



13637 60<sup>th</sup> Street SW • Cokato, Minnesota 55321 • (320) 286-2922 • Fax (320) 286-2875

## **WELCOME TO VILLAGE RANCH!**

Thank you for choosing services provided by Village Ranch, Inc. These services may be in the form of individual therapy, family therapy, group therapy, and skills-based therapy (CTSS), and/or a combination of any of the available services through in-home, residential or foster care placement with Village Ranch or another organization.

### **HISTORY**

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The Village Ranch began in 1988 in Cokato, Minnesota offering adolescent males a place to live (group home) as well as outpatient therapeutic services. Since then, our original group home has grown to a Residential Group Home with a 34-bed capacity and onsite school. In 2009, we expanded to Anoka, Minnesota where outpatient individual, family, group therapy, and skills-based therapy is offered. In 2010, we opened our first “Independent Living Program” for adolescent males in Hutchinson, Minnesota with 12 beds and, most recently in April of 2015 we opened a similar 12-bed Independent Living Program for adolescent males in Rochester, Minnesota and, most recently in 2016 we opened our first 16 bed Residential Group Home for adolescent females with an onsite school in Annandale, Minnesota. All four of these residential locations offer a 24/7 staffed living environment, skills-based therapy services and outpatient therapeutic services.

Because we agree with you that consistency in therapy is important in addressing the challenges you and your family may be having, we try to schedule therapy sessions as convenient as possible; however, we understand emergencies happen and there will be times you will need to cancel appointments.

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### **SERVICES AVAILABLE**

The following outpatient services are provided through Village Ranch Child and Family Services, Inc.: CTSS services, outpatient individual and family therapy, and diagnostic assessment services. We also offer residential group home and foster care placement which work in tandem with the outpatient therapeutic services. The children and families we support are in need of a rehabilitative mental health package and require varying therapeutic and skills-based therapy levels of intervention with the overarching design to enhance and support overall functioning.

The therapists which you and your family will be working with are all master’s level and/or licensed professionals with many years of experience in the field and use a variety of therapeutic techniques. All mental health practitioners who provide skills-based services and training meet the state requirements for training and experience in providing skills-based services to your child/adolescent.

Our philosophy is that every family system is unique, important and has strengths. We believe that working as partners through relationships, support, and caring, families are strengthened and experience greater success. The services provided, areas covered, and goals established are mutually agreed upon between client, family, and provider.



## **FINANCIAL RESPONSIBILITY (OUTPATIENT THERAPY SERVICES ONLY)**

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Copays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your copay is listed on your insurance card.

## **NO-SHOW POLICY (OUTPATIENT THERAPY SERVICES ONLY)**

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If you are unable to keep your scheduled appointments, please notify us at least 24 hours in advance so we can offer that time slot to someone on the waiting list. You may reschedule your appointment when you call us to cancel.

If there is a second no-show you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

## **LATE CANCEL POLICY**

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If you cancel your appointment with less than a 24-hour notice occasionally, we do understand. However, if a late cancel pattern develops, you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the late cancel issue and possibly transfer to another agency.

**(OUTPATIENT THERAPY SERVICES ONLY - Not applicable to residential, group home, or foster care placements)**

After the first no-show appointment (without a phone call to cancel) you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. You (not your insurance company) will be charged \$50 (using the credit card information that you provided to us during intake) for the time slot we were not able to fill when you were a no-show.

If there is a second no-show occurrence you will be required to meet with your therapist, county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

We want to keep services available to you and your family. Please feel free to address issues with your therapist or skills worker so we can all work together to resolve issues.

## **PARENTAL INVOLVEMENT**

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Through our experience, as well as available research, clients who do the best in treatment have involved families or support systems. Family involvement means actively supporting the therapeutic process which may include monthly family therapy sessions and general consistent contact with the client.

Please complete all the paperwork in a timely manner.



