Shelter Care
3619 SW 15th Ave, Willmar MN, 56201
Phone: (320)235-3664 Patient Health Records Fax: (651)925-0236

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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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 parent/guardian 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: ______________

Greater Minnesota Family Services
"Serving the Counties & Families of Minnesota"
2320 E Hwy 12, Suite 2 • Willmar, MN 56201
Tel. (320) 214-9692 • Fax (651) 925-0236
www.greaterminnesota.org

Application for Services

☐☐☐☐☐☐ ☐☐-☐☐-☐☐
Client Number Date Services Began

_____
GMFS Staff Name

Legal Name of Client: _____ Race: _____
Last First M.I.

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

Email address: _____@_____

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 ☐ SEED ___/___/___
6 ☐ Head Start ___/___/___
7 ☐ Group Therapy___/___/___
8 ☐ FGDM ___/___/___ _____
9 ☐ Connections ___/___/___
10 ☐ Shelter Care ___/___/___
11 ☐ Shelter Care FBS___/___/___
12 ☐ Psychiatric Services___/___/___
13 ☐
14 ☐ Other ___/___/___

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 providor 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 give my permission to release information to the MN Depart ment of Human Services for outcome measures.
☐ I am willing to receive these services. I have been offered a copy of the Notice of Privacy Practices, Client's Rights and Responsi bilities, and use of Electronic Communication 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:

Shelter Care
3619 SW 15th Ave, Willmar MN, 56201
Phone: (320)235-3664 Patient Health Records Fax: (651)925-0236

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 discharge 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
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

Shelter Care Missing Person Agreement

It should be understood that, should a resident be enrolled within the Willmar Public School District, if they choose to leave the school building during school hours, then they will be identified as a missing person.

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 any Willmar Public School grounds or buildings. This includes, but is not limited to, a child becoming injured after running away from the school and/or school staff members or the child committing some type of unlawful act after running away from the school and/or school staff members.

The resident will be declared a missing person for the purposes of allowing the Willmar Police Department to lawfully detain and return them.

Parent/Guardian _____ Date: _____

Resident _____ Date: _____

Shelter Care staff _____ Date: _____

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, _____ _____ | _____ | _____ **hereby authorize**
(Resident's Name) (Date of Birth)

all Greater Minnesota Family Services staff and _____ **at**
(Social Worker's Agency)

_____

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

_____ _____
(Social Worker's Name) (Social Worker's email address)

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-closed 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) (Probation Officer's email address)

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-closed 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, _____ _____ | _____ | _____ **hereby authorize**
(Resident's Name) (Date of Birth)

all Greater Minnesota Family Services staff and _____ **at**
(Organization)

_____

_____ | _____ | _____
(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

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-closed 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

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: _____

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 th ese 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 inc lude 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. Fo r example: A bill may be sent to you or a third party payer. The information on, or accompanying the bill may include information t hat 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.

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):

_____

_____

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 **E**motionally **D**isturbed diagnosis: _____

Medications: _____

Social Security #: _____ Heath Ins. Info: _____

Physical Health Concerns: _____

Medications: _____

Prior Placements: _____

Resident's Place of Birth: _____

Languages spoken/written: _____

Tribal Affiliation: _____

Last Educational Setting: School Name: _____
Address: _____ Grade: _____
_____
Phone: _____ IEP? Yes / No
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: _____

RESIDENT RIGHTS AND BASIC SERVICES

A resident has basic rights including, but not limited to, the rights in this subpart. The license holder must ensure that the rights in items A to R are protected:

A. right to reasonable observance of cultural and ethnic practice and religion;
B. right to a reasonable degree of privacy;
C. right to participate in development of the resident's treatment and case plan;
D. right to positive and proactive adult guidance, support, and supervision;
E. right to be free from abuse, neglect, inhumane treatment, and sexual exploitation;
F. right to adequate medical care;
G. right to nutritious and sufficient meals and sufficient clothing and housing;
H. right to live in clean, safe surroundings;
I. right to receive a public education;
J. right to reasonable communication and visitation with adults outside the facility, which may include a parent, extended family members, siblings, a legal guardian, a caseworker, an attorney, a therapist, a physician, a religious advisor, and a case manager in accordance with the resident's case plan;
K. right to daily bathing or showering and reasonable use of materials, including culturally specific appropriate skin care and hair care products or any special assistance necessary to maintain an acceptable level of personal hygiene;
L. right of access to protection and advocacy services, including the appropriate state-appointed ombudsman;
M. right to retain and use a reasonable amount of personal property;
N. right to courteous and respectful treatment;
O. the rights stated in Minnesota Statutes, sections 144.651 and 253B.03:

Subd. 21. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subject to the general rules of the treatment facility, a patient has the right to receive visitors and make phone calls. The head of the treatment facility may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

P. right to be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;
Q. right to be informed of and to use a grievance procedure; and
R. right to be free from restraint or seclusion used for a purpose other than to protect the resident from imminent danger to self or others.

