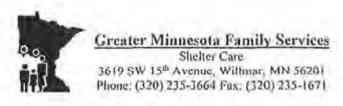
# GREATER MINNESOTA FAMILY SERVICES - SHELTER CARE (GMFS/SC) AGREEMENT JANUARY 1, 2021 – DECEMBER 31, 2022

ie	A	gency, (hereinafter referred to	as Agency) places and is financially responsible fo
	(recipient) while placed at GMF	S/SC, 3619 SW 15 <sup>th</sup> Avenue,	Willmar, MN 56201, as of
_	ncy and GMFS/SC agree to abide by the provisions outlined in this placement		
1.	The Agency shall, by written communication, provide GMFS/SC with a spelegal custody of the child.	ecific statement as to the legal	status of the child, and whom or which agency has
2.	GMFS/SC shall, within five (5) working days following the last day of each		
3.	name of child served; 2) number of days of service with daily rate (the unit The Agency shall, within thirty (30) calendar days of the date of receipt of t		
٥.	GMFS/SC for the total cost of services incurred by the resident. Any finance		
	between the recipient and the Agency and will not involve GMFS/SC. It is a		
	payments relative to the recipient's medical, psychological, psychiatric, den		
	medical insurance.	, 1	
4.	Insurance Company Co-pays for client's medical/medications will not be in		
	Contractor shall, within ten (10) working days following the last day of each		
	medical/medication needs not covered by the client's Medical Insurance to		
	day of each calendar month, submit on a standard invoice, the cost incurred have Medical Insurance, to the Agency.	by the Contractor for any cli	ent's medical/medication needs, when clients do not
5.	GMFS/SC shall inform the Agency within one (1) working day when the ch	ild is absent from GMES/SC	Mutual agreement shall be reached within one (1)
٥.	working day between GMFS/SC and the Agency as to how long the recipier		
	the Agency within five (5) working days.	or see shall be noted that yes	our communications made of commune in withing t
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 w	riting at the time of placem	ent:
	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		
	<ul> <li>d. Medical health problems (including names of physician last seen, far</li> <li>e. Educational data (IEP, achievement scores, and special programs);</li> </ul>	nny doctor, dentist, optician	, and specialist).
	f. Child health insurance information (medical assistance number/card	narent's health insurance	nolicy number)
	g. Out-of-home placement plan.	, parent's nearth mourance/	poncy number).
	h. Court order or voluntary placement agreement.		
8.	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 placeme
	to sign the necessary consent forms (if parents are unavailable, the child's gua		
	If GMFS/SC is requested by the referring Agency to transport residents to state	fing, hearings, medical/therap	by appointments, or court appearances, they will be
	included in the per hour costs.		::11:1+ -f.CMES/SC+:1
	The Agency agrees to pay full per diem costs to GMFS/SC if a child is given I date of official discharge as requested by the referring Agency.	iome visits. The child is cons	sidered a resident of GWFS/SC until
	aute of official discharge as requested by the referring regency.		
	GMFS/SC Representative	Date	
	GMI 6/50 Representative	Bate	
	Placing Agency Representative	Date	
11.	The Agency agrees to contract the following additional services: (The following	ng service fees are in addition	n to per diem charges and payment must be received
	within thirty (30) calendar days of the date of receipt of the invoice, with payr		
		<u>Masters</u>	<u>Doctorate</u>
	Psychological Evaluation	\$98.60/hr.	\$119.96/hr.
	Family Based Assessments	\$98.60/hr.	
	(Done by a professional counselor)	<b>#</b> 60 001	
	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.	Placing Agency Representative  The Agency does not wish to contract for additional services.	Date	
12.		Date	
12.	The Agency does not wish to contract for additional services.		
12.	The Agency does not wish to contract for additional services.		