## VILLAGE RANCH INFORMED CONSENT/CLIENT RIGHTS & RESPONSIBILITIES

### **CONFIDENTIALITY**

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 with this facility, whether the contact is in person, by mail, email, or by phone.

Every effort will be made to keep the information clients share with Village Ranch, Inc. staff confidential. All client information is maintained as private and/or confidential, consistent with ethical guidelines of professional practice, and the statutes of the laws of the State of Minnesota. A written consent must be signed before outside persons or agencies can obtain information in records or from family workers.

The Clinical Supervisor supervises all casework and serves as a secondary source of support for families in crisis when practitioners and/or therapists are not available.

### **CLIENT RECORDS**

The client information we collect from you, or that you authorize us to collect from others, is used for the purposes listed below. Because this list of purposes covers a variety of services and programs, some of the purposes will not apply to your information.

- To determine your eligibility for services provided by this agency
- To provide effective care and treatment of medical/social/psychological/educational needs
- For other purposes specifically authorized by you
- To make referrals to other agencies or professionals to provide additional services to you
- To collect reimbursement from other agencies or individuals for services we give you
- The legal or statute requirements, if any, of providing information
- To evaluate and monitor our performance as an agency licensed by the State of Minnesota
- To conduct evaluations and prepare statistical reports
- We cannot guarantee confidentiality of data transmitted (i.e., video, voice, email, etc.)

### **RELEASE OF CLIENT INFORMATION**

#### **Access by Client:**

As a client you have access to all public and private records about yourself or your children. (See section on “Minors” for exceptions regarding children.) Upon request you may review your records in the presence of one of our professional staff and may request copies of records at your expense.

#### **Access by Others:**

The professional staff of Village Ranch, Inc. will have access to information about you when their work requires it and for purposes of billing and collection of accounts in association with other professional consultation (e.g., accountant, attorney), if necessary. For training, supervision and/or consultation purposes, some clients may be asked to have their sessions observed and/or audio/video recorded. Such observations and/or recordings will only be conducted after the client has been fully informed of the specific uses of the observations/recordings and has consented to participate. All audio/video recordings will be destroyed following the training, supervision, or consultation.

Individuals or entities outside of Village Ranch, Inc. who are authorized with a release signed by you (or guardian), may share information for purposes of consultation, evaluation, diagnosis, and program planning, when necessary to account for federal funds and program, when law enforcement personnel are investigating or prosecuting a criminal or civil proceeding, and with or without a release with appropriate personnel in an emergency.

**MINORS:** Under certain circumstances, minor clients have the legal right to request that client information be withheld from their parents. This request must be in writing, must explain the reasons for withholding the information, and what you expect the consequences could be if it is not withheld. Your therapist, in consultation



with the professional staff will consider the request and a decision as to whether to withhold information will be made by Village Ranch, Inc. based on the best interests of the requesting minor.

In some cases, the law permits minors to consent to treatment and to withhold information from their parents with a formal request. This may be appropriate for a minor who is over the age of 16 and is financially independent and/or married, or when services relate to pregnancy, drug abuse or sexually transmitted disease. If you have any questions about this, ask the therapist who works with you.

**As a rule, we do not encourage the withholding of information from parents except when it is our clinical judgment that it would be clearly detrimental to the minor's welfare to disclose information.**

**MULTI-PARTY COUNSELING:** If you are involved in multi-party counseling such as couples or family therapy, our staff will treat all information acquired in that process in accordance with this confidentiality policy. In addition, Village Ranch, Inc. will stress the importance of maintaining confidentiality with all members of the family or couples therapy process, but we cannot be held responsible for breaches of confidentiality by other participants. Finally, records of such session belong to all participants and cannot be released without the consent of all participants.

In some circumstances individuals participating in couples or family counseling will also be involved in individual sessions with members of our professional staff. At times an individual may share information in individual sessions, which is of central importance to the couples or family therapy process. It is our belief that the family therapist should not place himself or herself in the position of holding secrets of families or couples; thus, by signing this policy you give the therapist permission to disclose information when it is our clinical judgment that such disclosure is in the best interest of the couple or family.

