



Prior to Intake Checklist

Initial **Resident Name:** _____ **Date:** _____

- _____ 1. **Copy** of Social Security Card or Card Number _____ - _____ - _____
- _____ 2. **Copy** of Birth Certificate _____ Mailed _____ Faxed
- _____ 3. State I.D./Permit/Drivers License Number _____
- _____ 4. Copy of Court Document Stating Official Guardianship
- _____ 5. **Copy** of Insurance Card or Card
 Insurance Carrier _____
 Insurance Number _____
 _____ Mailed _____ Faxed
 Family Coverage* _____ Yes _____ No
 *If family coverage – required information to verify insurance
 If Yes, Which Parent Covered _____
 Date of Birth of Parent Covered _____
- _____ 6. Prior Primary Health Care Provider (Name) _____
 Location _____
 Phone Number _____
 Will they continue as primary Health care Provider? _____
- _____ 7. Prior Psychiatric Clinic (Name) _____
 Location _____
 Phone Number _____
 Will they continue as primary Psychiatric Health Care Provider? _____
- _____ 8. Prior Pharmacy _____
 Location _____
 Phone Number _____
- _____ 9. Prior Dentist (Name) _____
 Location _____
 Phone _____
 Will they continue as primary Dental care Provider? _____
- _____ 10. Prior Eye Doctor (Name) _____
 Location _____
 Phone _____
- _____ 11. **S.W. Needs to do prior to their arrival at HGR**
 Primary care clinic needs to be changed to ACMC/Benson before appointments can be made
 or medications picked up

* In cases where Medical, Psychiatric, or Dental care is requested outside of our local providers, transportation would be provided by the placing county/ parent/ guardian.



189 Hwy 9 NE, Benson, MN 56215
Phone: 320.843.4815 Fax: 320.843.5105
www.heartlandgirlsranh.org

Page 2

**Original Forms Listed Below Must Be Signed
and Returned to HGR at Intake**

- * Contact Heartland Girls Ranch at (320) 843.4815 to have original paperwork mailed to you.

- a. Riding Instruction Agreement & Liability Release
- b. SCMC Behavioral Medicine Release of Information, Notice of Privacy Practices, and Consent for Treatment
- c. Greater Minnesota Family Services Application, Release of Information, Notice of Privacy Practices, and Consent for Treatment

HORSE ACTIVITIES COME WITH THESE WARNINGS

Heartland Girls' Ranch

Name of Stable or Party Providing These Warnings

189 Hwy 9 NE, Benson, MN 56215

Address of Warnings Provider

SECTION I. DEFINITIONS

The term "HORSE" herein shall refer to all equine species. The term "RIDER" shall herein refer to a person who rides a horse mounted or otherwise handles or comes near a horse from the ground. The terms "I", "ME", "MY" shall herein refer to the recipient listed on page 2 of this form and the parents or legal guardians thereof if a minor.

THE RECIPIENTS(S) OF THIS FORM IS/ARE HEREBY WARNED AS FOLLOWS:

SECTION II. PROTECTIVE ATTIRE

- A. **Protective Head Gear** Each horse handler should consider purchasing and wearing properly fitted and secured protective headgear (equestrian riding helmet), which meets or exceeds the quality standards of the SEI CERTIFIED ASTM STANDARD F 1163. Wearing of such headgear while driving, mounting, riding, dismounting and being near horses, may reduce severity of some of the wearer's head injuries and possibly prevent death from happening as the result of a fall and/or other occurrences.
- B. **Foot Protection** Horse handlers, riders and drivers should wear hard, smooth, full soled boots or shoes that cover the ankle and have at least 1 inch heels. Such boots or shoes provide protection for the feet in the event a horse steps on a foot, and also to assist in preventing the foot from slipping all the way through the stirrup and becoming caught while riding, mounting, dismounting, and/or other occurrences. Wearing soft socks provide additional protection against chafing and allows for easier removal of the foot from the boot.
- C. **Clothing** Horse handlers, riders and drivers should wear ankle length, flexible or moderately loose fitting pants to protect legs, and riders should also consider wearing equestrian pants, breeches or jodhpurs which have leather inner knee/calf patches, or chaps, or other leggings that provide inner leg grip and added stability in the saddle.

SECTION III. INHERENT RISKS

Nature of the Horse Horseback riding and horse driving is classified as RUGGED ADVENTURE RECREATIONAL SPORT ACTIVITY, and there are numerous obvious and non-obvious inherent risks always present in such activity despite all safety precautions. No horse is a completely safe horse. Horses are 5 to 15 times larger, 20 to 40 times more powerful, and 3 to 4 times faster than a human. If a rider falls from horse to ground it will generally be at a distance of from 3 1/2 to 5 1/2 feet, and the impact may result in injury to the rider. Horseback riding/horse driving is the only sport where one much smaller, weaker predator animal, the human, tries to control and become one unit of movement with another much larger, stronger prey animal, the horse, with each having a limited understanding of the other. If a horse is frightened or provoked it may divert from its training and act according to its natural survival instincts which may include, but are not limited to: stopping short; changing direction or speed at will; shifting its weight from side to side, bucking, rearing, falling, biting, kicking or running from what it perceives as danger.



PROTECTIVE EQUESTRIAN HEADGEAR AGREEMENT AND RELEASE
(TO BE COMPLETED WHEN RIDER WEARS HELMET OFFERED BY THIS PROVIDER)

Heartland Girls' Ranch

Provider's name—hereinafter known as **"This Provider"**

Location 189 Hwy 9 NE, Benson, MN 56215

PLEASE READ CAREFULLY BEFORE SIGNING

PRINT NAME OF RIDER _____

ADDRESS OF RIDER 189 Hwy 9 NE, Benson, MN 56215

This Provider has offered and provided, at my request, an equestrian helmet that meets or exceeds SEI certification – ASTM F 1163 standards for use when riding or near horses.

I, for myself and on behalf of my child and/or legal ward, heirs, administrators, personal representatives or assigns, release and discharge **This Provider** and their respective officers, directors, employees, agents, representatives, insurers, assigns, and others acting on their behalf, of and from all claims, demands, or causes of action, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of bodily injury or property damage that may be sustained, or property damage which may occur, as a result of the use of the helmet provided.

I also understand that neither **This Provider**, nor its employees can guarantee the suitability of any helmet provided.

SIGNER STATEMENT OF AWARENESS

I/WE, THE UNDERSIGNED, HAVE READ THE FOREGOING STATEMENT CAREFULLY BEFORE SIGNING AND DO UNDERSTAND ITS WARNINGS, ASSUMPTION OF RISK, AND RELEASE OF LIABILITY.

DATE _____

SIGNATURE OF RIDER (SPOUSES MUST SIGN FOR THEMSELVES)

DATE _____

SIGNATURE OF PARENT, GUARDIAN AND/OR SPOUSE #1 for _____
NAME OF RIDER (PLEASE PRINT)

DATE _____

SIGNATURE OF PARENT, GUARDIAN AND/OR SPOUSE #2 for _____
NAME OF RIDER (PLEASE PRINT)

OWNER'S NAME AND ADDRESS _____

OWNER'S PHONE _____

OWNER'S PHONE _____



Name DOB History#

A finance charge of 0.66% (annual percentage rate of 8%) will be applied to account balances after charges have remained unpaid for 90 days. The finance charge will be computed by applying the monthly percentage rate (.0066) to charges which have been outstanding for over 90 days, and after deducting payments made during the current billing period and prior finance charges.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Affiliated Community Medical Centers, P.A. to release any medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for related services. I authorize the release of any information to my referring physician or any other treating physicians. **ASSIGNMENT OF BENEFITS:** I hereby, authorize payment of benefits be made directly to Affiliated Community Medical Centers for services provided to me by Affiliated Community Medical Centers. I understand that I am financially responsible to Affiliated Community Medical Centers for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where by coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of Patient

Date

*If minor, then signature of responsible party



HEARTLAND RANCH INC CONSENT FOR MEDICAL TREATMENT

I, _____ am the _____ of _____
Parent/Guardian's Name Parent/Guardian Child's Name

a minor, and have authority to consent to medical treatment for said minor. I hereby authorize the Heartland Ranch Inc. staff to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to said minor on the advice of a licensed physician or dentist. I also consent to surgery and anesthesia in a medical emergency and when I am unavailable for specific consent. It is my understanding that except in the case of emergencies my daughter will receive medical and dental care in medical/dental facilities located in the city of Benson, MN, unless other provisions have been made.