# 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.

immediate danger to himself/herself or other	5.
I,	, parent/guardian of
(Parent/Guardian)	
(Resident)	*
facility and will not be held responsible for the they were to run from the facility located at 3 Shelter Care program is also not responsible program staff while on an off-site outing. The injured after running away from the facility at type of unlawful act after running away from	nily Services Shelter Care program is not a locked the health and welfare of the above named resident if \$619.15 <sup>th</sup> Ave. SW, Willmar, MN 56201. The for a child who chooses to run away from the is includes, but is not limited to, a child becoming and/or staff members or the child committing some the facility and/or staff members.
Kandiyohi County Sheriff's Department to in be considered for discharged at that point and	form them that a child is missing. The resident may d will not be allowed to return to the Shelter Care erved in a secure facility for a period no less than 24
Re-admittance into the Shelter Care program re-admit or not.	will be based on the Shelter Care team's decision to
Parent/Guardian	Date:
Referring Worker	Date:
Shelter Care staff	Date:



# Greater Minnesota Family Services

Application for Service

Legal Name of Client:	Race:
Lost First	M.I.
Address:	
Number/Street/Route	Fown/City State Zip
County of Residence:	TYPE OF SERVICE REQUESTED:
Date of Birtli:	(Initial & Date)
SSN:	1 Diagnostic Assessment / / 2 Family Based Services / /
Telephone: Home:()	3 School Mental Health / / / 4 Early Childhood FBS / /
Work: ()	5 CHCBS / /
Cell: ( )	5 HCBS / /
Who Referred You to GMFS?	7 Group Therapy / /
Self 2 Family/Friend	8 🖸 FGDM / _ / _
Other (Agency, Staff Person, and Phone):	9 Connections / / 10 Shelter Care / /
	11  Shelter Care FBS / /
Previous D.A. yes no if yes Agency Name D.A. Date	12 Psychiatric Services
COUNTY: OF RESIDENCE COUNTY: DIFFERENT THAN COUNTY OF RESIDENCE: GRANT/INSURANCE PRIMARY 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 Minneson Family Services (GMFS) be made directly to GMFS. I authorize GMFS to release to the aforementioned third porty 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.
SECONDARY INSURANCE	Signature of Client or Legal Guardian Date
COMPANY	
PHONE #	I, the Undersigned, Confirm that:
MEMBER I.D. #	I am willing to receive these services. I have been offered a copy of
POLICY/GROUP #	the Notice of I'rivacy Practices, Client's Rights and Responsibilities and use of Email Policy
POLICY HOLDER DOB	
	Signature of Client or Legal Guardian Date



Greater Minnesota Family Services Shelter Core 3619 SW 15<sup>6</sup> Aveque, Willmar, MN 56201 Pixone: (320) 235-3664 Fax: (320) 235-1671

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

## **Admissions Face Sheet**

	Last	Fire		Middle	
Resident's Nicknames:					
Date of Birth:	Age:	_			
Address:			Nity:	Sente:	Zip:
Parents:					
Address:		C	City:	State:	Zip:
Home Phoue:	Work	Phone:		Cell Phone:	
Emergency Contact:				Phone:	
Severely Emotionally Dist	arbed diagnosis;				
Medications:					
Social Security #:		Heath In	e. lufo:		
Physical Health Concerns:					
Medications:					
Prior Placeutents:					
Resident's Place of Birth:	-				
anguages spoken/written:					
Languages spoken/written: Tribel Affiliation:					
	School Name:				
Tribd Affiliation:	50			_	
Tribd Affiliation:	School Name: Address:			_	
Tribd Affiliation:	School Name:				
Tribd Affiliation:	School Name: Address: Phone: Contact Person:				
Fribel Affiliation: Last Educational Seaung:	School Name: Address: Phone: Contact Person:		Fomily:		
Fribal Affiliation:  Last Educational Setting:  ipiritual / Religion:	School Name: Address:  Phone: Contact Person: Resident:	□ Mother Only	Family:	D Other	-
Fribal Affiliation: Last Educational Setting: ipiritual / Religion: bysical Custody:	School Name: Address:  Phone: Contact Person: Resident:  D Mother & Father	Mother Only     Mother Only	Family:	D Other	