## **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.

## **MANDATED REPORTING:**

Although each provider uses their own judgment regarding the safety of the client and family and decisions to report are made in consultation with the Clinical Supervisor, all employees of Village Ranch, Inc. are mandated reporters and are required by law to report any of the following situations:

- Instances of abuse or neglect of a minor or vulnerable adult
- Behavior that may be a threat to one's life or that of another person
- Receipt of a court order
- Report of sexual abuse by a health professional

## **OUR RESPONSIBILITIES:**

- To meet with you/your family in your home or our office weekly at a convenient time for you.
- To be prompt and accessible for scheduled meetings.
- To listen respectfully and be culturally sensitive.
- To provide you with appropriate support and information.
- To provide collaborating agencies or the court with reports regarding your progress.
- To provide crisis counseling during emergency situations.

## **YOUR RESPONSIBILITIES:**

- To commit to scheduled meetings.
- To communicate and cooperate with staff respectfully.
- To report changes in your condition or symptoms.
- To participate in the choice of goals and progress towards them.
- To notify your provider at least 24 hours in advance if you are unavailable for an appointment and need to reschedule.





**VILLAGE RANCH APPLICATION FOR SERVICES**

Today's Date: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Name MI Last Name Date of Birth

\_\_\_\_\_  
Street Address City State Zip Code County

(\_\_\_\_)\_\_\_\_-\_\_\_\_ Living with: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Phone First, Last Name (Parent, Foster Parent, etc.)

Office Location: Cokato Hutchinson Rochester Annandale

**SERVICES REQUESTED:**

- Individual Skills Family Skills Group Skills RISE CLIMB  
Individual Therapy Family Therapy Group Therapy Sex-Specific Treatment

1) Are you currently receiving therapy or skills services? **YES NO**

(If you answered YES, please provide the name and address of the agency providing the services)

\_\_\_\_\_  
Agency Street Address/City/State/Zip

2) Have you completed a past Diagnostic Assessment? **YES NO**

(If you answered YES, Please provide the name and address of the agency with the DA on file)

\_\_\_\_\_  
Agency Street Address/City/State/Zip

**B. REFERRAL REASON/GOALS:**

- Supportive Services Psychoeducation Prevent Placement Reunification Assessment Only

Estimated Length of Service(s): \_\_\_\_\_

**C. CLIENT AND CLIENT'S FAMILY (if applicable) STRENGTHS/ASSETS:**

**D. Referent:**

- Self Therapist Social Worker Probation Officer Foster Parent Other:

\_\_\_\_\_  
First Name/Last Name Agency

\_\_\_\_\_  
Street Address City State Zip Code Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Phone Alternate Phone Email Address



Specific needs/requirements of Village Ranch (reports, etc.): \_\_\_\_\_

**E. CUSTODIAL (LEGAL) GUARDIANSHIP:** Check if information is the same as above

\_\_\_\_\_  
First Name/Last Name Relationship to Client (Parent, Foster Parent, etc.)

\_\_\_\_\_  
Street Address City State Zip Code County

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone Alternate Phone Email Address

**F. FOR RESIDENTIAL AND GROUP HOME PLACEMENTS ONLY:**

\_\_\_\_\_  
Placing Worker Date of Placement Placement is:  Voluntary  Court Ordered

Is client: Adjudicated?  Yes  No Registered offender?  Yes  No

Does client have community work service (CWS) hour or restitution obligations?  Yes  No

If client has restitution, can their restitution be satisfied through CWS hours?  Yes  No

Required hours/amount of restitution? \_\_\_\_\_

Comments on adjudication status and condition of placement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client's address prior to placement (if different from address in Section A: Client Information):

\_\_\_\_\_  
Street Address City State Zip Code County

Are there firearms in the home?  Yes  No

If yes, are they secure?  Yes  No

As Parent/Guardian it is my intention to be involved with:

