GREATER MINNESOTA FAMILY SERVICES - SHELTER CARE (GMFS/SC) AGREEMENT
JANUARY 1, 2021 – DECEMBER 31, 2022

The _____ Agency, (hereinafter referred to as Agency) places and is financially responsible for

_____(recipient) while placed at GMFS/SC, 3619 SW 15th Avenue, Willmar, MN 56201, as of _____.

The Agency and GMFS/SC agree to abide by the provisions outlined in this placement agreement.

1. The Agency shall, by written communication, provide GMFS/SC with a specific statement as to the legal status of the child, and whom or which agency has legal custody of the child.
2. GMFS/SC shall, within five (5) working days following the last day of each calendar month, submit an invoice to the Agency. The invoice shall contain: 1) name of child served; 2) number of days of service with daily rate (the unit cost is $246.00/day) and 3) total cost of providing services.
3. The Agency shall, within thirty (30) calendar days of the date of receipt of the invoice, make payment direct for services. The Agency is responsible to 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 child is absent from GMFS/SC. Mutual agreement shall be reached within one (1) working day between GMFS/SC and the Agency as to how long the recipient's bed shall be held. All verbal communications must be confirmed in writing by the Agency within five (5) working days.
6. GMFS/SC shall provide the Agency and the child's family with information relative to the procedures at GMFS/SC.
7. The Agency must allow access to GMFS/SC the following information in writing **at the time of placement:**
   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. exam has been given, GMFS/SC will set up as necessary).
   d. **Medical health problems (including names of physician last seen, family doctor, dentist, optician, and specialist)**.
   e. **Educational data (IEP, achievement scores, and special programs)**;
   f. **Child health insurance information (medical assistance number/card, parent's health insurance/policy number)**.
   g. **Out-of-home placement plan**.
   h. **Court order or voluntary placement agreement**.
8. At the time of placement, the Placing Worker shall complete admission face sheet, 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 guardian/Placing Worker shall sign the consent forms).
9. If GMFS/SC is requested by the referring Agency to transport residents to staffing, hearings, medical/therapy appointments, or court appearances, they will be included in the per hour costs.
10. The Agency agrees to pay full per diem costs to GMFS/SC if a child is given home visits. The child is considered a resident of GMFS/SC until date of official discharge as requested by the referring Agency.

_____ _____
GMFS/SC Representative Date

_____ _____
Placing Agency Representative Date

11. The Agency agrees to contract the following additional services: (The following service fees are in addition to per diem charges and payment must be received within thirty (30) calendar days of the date of receipt of the invoice, with payments made directly to GMFS/SC)

		Masters	Doctorate
_____	Psychological Evaluation	$98.60/hr.	$119.96/hr.
_____	Family Based Assessments (Done by a professional counselor)	$98.60/hr.	
_____	Family Based Counseling (skills)	$69.80hr	
_____	Transportation to and from placement by practitioner	$32.00/hr	
_____	Interpretative services (if available)	$50.00/hr	
_____	One-on-one aide for high-risk youth	$21.22/hr	
_____	Urine Analysis	$45.00/UA	
_____	Other county requests		
_____	Rule 25 CD Assessments	$130.00	

_____ _____
GMFS/SC Representative Date

_____ _____
Placing Agency Representative Date

12. The Agency does not wish to contract for additional services.

_____ _____
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 **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.

I, _____, parent/guardian of
(Parent/Guardian)

_____,
(Resident)

acknowledge that the Greater Minnesota Family Services Shelter Care program is not a locked facility and will not be held responsible for the health and welfare of the above named resident if they were to run from the facility located at 3619 15th Ave. SW, Willmar, MN 56201. The Shelter Care program is also not responsible for a child who chooses to run away from the program staff while on an off-site outing. This includes, but is not limited to, a child becoming injured after running away from the facility and/or staff members or the child committing some type of unlawful act after running away from the facility and/or staff members.

Shelter Care program staff, at the time a runaway has been found missing, will contact the Kandiyohi County Sheriff's Department to inform them that a child is missing. The resident may be considered for discharged at that point and will not be allowed to return to the Shelter Care facility until he/she has been placed and observed in a secure facility for a period no less than 24 hours.

Re-admittance into the Shelter Care program will be based on the Shelter Care team's decision to re-admit or not.