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

1 00000		nt's Name)		(Date of Birth)	
all Gre	cater Minnesota Family Servi	ces staff and			G:
	98		laiso2)	Worker's Agency)	
		-			
	(Mailing Address)	/	(Phono)		(Fax)
	(Social Worker's	Name)	-		
To:	Dísclose	Obtain From	Exchange	With	
x_	Insurance and Billing Information Psychological, Psychiatric I Reports and Consultations Family and Social History	Evaluations/Reports; M	Academic/School Tra	utscripts	al .
-	Treatment Plan, Discharge : Social Service Information		Court/Probation Infor	nation	
	Total Dot the internation		- Ottles	<del>V </del>	<del></del>
The info	ormation requested/exchanged To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request				
The info	To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request  UTHORIZATION FOR RELE reater Minnesota Family Ser  I understand that this authorization on to ATM: Data Privecy Officer, Great before this revocation shall not be a b provides my insure with the right of I understand that authorizing the disci	ASE OF INFORMATI vices' services are ter ay be revoked at any time. The Minneron Family Service reach of confidentiality. I wo contest a claim under my po- course of this information to	ON IS VALID UNTIL: o minated, whichever occurrence to the authorization recognise in elect, P.O. Dox 1810, Willmar MN aderstand that the revocation willion, voluntary, I can refuse to fign to	urs Arst, furthermo Fect vales it is speaked t 56201. Lunderstand the ill not apply to my interna- this puthorization. I need	re:  by revoked by written nutice  sny information released  nce company when the law  not sign this sudicrization
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THIS A whea G  1.  2.  3. 4.  Signstu Residen	To Effect a Continuum of C Evaluation/Treatment Financial Billing Per Client Request  UTHORIZATION FOR RELE reater Minnesota Family Ser  I understand that this eathorization as to ATN: Data Privecy Officer, Great before this revocation shall not be a b provides my insurer with the right to receive services unless the services dischouse to a third party (i.e. consul- t understand that have due right to le t understand that if the individual or regulations under Public Law #104-15 federal regulations. If I have question A photocopy or formile copy of this ferimile as well as the United States  tes:	ASE OF INFORMATI vices' services are ter ay be revoked at any time. The Minnerod Family Service contest a claim under my po coure of this information to lare count-ordered or are to to ulinos). Aspect and receive photo cop reganization that receives the D1. 1996, the information de to about disciturue of my he authorization is as effective Pustal Service.	ON IS VALID UNTIL: o minated, whichever occurs in the authorization remains in elect, P.O. Box 1810, Willmar MN aderstand that the revocation willow. The provided solely for the purposites of health information is not a health care actived in this authorization and alth information, I can contact Coast the original, I stee give my	urs first, furthermo Fect valeur it is spealted it 56201. Lunderstand the fill not apply to my insuran this authorization. I need use of creating protected h sed under this authorization to provider or health plan by be re-olosed and no loa Greater Minneavia Family permission to exchange i	by revoked by written indicated in the formation released ince company when the fare not sign this studiorization could information for covered by federal privacy gar protected by the same "Services" Privacy Officer.



ADTHORIZATION FOR RELEASE OF INFORMATION
Probation Officer
Greater Minnestole Foundly Services - Shelter Care.
3619 SW 15<sup>th</sup> Avenue, William, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

	(Resident's Name)	(Date of Birth)
all Gre	ater Minuesota Family Services staff and	at
		(Probation Officer's Agency)
	The state of the s	
	(Mailing Address)	(Phone) (Fax)
	(wanting Address)	(ras)
-	(Probation Officer's Name)	
To:	Disclore Obtain From	Exchange With
x_	Reports and Consultations	r; Medical Reports Including History and Physical  Academic/School Transcripts
Ξ	Family and Social History Treatment Plan, Discharge Summary Social Service Information	Court/Probetion Information Other
(I under	stand that the information to be obtained may inclu	ude Chemical Dependoncy Information.)
THIS A	reater Minnesota Family Services' services are in I underland that this sufficients used by revoluted at any tier to ATM: Data Privacy Offices, Oreales Minumous Family Ser	ATION IS VALID UNTIL: one year from the date of signature, or ferminated, whichever occurs first, forthermore:  This authorization remains in effect and on it is specifically sevoked by written unticarries; F.O. Box 1810, Willess MH 1620). I understand that any information released I confermed that the two confermed with any policy.
2. 4. 5.	I conference that exclamining the disclosure of this information to receive sorvious unless the services are court-ordered as are disallowers to a shirtly party (i.e. commissions).  I understand that I have the right to inspert and receive phase it understand that if the individual or expanitation that receives applications under Public Law 9104-191, 1990, the information federal regulations. If I have questions about disclosure of any	a le voluntary. I can octivue to algo this modern pales. Unced out togo, this evoluni ration to be provided solely for the purpose of unceting protected health information for
Signata	ren:	
Residen	t	Date
Parent/(	Guardian	Date



AUTHORIZATION FOR RELEASE OF INFORMATION
Medical Advisor
Greater Minnesota Family Services - Shelter Core
3619 SW 15<sup>th</sup> Avenue, Willman, MN 36201
Phone: (320) 235-3664 Fax: (320) 235-1671