Weekly Phone Calls and Visits  Staffings  Family Therapy  Off-Grounds Visits

Other (please explain): \_\_\_\_\_



**PAYMENT INFORMATION FOR CLIENT:** \_\_\_\_\_

**PARTY RESPONSIBLE FOR PAYMENT:**

- County of Residence
- County Different than County of Residence
- Self-Pay
- Primary Insurance Company
- Secondary Insurance Company
- Other: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relation: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_ ID #: \_\_\_\_\_

RXBIN#: \_\_\_\_\_ Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_ ID #: \_\_\_\_\_

RXBIN#: \_\_\_\_\_ Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**BILLING AND PAYMENT POLICY**

**INSURANCE BILLING**

Village Ranch, Inc. requires all insurance information be provided before services begin. This means any and all primary and secondary insurance policies on which the client is listed, i.e. mother, father, step-parents, etc., as well as medical assistance, so that claims can be properly submitted and processed.

**CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES**

Co-Pays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your co-pay is listed on your insurance card. If your policy is subject to a deductible, you will receive a bill from Village Ranch if you have not yet met any deductibles for your policy/policies. Any co-insurance due after claims are processed will be billed to the client as well. It is highly recommended that you apply for medical assistance, so that, if you qualify, your financial responsibility can be reduced or perhaps eliminated.

**COVERAGE LAPSES**

If, at any time and for any reason, your policy is terminated, it is your responsibility to inform Village Ranch immediately so steps can be taken to ensure services are not interrupted. This applies to commercial policies (ones for which a monthly premium is paid) **AND** medical assistance. If coverage is not reinstated, you will be responsible for any and all fees for services. Talk to your social worker or county contact for information regarding medical assistance lapses. If you are unable to meet these requirements, services may be suspended.

**SLIDING FEES**

If you do not have insurance or medical assistance of any kind, a sliding fee schedule is available for those who qualify. Please speak to your provider for assistance.

**By signing below, I understand this Billing & Payment Policy:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signature of Client or Authorized Person

Reason client is unable to sign:  Minor  Deceased  Other: \_\_\_\_\_





**Village Ranch, Inc. and Village Ranch Child and Family Services, Inc.**  
**RELEASE OF INFORMATION**

**Village Ranch Residential**  
13637 60<sup>th</sup> St. SW, Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-2875

**Village Ranch Child and Family Services, Inc.**  
13637 60<sup>th</sup> St. SW, Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-2875

**Village Ranch Foster Care**  
13637 60<sup>th</sup> St. SW, Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-2875

**Village Ranch Residential Girls Home**  
380 Annandale Blvd, Annandale MN  
Phone: (320) 261-5186 Fax: (320) 261-5188

**Village Ranch Rochester Group Home**  
1117 1st Ave NE, Rochester, MN 55906  
Phone and Fax: (507) 258-6309

**Village Ranch Hutchinson Group Home**  
851 Dale St SW, PO Box 305 Hutchinson, MN  
Phone: (320) 587-3447 Fax: (320) 587-3967

Client's Legal Name: (please print) \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Previous Names: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone (home/main): (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**1. I authorize Village Ranch, Inc. and Village Ranch Child and Family Services, Inc. to:**  
 Exchange information with  Release my records to  Obtain my records from  
Person, Clinic, Organization Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**2. I would like the following records released:**  
 All pertinent records, **OR** check those that apply below.  
 Discharge Summary  School Reports  Medical Reports  
 Mental Health Records  Progress Notes  Treatment Plans  
 Evaluations/Assessments  Legal Records  Social History  
 Social Service Records  Other: \_\_\_\_\_

**3. Purpose:**  
 Care Coordination  Treatment Planning  Evaluation/Assessment  
 Personal Use (*mark personal and confidential*)  Other: \_\_\_\_\_

**4. Staff member requesting information:** Village Ranch Foster Care Team (320) 286 - 2922  
Name Phone

- 5. I understand the following:**
- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the hospital, clinic or person named above. This includes details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions, and AIDS/HIV.
  - If I do not want these to be released, I will place a check mark here:  I do not want the following records released: \_\_\_\_\_
  - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
  - This form expires one year after I sign it, or on (expiration date): \_\_\_/\_\_\_/\_\_\_
  - There may be a fee for releasing these records.
  - Once the records are released to the hospital, clinic or person named above, the clinic or hospital releasing my records cannot prevent them from being shared by a third party. At that point, the records may no longer be protected by state or federal privacy laws.
  - To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
  - If I do not sign this form, I will still be treated, unless treatment is part of a research project.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signature of Client or Authorized Person Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign:  Minor  Deceased  Other: \_\_\_\_\_



**Village Ranch, Inc. and Village Ranch Child and Family Services, Inc.**  
**RELEASE OF INFORMATION**

**Village Ranch Residential**  
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Phone and Fax: (507) 258-6309

**Village Ranch Hutchinson Group Home**  
851 Dale St SW, PO Box 305 Hutchinson, MN  
Phone: (320) 587-3447 Fax: (320) 587-3967

Client's Legal Name: (please print) \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Previous Names: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone (home/main): (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**1. I authorize Village Ranch, Inc. and Village Ranch Child and Family Services, Inc. to:**  
 Exchange information with  Release my records to  Obtain my records from  
Person, Clinic, Organization Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**2. I would like the following records released:**  
 All pertinent records, **OR** check those that apply below.  
 Discharge Summary  School Reports  Medical Reports  
 Mental Health Records  Progress Notes  Treatment Plans  
 Evaluations/Assessments  Legal Records  Social History  
 Social Service Records  Other: \_\_\_\_\_

**3. Purpose:**  
 Care Coordination  Treatment Planning  Evaluation/Assessment  
 Personal Use (*mark personal and confidential*)  Other: \_\_\_\_\_

**4. Staff member requesting information:** Village Ranch Foster Care Team (320) 286 - 2922  
Name Phone

**5. I understand the following:**

- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the hospital, clinic or person named above. This includes details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions, and AIDS/HIV.
- If I do not want these to be released, I will place a check mark here:  I do not want the following records released: \_\_\_\_\_
- If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it, or on (expiration date): \_\_\_/\_\_\_/\_\_\_
- There may be a fee for releasing these records.
- Once the records are released to the hospital, clinic or person named above, the clinic or hospital releasing my records cannot prevent them from being shared by a third party. At that point, the records may no longer be protected by state or federal privacy laws.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless treatment is part of a research project.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signature of Client or Authorized Person Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign:  Minor  Deceased  Other: \_\_\_\_\_





**Consent for Participation in the  
MCCCA Student Data Reporting System**

Village Ranch, Inc. is engaged in ongoing data collection and evaluation of its services through the Minnesota Council of Child Caring Agencies (MCCCA). In cooperation with youth-serving agencies throughout the state, MCCCA collects information provided by member agencies on youth at intake, discharge and six (6) months after discharge. A confidential satisfaction survey will also be sent or given 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, Village Ranch, Inc. 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 Village Ranch, Inc. If you decide to participate you may withdraw this permission at any time.

If you agree to participate, you authorize Village Ranch, Inc. to:

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.**

Contact you and/or the County worker six (6) months after discharge for follow-up information.

**NAME OF CHILD:** \_\_\_\_\_

**X**  
\_\_\_\_\_  
Client/Legal Guardian Signature Date

**X**  
\_\_\_\_\_  
Client/Legal Guardian Signature Date



## Tele-Medicine Consent Form

Client's Name: \_\_\_\_\_

I, (print name): \_\_\_\_\_

Agree and consent to the use of tele-medicine as a means of conducting mental health session within the laws and limits of the Minnesota Health Care Programs (MHCP).

Do not approve these services.

Signed: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Date:

\*\*\*\*\*

## Video Camera Consent Form

For security purposes, we have/may have video cameras installed in rooms where meetings are conducted. These cameras are video only, not audio, in an effort to protect the privacy of the individuals in the meeting. This consent confirms you understand this procedure is for the safety and protection of all individuals involved.

I, \_\_\_\_\_, understand and consent to this practice of Village Ranch, Inc. and Village Ranch Child and Family Services, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Consent to participate in the AspireMN Children's Outcome Reporting and Evaluation (CORE) System

Village Ranch INC & Village Ranch CFS are part of a state-wide project with other programs that work with children and families to help improve care and outcomes. This system, called AspireMN CORE, is HIPAA compliant and securely collects demographic, assessment and intervention services data (herein after referred to as "data") provided by programs on children and families at intake, discharge, and six months after discharge. A confidential satisfaction survey is also given out at discharge.

If you agree to share your data, Village Ranch INC & Village Ranch CFS agrees that:

1. All data collected will be protected. In some cases, demographic data may be shared across service providers for the purpose of connecting records.
2. Only Village Ranch INC & Village Ranch CFS and the researchers who work on behalf of AspireMN will have access to private data for evaluation purposes. This secured data will be maintained for ongoing research and to inform practice.
3. Participation is completely voluntary. Your decision to participate or not will not impact the services provided to your child or family or your relationship with Village Ranch INC & Village Ranch CFS.
4. Even after agreeing to participate, you can discontinue participation in this data system at any time by contacting Village Ranch INC or Village Ranch CFS.

If you agree to participate, you authorize Village Ranch INC & Village Ranch CFS to:

1. Include data on services, outcomes, and satisfaction about your child and family in the AspireMN CORE system.
2. Contact you, your child, and the person that referred your family/child six months after discharge for follow-up information.

\_\_\_\_\_  
Name of child

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

*Opt-Out*

I do not agree to participation in the AspireMN CORE system.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date



# FOSTER CARE ONLY FORMS



**VILLAGE RANCH FOSTER CARE INTAKE INFORMATION**

**YOUTH INFORMATION**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Social Security Number: \_\_\_-\_\_\_-\_\_\_ Sex:  Male  Female  
Race: \_\_\_\_\_ Tribal Affiliation: \_\_\_\_\_ City/State of Birth: \_\_\_\_\_  
Medical Insurance and Number: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_  
Scars/Tattoos/Other Identifying Marks: \_\_\_\_\_

**PARENT INFORMATION**

Parent #1: \_\_\_\_\_ Relationship to Youth: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Marital Status: \_\_\_\_\_ Approved Contact:  Yes  No  
Parent #2: \_\_\_\_\_ Relationship to Youth: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Marital Status: \_\_\_\_\_ Approved Contact:  Yes  No

**GUARDIANSHIP/CUSTODY**

Legal Guardian: \_\_\_\_\_  
Legal Custody: \_\_\_\_\_

**EMERGENCY CONTACT**

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
24-Hour Crisis Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**TEAM INFORMATION**

**Social Worker:** \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Probation Officer:** \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Guardian Ad litem:** \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Tribal Worker:** \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Other:** \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_-\_\_\_\_





**PLACEMENT HISTORY:**

**REASON FOR PLACEMENT:**

**REASON FOR DISCHARGE FROM LAST PLACEMENT:**

**PRESENTING ISSUES (I.E., BOUNDARY CONCERNS, CHEMICAL USAGE, ETC.)**

**PLACEMENT GOAL (TREATMENT, REUNIFICATION/EMANCIPATION, ETC.)**

**ACTIVITIES/INTERESTS:**

**ESTIMATED LENGTH OF PLACEMENT:**

**CURRENT SERVICES:**

**WHAT SERVICES DO YOU REQUIRE FROM VILLAGE RANCH IN REGARDS TO THE PLACEMENT OF THIS YOUTH?**

**OTHER RECOMMENDED SERVICES:**

**FAMILY VISITATION PLAN:**



**PERSONS NOT ALLOWED CONTACT WITH:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SIBLING INFORMATION:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

Last School Attended: \_\_\_\_\_ Grade: \_\_\_\_\_  
IEP or 504:  Yes  No  
School Performance: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION:**

