, I hereby certify that I am the legal parent/guardian of the child listed below-

waivers/consents signed below shall be valid from the date of signing until I either withdraw my permission in writing or my child is no longer enrolled at NDMA. Student Name (Last/First) _____ Grade___ Name of Parent/Guardian completing this form (Print Name):____ Media Release I hereby grant permission for my child named above to be photographed, filmed, and/or interviewed for press releases or brochures about the school. I further give permission for my child to be included in other school related publications, including the school's website, for the purpose of publicizing and promoting the program. Signature of Parent/Guardian Date Field Trip Release I hereby grant permission for my child named above to participate in local field trips (may involve walking or riding a bus). I understand that I will be informed in advance about each planned trip. Signature of Parent/Guardian Date Medical Emergency In the event of an accident or sudden onset of illness, the school will not hesitate to seek proper care for any child. I understand that the school will attempt to contact me as soon as possible and that the school may transport my child to the nearest hospital or call an ambulance. I give the school my permission to provide and authorize emergency medical care if necessary.

Date

Signature of Parent/Guardian

New Century Academy

950 School Rd SW Hutchinson, MN 55350

Student Name

Phone:

(320) 234-3660

Fax:

(320) 234-3668

www.newcenturyacademy.com info@newcenturyacademy.com



First

Date	
Grade	
For Office Use	

Middle

STUDENT APPLICATION

Last .

Street Address							
City, State, Zip							
NAME of last school	ol attended						
DATE last attended	100			**************************************			
GRADE and SCHO applying for to ente		ou are	19-10-11 18-10-11 18-10-11				
	Pa	arent / Gu	ardian In	formation			
Parent / Guardian							
Name (1)	La	ist		First		Relatio	nship
Street Address		2000 Comment					
City, State, Zip		A					
E-mail							
Home Phone			Cel	l Phone			
Employer							
Occupation			Wo	rk Phone			
Parent / Guardian							
Name (2)	La	ast		First		Relatio	nship
Street Address			(*10) (*10) (*		1 /2		
City, State, Zip				and a design of the state of the			
E-mail					***************************************		
Home Phone			Cel	l Phone			
Employer							
Occupation			Wo	rk Phone			
Parent/Guardian					Date		
Signature					180, 100, 100	37	

New Century Academy

950 School Rd SW Hutchinson, MN 55350

Phone:

(320) 234-3660

Fax:

(320) 234-3668

www.newcenturyacademy.com info@newcenturyacademy.com



REQUEST FOR RELEASE OF STUDENT RECORDS

Date:									
 To:							anne dine e e e e e e e e e e e e e e e e e e		
	**************************************		Name of	former s	chool	your chil	d attended	Ł	
Address of School:	was do yan ifika da falama ka								
This student	has an IEP?		Stree	Yes		No	City	State	Zip
		Plea	se relea	se all st	udent	records	for:		
		, ,,, ,, , , , , , , , , , , , , , , ,	Stude	ent First	Last N	lame			
Who t	nas registere <u>New Cent</u>	<u>C</u> Include 1	OO NOT	send per wing inf	maner ormati	t record on and	s send to:		ademy
•	ALL School I State MARSS Transcript-or Extra-Currica Attendance I Health Recor Standardized Psychologica Special Educ	S Identific riginal co ular Eligit Records rds I Test Re al Service	eation Nu py (cours oility Stat sults es Report	ses taker tus ts		es earne	d, credits)		
Thank you!									
Parent / Guar	dian Name (P	lease Prii	nt)		Parent	/ Guardi	an Signati	ure	

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



Home Language Questionnaire ED-01336-08E

The following is to be completed by School District Personnel:

r					
		UDENT IDENTIFICATION	ON INFORMATION	ON	
Student's F					
Date Of Bir	<u>th</u>	Age		Grade Level	

	DISTRICT	INFORMATION/VERI	FICATION INFOR	RMATION	
School nam	e New Century Academy			Distric	t number 4093-07
I hereby ve	erify that the above inf	formation is true and	accurate to the b	oest of my kr	nowledge and belief.
		Name (Pri	nted)		
Antonima	Signature – Respons	ible Authority	Title	<u> </u>	Date
	The follov	ving is to be comple	ted by Parent/C	Guardian:	
	!	STUDENT LANGUAGE	INFORMATION		
In order to he	and Guardians: elp your child learn, your nd to the questions belov			language you	ır child uses most.
1 Which	languago did your child l	open first?	□ English □ C)thar/coorify):
 Which language did your child learn first? Which language is most often spoken in your home? 			-		
 Which language is most often spoken in your home? ☐ English ☐ Other (specify):					
		PARENT/GUARDIAN	INFORMATION		
l hereby v	erify that the above in	formation is true and	correct to the b	est of my kn	owledge and belief.
		Name (Prin	nted)		
	Signat	ure – Parent/Guardia	n		Date

RACE / ETHNICITY

Stude	nt Name:	
racial/	/ETHNICITY is used in federal and state civil rights and statistical reports. This is a nonscientific ethnic designation as defined by the U.S. Department of Education. The manner of collection is ped as follows in Minn. R. 3535.0120, Duties of District.	
In orde questi	er for New Century Academy to report the race/ethnicity of our students, please answer the followi	ng two
Is the	student Hispanic/Latino? (Choose only one with an "X")	
•	No, not Hispanic/Latino	
	Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)	· · · · · · · · · · · · · · · · · · ·
	ove part of the question is about ethnicity, <u>not race</u> . No matter what you selected above, please le to answer the following by marking one or more boxes to indicate what you consider your stude be.	ent's
What is	s 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	

NCA Computer Use Policy

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 New Century 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 only allowed with permission from a staff member. This includes 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 NCA Computer Use Policy:

I have read the NCA 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:

New Century Academy

950 School Rd SW Hutchinson, MN 55350 320.234.3660 320.234.3668 (fax) info@newcenturyacademy.com



LOCAL FIELD TRIP PERMISSION FORM

	_ has permission to attend local field trips during the school year
with New Century Academy. Tu	understand my child is covered by insurance if traveling on the
bus. New Century Academy is N	IOT responsible for any other accidents.
Parent / Guardian	Date