L			hereb	y authorize
	(Resident's Name)	(Date of Birth)		
all Great	tor Mianosota Family Services stuff and Family Practice Medical Center a	at 502 2nd St. SW.	Willman	MN 56101
Phanes	320-231-8886			
Fax:	320-231-8602			
Contact:	All FPMC staff			
The	Disclose Obtain From Exchange	With		
<u>-</u>	Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; Medical Reports Including I Reports and Consultations Family and Social History Treatment Plan, Discharge Superary Social Service Information Other	necipts	el .	
(I underst	and that the information to be obtained may include Chemical Dependency in	formstion)		
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Signature	22			
Residont		Date		
Parent/G	vardian	Date		
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AUTHORIZATION FOR RELEASE OF INFORMATION
Prescribing Physicine
Oreater Minnesota Founity Services - Shelter Cane
3619 SW 15th Avenue, Willmar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

to the last	(Resident's Name)		(Date o		
#U G	center Minnesota Family Services staff and			-	
		(Pre	eribing Physician	's Clinic)	
-					
*******	<del></del>				<del></del>
	(Mailing Address)	(Phone)		(Fux)	
-	(Prescribing Physician's Name)	_			
To:	Disclore Obtain From	Esc	ionge With		
,	Insurance and Billing Information				
_	Psychological, Psychiatric Evaluations Reports;	Medical Reports Inc.	uding History and	Physical	
	Reports and Consultations Family and Social History	Academic/Scho	al Transpoints		
	Treatment Plan, Discharge Summary	Court/Probation			
	Social Service Information	Other			
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The in	formation requested/exchanged is needed for the follo				
	To Effect a Continuum of Care For The Client's I  Evaluation/Treatment	gecovery.			
A	Financial Billing				
_	Per Client Request				
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					Light-Said Lists
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AUTHORIZATION FOR RELEASE OF INFORMATION
Primary Clinic
Greater Minnesons Family Services - Shelter Care
3619 SW 15th Avenue, Wilhnar, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

	(Resident's Name)		(Date o	and Mil		
all Gre	ater Minnesota Pamily Services staff and	/2	esident's Primary C	Gnie	_	ae
		(10	esidem's Filmay C	mici		
	1		i			
	(Mulling Address)	(Phone)		(1	Fax)	
	(Prinary Physician's Name)	-				
To:	Disclose Obtain From	Er	change With			
	Insurance and Billing Information Psychological, Psychiatric Evaluations/Reports; M Reports and Consultations Pamily and Social History	100000	cluding History and	Physical	A. I	
	Treatment Plan, Discharge Summary Social Service Information	Coun/Probati-	on Information			
Lunder	stand that the information to be obtained may include	Chemical Depen	dency Information.	).		
	Evaluation/Treatment Financial Billing Per Client Request  UTHORIZATION FOR RELEASE OF INFORMAT'S reator Minnerota Family Services' services are ter I understand ther this anthonyminion may be revoked of any time. To ATTS: Data Privacy Offices, General Michaestan Family Service before this revocation shall not be a breach of confiderability. In I understand fluid authorizing the disclosure of this information is to receive services under the services are count-ordered or are to disclosure to a third party (i.e. consultations). I understand that it was the right to import and receive photo cop I understand that it was the right to import and receive photo cop I understand that it is the individual or organization that encovives the regulations under Public Law #104-191, 1996, the information de faderal regulations. If I have questions about diaclosure of my he A photocopy or factuable copy of this subsociation is as officency	militated, whilehed The sudisting reason, N.O. Bus 1810, W. Inderstand that the rest fier. Voluntary. I can refuse be provided solely for ier of health information is not a least with information is not a least with information, it can add in this cubbon add in this cubbon add in this cubbon	wer occurs first, further had the affect unless in affect unless in the thousand the transfer will and apply to be to sign this outheritall the purpose of creating to dischard under this health care provider or hustion may be re-closed a contest Misson or when the closer Misson occurs of the contest of th	rthermon specifically critical that any increase m. I need a protested be contacted by contacted	ret prenaled by may information on company not eign thin with informa- tion on protection Sendom' Pr	y written outloy atlou colessed when the law authorization affect for coleral privacy I by the tense tivacy Officer.
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Parent/	Guardian		1	ate		_1
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AUTHORIZATION FOR RELEASE OF INFORMATION
Pharmacy
Greater Minnesons Family Services - Sheker Care
3619 SW 15<sup>th</sup> Avenue, Willman, MN 56201
Phone: (320) 235-3664 Fax: (320) 235-1671