I also authorize the staff of Heartland Ranch Inc. to administer prescription medication to the above-named minor as directed and prescribed by a duly licensed physician or dentist.

In addition, I authorized the staff of Heartland Ranch Inc. to administer over-the-counter medications as approved by the local Public Health Agency, and as directed on the product label.

The above authorizations shall remain in effect so long as the above-named minor is a resident of Heartland Ranch Inc.

INSURANCE BILLING PROCEDURE:

Company Name _____
Policy/Group Number _____
Other medical costs will be borne by _____

Parent/Guardian Signature

Date

NOTIFICATION OF RESPONSIBILITY FOR MEDICAL TREATMENT

PART I:

The Heartland Girls' Ranch cannot accept financial responsibility for children in our care who need medical services. To ensure that our vendors receive payment, please sign off on the following statement:

When a child is placed without adequate medical insurance (or whose medical insurance is cancelled/terminated while at the Heartland Girls' Ranch) and who has no Medical Assistance as back-up, our vendors will be instructed to directly bill the financially responsible agency/county/parent.

Signature

Date

PART II:

The parent and/or financially responsible agency/county have the option to arrange for all medical, dental, or vision services and to provide transportation to and from appointments while the child is a resident of the Heartland Girls' Ranch.

Signature

Date

Heartland Girls Ranch Consent for Participation in the MCCA Student Data Reporting System

Heartland Girls Ranch is engaged in ongoing data collection and evaluation of its services through the Minnesota Council of Child Caring Agencies (MCCA). In cooperation with youth serving agencies throughout the state, MCCA collects information provided by member agencies on youth at intake, discharge and six months after discharge. A confidential satisfaction survey will also be sent to you at discharge. This information does not identify individual children or families by name.

You and your child are invited to participate in this evaluation process so that we may better serve all children and families. The information collected will be used in summary form to improve outcomes, complete funding report requirements, and advocate for services for children and families.

If you agree to participate, Heartland Girls Ranch agrees that:

1. All information collected will be treated as private. This will be assured through the use of identification numbers and publication of summary results.
2. The names of children/youth/parents will not appear on any data collection instrument, and will be unknown to anyone receiving the data or in any document describing the results.
3. Participation is completely voluntary. Your decision about participation will not affect your relationship with Heartland Girls Ranch. If you decide to participate you may withdraw this permission at any time.

If you agree to participate, you authorize Heartland Girls Ranch to:

1. Include information on your child/family in this data collection, evaluation and follow up program. This information will not identify your child or family by name.
2. Contact you and/or the County worker six months after discharge for follow up information.

Name of Child

Signature of Parent/Guardian

Signature of Child (if appropriate)

Date

Date

Date Revoked

Expiration Date

**INTAKE FORM
 MINNESOTA COUNCIL OF CHILD CARING AGENCIES**

1. MCCA AGENCY NO. 3800		AGENCY CHILD NO. 3800 _ _ _		2. DATE FORM COMPLETED - - - Month Day Year	
3. SOCIAL SECURITY NUMBER			NAME OF PERSON COMPLETING FORM		4. PLACING COUNTY
5. ADMISSION DATE - - Month Day Year		6. CHILD'S SEX 1. <input type="checkbox"/> male 2. <input type="checkbox"/> female		7. CHILD'S BIRTHDATE - - - Month Day Year	
9a. CHILD'S RACE (Check all that apply) 1. <input type="checkbox"/> White 3. <input type="checkbox"/> Native American 5. <input type="checkbox"/> Asian-Pacific Islander 2. <input type="checkbox"/> Black 4. <input type="checkbox"/> Eskimo-Aleutian 6. <input type="checkbox"/> Other				9b. ETHNICITY: 1. <input type="checkbox"/> Hispanic 3. <input type="checkbox"/> Somali 2. <input type="checkbox"/> Hmong	
10. PRIMARY DSM DX		11. PRIMARY REFERRAL SOURCE (√ one) 1. <input type="checkbox"/> Social Worker 3. <input type="checkbox"/> Parent(s) 2. <input type="checkbox"/> Probation Officer 4. <input type="checkbox"/> School Official			5. <input type="checkbox"/> Doctor/hospital 6. <input type="checkbox"/> Relative 7. <input type="checkbox"/> Other
12. PRIMARY SOURCE OF PER DIEM FINANCIAL SUPPORT (√ one) 1. <input type="checkbox"/> County 3. <input type="checkbox"/> Parent(s) 5. <input type="checkbox"/> Indian Funds 7. <input type="checkbox"/> State 2. <input type="checkbox"/> School 4. <input type="checkbox"/> Private insurance 6. <input type="checkbox"/> Consolidated Fd. 8. <input type="checkbox"/> Other					13a. PERMANENT ZIP
13b. COUNTY OF RESIDENCE		14. CHILD'S PRIMARY HOUSEHOLD (√ one) 1. <input type="checkbox"/> Birth Parent(s) 3. <input type="checkbox"/> Adoptive Parent(s) 6. <input type="checkbox"/> No permanent living arrangement 2. <input type="checkbox"/> One Birth/One Step Parent or Permanent Live-in 4. <input type="checkbox"/> Foster Parent(s) 7. <input type="checkbox"/> Other 5. <input type="checkbox"/> Relatives			
15. IS PRIMARY HOUSEHOLD RECEIVING PUBLIC ASSISTANCE? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No			16. IS PRIMARY HOUSEHOLD A SINGLE PARENT HOUSEHOLD? (Only one parental figure) 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No		
17. IS CHILD A STATE WARD? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No			18. HAS CHILD BEEN ADOPTED? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No		
19a. IF CHILD HAS BEEN ADOPTED, AGE AT FIRST ADOPTION ____ yrs. or ____ mths.					19b. NUMBER OF FINALIZED ADOPTIONS ____
20a. INDICATE THE NUMBER OF PREVIOUS PLACEMENTS FOR EACH FACILITY:		LIVING SITUATIONS		20b. WHERE WAS THE CHILD JUST BEFORE CURRENT PLACEMENT? (check one)	21. PROJECTED POST-DISCHARGE LIVING ARRANGEMENT (check one)
		1. Parent(s) home			
		2. Pre-adoptive placement			
		3. Independent living/living independently			
		4. Board and Care Facility			
		5. Relative/extended family			
		6. Foster care home			
		7. Group home			
		8. Shelter/shelter foster care			
		9. Residential treatment program			
		10. Inpatient psychiatric facility/hospital			
		11. Chemical Dependency treatment program			
		12. Correctional facility (jail, prison, etc.)			
		13. Detention			
		14. Other			
		15. Unknown			
22a. IS THIS PLACEMENT COURT ORDERED? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No					
↓					
22b. 1. <input type="checkbox"/> CHIPS 2. <input type="checkbox"/> Delinquency					
23. HAS CHILD EVER RECEIVED ANY OF THE FOLLOWING OUTPATIENT SERVICES? Intensive home-based services? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No Outpatient chemical dependency treatment? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No Outpatient mental health services? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No Day treatment/partial hospitalization 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No				24. DELINQUENCY HISTORY Has child ever been adjudicated/convicted for a: A. status offense? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 8. <input type="checkbox"/> Unknown B. crime against persons? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 8. <input type="checkbox"/> Unknown C. crime against property? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 8. <input type="checkbox"/> Unknown D. felony? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 8. <input type="checkbox"/> Unknown	