Date of most recent physical exam: \_\_\_/\_\_\_/\_\_\_  
Date of most recent dental exam: \_\_\_/\_\_\_/\_\_\_  
Date of most recent eye exam: \_\_\_/\_\_\_/\_\_\_  
Any known allergies: \_\_\_\_\_  
\_\_\_\_\_  
Any known medical conditions: \_\_\_\_\_  
\_\_\_\_\_  
Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
Current Mental Health Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
Current Therapist: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Current Psychiatrist: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_ - \_\_\_\_



**VILLAGE RANCH FOSTER CARE PLACEMENT AGREEMENT**

\_\_\_\_\_ agrees to place and is financially responsible for \_\_\_\_\_  
Placing Agent Client

The client will be placed into the \_\_\_\_\_ Foster Care Home licensed with Village Ranch, Inc.

A daily administrative rate is assigned to each child placed. The administrative rate for this placement is \$\_\_\_\_\_.

*(Please note: The Administrative Rate for placement is subject to change at the discretion of the Village Ranch, Inc. Factors leading to a change include but are not limited to a change in the Host County Contract and/or a higher rate being assessed based upon the supervisory and service needs of the youth placed.)*

A MAPCY assessment has been completed and a LEVEL \_\_\_\_\_ has been assigned.

1. If the MAPCY rate has not yet been set, and this is an emergency placement or initial placement in foster care, then Village Ranch, Inc. will bill at a **LEVEL D** for days 1-30 of the placement.
  - If the MAPCY rate comes out higher than a LEVEL D, the placing county will pay the higher rate back to the date of placement.
  - If the MAPCY rate is lower than a LEVEL D, the effective date of the new MAPCY rate shall be effective to Day 31 of the placement.
2. If the placement is not an emergency placement or initial placement in foster care, Village Ranch, Inc. will bill at the Basic Rate until the MAPCY is completed. The placing county will pay the MAPCY rate back to the date of placement.

The \_\_\_\_\_ County Social Service Agency and Village Ranch, Inc. agree to abide by the provisions outlined in this placement agreement:

1. The Agency shall, by written communication, provide at the time of placement, Village Ranch, Inc. with a specific statement as to the legal status of the child, and whom or which specific agency has legal custody of the child, along with a copy of a Juvenile Court Order, authorizing placement.
2. Village Ranch, Inc. shall, within (5) five working days following the last calendar day of the month, submit an invoice to the agency. The invoice shall contain: the name of the child served and the number of days of service with the daily rate and a total cost for providing services.
3. The agency shall within thirty (30) calendar days of the date of receipt of the invoice make payment directly to Village Ranch, Inc. for services purchased. The agency is responsible to Village Ranch, Inc. for the total cost of services incurred by the resident. Any financial arrangement or obligations on the part of the recipient's parents will be between the placing agency and the recipient's parents and will not involve Village Ranch, Inc. It is also our understanding, with prior approval of the agency, that vendor payment relative to the



recipient's medical, dental, or optical care will be billed from the vendor to the placing agency.

4. Village Ranch, Inc. shall inform the placing agency within one (1) working day when the child is absent from Village Ranch, Inc. foster home.
5. Village Ranch, Inc. shall provide updates (*both verbal and written*) to the placing county on a regular basis, and will schedule a client staffing on a quarterly basis.
6. Village Ranch, Inc. agrees to provide the placing agent and the child's family with information relative to the procedures at the Foster Care home.
7. The placing agency must complete and submit the intake documentation prior to placement and must sign the Placement Agreement at placement. Once the MAPCY rate is set, Village Ranch, Inc. will request the placing agency sign an update Placement Agreement.

\_\_\_\_\_  
Placing Agency Name (please print)

(\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Phone Number

\_\_\_\_\_  
Placing Agent Signature

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Village Ranch, Inc. Foster Care Program Director

\_\_\_/\_\_\_/\_\_\_  
Date