I.		bereby authorize
(Resident's Name)	(Oute of Birth)	
all Greater Minnesota Family Services staff and Thrilly White Brug at 1600 F	Brit St. SW, Willman, M.	N 56201
Phone: 320-235-1930		
Fax: 320-235-7801		
Contact: All Thrifty White Drug staff		
Tat Disclose Obtain From Exchar	nge Widi	
Insurance and Billing Information     Psychological, Psychiatric Evaluations/Reports; Medical Reports Includ     Reports and Consultations     Family and Social History Academic/School     Treatment Plan, Discharge Summary Court/Probation In	Transcripts	
Social Service Information Other		-0
(f understand that the information to be obtained may include Chemical Dependence	y information.)	
The information requested/exchanged is needed for the following purpose(s):  _s To Effect a Continuum of Care For The Client's Resovery _s Evaluation/Treatment _x Financial Billing Per Client Request  THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID UNTIL		
when Greater Minacrota Family Services' services are ferminated, whichever		20010
<ol> <li>I understand that this potherization copy by revoked at any time. This potherization remains a to ATTAL Data Privacy Officer, Oreater Misoscota Family Services, P.O. Doe. 1810, Williams before this revocation due to be a breach of confidentiality. I understand that the regist to constant of this ander top policy.</li> <li>I understand that authorizing the disclosure of this information is voluntary. I can refuse to a to receive services unless the services are count-ordered or are to be provided colely for the perductariant for third party (i.e. consultations).</li> <li>I understand that I have the right to import and receive photo copies of hashin information distributions to the information to the regulations to the information to one a benth regulations under Public Law 4104-171, 1996, the information described in this authorization federal regulations. If it have quantions about dischauce of any health information, I can conduct the regulations of the information of the physical service.</li> <li>A physicatopy or Sectionials copy of this authorization is a effective as the original. I also give facerinile as well as the Upited States Partial Service.</li> </ol>	hOV 56201. I underwand that a a will not apply to my instruc- ign this sutherization. I need no appear of menting protested has aclosed under this sutherization care provides or teathly fine no many be re-classed and no langu- ant Greater Manocaula Foreity 8	ay information released e company when the law of ergn this audientization (th beformation for exercit by featers) privacy or previously the same environ? Pairway (Mines
Siguatures:		
Resident	Date	
Parent/Guardisa	Dute	



AUTHORIZATION FOR RELEASE OF INFORMATION

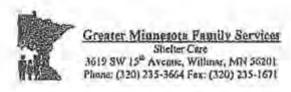
General

Orealer Minnesous Family Services - Shelter Care

3619 SW 15<sup>th</sup> Avenue, William, MN 56201

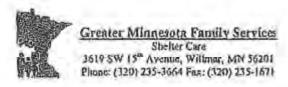
Phone: (320) 235-3664 Fax: (320) 235-1671

	(Resid	ent's Name)		(Date of B	irth) boreby autho
all Gre	ater Minnesols Family Serv	dees stall and			
			((	Organization)	
	(Mailing Address)	· · · · ·	(Phone)		(Fax)
	(Contact Perso	n)	-		
Fo:	Disclose	Obtain From	Exch	iange With	
	Insurance and Billing Info Psychological, Psychiatric Reports and Consultations Family and foodal History Treatment Plan, Discharge	Evaluations/Reports, M	Academic/Scho Court/Probation	of Transcripts	bysical
Constitution of the consti	Social Service Information to I		Other		_
	Per Client Request  THORIZATION FOR RELI				
i	reater Minterota Family Se I undersund that this authorization to an ATTN: Data Privacy Officer, Ora before this revocation that not be a paroides my insure, with the right to I coderstand that authorizing the dis- to releave services unless the service fineforms to a third party (Le. avera I understand that I have the right to i I understand that I have the right to i I understand that if the individual as populations under Public Law 1104- Coloral cogulations. If I have questly A photomory or financials copy of the factionic as well as the United Scale	may be revoked at any time. I stee Mismesons Family Service breach of confidentiality. I us contest a claim under my pol- change of this information is a mare court-ordered or see to be dealisms). happed and secrive plants copi organization that receives the 191, 1996, the information of me about disclosure of my bea to abboritation is a effortive to abboritation is a effortive	this authorization remains, P.O. Box 1810, Wains of created that the retrocation, robinstary. I can refuse it to provided solely for the created that the created in the carbon created in this authorization is son a beautiful information, I can expended the information, I can expended.	as in effect tenters it is spen any AAA 56286. I understation will and apply to say a sign this submitation. a purpose of executing post disclosed coaler this sub- th care provider or bank for may be re-aloued and author Greater Manacook	edited by sevaked by written or and that any inferences refear- insurance company whole the I I need not right this anticritus acted breach information for unionized, a plan account by foderal prive on longer proveded by the can Fundry Services' Privacy Office
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# Activity Waiver (Informed Consent and General Waiver)