INTAKE FORM MINNESOTA COUNCIL OF CHILD CARING AGENCIES

<p>25. SCHOOL RELATED (Check all that apply)</p> <p>A. <input type="checkbox"/> Learning disabled B. <input type="checkbox"/> Developmentally disabled (M.R.) C. <input type="checkbox"/> Truancy D. <input type="checkbox"/> Lack of academic motivation E. <input type="checkbox"/> Other (Specify): _____ F. <input type="checkbox"/> No problems</p>	<p>27. PHYSICAL CONDITION/HEALTH (Check all that apply)</p> <p>A. <input type="checkbox"/> Neurological impairment B. <input type="checkbox"/> Auditory impairment C. <input type="checkbox"/> Mobility impairment/ambulatory D. <input type="checkbox"/> Mobility impairment/non-ambulatory E. <input type="checkbox"/> Speech impairment F. <input type="checkbox"/> Visual impairment G. <input type="checkbox"/> Prenatal drug exposure (e.g., Cocaine, FAS/FAE) H. <input type="checkbox"/> Asthma/allergies I. <input type="checkbox"/> Pregnancy J. <input type="checkbox"/> Special medical care K. <input type="checkbox"/> Terminally ill L. <input type="checkbox"/> Seizure disorder M. <input type="checkbox"/> Diabetes N. <input type="checkbox"/> Chemical dependency O. <input type="checkbox"/> Other P. <input type="checkbox"/> No concerns</p>																																																																																																																																																																
<p>26. VICTIM OF ABUSE/NEGLECT (Rate each item)</p> <table border="1" style="margin-left: 20px; width: 60%;"> <tr> <th colspan="2" style="text-align: center;">CODES</th> </tr> <tr> <td style="padding: 2px;">0 = NO</td> <td style="padding: 2px;">2 = DOCUMENTED</td> </tr> <tr> <td style="padding: 2px;">1 = SUSPECTED</td> <td style="padding: 2px;">8 = UNKNOWN</td> </tr> </table> <p>A. 0 1 2 8 Emotional abuse/neglect B. 0 1 2 8 Physical abuse C. 0 1 2 8 Physical neglect (Food, medical care, etc.) D. 0 1 2 8 Sexual abuse</p>		CODES		0 = NO	2 = DOCUMENTED	1 = SUSPECTED	8 = UNKNOWN																																																																																																																																																										
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1 = SUSPECTED	8 = UNKNOWN																																																																																																																																																																
<p>28. PRESENTING PROBLEMS:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%; border-bottom: none;"> Frequency: 0=Not True (as far as you know) 1=Sometimes True </td> <td style="width:10%; border-bottom: none; text-align: center;"> 2=Often True 8=Unknown 9=Not Applicable </td> <td style="width:20%; border-bottom: none; text-align: center;"> FREQUENCY </td> <td style="width:25%; border-bottom: none; text-align: center;"> "X" IF FOCUS OF TREATMENT </td> </tr> <tr> <td style="border-top: none;">A. Chemical use/abuse (alcohol or drugs)</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">B. Communication disorder, e.g. non-verbal/unable to communicate</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">C. Compulsive, repeats certain acts over and over</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">D. Cruel to animals</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">E. Depressed, sad or unhappy</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">F. Disobedient, oppositional</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">G. Eating disorder, bulimia, anorexia</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">H. Fights or physically attacks people</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">I. Fire setting</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">J. Guiltless after misbehaving</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">K. Hyperactive, restless, can't sit still</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">L. Impulsive, acts without thinking</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">M. Loss or grief suffering</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">N. Lying or cheating</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">O. Messes pants, encopretic</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">P. Parent/parent figure relationship difficulty</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">Q. Peers/others own age relationship difficulty</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">R. Phobias, unreasonable fears</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">S. Prostitution or pimping</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">T. Racial, ethnic identity confusion</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">U. Reality perceptions distorted, strange ideas</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">V. Runs away</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">W. Verbal tantrums</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">X. Self-mutilating, head banging, scratching, hair pulling</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">Y. Self-esteem problems</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">Z. Sexually assaultive, molesting</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">AA. Sexual problems, behaviors, sexual identity (other than Z)</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">BB. Sibling(s) relationship difficulty</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">CC. Sleeping problems</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">DD. Smears or plays with bowel movements</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">EE. Stealing</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">FF. Stubborn, sullen, irritable</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">GG. Suicidal thoughts or behaviors</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">HH. Vandalism, destroys property</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">II. Verbally abusive, threatens people</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">JJ. Wets bed or wets during day, enuretic</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">KK. Younger acting than own age</td> <td style="border-top: none; text-align: center;">0 1 2 8 9</td> <td style="border-top: none;"></td> <td style="border-top: none;"></td> </tr> <tr> <td style="border-top: none;">LL. 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Hyperactive, restless, can't sit still	0 1 2 8 9			L. Impulsive, acts without thinking	0 1 2 8 9			M. Loss or grief suffering	0 1 2 8 9			N. Lying or cheating	0 1 2 8 9			O. Messes pants, encopretic	0 1 2 8 9			P. Parent/parent figure relationship difficulty	0 1 2 8 9			Q. Peers/others own age relationship difficulty	0 1 2 8 9			R. Phobias, unreasonable fears	0 1 2 8 9			S. Prostitution or pimping	0 1 2 8 9			T. Racial, ethnic identity confusion	0 1 2 8 9			U. Reality perceptions distorted, strange ideas	0 1 2 8 9			V. Runs away	0 1 2 8 9			W. Verbal tantrums	0 1 2 8 9			X. Self-mutilating, head banging, scratching, hair pulling	0 1 2 8 9			Y. Self-esteem problems	0 1 2 8 9			Z. Sexually assaultive, molesting	0 1 2 8 9			AA. Sexual problems, behaviors, sexual identity (other than Z)	0 1 2 8 9			BB. Sibling(s) relationship difficulty	0 1 2 8 9			CC. Sleeping problems	0 1 2 8 9			DD. Smears or plays with bowel movements	0 1 2 8 9			EE. Stealing	0 1 2 8 9			FF. 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INTAKE FACE SHEET

Admission Date _____ / _____ / _____ Admission Time: _____ a.m. p.m.

A. BACKGROUND INFORMATION:

Name _____ D.O.B.: ___ / ___ / ___
(first) (middle) (last)

Last Known or Permanent Address: _____

Gender: _____ Weight: _____ Height: _____ Eyes: _____ Hair: _____

Age: _____ Race or Cultural Heritage: _____ Religion: _____

Social Security Number: _____ - _____ - _____ Place of Birth: _____

Scars/Tattoos: _____ County: _____

Permanent Custody: _____ Current Guardianship: _____

Languages The Resident Speaks or writes: _____

Tribal Affiliation If Any: _____

Have you ever used another name? If yes, specify: _____

B. FAMILY:

Father: _____ Phone: (H) _____ (W) _____

Address: _____
(Street) (City) (State) (Zip)

(E-mail address)

Mother: _____ Phone: (H) _____ (W) _____

Address: _____
(Street) (City) (State) (Zip)

(E-mail address)

Stepfather: _____ Phone: (H) _____ (W) _____

Address: _____
(Street) (City) (State) (Zip)

(E-mail address)

Stepmother: _____ Phone: (H) _____ (W) _____

Address: _____
(Street) (City) (State) (Zip)

(E-mail address)



B. FAMILY CONTINUED:

Siblings (Include Step-Siblings): Age: Living Arrangements (with mom, foster care, etc)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Others Living in the Home:

Relationship:

_____	_____
_____	_____

C. WORKER INFORMATION:

Social Worker: _____

Mailing Address: _____

Office Phone: _____ Home Phone: _____

Supervisor's Name: _____ Supervisor's Phone: _____

After Hours Contact Number: _____

E-Mail Address: _____

Probation Officer: _____

Mailing Address: _____

Office Phone: _____ Home Phone: _____

Supervisor's Name: _____ Supervisor's Phone: _____

After Hours Contact Number: _____

E-Mail Address: _____

Detention Center Preference: _____

Hammergren Warning: Yes _____ No _____ (If yes, please attach a copy for file)



WORKER INFORMATION CONTINUED:

Guardian ad Litem/Other: _____

Mailing Address: _____

Office Phone: _____ Home Phone: _____

Supervisor's Name: _____ Supervisor's Phone: _____

After Hours Contact Number: _____

E-mail Address: _____

Additional (Ex. Tribal Worker, Mental Health Worker, etc):

Mailing Address: _____

Office Phone: _____ Home Phone: _____

Supervisor's Name: _____ Supervisor's Phone: _____

After Hours Contact Number: _____

E-Mail Address: _____

D. PREVIOUS PLACEMENTS: (most recent first)

Placement: _____ Reason for Discharge: _____

E. COMMENTS/CONCERNS: _____

F. HEARTLAND GIRLS' RANCH—EMERGENCY BACKUP PLAN

(Please attach any court orders for emergency response)

1. **Emergency After Hours Phone Numbers for Social Worker/Probation Officer:**
Name: _____ **Phone:** _____

2. **Detention Center Available for Emergency Placement:** _____

Phone Number: _____

Address: _____

Transportation Plan: _____

Phone Number: _____

3. **Crisis Center Available for Emergency Placement:** _____

Phone Number: _____

Address: _____

Transportation Plan: _____

Phone Number: _____

4. **Other Plan Available for Emergency Placement:** _____

Phone Number: _____

Address: _____

Transportation Plan: _____

Phone Number: _____

*An emergency plan must be in place for each child for response to a crisis situation, out of control behavior, or unsafe behavior.