Parent/Guardian _____ Date: _____

Referring Worker _____ Date: _____

Shelter Care staff _____ Date: _____

Greater Minnesota Family Services  *Application for Services*

☐☐☐☐☐ Client Number ☐☐-☐☐-☐☐ Date Services Began _____ GMFS Staff Name

Legal Name of Client: _____ (Last / First / M.I.) **Race:** _____

Address: _____ (Number/Street/Route / Town/City / State / Zip)

County of Residence: _____

Date of Birth: _____

SSN: _____ ☐ Male ☐ Female

Telephone: Home: (_____) _____
Work: (_____) _____
Cell: (_____) _____

Who Referred You to GMFS?
1 ☐ Self 2 ☐ Family/Friend
3 ☐ Other (Agency, Staff Person, and Phone): _____

Previous D.A. yes___ no___ if yes _____ (Agency Name) _____ (D.A. Date)

TYPE OF SERVICE REQUESTED:
(Initial & Date)

1 ☐ Diagnostic Assessment ___/___/___
2 ☐ Family Based Services ___/___/___
3 ☐ School Mental Health ___/___/___
4 ☐ Early Childhood FBS ___/___/___
5 ☐ HCBS ___/___/___
6 ☐ Day Treatment ___/___/___
7 ☐ Group Therapy ___/___/___
8 ☐ FGDM ___/___/___
9 ☐ Connections ___/___/___
10 ☐ Shelter Care ___/___/___
11 ☐ Shelter Care FBS ___/___/___
12 ☐ Psychiatric Services

Party Responsible for Payment (PLEASE CHECK ONE):

☐ COUNTY OF RESIDENCE
☐ COUNTY: DIFFERENT THAN COUNTY OF RESIDENCE: _____
☐ GRANT/INSURANCE _____
☐ PRIMARY INSURANCE
COMPANY _____
PHONE # _____
MEMBER I.D. # _____
POLICY/GROUP # _____
POLICY HOLDER _____ DOB _____
☐ SECONDARY INSURANCE
COMPANY _____
PHONE # _____
MEMBER I.D. # _____
POLICY/GROUP # _____
POLICY HOLDER _____ DOB _____

Client Authorization for Third Party/Other Payment Claims:

I request that payment for services received from Greater Minnesota Family Services (GMFS) be made directly to GMFS. I authorize GMFS to release to the aforementioned 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. This authorization 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 already disclosed data.

_____ (Signature of Client or Legal Guardian) _____ (Date)

I, the Undersigned, Confirm that:

I am willing to receive these services. I have been offered a copy of the Notice of Privacy Practices, Client's Rights and Responsibilities, and use of Email Policy

_____ (Signature of Client or Legal Guardian) _____ (Date)

Reason for Referral (check one): ☐ Prevent Placement of Children ☐ Supportive Services ☐ Other
☐ Assessment Only ☐ Reunification

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

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

For Office Use Only:

Date of Arrival: _____

Time of Arrival: _____

Admissions Face Sheet

Resident's Name: _____
Last First Middle

Resident's Nicknames: _____

Date of Birth: _____ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Parents: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Severely Emotionally Disturbed diagnosis: _____

Medications: _____

Social Security #: _____ Health Ins. Info: _____

Physical Health Concerns: _____

Medications: _____

Prior Placements: _____

Resident's Place of Birth: _____

Languages spoken/written: _____

Tribal Affiliation: _____

Last Educational Setting: School Name: _____
Address: _____
_____
Phone: _____
Contact Person: _____

Spiritual / Religion: Resident: _____ Family: _____

Physical Custody: ☐ Mother & Father ☐ Mother Only ☐ Father Only ☐ Other _____

Legal Custody: ☐ Mother & Father ☐ Mother Only ☐ Father Only ☐ Other _____

Visitation Rights: ☐ Mother & Father ☐ Mother Only ☐ Father Only ☐ 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

I, _____ (Resident's Name) _____/_____/_____ (Date of Birth) hereby authorize all Greater Minnesota Family Services staff and _____ (Social Worker's Agency) at _____

_____ (Mailing Address) | _____ (Phone) | _____ (Fax)

_____ (Social Worker'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
_____ Family and Social History
_____ Treatment Plan, Discharge Summary
_____ Social Service Information
_____ Academic/School Transcripts
_____ Court/Probation Information
_____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