	to participate in any trips,
events, community service and skills learn GMFS team. These include, but are not lit recreational activities; and events which re	(Resident) ing groups, and/or officer activities deemed appropriate by the mited to: cleaning and maintenance; water, leisure and quire travel in automobiles.
I,(Puren//Quardian)	agree for participant, myself, my heirs,
nor any of its officers, members, agents, re implied or otherwise, or any personal inju-	asigns that neither Greater Minnesota Family Services (GMFS) presentatives, nor employees shall be liable for any negligence y, or death, or property loss, medical expense or other damage sant named above in connections with or arising from any ised by GMFS.
assume all risk whatsoever of personal inju- in connection with any or all activities eng- supervised by GMFS and I absolve and rel- and/or employees from all liability and cov GMFS on account of any personal injury or express intention and purpose to waive any from any activity sponsored, supervised or and purpose to bind participant/myself, my	secutors, administrators, successors and assigns, I expressly try or death or property damage, medical expense or other loss aged in by ma/participant named above and sponsored or case GMFS, its officers, members, agents, representatives, cenant and agree not to sue or prosecute any claim against or death or property damage or loss of any kind. It is my potential claim for any liability acising or claimed to arise participated in by GMFS and it is further my express intent beirs, executors, administrators, and assigns by this express
waiver and assumption of risk.	
	y other consent or waiver which may be signed concurrently intended to be permanent and shall remain in offect unless
Not withstanding any expiration date of an with this waiver or otherwise, this waiver is specifically revoked.  If signing as a parent, natural guardian, app	
Not withstanding any expiration date of an with this waiver or otherwise, this waiver is specifically revoked.  If signing as a parent, natural guardian, apprepriesent and warrant that I possess the full ward, conservatee, or other person.	intended to be permanent and shall remain in offect unless cointed guardian, or in any other representative capacity, I
Not withstanding any expiration date of an with this waiver or otherwise, this waiver is specifically revoked.  If signing as a parent, natural guardian, apprepresent and warrant that I possess the followard, conservatee, or other person.  Parent/Guardian	intended to be permanent and shall remain in offect unless cointed guardian, or in any other representative capacity, I legal authority to enter this agreement on behalf of my child,



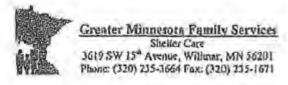
(Parent Guardian)	parent/guardian of
(Rasident)	
	ervices Shelter Care staff members to monitor the d minor, under the laws of the State of Minnesota
bis authorization shall remain in effect so los are, and control of Greater Minnesota Family	ng as the said minor is in the physical custody, Services Shelter Care program.
arent/Guardiau	Date:
helter Care staff	Date:



Greater Minnesots Family Services Shelter Caca 3619 SW 15th Avenus, Willmar, MN 56201 Phone: (320) 235-3664 Fax: (320) 235-1671

# Information Needed Prior To Admission

Resident's 1	Vame:		
Gender:	М	F	
Race:			
Heighr:			
Weight:			
Eye Color:	***************		
Tattoos:			
Piercings:			The state of the s
Date of Last	Physical E	Exam:	
Date of Last	Dental Vis	sit:	
Primary Phy	sician;		
Primary Clin	ic:		
Address:			
Phone:		*****	
Fax:		***************************************	nangan manan-kabandan-kabanan-kaban
Prescribing F	bysician:		
Clinic:			
Address:		erenganius vizzo programa.	
Phone:	-		and and a first a firs
Fax:	L'e		