_____ _____
Parent/Guardian's signature Date

_____ _____
Resident's signature Date

Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Behavioral Checklist

Resident Name:

	When did it start?	How often does it occur?
Attention:		
Careless mistakes		
Short attention span		
Doesn't listen		
Doesn't finish tasks		
Problems with organization		
Loses important items		
Fidgety, squirming		
Interrupting others		
Unable to wait their turn		
Oppositional Behaviors:		
Easily annoyed, touchy		
Argumentative		
Defiant of rules or directions		
Irritable or angry a lot		
Bothers others deliberately		
Spiteful or mean		
Blames others for mistakes		
Conduct:		
Bullies or threatens others		
Starts fights		
Physically cruel to animals or people		
Has forcibly stolen from someone		
Forces sexual activity		
Deliberately destroys property		
Broken into someone else's property		
Lies or cons others		
Stolen without confronting the victim		
Physical:		
Loss of appetite		
Low energy		
Excessive energy		
Difficulty falling asleep		
Difficulty staying asleep		

Emotional:	When did it start?	How often does it occur?
Crying spells		
Loss of interest or pleasure		
Hopeless feelings		
Guilty feelings		
Isolates self		
Low self esteem		
Gives away things		
Injures self		
Rage outbursts		
Anxiety:		
Worries something terrible will happen to self		
Worries something terrible will happen to important adults in their life		
Refuses to go somewhere		
Avoids being alone/is clingy		
Nightmares		
Physical complaints when separating from an adult		
Intense fears/phobias		
Extreme fear of new places or situations		
Thinking Concerns:		
Hears voices others don't		
Expresses unusual thoughts or ideas		
Thinks about violence/death often		
Wishes to be dead		
Suicidal comments/ideas		

Other comments:

Resident:
Date:

Shelter Care Baseline Checksheet

Person Rating Baseline

	1-Absent or minimal	2- Occasionally occurs with prompts	3 - Displays often with prompts	4 - Displays often without prompts	5 - Presents appropriate by self	
Express concerns, needs or thoughts in words	1	2	3	4	5	Respect Total:
Seek relationship appropriately	1	2	3	4	5	
Start conversation, enter into groups, connecting with people	1	2	3	4	5	
Empathize with others/looking at another's point of view	1	2	3	4	5	
Manage transitions well	1	2	3	4	5	Responsibility Total:
Persist on challenging/tedious tasks	1	2	3	4	5	
Consider likely outcomes or consequences of actions	1	2	3	4	5	
Acknowledge how behavior is affecting others	1	2	3	4	5	
Manage emotional respnose to frustration	1	2	3	4	5	Safety Total:
Follow rules	1	2	3	4	5	
Manage adequate personal hygeiene	1	2	3	4	5	
Maintain appropriate physical boundaries	1	2	3	4	5	

Comments:

Total:

Shelter Care
3619 SW 15th Ave, Willmar MN, 56201
Phone: (320)235-3664 Patient Health Records Fax: (651)925-0236

Information Needed Prior to Admission

Resident's Name: _____

Gender: _____

Race: _____

Height: _____ Allergies: _____

Weight: _____ _____

Eye Color: _____

Tattoos: _____

Piercings: _____

Date of Last Physical Exam: _____

Date of Last Dental Exam: _____

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 _____

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. 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
   Bacitracin
   BioFreeze

2. **Analgesics**
   Tylenol 325mg 1-2 tabs q 4-6 hrs PRN for headache/pain.

   Ibuprofen 200mg 1-2 tabs q 4-6 hrs PRN for headache/pain

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

4. **Laxative**
   MiraLAX 17grams daily PRN for 3 days
   May hold laxative if loose stools, evaluate daily

5. **Antitussives & Expectorants**
   Cough Drops, Cough Syrup without Alcohol base

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

7. **Head Lice Treatment**

8. **Dry Eyes**
   OTC Artificial Tears

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

10. **Supplements**
    Multiple Vitamin, Calcium, Vitamin D3 at request of parent/guardian

11. *May substitute liquid meds for tabs
    *May crush meds if dosage allowed
    *Generic drugs may be used unless specified by MD

12. **Basic Skin Care**
    May use OTC lotions/ointments for dry skin, acne, sunscreen
    Hydrocortisone 1% cream for itch

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

Physician Signature: _____ _____/_____/____

FAX TO: Shelter Care RN **320-235-1671** (Phone 320-235-3664)

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

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 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-closed 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, _____ _____ | _____ | _____ **hereby authorize**
(Resident's Name) (Date of Birth)

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

_____

_____ | _____ | _____
(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

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-closed 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, _____ _____ | _____ | _____ hereby authorize
(Resident's Name) (Date of Birth)

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

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-closed 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, _____ _____ | _____ | _____ hereby authorize
(Resident's Name) (Date of Birth)

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

Insurance Info:

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-closed 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.

As of (date of intake):

Signatures:

Resident _____ **Date _____ | _____ | _____**

Parent/Guardian _____ **Date _____ | _____ | _____**

AUTHORIZATION FOR RELEASE OF INFORMATION

Previous Pharmacy

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**
(Resident's Pharmacy)

_____

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

Contact: All Pharmacy 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

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-closed 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 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	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.

Parent / Guardian signature: _____ Date: _____

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

Medication Orders on Intake

Resident _____ D.O.B. _____

Medication Name/Generic	Instructions/Route	Size	Dosage	Time Given AM/PM	Form	Purpose	When to Contact Doctor

☐ I give permission to Shelter Care staff to administer the above medications to the resident in the manner prescribed above.

Prescribing Physician's signature: _____ Date: _____