H. SIGNATURES:

Signature of Resident

date

Signature of Person Placing Resident

date



INTAKE HEALTH SCREEN/MEDICAL INFORMATION Date: _____

Name: _____ D.O.B. _____

Custodial Parent/ Guardian to contact for med changes if resident prescribed psychotropic or behavioral medications. Name: _____ Phone: _____

Last medical appointment and reason for appointment: _____

Most recent eye exam: _____ Glasses/Contacts: yes/no Most recent dental exam: _____

Current Diagnoses/ Health Concerns: _____

(i.e. asthma, seizures, depression, anxiety, chemical dependency, hearing concerns, fractures, scoliosis, joint pain, rashes, cavities, chronic strep throat, bedwetting, emergency medications needed)

Allergies (FOODS: nuts, berries, citrus /MEDICATIONS /SEASONAL /ENVIRONMENTAL: latex, dyes, soaps): _____

Is there any limitation of movement or activity? yes/no (If yes, please explain) _____

Current Medications	Dose	Time	Used for	Count	#Refills
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Location of Refills: _____

Please list any scars/ tattoos/ piercings: _____

Please list any special dietary considerations or treatments needed: _____

Please list any medical/ personal supplies needed and reason (such as: nebulizer, incontinence products, brace, etc.): _____

Birth Control? yes/ no If yes, type: _____ If depo, last shot: _____

Last pap test: _____

Requesting Flu Vaccine ___ injection or ___nasal mist (not available if respiratory problems present)
-OR- Declining Flu Vaccine ___ reason optional (already had/do not want/other: _____)



**HEARTLAND GIRLS RANCH CONSENT FORM
 FOR PROFILE II TEST SYSTEM DRUG TESTING**

PART 1

Test Subject Name: _____ Date: _____
 Patient DOB: _____ Patient History Number: _____
 ACMC Collector signature: _____

PART 2

I grant permission for Affiliated Community Medical Centers, P.A. (ACMC), to collect a urine specimen from me. I understand that the specimen collected by ACMC may be examined and analyzed by ACMC to determine that the specimen is mine and has not been diluted or adulterated. I understand that my specimen may be screened by certified ACMC staff for the presence of drugs of abuse, and that these screening results may be released to the physician/provider requesting this testing. I understand that, if necessary, my specimen may be transported to MEDTOX Laboratories, Inc., a SAMHSA certified laboratory in St. Paul, Minnesota, for further confirmatory testing. I grant permission for MEDTOX Laboratories to further examine and analyze my specimen to determine whether drugs or drug metabolites are present. I understand that these results will be forwarded to the physician/provider requesting this testing.

 Signature of Test Subject or Guardian Date and Time

PART 3 – TO BE FILLED OUT BY ACMC

Comments:

 Tester Signature Date and Time

Admindoc/forms/heartland hjr 12/2011

- | | | | |
|--|---|--|--|
| <p>ACMC-Benson
 1805 Wisconsin Avenue Benson, MN 56215
 Phone: (320) 843-2030 Fax: (320) 314-1506</p> <p>ACMC-Granite Falls
 295 Tenth Avenue Granite Falls, MN 56241
 Phone: (320) 564- 2511 Fax: (320) 313-4024</p> <p>ACMC-Hancock
 668 Atlantic Avenue Hancock, MN 56244
 Phone: (320) 392-5247 Fax: (320) 314-1506</p> | <p>ACMC-Litchfield East
 611 South Sibley Avenue Litchfield, MN 55355
 Phone: (320) 693-3233 Fax: (320) 373-3191</p> <p>ACMC-Litchfield West
 520 South Sibley Avenue Litchfield, MN 55355
 Phone: (320) 693-3233 Fax: (320) 693-3290</p> <p>ACMC-Marshall Bruce Street Clinic
 300 South Bruce Street Marshall, MN 56258
 Phone: (507) 532-9631 Fax: (507) 532-1905</p> | <p>ACMC-Marshall Market Street Clinic
 1420 East College Drive Marshall, MN 56258
 Phone: (507) 532-9631 Fax: (507) 532-1176</p> <p>ACMC-New London/Spicer
 600 Peterson Parkway New London, MN 56273
 Phone: (320) 354-2222 Fax: (320) 354-2274</p> <p>ACMC-Redwood Falls
 1100 East Broadway Redwood Falls, MN 56283
 Phone: (507) 637-2985 Fax: (507) 697-6666</p> | <p>ACMC-Willmar Main Clinic and Corporate Office
 101 Willmar Avenue SW Willmar, MN 56201
 Phone: (320) 231-5000 Fax: (320) 231-5067</p> <p>ACMC-Willmar Skylark Center
 1604 South First Street Willmar, MN 56201
 Phone: (320) 231-5000 Fax: (320) 214-6147</p> <p align="right">www.acmc.com</p> |
|--|---|--|--|



AFFILIATED COMMUNITY MEDICAL CENTERS, P.A.

PATIENT INFORMATION

(Please Print)

DATE SOCIAL SECURITY NUMBER

PATIENT'S FULL LEGAL NAME

(last, first, middle)

MAILING ADDRESS

City State Zip Male Female

DATE OF BIRTH PHONE # CELL PHONE #

(month, day, year)

OCCUPATION MARITAL STATUS

EMPLOYER PHONE #

Address City State Zip

RESPONSIBLE PARTY: Name

Date of Birth Social Security Number

(month, day, year)

Address City State Zip

Phone # Occupation Employer

Employer's Phone # Address

MOTHER'S NAME (if patient is child) CELL PHONE #

EMPLOYER Work #

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

Address Phone #

Relationship to Patient

REFERRING PHYSICIAN Address

(city, state)

INSURANCE: Medicare #

Medical Assistance # County

INSURANCE COMPANY

(name)

Subscriber's Name Subscriber's Date of Birth

Coverage: Single or Family

Address

Policy # I.D. #

A finance charge of 0.66% (annual percentage rate of 8%) will be applied to account balances after charges have remained unpaid for 90 days. The finance charge will be computed by applying the monthly percentage rate (.0066) to charges which have been outstanding for over 90 days, and after deducting payments made during the current billing period and prior finance charges.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Affiliated Community Medical Centers, P.A. to release any medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for related services. I authorize the release of any information to my referring physician or any other treating physicians. ASSIGNMENTS OF BENEFITS: I hereby, authorize payment of benefits to be made directly to Affiliated Community Medical Centers for services provided to me by Affiliated Community Medical Centers. I understand that I am financially responsible to Affiliated Community Medical Centers for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where by coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

DATE

Signature of Patient - If minor, then signature of responsible person



HEARTLAND RANCH INC. PLACEMENT AGREEMENT

This is placement agreement between _____ located at _____, an Agency duly authorized by the State of Minnesota to place children into substitute care, hereinafter called the "Agency" and Heartland Ranch Inc., a Department of Corrections licensed facility, hereinafter called "HGR." In consideration of the agreement herein made between the Agency and HGR, HGR accepts _____ for services for the period beginning ___/___/201__ and tentatively ending on or about ___/___/201__ .

A. HGR agrees to the following:

- To assume responsibility for giving care and supervision to the child in a properly licensed facility.
- To develop within 30 days, in conjunction with the Agency's designated representative, an individualized written treatment plan for the child.
- To provide casework services to the child and arrange for educational, psychiatric, medical, dental and other necessary treatment services.
- To obtain parental/guardian written permission for major medical treatment or surgery except in emergency situations in which neither parents or guardians can be contacted.
- To arrange for any necessary detention or in-patient crisis mental health services for the child.
- To provide the Agency's designated representative with periodic written reports, no less than every 90 days, as well as periodic phone contacts.
- To submit claims for financial reimbursement to the Agency on a timely basis for services directly provided or arranged.

B. The Agency agrees to the following:

- To cooperate with HGR in the development of an individualized written treatment plan within 30 days of the child's admission to HGR.
- To participate in appropriate staffings held with regards to the child.
- To arrange and pay for transportation of the child to HGR for initial placement and discharge.
- To arrange for the initial clothing allowance in conformity with the prevailing Department of Human Services rates based upon the age of the child.
- To directly pay or reimburse HGR for any costs of detention or in-patient crisis mental health services determined necessary by HGR.
- To reimburse HGR at the current host county approved per diem rate.