# Consent for Medical Treatment

		- Posters	/guardian of
	(Parens/Guardian)		
	(Resident)	-	(Date of Birth)
Minnesota Famil anesthetic, or sur, under the general	y to consent for medical treats y Services Shelter Care staff t gloal diagnosis; for treatment or special supervision and on a law of the State of Minneson	nembers to consent and hospital care, to the advice of a phy	to any x-ray examination; to be rendered to said minor
minors referring a from Greater Min to release to third		I request that pay (S) be made directly es, type and provide	ment for all services received y to GMFS. I authorize GMFS er of service(s) regarding
also authorize G	MFS Shelter Care staff to add	ninister medication	to the said minor as directed
	a duly licensed physician or	surgeon.	***************************************
and prescribed by			e Notice of Privacy Practices.
and prescribed by am willing to rec This authorization		ectived a copy of the	e Notice of Privacy Practices,
and prescribed by am willing to rec This authorization	ceive these services. I have re	ectived a copy of the ste signed. I unders MFS has already dis	te Notice of Privacy Practices, stand that I may revoke my sclosed data.
and prescribed by am willing to rec This authorization consent at any time earent/Guardian	ceive these services. I have to expires one-year from the da e except to the extent that GN	eceived a copy of the ste signed. I unders MFS has already dis	te Notice of Privacy Practices, stand that I may revoke my sclosed data.
and prescribed by am willing to rec This authorization consent at any time arent/Guardian	ceive these services. I have to expires one-year from the de se except to the extent that GM	eceived a copy of the ste signed. I unders MFS has already dis	tand that I may revoke my sclosed data.  Date:



# Greater Minnesota Family Services

Shelter Care 3619 SW 15<sup>th</sup> 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 & C	current Doctor's Orders	
Upcoming Labs/Treatment Needed		
Physician's Signature	Date	

				DHS-4208 11-0	
Informed Consent	THOMOMA			10	
Form for Psychotropic	DATE (MM/DO	VAA	CONSONT EXPRATIO	HIPM/CO/YYI	
Medication(s)	PHYSICIAN		CASE MANAGER		
Psychotropic(s)					
Generic punte:		Current L	Proposed		
Trade name:					
Dose:	_mg/day	Dose:		mg/day	
Maximum dose:		Maximum dose: _ Route:			
Route:  Current Proposed  Generic name:		Comments/Other:			
Trade name: Dose: Maximum dose:					
Route:					
Oral Communication		Written inform	nation includ	ling possible	
No, could not reach Yes:		side-effects(*)		A 5 6 5 6 100	
Telephone on	1-1-	Given at mee		it with this form	
		Not provided			
Person to contact for questions or con	cerns	Tardive Dyski	3. 10. 1		
MAME		Present		t present	
ADOKESS		Nor applicab			
	Leave I've		(*)Specify the exact side-effects and/or TD fo provided:		
CHY STATE DE		Provided:			
TELEPHONE					
		-			
he following information has been e isted and written information has be	xplained en provid	ded about the psycho	tropic medic	ation(s)	
. The reasons for the medication(s)					
A description of the behavior/condition in a		ervable and measurable	terins		
The rate and intensity of the behavior/cond. The benefits of the medication(s)	ition				
The alternative therapies available					
The risks including possible side-effects and	their treats	ment			
. Specific aspects of the medication(s) such as	name, dose	e, maximum dose, rout	e, etc.		
The fact that I may refuse consent, on if give			ny rime		
The fact that my consent expires in one year  The names, addresses, and phone numbers of			isc.		
ased upon the above (Check one):	Frankis II	Comments:			
Lapprove the use of the psychotropic(s) liste	d.	Continuents,			
I do not approve the use of the psychotropic  I only approve as follows (specify in comme	(s) listed.				
IGNATURE DATE					
7.6.					

# 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 Do	Dosage Times Given	Form	Container Type	Intake Amount	Intake Amount Discharge Amou
				ores constitution				
				The state of the s				
	Intake Responsible Party:		Time:			Date;		
Intake 5	Intake Shelter Care Staff Member:	in the second se	Time:			Date:		
i	Discharge Responsible Party:		Time:			Date:		
Discharge 5	Discharge Shelter Care Staff Member:		Time;			Date:	The state of the s	
I acknowledge are consistent are my child.	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.	heir content of medication inted on the labels. I giv	on that I am pr e permission	oviding to Shelter C. to Shelter Care staff t	are for my o administ	child at the time of t er the above medica	their intake trions to	
I acknowledge	I acknowledge that my child has no medications at the time of their intake.	cations at the time of the	ir intake.					
I give GMFS	[ ] I give GMFS Shelter Care staff permission to administer Acetaminophen 325mg caplets (1-2 caplets) to my child, as needed.	n to administer Acetami	nophen 325m	g caplets (1-2 caplets	) to my ch	lld, as needed.		
Parent / Guare	Parent / Guardian ciananica.					ţ		
Tan court on the	dian signature,					Date:		1