_x_ To Effect a Continuum of Care For The Client's Recovery
_x_ Evaluation/Treatment
_x_ Financial Billing
_____ Per Client Request

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: **one year from the date of signature, or when Greater Minnesota Family Services' services are terminated, whichever occurs first, furthermore:**

1. I understand that this authorization may be revoked at any time. This authorization remains in effect unless it is specifically revoked by written notice to ATTN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Willmar MN 56201. I understand that any information released before this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply to my insurance company when the law 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 authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

I, _____ ____/____/____ hereby authorize
(Resident's Name) (Date of Birth)

all Greater Minnesota Family Services staff and _____ at
(Probation Officer's Agency)

_____

_____ | _____ | _____
(Mailing Address) (Phone) (Fax)

_____
(Probation Officer'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
____ Family and Social History
____ Treatment Plan, Discharge Summary
____ Social Service Information
____ Academic/School Transcripts
____ Court/Probation Information
____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):
__x__ To Effect a Continuum of Care For The Client's Recovery
__x__ Evaluation/Treatment
__x__ Financial Billing
____ Per Client Request

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2. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law 0104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date ____/____/____

Parent/Guardian _____ Date ____/____/____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

I, _____ (Resident's Name) _____/_____/_____ (Date of Birth) hereby authorize

all Greater Minnesota Family Services staff and Family Practice Medical Center at 502 2nd St. SW, Willmar, MN 56201

Phone: 320-231-8888

Fax: 320-231-8602

Contact: All FPMC staff

To: _____ Disclose _____ Obtain From _____ Exchange With

- _X_ Insurance and Billing Information
- _____ Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History and Physical Reports and Consultations
- _____ Family and Social History
- _____ Treatment Plan, Discharge Summary
- _____ Social Service Information
- _____ Academic/School Transcripts
- _____ Court/Probation Information
- _____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

- _X_ To Effect a Continuum of Care For The Client's Recovery
- _X_ Evaluation/Treatment
- _X_ Financial Billing
- _____ Per Client Request

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2. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law 9104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

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

I, _____ _____/_____/_____ hereby authorize
(Resident's Name) (Date of Birth)

all Greater Minnesota Family Services staff and _____ at
(Prescribing Physician's Clinic)

_____

_____ | _____ | _____
(Mailing Address) (Phone) (Fax)

_____
(Prescribing 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
_____ Family and Social History
_____ Treatment Plan, Discharge Summary
_____ Social Service Information
_____ Academic/School Transcripts
_____ Court/Probation Information
_____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

_X_ To Effect a Continuum of Care For The Client's Recovery
_X_ Evaluation/Treatment
_X_ Financial Billing
_____ Per Client Request

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL: one year from the date of signature, or when Greater Minnesota Family Services' services are terminated, whichever occurs first, furthermore:

1. I understand that this authorization may be revoked at any time. This authorization remains in effect unless it is specifically revoked by written notice to ATTN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1610, Willmar MN 56201. I understand that any information released before this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply to my insurance company when the law 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 authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

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

I, _____ (Resident's Name) _____/_____/_____ (Date of Birth) hereby authorize

all Greater Minnesota Family Services staff and _____ (Resident's Primary Clinic) at

_____

_____ (Mailing Address) | _____ (Phone) | _____ (Fax)

_____ (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
_____ Family and Social History
_____ Treatment Plan, Discharge Summary
_____ Social Service Information
_____ Academic/School Transcripts
_____ Court/Probation Information
_____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

__X__ To Effect a Continuum of Care For The Client's Recovery
__X__ Evaluation/Treatment
__X__ Financial Billing
_____ Per Client Request

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2. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

I, _____ (Resident's Name) _____/_____/_____ (Date of Birth) hereby authorize

all Greater Minnesota Family Services staff and Thrifty White Drug at 1600 First St. SW, Willmar, MN 56201

Phone: 320-235-1930

Fax: 320-235-7801

Contact: All Thrifty White Drug staff

To: _____ Disclose _____ Obtain From _____ Exchange With

_X_ Insurance and Billing Information
_____ Psychological, Psychiatric Evaluations/Reports; Medical Reports Including History and Physical Reports and Consultations
_____ Family and Social History
_____ Treatment Plan, Discharge Summary
_____ Social Service Information
_____ Academic/School Transcripts
_____ Court/Probation Information
_____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

_X_ To Effect a Continuum of Care For The Client's Recovery
_X_ Evaluation/Treatment
_X_ Financial Billing
_____ Per Client Request

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1. I understand that this authorization may be revoked at any time. This authorization remains in effect unless it is specifically revoked by written notice to ATTN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Willmar MN 56201. I understand that any information released before this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply to my insurance company when the law 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 authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

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

I, _____ (Resident's Name) _____/_____/_____ (Date of Birth) hereby authorize all Greater Minnesota Family Services staff and _____ (Organization) at _____

_____ (Mailing Address) | _____ (Phone) | _____ (Fax)

_____ (Contact Person)

To: _____ Disclose _____ Obtain From _____ Exchange With

_x_ Insurance and Billing Information
____ Psychological, Psychiatric Evaluations/Reports, Medical Reports Including History and Physical Reports and Consultations
____ Family and Social History
____ Treatment Plan, Discharge Summary
____ Social Service Information
____ Academic/School Transcripts
____ Court/Probation Information
____ Other _____

(I understand that the information to be obtained may include Chemical Dependency Information.)

The information requested/exchanged is needed for the following purpose(s):

_x_ To Effect a Continuum of Care For The Client's Recovery
_x_ Evaluation/Treatment
_x_ Financial Billing
____ Per Client Request

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1. I understand that this authorization may be revoked at any time. This authorization remains in effect unless it is specifically revoked by written notice to ATTN: Data Privacy Officer, Greater Minnesota Family Services, P.O. Box 1810, Willmar MN 56201. I understand that any information released before this revocation shall not be a breach of confidentiality. I understand that the revocation will not apply to any insurance company when the law 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 authorization. I need not sign this authorization to receive services unless the services are court-ordered or are to be provided solely for the purpose of creating protected health information for 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 covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact Greater Minnesota Family Services' Privacy Officer.
5. A photocopy or facsimile copy of this authorization is as effective as the original. I also give my permission to exchange information by use of facsimile as well as the United States Postal Service.

Signatures:

Resident _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

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/or other activities deemed appropriate by the GMFS team. These include, but are not limited to: cleaning and maintenance; water, leisure and recreational activities; and events which require travel in automobiles.

I, _____, agree for participant, myself, my heirs,
(Parent/Guardian)
executors, administrators, successors and assigns that neither Greater Minnesota Family Services (GMFS) nor any of its officers, members, agents, representatives, nor employees shall be liable for any negligence implied or otherwise, or any personal injury, or death, or property loss, medical expense or other damage or loss suffered or sustained by me/participant named above in connections with or arising from any activities of GMFS or sponsored or supervised by GMFS.

Further, for participant/myself, my heirs, executors, administrators, successors and assigns, I expressly assume all risk whatsoever of personal injury or death or property damage, medical expense or other loss in connection with any or all activities engaged in by me/participant named above and sponsored or supervised by GMFS and I absolve and release GMFS, its officers, members, agents, representatives, and/or employees from all liability and covenant and agree not to sue or prosecute any claim against GMFS on account of any personal injury or death or property damage or loss of any kind. It is my express intention and purpose to waive any potential claim for any liability arising or claimed to arise from any activity sponsored, supervised or participated in by GMFS and it is further my express intent and purpose to bind participant/myself, my heirs, executors, administrators, and assigns by this express waiver and assumption of risk.

Not withstanding any expiration date of any other consent or waiver which may be signed concurrently with this waiver or otherwise, this waiver is intended to be permanent and shall remain in effect unless specifically revoked.

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: _____

Resident _____ 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

Consent to Monitor Incoming & Outgoing Communications

I, _____, parent/guardian of
(Parent/Guardian)

_____
(Resident)

hereby authorize Greater Minnesota Family Services Shelter Care staff members to monitor the incoming and outgoing correspondence of said minor, under the laws of the State of Minnesota.

This authorization shall remain in effect so long as the said minor is in the physical custody, care, and control of Greater Minnesota Family Services Shelter Care program.

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 Name: _____

Gender: M F

Race: _____

Height: _____

Weight: _____

Eye Color: _____

Tattoos: _____

Piercings: _____

Date of Last Physical Exam: _____

Date of Last Dental Visit: _____

Primary Physician: _____

Primary Clinic: _____

Address: _____

_____

Phone: _____

Fax: _____

Prescribing Physician: _____

Clinic: _____

Address: _____

_____

Phone: _____

Fax: _____

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)

_____ _____,
(Resident) (Date of Birth)

have the authority to consent for medical treatment for said minor. I hereby authorize Greater Minnesota Family Services Shelter Care staff members to consent to any x-ray examination; anesthetic, or surgical diagnosis; for treatment and hospital care, to be rendered to said minor under the general or special supervision and on the advice of a physician or surgeon duly licensed under the law of the State of Minnesota.

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 to receive these services. I have received a copy of the Notice of Privacy Practices.

This authorization 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 already disclosed data.

Parent/Guardian _____ Date: _____

Shelter Care staff _____ Date: _____

Primary Insurance:

Company _____
Phone _____
Member ID _____
Policy/Group _____
Policy Holder _____
Date of Birth _____

Secondary Insurance:

Company _____
Phone _____
Member ID _____
Policy/Group _____
Policy Holder _____
Date of Birth _____

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

Physician's Orders & Progress Notes

This record provides an account of your patient's allergies, medications, physician's orders, and upcoming treatment needed to guide Shelter Care staff in the care of the patient.

Name of Patient	Diagnosis
Date of Birth	Attending Physician
Allergies	
Current Medications Prescribed & Current Doctor's Orders	
Upcoming Labs/Treatment Needed	
Physician's Signature	Date

DHS-4219-B 11-04

Informed Consent Form for Psychotropic Medication(s)

INDIVIDUAL	ID
DATE (MM/DD/YY)	CONSENT EXPIRATION (MM/DD/YY)
PHYSICIAN	CASE MANAGER

Psychotropic(s)

☐ Current ☐ Proposed
Generic name: _____
Trade name: _____
Dose: _____ mg/day
Maximum dose: _____ mg/day
Route: _____

☐ Current ☐ Proposed
Generic name: _____
Trade name: _____
Dose: _____ mg/day
Maximum dose: _____ mg/day
Route: _____

☐ Current ☐ Proposed
Generic name: _____
Trade name: _____
Dose: _____ mg/day
Maximum dose: _____ mg/day
Route: _____

Comments/Other: _____

Oral Communication

☐ No, could not reach ☐ Yes:
☐ Telephone on ___/___/___
☐ Meeting on ___/___/___

Person to contact for questions or concerns

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE ( )		

Written information including possible side-effects(*)

☐ Given at meeting ☐ Sent with this form
☐ Not provided

Tardive Dyskinesia (TD)(*)

☐ Present ☐ Not present
☐ Not applicable to the psychotropic and case
(*)Specify the exact side-effects and/or TD forms provided:

_____
_____
_____

The following information has been explained about the psychotropic medication(s) listed and written information has been provided about:

1. The reasons for the medication(s)
2. A description of the behavior/condition in specific observable and measurable terms
3. The rate and intensity of the behavior/condition
4. The benefits of the medication(s)
5. The alternative therapies available
6. The risks including possible side-effects and their treatment
7. Specific aspects of the medication(s) such as name, dose, maximum dose, route, etc.
8. The fact that I may refuse consent, or, if give, that I may change my mind at any time
9. The fact that my consent expires in one year (or less), and must be renewed
10. The names, addresses, and phone numbers of people to contact if questions arise.

Based upon the above (Check one):

☐ I approve the use of the psychotropic(s) listed.
☐ I do not approve the use of the psychotropic(s) listed.
☐ I only approve as follows (specify in comments).

SIGNATURE	DATE

Comments:

_____
_____
_____
_____
_____

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

Intake / Discharge Medication Inventory

Resident _____ D.O.B. _____

Rx Number	Prescribing Physician	Medication Name	Size	Dosage	Times Given	Form	Container Type	Intake Amount	Discharge Amount

Intake Responsible Party: _____ Time: _____ Date: _____

Intake Shelter Care Staff Member: _____ Time: _____ Date: _____

Discharge Responsible Party: _____ Time: _____ Date: _____

Discharge Shelter Care Staff Member: _____ Time: _____ Date: _____

☐ 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.

☐ I acknowledge that my child has no medications at the time of their intake.

☐ I give GMFS Shelter Care staff permission to administer Acetaminophen 325mg caplets (1-2 caplets) to my child, as needed.

Parent / Guardian signature: _____ Date: _____

SHELTER CARE PROGRAM
3619 SW 15TH STREET
WILLMAR MN 56201

PHYSICIANS CONSENT TO ADMINISTER ROUTINE STANDING ORDERS

The following client of yours _____ ____/____/____ will be admitted to Greater Minnesota Family Services' Shelter Care Program. Please verify that the following over the counter medications can be administered PRN as Standing Orders.

ROUTINE STANDING ORDERS

It is understood that the SHELTER CARE PROGRAM RN must be notified before or 24 hours after the administration of any PRN over the counter medication. Also the client's physician will be contacted if the following orders do not result in relief of symptoms within 24 hours, or if the client's condition changes significantly. Any standing order that is used regularly for over 5 days will be brought to the attention of the physician.

1. Ointment for treatment
   Triple Antibiotic Ointment TID PRN
   A & D TID PRN
   Vicks TID PRN

2. Analgesics
   Tylenol 325 mg 1-2 tabs q 4-6 hours PRN for relief of temporary pain.
   Ibuprofen 200 mg 1-2 tabs q 4-6 hours PRN for relief of temporary pain

3. Anti-diarrheal
   Pepto-Bismol 2 Tbsp q. 2-3 hours PRN
   Kaopectate Conc. 1-2 Tbsp q 4 hours PRN

4. Laxative
   MOM 15-20 cc daily PRN for 1-2 days
   Dulcolax Supp 10mg daily PRN
   May hold laxative if loose stools, evaluate daily

5. Antitussives & Expectorants
   Cough Drops, Cough Syrup with out Alcohol base

6. Antacid
   Maalox 1-2 tsp TID PRN
   Antacid Tablet 1-2 tabs QID PRN

7. RID Head Lice Treatment

8. HC Cream 0.5%
   Up to TID PRN for itch

9. Debrox/Murine
   3-4 drops to affected ears BID X 4 day

10. Multiple Vitamins

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

12. Basic Skin Care
    May use OTC lotions/ointments for
    Dry skin
    Skin Tears: cleanse with sterile
    solution, apply ointment,
    Band aid, telfa pad & tape
    Small Ulcer: cleanse with sterile
    saline solution, apply ointment,
    cover with band aid/telfa
    Transparent Dressing QID PRN
    for skin breakdown/nurse

I give permission for the client named above to receive these Standing Orders.

Parent/Guardian: _____ ____/____/____

Call 320-212-0464 for any questions

SHELTER CARE PROGRAM
GREATER MINNESOTA FAMILY SERVICES
3619 15TH A VE 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 client of yours _____ ____/____/_____
(Resident) (DOB)

has been admitted to our Shelter Care. Please verify that the following are medications that you have doctor's orders for and have been recently filled for this resident by faxing the **medication information sheets** for the medications listed on *this* form.

_____ _____ give permission for
(Parent/Guardian} (Date)

_____ _____ _____
(Pharmacy) (Address)

to release the information to Shelter Care Program. **ALLERGIES:** _____

RX Number	Prescribing Physician	Medication / Strength	Dose	Times Given	Symptoms/Reason

PLEASE FAX THIS FORM BACK WITH THE MEDICATON INFORMATION SHEETS FOR THE MEDICATIONS THE RESIDENT IS TAKING. FAX: 320-235-1671

If this information is correct, please sign below. Please contact 320-235-3664 if there are questions or comments. Thank you.

_____ _____/_____/_____
Pharmacist Signature Date

Form 23005

GREATER MINNESOTA FAMILY SERVICES

2320 E Hwy 12, Suite 2, 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 info1mation. 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.

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 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

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

SUGGESTIONS OR COMPLAINTS
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.

1mtact **Information for Privacy Official:**
Greater Minnesota Family Services
ATTN: Data Privacy Office
2320 E Hwy 12, Suite 2,
Willmar, MN 56201
Phone: 320-214-9692
Fax: 320-214-9924

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):

_____

_____

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

Approved Contacts

Residents Name: ____

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

Name: _________________________________ Phone: _______________________ Relationship to Resident: __________________________
☐ Phone ☐ Mail ☐ On-site Visit ☐ Off-site Visit ☐ Home Visit

☐ Yes ☐ No Must have worker approval prior to visit ☐ Yes ☐ No Must have worker approval prior to visit

I give my permission for the above people to have contact with my child and Shelter Care staff.

Parent/Guardian ____ Date: ________________