For purposes of detention and in-patient crisis mental health services, HGR needs to contact the following Agency persons for any necessary prior authorizations:

Name: _____ Title: _____ Phone: _____
 Name: _____ Title: _____ Phone: _____
 After customary business hours, the contact should be made with:
 Name: _____ Title: _____ Phone: _____

The purpose of this document is to formalize the agreement between the Agency and heartland Girls' Ranch when a child is placed at the Ranch:

_____	_____	_____
Referring Agency Representative	Phone	Date
_____	_____	_____
Heartland Girls' Ranch Representative	Phone	Date



Heartland Ranch School
Benson Public School ISD 777
Phone: 320-842-2712
Fax: 320-843-2262
E-mail: michele.reese@swsc.org

In order for Heartland Ranch School and Benson Public Schools to determine the student's resident school district for tuition billing, please answer the following:

Mother's Status

- a. Parental Rights: Intact Terminated Permanent Suspension by Tribal Court Deceased
- b. City and State where living: _____ Unknown
- c. Living in a Minnesota Correctional Facility under Minnesota Department of Corrections? Yes No
- d. Was student living with mother just prior to placement? Yes No Unknown
- e. Is mother homeless? No Yes, living in a shelter Yes, not living in a shelter Unknown

Father's Status

- a. Parental Rights: Intact Terminated Permanent Suspension by Tribal Court Deceased
- b. City and State where living: _____ Unknown
- c. Living in a Minnesota Correctional Facility under Minnesota Department of Corrections? Yes No
- d. Was student living with father just prior to placement? Yes No Unknown
- e. Is father homeless? No Yes, living in a shelter Yes, not living in a shelter Unknown

If both parents' rights have been terminated, are deceased, not living in Minnesota after placement, or remanded to a Minnesota Correctional Facility, has a court assigned a guardian for the student? Yes No

If yes, indicate who: _____

If parent's rights are terminated, provide court documents stating such.

Name of person completing this form:

Benson High School Eligibility Confirmation & Consent Form

Benson High School Activities Director: Mike Knutson

I have read, understand and agree to abide by the MSHSL Regulations, and the Benson High School Athletic and Fine Arts Regulations, have furnished a copy to my parents or guardians, and have secured my parent or guardians signature herein, which acknowledges receipt of this information.

Students: Your participation in high school activities is dependent on your eligibility. PROTECT that eligibility by reviewing with your parent(s)/guardian(s) this summary of Minnesota State High School League rules which govern your participation. Complete regulations are found in the MSHSL Official Handbook which is available at each member high school and which is also posted on the MSHSL Web site: www.mshsl.org. Please keep this brochure for reference, and if there is a question about any rule interpretation, CONTACT YOUR SCHOOL PRINCIPAL OR ATHLETIC/ACTIVITIES DIRECTOR.

Parents/Guardians: REVIEW the following rules with your son or daughter. Your role in stressing the value of following these rules cannot be overstated.

Checklist for Student Eligibility (If you cannot check all 10 items, see your athletic director or principal)

1. Making academic progress toward graduation.
2. Will not have turned 20 before the start of the season in which I participate.
3. Physical exam within the last three (3) years on file with the school.
4. Have not transferred schools.
5. Will not play more than four (4) seasons in any sport in grades 9-12.
6. Have not dropped out of school or repeated a grade while in high school.
7. Have not accepted cash in any amount or merchandise valued at more than \$100 for participating in a sport.
8. Have not and will not compete in non-school events in my sport after reporting for the school team.
9. Have not and will not; use or possess tobacco or alcoholic beverages, use, consume, have in possession, buy, sell or give away any other controlled substance, including steroids, violate the Student Code of Conduct.
10. Have not and will not violate the racial/religious/ sexual harassment/violence/and hazing bylaws of the MSHSL.

Signatures Herewith:

- Grants the student named permission to participate in all league activities, extracurricular and co-curricular activities, fine arts activities and school related activities and field trips.
- Grants permission to take said student on supervised trips connected with all activities.
- Grants permission, in the event of an emergency, to district staff/coaches/administrators, to see to medical attention, as deemed necessary, if my child is injured and I am unable to be contacted. I understand the decision to request medical attention will be based on the discretion of district staff, who will be acting in the best interest of my child.

- Grants permission to a dentist, physician or other hospital personnel, designated by Benson High School Staff to attend to my son/daughter in the event medical attention is deemed necessary.

- Understands that the student must refrain from practice or play during medical treatment until he/she is given a written permit by the attending physician to resume participation.

- Certifies that the answers to the questions are correct and true.

- Certifies that the student named is physically fit and eligible to participate in all high school activities.

I have read, understand, and acknowledge receiving the **MSHSL & BHS Eligibility Information**, which contains a summary of the eligibility rules of the Minnesota State High School League, and Benson Public Schools. I understand that a copy of the Official Handbook of the MSHSL is on file in the Benson High School Activities Office and that I may review it, in its entirety, if I so choose. The Benson High School Student Policy Manual can be viewed on the BHS website.

I further understand that a member school of the MSHSL must adhere to all rules and regulations that pertain to the League athletic activities a school may sponsor, but that local rules may be more stringent than MSHSL rules.

The Parent's Permit and Health Questionnaire on the back of this form must also be completed, signed and on file in the school office each year before the student will be permitted to practice, play, or participate in any school sponsored activity.

Date: _____

Parent/Guardian Signature: _____

Student Signature: _____ Print: _____ Grade: _____



2011-2012 MSHSL ELIGIBILITY STATEMENT

Statement to be signed by the participant from a MSHSL member school and by the participant's parent or guardian

Please check all items

- I have read, understand, and acknowledge receiving the 2011-2012 MSHSL Eligibility Brochure, which contains only a summary of the eligibility rules of the Minnesota State High School League. I understand that a copy of the Official Handbook of the MSHSL is on file with the senior high school athletic director and or principal and that I may review it, in its entirety, if I so choose. The Official Handbook and MSHSL bylaws are also posted on the MSHSL Web site: www.mshsl.org under Handbook.
- We, the student and parent, have reviewed Concussion Management Recommendations for MSHSL Athletes contained in the Eligibility Brochure and on the following website: www.cdc.gov/concussion**
- I understand that once I sign the eligibility statement all eligibility rules apply:
 - Twelve (12) months of the year;
 - Whether I am currently participating or not;
 - Continuously from the first signing of the statement through the completion of my high school eligibility.
- I further understand that a member school of the MSHSL must adhere to all of the rules and regulations that pertain to the League athletics/activities a school may sponsor and that local rules may be more stringent, and penalties more severe, than MSHSL rules.

STUDENT CODE OF RESPONSIBILITIES

- As a student participating in my school's interscholastic activities, I understand and accept the following responsibilities:
 - I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
 - I will be fully responsible for my own actions and the consequences of my actions.
 - I will respect the property of others.
 - I will respect and obey the rules of my school and the laws of my community, state and country.
 - I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country.

A student whose character or conduct violates the Student Code of Responsibilities or is suspended or expelled is not in good standing and is ineligible for a period of time as determined by the principal. While a student not in good standing, a student may not serve any penalty for MSHSL Bylaw violations.

- Informed Consent:* By its nature, participation in interscholastic athletics includes risk of injury and the transmission of infectious diseases such as HIV, Herpes and Hepatitis B and others. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have the responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN MSHSL-SPONSORED ACTIVITY WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**
- I consent to the athletic trainer or coach treating injuries and authorize them to discuss those injuries with and release any applicable medical information or records relating to those injuries to coaches, school staff and other qualified health care providers as deemed necessary within their scope of practice.
- I further understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.
- By signing this we acknowledge that we have read the information contained in the MSHSL Eligibility Brochure and Statement.
- I/we acknowledge the electronic signature confirms I/we have read and reviewed the information contained in the contents of the Eligibility Brochure and Statement. I/we also acknowledge this electronic signature has the same legal effect, validity, and enforceability as a signature in a non-electronic form.

The student/parent authorizes the release of documents and other pertinent information by the school in order to determine student eligibility. In addition, the student/parent understands and agrees that public information shall include names and pictures of students participating in or attending extra-curricular activities, school events, and High School League activities or events.

<i>Student's Printed Name</i>	<i>Birth Date</i>	<i>Grade in School</i>
<i>Student's Signature</i>	<i>Date</i>	
<i>Parent's or Guardian's Signature</i>	<i>Date</i>	



MSHSL ANNUAL SPORTS HEALTH QUESTIONNAIRE

DATE ___ / ___ / ___
Name _____ Male [] Female [] Age ___ Birth Date ___ / ___ / ___
Grade ___ School _____ Sport(s) _____
Address _____
Phone _____ Date of Last Sports Qualifying Physical Exam (SQPE) ___ / ___ / ___

Check Yes or No boxes for each question or Circle question numbers for which you cannot answer.

IN THE LAST YEAR, since your last complete Sports Qualifying Physical Exam with your physician or your Year 2 Annual Health Questionnaire, HAVE YOU HAD ANY CHANGES TO THE FOLLOWING QUESTIONS:

- 1. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to return to sports?
IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU IN THE LAST YEAR
2. In the last year, have you passed out or nearly passed out during or after exercise?
3. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise?
4. In the last year, does your heart race or skip beats (irregular beats) during exercise?
5. In the last year, do you get light-headed or feel more short of breath than expected during exercise?
6. In the last year, have you had an unexplained seizure?
IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY IN THE LAST YEAR
7. In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason?
8. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50...
9. In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning?
10. In the last year, has anyone in your immediate family developed hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT Syndrome, short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?
11. In the last year, has anyone in your immediate family been diagnosed with Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?
12. In the last year, has anyone in your immediate family under age 50 had a heart problem, pacemaker, or implanted defibrillator?
MEDICAL RISK QUESTIONS IN THE LAST YEAR
13. Have you had infectious mononucleosis (mono) within the last month?
14. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches?
15. In the last year, have you had numbness, tingling, weakness in, or inability to move your arms or legs after being hit or falling?

Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important for the coaches or athletic/activities director to know.

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

Parent or Legal Guardian Signature Athlete Signature Date

Athletic/Activity Director Notes: (a YES answer to any of the questions above requires a clearance note from a physician prior to participation.)

SQPE Due ___ / ___ / ___ CLEARED FOR SPORTS: YES [] NO []



2011-2012

MSHSL ELIGIBILITY BROCHURE CONCUSSION MANAGEMENT ADDENDUM

Students: Your participation in high school activities is dependent on your eligibility. PROTECT that eligibility by reviewing with your parent(s)/guardian(s) this summary of Minnesota State High School League rules which govern your participation. Complete regulations are found in the MSHSL Official Handbook which is available at each member high school and which is also posted on the MSHSL Web site: www.mshsl.org. Please keep this brochure for reference, and if there is a question about any rule interpretation, **CONTACT YOUR SCHOOL PRINCIPAL OR ATHLETIC/ACTIVITIES DIRECTOR.**

I understand that once I sign the eligibility statement all eligibility rules apply:

- Twelve (12) months of the year;
- Whether I am currently participating or not;
- Continuously from the first signing of the statement.

Parents/Guardians: REVIEW the following rules with your son or daughter. Your role in stressing the value of following these rules cannot be overstated.

General Student Eligibility Checklist (must be completed by all students) (If you cannot check all 7 items, see your athletic/activities director or principal)

- _____ 1. Making academic progress toward graduation.
- _____ 2. Will not have turned 21 before the start of the season in which I participate.
- _____ 3. Have not dropped out of school or repeated a grade while in high school.
- _____ 4. Have not and will not use or possess tobacco or alcoholic beverages, use, consume, have in possession, buy, sell or give away any other controlled substance, including steroids.
- _____ 5. Have not and will not violate the racial/religious/sexualharassment/violence/and hazing bylaws of the MSHSL.
- _____ 6. I agree to fully cooperate in any investigation honestly and truthfully.
- _____ 7. Both the student and parent have reviewed the concussion management information contained in the Eligibility Brochure and found on the following website: www.mshsl.org

Athletic Eligibility Checklist (must be completed by all athletes) (If you cannot check all 5 items, see your athletic/activities director or principal)

- | | |
|---|--|
| _____ 1. Physical exam within the last three (3) years on file with the school. | _____ 4. Have not accepted cash in any amount or merchandise valued at more than \$100 for participating in a sport. |
| _____ 2. Have not transferred schools. | _____ 5. have not and will not compete in non-school events in my sport after reporting for the school team. |
| _____ 3. Will not participate in more than six (6) seasons in any sport in grades 7-12. | |

INFORMED CONSENT: By its nature, participation in interscholastic athletics includes risk of injury and the transmission of infectious diseases such as HIV, Hepatitis B, herpes and others. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have the responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

2011-2012 MSHSL Eligibility Brochure—Concussion Addendum

Newly passed Minnesota Statute 121A.323 and Minnesota Statute 121A.045 effective for the 2011-2012 school year, now requires the MSHSL to make information and training available about the nature and risks of concussions, including the effects of continuing to play after receiving a concussion, for all student athletes and their parents or guardians.

This information shall include protocols and content consistent with current medical knowledge from the Centers for Disease Control and Prevention, related to:

- The nature and risks of concussion associated with athletic activity;
- The signs, symptoms, and behaviors consistent with a concussion;
- The need to alert appropriate medical professionals for urgent diagnosis and treatment when a student athlete is suspected or observed to have received a concussion; and
- The need for a student athlete who sustains a concussion to follow proper medical direction and protocols for treatment and returning to play.

Additionally, the provisions of this law require a record to be kept indicating every student athlete and his or her parent or legal guardian were provided information about the nature and risk of concussions. The MSHSL Eligibility Statement will serve as the confirmation document.

Currently, parents and students must sign the MSHSL Eligibility Brochure each year prior their participation in MSHSL Varsity, Junior Varsity or "B" Squad activities. The form has had an Informed Consent section for the past several years, and the information will now meet the requirements of the statute effective with the fall of the 2011-2012 school year.

If your school's Eligibility Brochure has already been sent to your students, an addendum signed by the student and the student's parents must be attached to the Eligibility Brochure when the Brochure is submitted to the school prior to each sport season. Students and their parents or guardians must review the information in this document and submit a signed 2011-2012 MSHSL Eligibility Statement—Concussion Addendum to the school administration.



CONCUSSION MANAGEMENT RECOMMENDATIONS FOR MSHSL ATHLETES

Acute injury

When a player shows any symptoms or signs of a concussion, the following should be applied.

1. The player should not be allowed to return to play in the current game or practice.
2. The player should not be left alone, and regular monitoring for deterioration is essential over the initial few hours after injury.
3. The player should be medically evaluated after the injury.
4. Return to play must follow a medically supervised stepwise process.

A player should never return to play while symptomatic. "When in doubt, sit them out!"

Return to play protocol

Return-to-play decisions are complex. An athlete may be cleared to return to competition only when the player is free of all signs and symptoms of a concussion at rest and during exercise. Once free of symptoms and signs of concussion, a stepwise symptom free exercise process is required before a player can return to competition.

- Each step requires a minimum of 24 hours.
- The player can proceed to the next level only if he/she continues to be free of any symptoms and or signs at the current level.
- If any symptoms or signs recur, the player should drop back to the previous level.

The return to play after a concussion follows a stepwise process:

1. No activity, complete rest until all symptoms have resolved. Once asymptomatic, proceed to level 2.
2. Light aerobic exercise such as walking or stationary cycling, no resistance training.
3. Sport specific exercise—for example, skating in hockey, running in soccer; progressive addition of resistance training at steps 3 or 4.
4. Non-contact training drills.
5. Full contact training after medical clearance.
6. Game play.

The final return to competition decision is based on clinical judgment and the athlete may return only with written permission from a health care provider who is registered, licensed, certified, or otherwise statutorily authorized by the state to provide medical treatment; is trained and experienced in evaluating and managing concussions; and is practicing within the person's medical training and scope of practice.

Neuropsychological testing or balance testing may help with the return to play decision and may be used after the player is symptom free, but the tests are not required for the symptom free player to return to play.

For more information please refer to the references listed below and www.concussionsafety.com.

Signs Observed By Coaching Staff

Appears dazed and stunned
 Is confused about assignment or position
 Forgets sports plays
 Is unsure of game, score, or opponent
 Moves clumsily
 Answers questions slowly
 Loses consciousness (even briefly)
 Shows behavior or personality changes
 Can't recall events prior to hit or fall
 Can't recall events after hit or fall

Symptoms Reported By Athlete

Headache or "pressure" in head
 Nausea or vomiting
 Balance problems or dizziness
 Double or blurry vision
 Sensitivity to light
 Sensitivity to noise
 Feeling sluggish, hazy, foggy, or groggy
 Concentration or memory problems
 Confusion
 Does not "feel right"

HEARTLAND RANCH INC.

YOUR PRIVACY RIGHTS INFORMATION ABOUT YOUR RIGHTS UNDER THE MINNESOTA DATA PRACTICES ACT

The Minnesota Data Practices Act seeks to protect the privacy of the individuals when governmental agencies or private agencies under contract with public agencies collect data about them. The Minnesota Data Practices Act also helps people get information that is public. The information on this sheet applied to your current and future contacts with this facility, whether the contact is in person, by mail, or phone.

When we ask you to provide us with private or confidential information about yourself, you will be told:

- The purpose and intended use of the data within this agency;
- The legal requirements, if any of providing information;
- The consequences of providing or refusing to provide the information requested; and
- The identity of other persons or agencies authorized by statute to receive the information.

PURPOSES:

The purposes of collecting information from you are:

- To determine your eligibility for services provided by this agency;
- To provide effective care and treatment of your medical/social/psychological/educational needs;
- To make referrals to other agencies or professionals to provide additional services to you;
- To conduct evaluations and prepare statistical reports;
- To collect reimbursement from other agencies or individuals for services we give you;
- To determine whether you or your children need protective services;
- To evaluate and monitor our performance as an agency licensed by the State of Minnesota.

LEGAL REQUIREMENTS:

In most cases, you are not legally required to provide the information requested. If there is such a legal requirement, you will be informed of the specific law that requires it. Generally, if you do not provide the information requested, the Court and/or your caseworker will be notified.

MINORS:

If you are a minor (a child under eighteen years of age), you have the right to request that private data about you be kept from your parents. You must make this request in writing. You must explain why you want this information to be withheld and what you expect the consequences to be if it is not withheld. If the Heartland Ranch Director agrees that withholding the information from your parents is in your best interest, it will not be shown to them.

SHARING INFORMATION:

The information you provide will be shared only under the following circumstances:

- With employees of the Heartland Ranch for diagnosis, case consultation, billing and record keeping, supervision, evaluation, and administration.
- With other professionals working with the Heartland Ranch for case consultation, evaluation, diagnosis, and program planning.
- With any individual or agency or institution or organization, where you authorize sharing by signing a consent for the release of information. You have the right to revoke your consent at any time before the information is actually shared.
- With a court when the court issues a court order.
- With the federal government when necessary to account for federal funds and programs.
- With appropriate people in an emergency.
- With authorized representatives of the county human services agency or probation agent who are responsible for your care and treatment.
- With representatives of either law enforcement or human services when a child or vulnerable adult is in danger.

Details about how the information will be shared may be provided on the forms you are asked to complete. Additional information is available from the staff people helping you.

OTHER RIGHTS:

- You have the right to know what information is being kept by the Heartland Ranch about you.
- You have the right to see all public and private information about you kept by the Heartland Ranch. This includes the right for you to authorize other people or agencies to see it.
- You have the right to have this data explained to you.
- You have the right to challenge the accuracy or completeness of any private information about your records. If you want to challenge any information, write to the person who wrote the report. You may also talk with the person at the Heartland Ranch who works with you. You will get an answer within 30 days.

I have read this explanation of my private right and I understand the purposes and consequences of giving the information and who is authorized to see it.

Client/Resident—Data Subject Signature

Date

Parent/Guardian Signature

Date

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

The information regarding race, color, or national origin designation is requested in order to assure the Federal Government, that Heartland Ranch complies with Federal Laws prohibiting discrimination on the basis of race, color, or national origin. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your request for services or to discriminate against you in any way. However, if you choose not to furnish this information, we are required to note your race/color/national origin on the basis of visual observation or surname.

Please check the appropriate information below:

RACIAL CATEGORIES:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White

ETHNIC CATEGORIES:

- Hispanic or Latino
- Not Hispanic or Latino

Resident's initials for HGR identification: _____

Date: _____

File:
Resident's File
USDA Racial/Ethnic Participation File

RESIDENT RIGHTS AND BASIC SERVICES

Basic Rights:

A resident has basic rights including, but not limited to, the rights below.

- 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. if applicable, the rights stated in Minnesota Statutes, sections **144.651** and **253B.03**;
- 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, except for the use of disciplinary room time as it is allowed in the correctional facility's discipline plan.

Resident Signature

Date

AUTHORIZATION TO RELEASE/EXCHANGE OF INFORMATION

Patient's Name: _____ Date of Birth: _____
 Today's Date: _____ Social Security #: _____

I request and authorize **Heartland Girls Ranch** to release/exchange healthcare/personal information of the patient named above to:

Y	N	Please check all that apply	Y	N	
		Heartland Girls Ranch/Benson Public School			Benson Family Dental & Eye Care
		Affiliated Community Medical Center			Breen's Pharmacy
		Swift County Benson Hospital			County Social Worker
		Countryside Public Health			Non Custodial Parent (Name) :
		Stevens County Medical Center			Boy scouts of America (Name and D.O.B. ONLY)
		Greater Minnesota Family Services			OTHER:
		Crossroads Counseling			OTHER:
		Rice Memorial Hospital			OTHER:
		Hancock Dental Clinic			OTHER:

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All healthcare information
- Other: _____

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date Signed:** _____

Signature and relationship of parent, guardian or authorized representative (if required) **Date signed:**

THIS AUTHORIZATION EXPIRES 7 DAYS AFTER PERSON LISTED ABOVE IS DISCHARGED FROM PROGRAM.

RESIDENT AND PARENTAL/GUARDIAN AUTHORIZATION AND ACKNOWLEDGEMENT

Name of Resident: _____

Resident's Initials:	Parent's Initials:	Worker's Initials:
-------------------------	-----------------------	-----------------------

AUTHORIZATION TO USE PHOTOGRAPHS:

I hereby authorize the Heartland Ranch to use a photograph containing my child in brochures, newsletters, or other publications. Confidential information about the child shall not be used/released with any photograph.

Resident's Initials:	Parent's Initials:	Worker's Initials:
-------------------------	-----------------------	-----------------------

AUTHORIZATION TO TAKE PHOTOS & MAKE THEM AVAILABLE TO OTHER RESIDENTS AND STAFF:

I hereby authorize the Heartland Ranch to take photographs of my child, both individually and/or as part of a group. I also authorize that the photographs maybe purchased by other residents/staff who are at the ranch at the same time as my child. Only residents who are in a picture may purchase a picture that has another resident in it.

Resident's Initials:	Parent's Initials:	Worker's Initials:
-------------------------	-----------------------	-----------------------

INCOMING AND OUTGOING MAIL:

Mail will be given to each resident personally. Staff will require you to open mail in the presence of staff to ensure that no contraband is being brought in. Staff will scan all incoming and outgoing mail. If staff has reasonable cause to suspect that the contents of mail poses a threat to a resident (i.e. plans to run, etc.), mail may be read by staff. In cases where mail is withheld due to court order or safety reasons, written notice will be given to the resident and the mail will be filed in the resident's file until discharge at which time it will be given to the person.

Resident's Initials:	Parent's Initials:	Worker's Initials:
-------------------------	-----------------------	-----------------------

TELEPHONE CALLS:

Each week residents are given a card to make one (1) phone call. Depending on which level a resident is on and how many days they pass that week determines the number of additional cards they can earn. Phone Cards are given out on Fridays. Residents can use these cards during the week to call people on their phone lists. When a resident makes a phone call, the card must be turned in to staff. Residents may still receive incoming calls from approved callers for 10 minutes. The ranch will pay for calls to social workers, probation officers, attorneys and guardians.



Resident's Initials:	Parent's Initials:	Worker's Initials:

PERSONAL BELONGINGS AGREEMENT:

I hereby agree and understand that I am fully responsible for the property (including clothing, money, and any other personal belongings), which I may bring with me during my stay at Heartland Ranch. I will take full responsibility for losses and damages. The Heartland Ranch is not responsible for any losses or damage of my property.

I further understand that it is my responsibility to remove all such property when I leave or am discharged from the Heartland Ranch. Any property of mine, which is at Heartland Ranch for a period exceeding ten days following my discharge I leave with the express intent that it becomes the property of Heartland Ranch. I agree not to hold Heartland Ranch responsible in any way for such property and expressly approve Heartland Ranch's use or disposal of such items in any way it wishes.

Resident's Initials:	Parent's Initials:	Worker's Initials:

AUTHORIZATION TO SUPERVISE RECREATIONAL AND WORK ACTIVITIES:

I hereby authorize Heartland Ranch to supervise the recreational and work activities of my child and to permit her attendance at/or participation in sports, bowling, swimming, horseback riding, museums, softball, other ball sports, and any other outings that the representatives of Heartland Ranch may deem appropriate. I also extend my permission to include the Benson School system for field trips or course work offered in settings other than the designated building areas.

I realize that Heartland Ranch intends to take precautions against injuries and accidents. Nevertheless, I agree absolutely that Heartland Ranch and all of its employees are free from any responsibilities for any accident, injury, or other mishap that may occur with my child. This authorization expires upon discharge from Heart Ranch program.

Resident's Initials:	Parent's Initials:	Worker's Initials:

AUTHORIZATION FOR RESTRICTIVE PROCEDURES:

I hereby authorize Heartland Ranch to use restrictive procedures to protect the safety of my child, other residents, and staff according to the Heartland Girls' Ranch Policy and my child's individual treatment plan.

I would like to be contacted:

___ When full restraint applied.

___ When any restrictive procedure is used.

___ Other: _____.

I would like to be notified when a restrictive procedure has been used with my child: ___ Immediately ___ Next business day

Resident's Initials:	Parent's Initials:	Worker's Initials:

CONTRABAND:

When found anytime throughout placement these items will be confiscated and destroyed:

- Tobacco Products
- Lighters/ Matches
- Drugs/ Alcohol
- Permanent Markers
- Razors (Ranch supplies a bladeless one)
- Cell Phones
- Compact Discs (Ranch supplies this)
- Ipods/ MP3 Players
- Weapons
- Nail Polish (Ranch supplies this)
- Nail Polish Remover (Ranch supplies this)
- Inappropriate Pictures
- Inappropriate Clothing (gang related, profanity, etc)
- Others as appropriate

The Following items need to be in locked storage while here:

- Pump Sprays
- Products containing alcohol
- Perfume
- Others as appropriate

Resident's Initials:	Parent's Initials:	Worker's Initials:

GENERAL REQUIREMENTS AND TIME FRAME FOR GRADUATION:

This is a 5 level program. The length of time you spend in the program is based on your commitment to and work on daily requirements, goal work, activity participation and placement work. The fastest time frame in which you can graduate is 120 days. The average length of stay is 6 – 11 months. There is no appropriate amount of time to graduate. It is based on individual needs and issues.

Resident	Date
Worker	Date
Parent	Date

To: Hennepin County Social Service Workers

Re: Utilization Review Paperwork

Heartland Girls Ranch requires that all Hennepin County referrals must have the completed Utilization Review paperwork at intake.

After discussion with Larry Molstad, it was made clear that Hennepin County is requiring Utilization Review paperwork in Hennepin County files. This may be linked to vendor payment in the near future. We cannot accept Hennepin County Social Services cases without this paperwork.

If you have any questions, please contact us at 320.843.4815.

Thank you!

MISSING PERSONS REPORT

Swift County Sheriff's Department

Name: (Last, First Middle)					Photo Available: (Yes / No) Yes	
Address: Heartland Girls Ranch, 189 Hwy 9 NE Benson, MN 56215				Phone Number: 320.842.4472/320.843.4815		
DOB:	Sex:	Race:	Eye Color:	Hair:	Height:	Weight
Beard/Mustache:			Complexion:		Build:	
Scars, Marks, Tattoos, Piercings, Deformities:						
Mental/Emotional Status:						
Medications Taken:						
Missing Since: (Date/Time)				Last Seen at: (Location)		
Last Seen with:				Possible Destination:		

Clothing Description:

Coat	Dress	Shirt / Blouse	Skirt
Pants	Shoes	Hat	Jewelry



**Missing Person Report
Swift County Sheriff's Dept.**

Reporter Information:

Reported by: (Last, First, Middle)	Date of Birth:	Relationship:
Address:		Phone Number:

Heartland Girls' Ranch Info:

Court Ordered Placement: Yes No	If yes, what County:
Probation Officer's Name:	Probation Officer's Phone Number:
Social Worker's Name:	Social Worker's Phone Number:
Ranch willing to transport juvenile back from where located? Yes No	

Details:



**Missing Person Report
 Swift County Sheriff's Dept.**

I certify that the person described in this report is absent due to the following reason and that the information is true and correct to the best of my knowledge:

- D Missing Person Disability** - person of any age who is missing and under proven physical/mental disability or is senile, thereby subjecting himself or others to personal and immediate danger.
- E Endangered** - person of any age who is missing under circumstances indicating that his physical safety may be in danger.
- I Involuntary** - person of any age who is missing under circumstances indicating that the disappearance was not voluntary, i.e. abduction or kidnapping.
- V Victim** - person of any age who is missing after a catastrophe.
- J Juvenile** - a person who is missing and who is not declared emancipated and **who does not meet the criteria for entry under any other record type.** This code is used for juvenile runaways.

Date: _____

 Reporter's Signature

Date: _____

 Investigating Officer's Signature

Date Entered into NCIC:	Entering CCO's initials:	2nd check CCO's initials:
--------------------------------	---------------------------------	---

Located/Returned: (Date/Time)	Located at: (Address)
Located by:	Investigating Officer's Signature:
Date Cancelled NCIC:	Cancelling CCO's initials

HGR RESIDENT INVENTORY

Resident Name _____ **Date** _____

Circle One: **Initial Discharge Change:** Shopping/ Brought Home/ Brought from Home/ Other

(Put number of clothing items in blanks)

Clothing (Bottoms):	
Jeans (6-8)	_____
Sweat Pants (4)	_____
Dress Pants (6-8)	_____
Shorts (4)	_____
Capri's (4)	_____
Skirts (2)	_____

Misc. Clothing:	
Dresses (2)	_____
Swimsuit (2)	_____
Pajamas (4)	_____
Bath Robe (1)	_____

Clothing (Tops):	
Dress Shirts (4)	_____
Tanks/A-Frames (7)	_____
T-Shirts (7)	_____
Sweaters (4)	_____
Sweatshirts (4)	_____
"Hoodies" (4-6)	_____

Undergarments:	
Socks (8-10)	_____
Underwear (8-10)	_____
Bras (6)	_____

Shoes/Footwear:	
Tennis Shoes (2)	_____
Flip Flops (4)	_____
Dress Shoes (1)	_____
Slippers (1)	_____
Riding Boots (1)	_____
Winter Boots (1)	_____

Misc. Items:	
Meds	_____
Money	\$ _____
Books	_____
St. Animals (5)	_____
Suitcase	_____
CD Player (personal)	Yes/No _____
Make Up	Yes/No _____
Jewelry	Yes/No _____
Other:	_____

Outerwear:	
Jacket (2)	_____
Winter Coat (2)	_____
Hats (2)	_____
Gloves/Mitts (2)	_____
Scarves (2)	_____

Items Put In Confiscation:	

Staff Signature _____

Resident Signature _____

FORMS CHECKLIST

**Initial upon
Completion**

Resident Name: _____ **Date:** _____

- _____ Prior to Intake Check List – Page 1
- _____ Original Forms – Page 2
 - a. Riding Instruction Agreement & Liability Release
 - b. ACMC Patient Information, Medical History Worksheet, & Consent for Urine Drug Screening
 - c. SMC Behavioral Medicine Release of Information
 - d. Greater Minnesota Family Services Client Information, Application, Consent for Treatment, Releases
- _____ Horse Activities Come with These Warnings – Pages 3 - 4
- _____ RProtective Equestrian Headgear Agreement & Release – Page 5
- _____ ACMC Insurance Release – Page 6
- _____ HGR Consent for Medical Treatment – Page 7
- _____ Notification of Responsibility for Medical Treatment – Page 8
- _____ Consent for Participation in the MCCA Student Data Reporting System – Page 9
- _____ Intake SDRS (Student Data Reporting System) – Page 10 - 11
- _____ Intake Face Sheets – Page 12 – 16
- _____ ACMC Consent for Urine Drug Screen Testing- Page 17
- _____ ACMC Patient Information Sheet- Page 18
- _____ Heartland Ranch Placement Agreement – Page 19
- _____ Benson High School Student Information Sheets and Eligibility Forms – Page 20 - 25
- _____ Privacy Rights under Minnesota Data Practices Act – Page 26 - 27
- _____ Civil Rights Act of 1964 – Page 28
- _____ Resident Rights and Basic Services – Page 29
- _____ HGR Release of Information – Page 30
- _____ Approved Caller and Visitor List – Page 31
- _____ Resident and Parental Authorization and Acknowledgment – Page 32 - 34
- _____ Copy of Utilization Review (Hennepin County only) – Page 35
- _____ Pictures and Form for Law Enforcement (Copy to Law Enforcement) – Page 36 - 38
- _____ Inventory Sheet – Page 39
- _____ Resident Intake Forms Check List – Page 40