# SHELTER CARE PROGRAM 3619 SW 15<sup>TH</sup> STREET WILLMAR MN 56201

# PHYSICIANS CONSENT TO ADMINISTER ROUTINE STANDING ORDERS

The following client of yours	
will be admitted to Greater Minnesota Family Services' Sho over the counter medications can be administered PRN as S	elter Care Program. Please verify that the following standing Orders.
ROUTINE STANDI	NG ORDERS
It is understood that the SHELTER CARE PROGRAM RN must be not over the counter medication. Also the client's physician will be contact within 24 hours, or if the client's condition changes significantly. Any brought to the attention of the physician.	led if the following orders do not result in relief of symplome
1. Ointment for treatment	8. HC Cream 0.5%
Triple Antibiotic Ointment TID PRN A & D TID PRN	Up to TID PRN for itch
Vicks TID PRN	9. Debrox/Murine
	3-4 drops to affected ears B ID X 4 day
<ol> <li>Analgesics         Tylenol 325 mg 1-2 tabs q 4-6 hours PRN for relief of to Ibuprofen 200 mg 1-2 tabs q 4-6 hours PRN for relief of     </li> </ol>	emporary pain. 10. Multiple Vitamins of temporary pain
3. Anti-diarrheal	11. May substitute liquid meds for tabs
Pepto-Bismol 2 Tbsp q. 2-3 hours PRN	May crush meds if dosage allowed
Kaopectate Conc. 1-2 Tbsp q 4 hours PRN	Generic drugs may be used unless
4.1	Specified by MD
4. Laxative	Artificial Tears I gu QID PRN
MOM 15-20 cc daily PRN for I-2 days	Ye recovered to the
Dulcolax Supp 10mg daily PRN	12. Basic Skin Care
May hold laxative if loose stools, evaluate daily	May use OTC lotions/ointments for Dry skin
<ol><li>Antitussives &amp; Expectorants</li></ol>	Skin Tears: cleanse with sterile
Cough Drops, Cough Syrup with out Alcohol base	solution, apply ointment, Band aid, telfa pad & tape
6. Antacid	Small Ulcer: cleanse with sterile
Maalox I-2 tsp TID PRN	saline solution, apply ointment,
Antacid Tablet 1-2 tabs QID PRN	cover with band aid/telfa
	Transparent Dressing QID PRN
7. RID-Head-Lice-Treatment	for skin-breakdown/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 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 c	lient of yours	(Resident)			/
has been admitte	ed to our Shelter Care	. Please verify that the follo	owing are	medicatio	ons that you have doctor's
orders for and ha	ave been recently filled	d for this resident by faxing	the medic	cation inf	formation sheets for the
medications liste	ed on this form.				
(Parent/Guardian	}			(Date)	give permission for
(Pharmacy) to release the inf	Formation to Shelter Ca	(Address) are Program. ALLERGI	ŒS:		
RX Number	Prescribing Physician	Medication / Strength	Dose	Times Given	Symptoms/Reason
MEDICATIONS	n is correct, please sig	WITH THE MEDICATOR S TAKING. FAX: 320-235 n below. Please contact 32	5-1671		

Date

Pharmacist Signature

#### 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"

Kesident'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 15<sup>th</sup> Ave, Willmar MN, 56201 Phone: (320)235-3664 Fax: (320)235-1671

# Approved Contacts

	Resident	ts Name	:				
Name:				Phone:			Relationship to Resident:
runic.	□ Phone	□ Mail	□ On-site Visit		□ Home	Visit	Relationship to resident.
	□ Yes	□ No	Must have worker a	pproval 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 a	pproval 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 a	pproval 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 a	pproval 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 a	pproval 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 a	pproval 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 a	pproval 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 a	pproval 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 a	pproval prior to visit	□ Yes	□ No	Must have worker approval prior to visit
		I give	my permission f	or the above peop	le to have	contac	t with my child and Shelter Care staff.
		Parent	/Guardian				Date: