VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

13637 60th 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

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, in 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.

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.

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

FINANCIAL RESPONSIBILITY (OUTPATIENT THERAPY SERVICES ONLY)

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)

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

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

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
A CONTINUUM OF FAMILY SERVICES

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
A CONTINUUM OF FAMILY SERVICES

YOUR RIGHTS:

- To be treated with respect, dignity, consideration, and compassion
- Be informed of the qualifications of your practitioner and/or therapist (education, experience, professional counseling certifications, and license(s))
- Be informed of the limitations of the practitioner and / or therapist's practice to special areas of expertise (career development, ethnic groups, etc.) or age group (adolescents, older adults, etc.)
- Receive an explanation of services offered, your time commitments, fee scales, and billing policies prior to receipt of services.
- Confidential treatment of personal and medical records and the approval of refusal of their release to any individual outside of our agency.
- To see the contents of my file, the reasons for its retention, and any part of the file explained.
- To contest inaccuracies or incompleteness of the data maintained in the client record by submitting a written request to the author of said record. Village Ranch, Inc. replies to such requests within 30 days of receipt.
- Ask questions about the skills/therapy techniques and strategies and be informed of your progress.
- Participate in setting goals and evaluating progress toward meeting them.
- Be informed of how to contact the practitioner and/or therapist in an emergency situation.
- Request a referral for a second opinion at any time.
- Terminate the relationship at any time.
- Prompt and reasonable response to your questions and requests.
- Contact the appropriate professional organization with concerns or complaints relative to the professional's conduct.
- The right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint. It is our hope that the client will approach our agency employee first to try resolving the issue directly. A complaint regarding the violation of client's rights may be filed by contacting Village Ranch, Inc. at 13637 60th St. SW, Cokato, MN 55321, or 320-286-2922. You will receive a written response by our Director in 15 working days. If you are not satisfied with the actions taken, you may register a complaint with the Dept. of Human Rights, State Office Building, St. Paul, MN 55155, or 651-296-5663, or the Division of Licensing, Dept of Human Services Building, 444 Lafayette Road North, St. Paul, MN 55155 or 651-296-3971.
- You have the right to file a complaint with the appropriate state licensing Board.
  Board of Psychology: (612) 617-2230 Board of Social Work: (888) 234-1320
  Board of Marriage & Family Therapy: (612) 617-2220 Board of Behavioral Health & Therapy: (612) 617-2178

OUR RIGHTS:

- Staff have a right to privacy and should only be contacted by a client to cancel or reschedule an appointment or in time of family crisis.
- Staff should have the right as for consultation on your case.
- Staff has the responsibility to report to authorities if the client has committed a crime or threatened to commit a crime while receiving services from Village Ranch, Inc.
- Staff have the right to not be harassed by the client, specifically sexual harassment. This includes suggestive sexual language, kissing, dating, sexual touching, sexual penetration, and/or any other type of sexual contact while they are providing treatment to you.

CONSENT TO TREATMENT: I affirm that prior to becoming a client of Village Ranch, Inc., I was given sufficient information to understand the nature of mental health services. I consent to participate in evaluation and treatment and I understand I may refuse services at any time. I am aware the service provider will participate in case consultation/ supervision, as required at the clinic. My signature below affirms my informed and voluntary consent to receive therapy/outpatient services.

_____	_____	_____	_____
Client Signature	Date	Legal Guardian Signature	Date
_____	_____	_____	_____
Therapist/Mental Health Practitioner	Date	Clinical Supervisor	Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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:

_____ Placement is: ❒ Voluntary
Placing Worker Date of Placement ❒ 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): _____

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH FACE SHEET

I. CLIENT

Client's Name: _____ Nickname: _____

Race: _____ Sex: ❒ M ❒ F Ethnicity: _____

Age: _____ Date of Birth: ___/___/_____ Place of Birth: _____

Social Security Number (optional): _____-____-_____ Religion: _____

Height: _____ Weight: _____ lbs. Hair Color: _____ Eye Color: _____

Special Medical Problems, Safety Concerns or Allergies: _____

_____

_____

_____

_____ _____ _____ _____ (____) ____-_____

Current Address: Street City State Zip Code Phone

Current Student: ❒ Yes ❒ No

Name of Last School Attended: _____

School Contact: _____ Phone: (_____) _____-_____

Grade: _____ IEP: ❒ Yes ❒ No Currently Employed: ❒ Yes ❒ No

Employment Experience: _____

IN CASE OF EMERGENCY, CALL:

Name: _____ Phone: (_____) _____-_____

Name: _____ Phone: (_____) _____-_____

II. FAMILY (please complete if client is under 18 years of age)

PARENT/CAREGIVER DESCRIPTION OF THE PROBLEM (PLEASE INCLUDE FREQUENCY, INTENSITY, DURATION AND ONSET):

VILLAGE RANCH

A CONTINUUM OF FAMILY SERVICES

PARENT/GUARDIAN NAME: ___________________________________ RELATION: ______________________

ADDRESS: ____ CITY/STATE/ZIP: ____________________________

HOME PHONE: (______) _______-________   CELL PHONE: (______) _______-________

EMAIL ADDRESS: _____________________________________ DATE OF BIRTH: ___/____/_______

RACE: __________   ETHNICITY: __________ RELIGION: _____________   MARITAL STATUS: ____________

CUSTODY RIGHTS: ______________________________

OCCUPATION: ______________________________   EMPLOYER: _____________________________________

==

PARENT/GUARDIAN NAME: ___________________________________ RELATION: ______________________

ADDRESS: ____ CITY/STATE/ZIP: ____________________________

HOME PHONE: (______) _______-________   CELL PHONE: (______) _______-________

EMAIL ADDRESS: _____________________________________ DATE OF BIRTH: ___/____/_______

RACE: __________   ETHNICITY: __________ RELIGION: _____________   MARITAL STATUS: ____________

CUSTODY RIGHTS: ______________________________

OCCUPATION: ______________________________   EMPLOYER: _____________________________________

==

PARENT/GUARDIAN NAME: ___________________________________ RELATION: ______________________

ADDRESS: ____ CITY/STATE/ZIP: ____________________________

HOME PHONE: (______) _______-________   CELL PHONE: (______) _______-________

EMAIL ADDRESS: _____________________________________ DATE OF BIRTH: ___/____/_______

RACE: __________   ETHNICITY: __________ RELIGION: _____________   MARITAL STATUS: ____________

CUSTODY RIGHTS: ______________________________

OCCUPATION: ______________________________   EMPLOYER: _____________________________________

==

PARENT/GUARDIAN NAME: ___________________________________ RELATION: ______________________

ADDRESS: ____ CITY/STATE/ZIP: ____________________________

HOME PHONE: (______) _______-________   CELL PHONE: (______) _______-________

EMAIL ADDRESS: _____________________________________ DATE OF BIRTH: ___/____/_______

RACE: __________   ETHNICITY: __________ RELIGION: _____________   MARITAL STATUS: ____________

CUSTODY RIGHTS: ______________________________

OCCUPATION: ______________________________   EMPLOYER: _____________________________________

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VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

III. CLIENT'S COUNTY/STATE CARE TEAM

SOCIAL WORKER: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

CHILD PROTECTION WORKER: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

MENTAL HEALTH CASE WORKER: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

PROBATION OFFICER: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

GUARDIAN AD LITEM: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

_____: _____ COUNTY: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____-_____ CELL: (____) _____-_____

FAX NUMBER: (____) _____-_____ EMAIL ADDRESS: _____

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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
A CONTINUUM OF FAMILY SERVICES

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

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

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

Village Ranch Foster Care
13637 60th 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:** _____ (___)____-_____
   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: _____

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A CONTINUUM OF FAMILY SERVICES

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

Village Ranch Residential
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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: (___) ____-_____

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   ❒ 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:** _____ (___)____-_____
   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
A CONTINUUM OF FAMILY SERVICES

ACTIVITY INVOLVEMENT AUTHORIZATION FORM

I grant permission for _____ to participate in extra-curricular activities while a resident at Village Ranch Residence. If my child is placed in foster care upon the signing of this form, I give permission for the foster parents to sign permission forms for school and other group events such as class trips or to attend youth group gatherings.

☐ To attend/participate in activities with other clients of Village Ranch, Inc.

Foster Care Placement Only: With regards to Foster Care Providers:

☐ I understand the foster family will be allowed to attend all education meetings including school conferences.

Residential, Group Home, & Foster Care Placement Only: I further state that my child may attend the following:

☐ Routine haircuts ☐ To attend any church and youth group meetings

☐ Bible Study ☐ Any Denomination ☐ Specific Denomination: _____

All of our residents are offered the opportunity to explore their spirituality and/or grow spiritually.

NOTE: Consent for these activities also includes permission for my child (and other family members during CTSS sessions) to be transported to and from such activities by Village Ranch, Inc. staff or community volunteers.

X _____

Parent/ Legal Guardian Signature Date

X _____

Placing Agent Date

PROMOTION AUTHORIZATION FORM

I, _____, give Village Ranch permission to use a likeness or photograph of _____, in brochures or video presentations for public education about Village Ranch, Inc. I also understand that my child could participate in community outreach projects requiring him/her to be in the community under Village Ranch staff supervision. I understand that my child's name will not be used or published, and all data privacy rules and regulations will be followed. This pertains to any pictures or videos taken of my child's rendering of services through Village Ranch. This consent is voluntary and I understand that I may revoke it at any time.

❒ **REFUSED** *(please check if you do not wish your child to participate)*

X _____

Client Signature Date

X _____

Legal Guardian Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

CONSENT FOR MEDICAL TREATMENT

I hereby authorize Village Ranch, Inc. Staff to consent to any routine and emergency medical care (including surgery, anesthesia, tests, etc.) to for medical, dental, and eye exams or treatment, under general or special supervision, and on the advice of a physician, nurse, dentist, or surgeon duly licensed by the State of Minnesota.

I also authorize Village Ranch, Inc. to administer medication to the below-named minor as directed and as prescribed by a duly licensed physician or surgeon.

This authorization shall remain in effect so long as the named minor below is in the care and control of Village Ranch, Inc.

Foster care and residential/group home placement please answer the next two questions:

I AUTHORIZE QUALIFIED MEDICAL PERSONNEL TO:

ADMINISTER REQUIRED IMMUNIZATIONS ❒ **YES** ❒ **NO**

ADMINISTER RECOMMENDED SEASONAL VACCINATION ❒ **YES** ❒ **NO**

ILLNESS/ALLERGY DISCLOSURE

Please indicate when and what illnesses or allergies your child has experienced and the action that was taken. Please use a separate piece of paper if more space is needed.

DATE:	**ILLNESS/ALLERGIES:**	**ACTION TAKEN:**
Example: 9/25/98	*Strep throat, chicken pox, etc.*	*Doctor, Antibiotics, Rest*

By signing this document, I acknowledge I have authority to consent to medical treatment for:

_____ (Child's name)

_____ ___/___/_____

Client/Legal Guardian Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

TEXT AND EMAIL NOTIFICATIONS FROM PROCENTIVE SOFTWARE

Client's Name: _____

OVERVIEW

Procentive is the trusted electronic health records system (EHR) for behavioral health. This system allows us to communicate with parents through text and email. With the input of your text number and/or email address our system allows us to set up notifications that will be directly sent to your phone and/or email address to remind you of an upcoming appointment or to review a document that requires a signature.

HOW IT WORKS

- Text/Email Notifications: Our system will automatically send you a text and/or email reminder two (2) days before and the day of your scheduled appointment, reminding you of your upcoming appointment.

- Email Notifications: Using the kiosk feature we are also able to send documents that require a signature electronically through email. The provider will send an email with the subject line "Village Ranch Paperwork". There will be a link directing you to the document.
  *(Note this document can only be opened once). Once opened you can review the document and sign it in the designated signature box using your mouse.

With your permission, we ask that you provide us with your text number and email address:

Text Number: (_____) _____-_____

Email Address: _____@_____._____

How would you prefer to be notified for an upcoming appointment? ❒ Text ❒ Email

_____
Client/Legal Guardian Signature Date

_____
Client/Legal Guardian Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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

AspireMN CORE CHILDREN'S OUTCOME REPORTING AND EVALUATION

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

RESIDENTIAL ONLY FORMS

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH RESIDENTIAL PLACEMENT AGREEMENT

_____ ❒ **JUVENILE PROBATION** **Agency,**
Name of county ❒ **SOCIAL SERVICE**

INCLUDING ITS ASSIGNED WORKER(S) ("Agency"),

PLACES AND IS FINANCIALLY RESPONSIBLE, FOR:
RECIPIENT OF SERVICES:

_____
First Middle Last

DATE OF BIRTH: _____

AT

Village Ranch Inc. Hutchinson Location 851 Dale St. SW Hutchinson, MN 55350

AS OF _____

The unit cost from January 1, 20___ through December 31, 20___ is $_____ per day.

The Agency and Village Ranch agree to abide by the provisions outlined in this PLACEMENT AGREEMENT:

1. The Agency shall, by written communication, provide at the time of placement, with a specific statement as to the legal status of the child, and whom or which specific agency has legal custody of the child.
2. Village Ranch shall, within five (5) working days following the last day of each calendar month, submit an invoice to the Agency. The invoice shall contain:
   a) Name of child served;
   b) Number of days of service with daily rate and 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 for services purchased. The Agency is responsible to Village Ranch for the total cost of services incurred by the resident. Any financial arrangements or obligations on the part of the recipient's parents will be between the recipient and the Agency and will not involve Village Ranch.

4. Village Ranch shall inform the Agency within one (1) working day when the child is absent from Village Ranch. A mutual agreement shall be reached within one (1) working day between the Residential Facility and the Agency as to how long the recipient's bed shall be held. All verbal communication must be confirmed in writing by the Agency within five (5) working days.
5. Village Ranch shall provide Social Service Progress Reports to the Agency each quarter after the staffing. Written progress reports will be supplied upon request.
6. Village Ranch agrees to provide the Agency and the child's family with information relative to the procedures at the Residential Facility.
7. The Agency must provide Village Ranch with the following information in writing prior to placement:
   a) Social history on child and family;
   b) Results of recent psychological and/or physical consultations;
   c) Results of physical examination which has been given within the last year as well as history of health problems and immunization records;
   d) Educational data which would include achievement scores;
   e) The Agency case record number and when available, the Medical Assistance number or statement of financial responsibility for medical services.
8. The Agency's participation is required at the time of placement, the Intake Staffing and Reviews. The Agency is responsible for implementing and carrying forth work with the family and to provide reports indicating the goals and objectives of family treatment and the time limits in which they will try to reach them.

At the time of placement, the Agency will have completed a Face Sheet provided by Village Ranch. He/she would also have the consent forms relative to placement signed by the parents or guardian.

_____ ___/___/_____
Agency Worker Signature **Date**

_____
Print Name

_____ ___/___/_____
Village Ranch, Inc. Signature **Date**

_____
Print Name

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH BANKING CONTRACT

As a resident of Village Ranch (Hutchinson or Rochester), you are expected to attain a job as quickly as you can, when staff feel you are ready. Part of this employment experience is learning to balance your spending money and, at the same time, saving money for your future. It is our desire to help you with this so the following is an agreement we are asking you to sign to allow us to assist you in this.

- You may keep 30% of your paycheck for personal spending either in cash or a debit card.
- A spending register may be required of you if staff feel you need to keep better track of how much you spend.
- You will put 70% of your paycheck into a general savings account that the House maintains. A record of your deposits will be kept.
- When you are discharged from the Village Ranch, you will be given any savings you have accrued during your time with us.

_____

Client/Legal Guardian Signature **Date**

_____

Client/Legal Guardian Signature **Date**

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH CELL PHONE CONTRACT

During your stay with us at Village Ranch (Hutchinson or Rochester), you may earn the privilege to purchase and keep a cell phone, once certain requirements and levels are met. This privilege comes with responsibilities and accountability. This contract is to ensure you understand and agree to the expectations of your responsibilities and accountability so we may assist you in keeping and learning the privilege of a cell phone.

Below is what is expected of you.

- The privilege of having a cell phone may be earned once you have attained Level 2 of our program.
- You must purchase the cell phone with your own money or you may keep one you have previously purchased.
- If your cell service is on your parent's plan you will be expected to send them money each month to assist with paying your bill. The amount depends on your plan and service.
- You may also be expected to pay Village Ranch an additional $5-$10 each month for the accountability/monitoring service we use. Our monitoring service allows us to view your text messages, emails, messages, phone calls, web activity, photos, videos, social networking activity, and track whereabouts, etc.
- If you do not already have a cell phone, staff will assist you with purchasing one as well as setting up the account with the provider of your choice.
- Cell phones are to be turned off and placed on a charger by the fireplace each night at bedtime (9:30 p.m.).
- Cell phones are not to be brought to school. You may not use your cell phone until after school.
- You will lose your cell phone, for a time determined by staff, if you misuse it by:
    - Accessing inappropriate websites
    - Using your cell phone to harass another person
    - Use your cell phone to contact anyone you are prohibited to contact

By signing below, you are agreeing to the terms states above for having and maintaining the privilege of a cell phone and cell phone service.

_____

Client Signature Date

_____

Legal Guardian (if applicable) Signature Date

_____

Village Ranch Staff Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH DISCLAIMER OF RESPONSIBILITY

I, _____, do hereby release Village Ranch, Inc. and its employees from responsibility (either monetary or replacement) for personal items that I insist upon keeping rather than returning to home. If any personal item is broken or stolen, I will bear sole responsibility for its loss and/or replacement.

If I acquire additional items during my stay at Village Ranch, which includes any clothing or personal items, I am fully responsible for informing staff and documenting the changes on my inventory sheet immediately.

_____ ___/___/_____
Client/Legal Guardian Signature Date

_____ ___/___/_____
Client/Legal Guardian Signature Date

MEDICATION MANAGEMENT

Resident's Name _____ Date of Birth: ___/___/____

TYPE OF MEDICATION	DOSAGE	QUANTITY UPON ADMISSION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

- Has parental/guardian verbal/written consent been given? ❒ YES ❒ NO
- Has Village Ranch nursing staff been notified: ❒ YES ❒ NO
- Has the medication been verified by prescribing pharmacy? ❒ YES ❒ NO

Please advise how the medication was verified and give documentation of parental/guardian consent:

_____
_____

_____ _____ ____/____/_____
Village Ranch Staff Signature Print Name Date

_____ ____/____/_____
Parent/Guardian Written Consent Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Village Ranch Hutchinson House Drug Use Policy

The Village Ranch Hutchinson House prohibits any use of illegal or non-prescribed drugs or medications of any type or sort.

If a client is found to be using, distributing, or in possession of illegal drugs, while a resident of the Hutchinson house, he will lose privileges and receive consequences determined by staff.

The guidelines of said loss of privileges and consequences will be as follows. However, these are not conclusive and may be altered at the discretion of staff.

The House staff will take into consideration a client's amenability to treatment and time frame between infractions of this expectation when determining consequences for offenses.

Use of illegal drugs or non-prescribed medications – **1st offense:**

- Loss of all privileges in the House
- Table time – determined by staff
- Reduced to Level 1
- Loss of any extracurricular school activity or events
- Loss of any House off campus non-supervised activity

Use of illegal drugs or non-prescribed medications – **2nd offense**: *(In addition to consequences above)*

- Loss of job
- Hutchinson "House Arrest"
- An emergency staffing will be arranged to discuss the potential options for the Client.

Use of illegal drugs or non-prescribed medications – **3rd offense**:

- Unsuccessful discharge from the Hutch House

Possession of or bringing illegal drugs or non-prescribed medications onto Hutch House property:

- Unsuccessful discharge from Hutch House

Distribution (give, sale or trade) of illegal drugs or non-prescribed medications:

- Unsuccessful discharge from Hutch House

The Village Ranch Hutch House reserves the right to discharge a client unsuccessfully at any time for any reasons of non-cooperation with our program.

Client Signature _____ Date ___/___/____

Worker Signature _____ Date ___/___/____

Staff Signature _____ Date ___/___/____

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

RESIDENT BASIC RIGHTS

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.

_____ ____/____/_____

Client Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH GRIEVANCE POLICY & PROCEDURES

A. INTERNAL PROCEDURE:

1. Residential Home Staff will provide a Resident who wishes to report a grievance with a copy of the Grievance Form.
2. Resident Grievance Forms completed will be delivered by the staff without reading, altering, interference, or delay to the Chief Executive Officer.
3. Upon receipt of the Resident's Grievance, the Chief Executive Officer will conduct an investigation *(if the grievance is not frivolous)* into the Resident's complaint. The Chief Executive Officer will submit a written report of findings and recommendations, if any, to the Grievance Committee within three (3) working days from the time the grievance was received.
4. When a grievance is of an emergency matter, the Chief Executive Officer will conduct an investigation into the Resident's complaint and complete a written report and the action taken, if any, within 24 hours from the time the grievance was received.
5. The Chief Executive Officer will provide the Resident reporting the grievance with a copy of his findings and recommendations.
6. The Grievance Committee will consist of a member of the Village Ranch Board, a probation/law enforcement officer and the Residential Home Chaplain.
7. The Grievance Committee will:
    a. Review the Chief Executive Officer's investigation and findings.
    b. Hear any added information or rebuttal from the Resident reporting the grievance.
    c. Discuss possible corrective plans of action with the Chief Executive Officer and complaining resident.
    d. Decide on the Chief Executive Officer and Residential Home staff to take steps necessary to implement the corrective plan of action and report back to the Committee on the results of said plan within 30 days.

B. EXTERNAL PROCEDURES

1. Residential Home staff will provide a Resident who wishes to report a grievance with a copy of the Grievance Form.
2. Resident Grievance Forms, if not submitted to the Chief Executive Officer will be mailed to the Residential Home Board according to procedures applying to regular correspondence/private mail.
3. The Residential Care Staff will provide postage to Residents who wish to mail grievances to the Chief Executive Officer or Village Ranch Board.
4. The Residential Care Staff will cooperate with the Grievance Committee in order to resolve the grievance issues.

_____ ___/___/_____

Client/Legal Guardian Signature Date

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Additional Forms Needed for Treatment

Please Print or Complete During On-site Intake Meeting

HealthPartners®

Permission to Verbally Discuss Protected Health Information with Family and Friends

---Completion of this form is optional ---

VERBAL

Patient name	Date of Birth	Medical Record #, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the HealthPartners Family of Care to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. ***(check all boxes that apply)*** **This form does not authorize releasing copies of my records.**

- [x] Scheduling/Appointment information
- [x] Medical information, including my symptoms, diagnosis, medications and treatment plan
- [x] Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - [x] Substance use disorder
  - [ ] Developmental disorder
- [x] Lab/test results ([ ] Check here to include HIV results)
- [x] Billing and payment information
- [ ] Other (describe): _____

The HealthPartners Family of Care has my permission to discuss the above information with the following family member, friend or other person. List only 1 person on each form. This information is directly relevant to their involvement in my health care (or payment for that care).

Name Village Ranch

Street address Po Box 305

City, State, Zip Hutchinson MN 55350

Home phone 320-587-3967 Work phone _____

I understand that in certain situations the HealthPartners Family of Care may speak to other individuals who are involved in my care or
payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.** If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

X _____

Signature of Patient/Authorized Representative **Date**

X If other than patient, state relationship and authority to sign _____

NOTE: For copies of medical records, contact Health Information Management at 952-993-7600 or www.healthpartners.com.

Patient/Staff Instructions: Immediately upon completion send form to HIM (details on back)

HealthPartners®

Patient authorization for Release of Protected Health Information

AUTHR

Instructions for completing and mailing this form are on page 2.

Patient Information

Patient name	Previous last name (if any)	Phone number

Street address	City	State	ZIP code	Date of birth

Release my records from:

- ☐ Amery Hospital & Clinics
- ☐ HealthPartners Central MN Clinic
- ☐ HealthPartners Medical Clinics: location _____
- ☐ Hudson Hospital & Clinics
- ☒ Hutchinson Health Hospital & Clinics
- ☐ Lakeview Hospital
- ☐ Methodist Hospital
- ☐ Olivia Hospital & Clinic
- ☐ Park Nicollet Clinics/TRIA: location _____
- ☐ Regions Hospital & Clinics
- ☐ Stillwater Medical Group
- ☐ Westfields Hospital & Clinics

☐ External/Outside facility *(complete this section only if requesting outside records)*

Phone number	Fax number

Street address	City	State	ZIP code

Send my records to:

Person/Business/Hospital/Clinic	Phone number	Fax number
Village Ranch Hutch House	320-587-3967	

Street address	City	State	ZIP code
Po Box 305	Hutchinson	MN	55350

Information to be released

- *check only what applies*
- *there may be a charge for records*
- *instructions on back of form*

I want health records related to this diagnosis/condition ▸ _____

I want health records for these dates of service ▸ _____

I am requesting summary of care from:

☐ Clinic visit (includes):
- imaging report
- immunizations
- lab results
- medication list
- provider note

☐ Hospital care (includes):
- lab results
- imaging report
- emergency dept. note
- discharge summary
- operative report
- history & physical

- AND / OR - Choose Individual reports

I only need the following individual reports/results:

- ☐ Billing or Itemized statements
- ☐ Consult report
- ☐ Discharge summary
- ☐ Eye or Optical
- ☐ Emergency department notes
- ☐ HealthPartners Dental *(give request to your dental clinic)*
- ☐ History and physical
- ☐ Immunization record
- ☐ Lab or Pathology report
- ☐ Medication list
- ☒ Mental health records
- ☐ Operative report
- ☐ Pathology glass slides
- ☐ Provider note/clinic visit
- ☐ X-ray/Imaging report
- ☐ X-ray/Imaging CD (describe) _____
- ☐ Other _____

Special Permissions

In compliance with federal law, special permission is required to release the following records:

☐ Programs for Change ☐ Alcohol and Drug Abuse Program *(ADAP)* ☐ Hutchinson SUD Program

WISCONSIN RECORDS ONLY: Special permission is required to release the following records:

☐ HIV test results ☐ Mental health ☐ Developmental disability ☐ Substance use disorder

Purpose for release

- ☒ Continuity of care
- ☐ Transfer of care
- ☐ Personal/My request
- ☐ Insurance
- ☐ Disability
- ☐ Legal
- ☐ Other (list specific purpose below) _____

Release method *(choose one)*

▾ Date records needed ____ / ____ / ____

- ☐ Mail
- ☐ Fax ▸ Number _____
- ☐ Release to my online account (patient portal). *Not available with all proxy access (see pg2, 7d).*
- ☐ Secure email ▸ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service.** Radiology images cannot be sent via email.*
  ▸ Email address _____

Authorization and Revocation

- I authorize HealthPartners to release the information marked above. HealthPartners will not withhold treatment or insurance payment based on whether I sign this form.
- Records released may include information received from other organizations.
- Records released may no longer be protected by law and could be redisclosed by the recipient. Federal regulations prohibit the recipient of substance use disorder records from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted (42.CFR.2.32).
- **There may be a charge for records.**
- This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified. ▸ _____
- I may revoke this authorization by sending a written request to the appropriate HealthPartners Release of Information department *(see section 8 on back of form).*

Patient signature	Date	If other than patient, state relationship and authority to sign

HealthPartners®

Encounter Date: 5/4/2023

CAUTH

CONSENT TO ARRANGE FOR PAYMENT AND FOR SHARING OF MY INFORMATION

Your privacy is important. If you don't understand this form, ask questions. If you'd like us to consider any special requests, please refer to the Notice of Privacy Practices for contact information. We cannot accept changes to this form.

My consent to sharing (release) of my information

- **For treatment**: I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating my care, and related services.
- **For payment**: I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payers to perform.
- **To run your organization (health care operations)**: I authorize you, as my provider, to share my information with others to improve the quality of my care and experience, and to manage your business operations. This includes activities such as licensing and accreditation, and evaluating quality.
- **Health plan information:** I authorize my health plans to share my information (about services I have received) with you, as my provider, and with other professionals and facilities from whom I receive healthcare, as needed for treatment, management and coordination of my care, accreditation and quality review/measurement.
- **Health plan release of information:** My health plans may share my claims data with you, as my provider, about services I have received from you and other caregivers outside of this organization. This does not include written medical records. This data will assist in the coordination of my care with all of my caregivers, inside and outside of this organization.

☐ I do NOT want claims data shared by my health plan (valid only if my health plan allows me to opt out of this sharing).

My responsibility for payment and assignment of benefits

- **I authorize you**, as my provider, to bill my health plans (including Medicare/Medicaid and other third party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.
- **I agree that** it is my responsibility to pay for any items or services not covered by my health plans, such as co-payments, deductibles or co-insurance.

My consent to share my information with external health researchers

Research leads to new and better ways to understand and treat diseases and improve care. Our organization often works with outside health researchers. Any health research involving my information is required to get prior review and approval from an Institutional Review Board (IRB). The IRB is charged with the protection of research subjects and helps ensure research is conducted responsibly. Any published results will not identify specific patients.

Unless I check the box below, I authorize the sharing of my information with external health researchers in accordance with the law.

☐ I do NOT want to have my information shared with external health researchers.

My consent to be included in the hospital directory

By being included in the hospital directory, hospital staff may inform callers and visitors that I am a patient at the hospital. I will also be able to receive deliveries like flowers, mail, care packages, and phone calls.

☐ I do NOT want to have my information shared in the hospital directory.

My signature and acknowledgment

My consent will be valid for ten years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purposes of my consent, "provider" means the organizations that are part of HealthPartners (see the list in the Notice of Privacy Practices), and use of my information within this group is permitted and is not a "release" of my information. "My information" means information that identifies me and relates to my health and services received, as explained in more detail in the Notice of Privacy Practices.

My provider's Notice of Privacy Practices has been made available to me. It describes my privacy rights and additional disclosures my provider may make according to law.

X _____ _____

Signature of patient/authorized representative — Date — Time

_____ _____

Print name — Patient Date of Birth

_____ _____

If authorized representative, relationship to patient — Reason Patient is Unable to sign

Distinctive Dental Services, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Michael J. Thoennes, DDS

Telephone: (320) 485-4344 Fax: (320) 485-4734

Address: 131 Main Avenue West, P.O. Box 599 Winsted, MN 55395

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also agree that my spouse (if any) may receive my protected health information without further authorization.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Account/Patient Registration

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Patient: _____ Date: _____

Patient Name: _____

Date of Birth: _____ SS# _____

If minor/child who is head of the acct?: _____

College Student? Name of school: _____

DENTAL HISTORY (Please circle your answer).

1. Why are you here today? Emergency? Yes No
   Initial (first) Exam? Yes No
   Periodic Exam Yes No
   Consultation/2nd opinion? Yes No
2. Do you have a specific dental concern today? Explain ----->
3. How long has it been since you have last been to a dentist?
   ____ months? _____ years?
4. Do you usually make routine visits for check ups? Yes No
5. When were your last xrays taken?? _____
6. Have any of your teeth been removed/extracted? Yes No
   If yes, have they been replaced? (with denture? partial? bridge?)
7. Have you ever had any unusual complications with dental treatment? __ Yes __No Please explain ------->
8. Does food get stuck between your teeth? Yes No
9. Are you aware that you clench or grind your teeth? Yes No
10. Does your jaw ever ... Hurt? Click? Snap? Yes No
11. Do you have sensitive teeth? Yes No
    Hot? [ ] Cold? [ ] Brushing? [ ] Sweets ? [ ] Chewing? [ ]
13. Do your gums ever bleed or hurt? Yes No
14. Have you ever been treated for gum disease? Yes No
    Please explain --------->
15. Are your aware of any broken or chipped teeth? Yes No
    Please explain ---------->
16. Are you happy or unhappy with the looks of your teeth?
    What would you change? Please explain --------->
17. Do you feel your breath is offensive? Yes No
18. Have you ever had braces (orthodontics)? Yes No
19. Have you ever had an unpleasant dental visit? Yes No
20. Are you taking medication for bone density? Yes No

LIST ALL MEDICATIONS BELOW: ***(or indicate what the medications are for if unsure of the spelling) Include herbal supplements and over the counter meds***

Medication	For

Use this space to explain your answers)

MEDICAL HISTORY: (Please circle your answer)

1. Physician's Name: _____

Name of Medical Clinic or Location _____

2. Are you presently under a physician's care? Yes No
   If yes, please explain in the comments section ------->
3. Are you using any medications or substances? Yes No
   If yes, please explain in the comments section ------->
4. Do you have any allergies to:
   - Local Anesthetics? Yes No
   - Penicillin? Yes No
   - Other antibiotics? Yes No
   - Latex (rubber gloves, tape? etc.) Yes No
   - Codeine? Yes No
   - Narcotics? Yes No
   - Other medications? Yes No

   If yes, please explain in the comments section ------->
5. Are you sensitive to any metals? Yes No
   If yes, please explain in the comments section ------->
6. Are you pregnant? (Due date: _____) Yes No
7. Do you use any birth control medications? Yes No
   (*Some medications used can react with these)
8. Do you have heart problems? Heart attack? Stroke?
   Pacemaker? Heart Murmur? Please explain: Yes No
9. Do you have high or low blood pressure? Yes No
   If yes, please explain in the comments section ------->
10. Do you have any artificial joints or prosthetics? Yes No
    If yes, please explain in the comments section ------->
11. Do you have blood disorders (anemia, leukemia) Yes No
    If yes, please explain in the comments section ------->
12. Do you bleed easily after being cut or injured? Yes No
    If yes, please explain in the comments section ------->
13. Have you ever had a serious injury or surgery? Yes No
    If yes, please explain in the comments section ------->
14. Are you having stomach problems? Yes No
    If yes, please explain in the comments section ------->
15. Are you having liver problems? Yes No
    If yes, please explain in the comments section ------->
16. Are you having kidney problems? Yes No
    If yes, please explain in the comments section ------->
17. Are you diabetic? Yes No
    If yes, do you use insulin? Yes No
18. Do you have asthma? Yes No
19. Do you have epilepsy? Yes No
20. Do you have AIDS? Yes No
21. Are you HIV positive? Yes No
22. Do you or have you had hepatitis? Yes No
23. Do you have thyroid problems? Yes No
24. Do you or have you ever had a venereal disease? Yes No
25. Do you have glaucoma? Eye conditions? Yes No
26. Do you or have you had TB (tuberculosis) Yes No
27. Do you smoke, use snuff, or chew tobacco? Yes No
28. Are you chemically dependent? __ Yes __ No
    Drugs? _____ Alcohol? _____
29. Any other medical concerns? ____ Yes *See Comments

Please list for us:

EMERGENCY CONTACT: _____

PHONE: _____

I hereby certify that the information I provided is complete, accurate and true. I understand this health information is necessary for the dentist's professional consideration in providing me with safe dental care and treatment. I also understand that any information I provide is protected by the HIPAA privacy protection mandates and is kept confidential.

Patient/Parent Signature: _____

Date signed: _____

Dentist's Signature: _____

Date signed: _____

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Strengths and Difficulties Questionnaire

S 11-17

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

Your name..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

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

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

- How long have these difficulties been present?

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

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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

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

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Your Signature ..... Today's Date .....

Thank you very much for your help

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Strengths and Difficulties Questionnaire

P 11-17

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

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

Date of birth.....

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

Do you have any other comments or concerns?

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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

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

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

- How long have these difficulties been present?

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

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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

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

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

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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

Mother/Father/Other (please specify:)

Thank you very much for your help

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

VILLAGE RANCH

A CONTINUUM OF FAMILY SERVICES

Hutchinson High School Enrollment Forms

Student Enrollment

Hutchinson Public Schools, ISD 423

Primary Household Information

Include full legal names as they appear on a Driver's License or other official ID.

Street Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip:_____

Is this address within the Hutchinson School District boundaries? Yes No

- Proof of residency must be turned in with enrollment forms (see front cover for more information).
- If your address is outside of the District boundaries, complete the Enrollment Options Form.

Primary Parent / Guardian - #1

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ Gender: M or F Relationship to Student:_____

Email:_____ Cell #:_____ Work #:_____

Employer:_____ Legal Guardian? Yes or No

Primary Parent / Guardian - #2

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ Gender: M or F Relationship to Student:_____

Email:_____ Cell #:_____ Work #:_____

Employer:_____ Legal Guardian? Yes or No

Other Household Members

List full names of all other children and/or adults living at this address.

First, Middle & Last Name	Date of Birth DD/MM/YYYY	Gender	Relationship to Student	Preschool Screened	If yes, list location
_____	_____	M or F	_____	Yes or No	_____
_____	_____	M or F	_____	Yes or No	_____
_____	_____	M or F	_____	Yes or No	_____
_____	_____	M or F	_____	Yes or No	_____
_____	_____	M or F	_____	Yes or No	_____
_____	_____	M or F	_____	Yes or No	_____

Non-Household Emergency Contact - List Someone Other than Parent / Guardian

Emergency Contact Name:_____ Relationship to Student:_____

Street Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip:_____

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

Secondary Household Information (if applicable)

Street Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip:_____

Is this address within the Hutchinson School District boundaries? Yes No

- Proof of residency must be turned in with enrollment forms (see front cover for more information).
- If your address is outside of the District boundaries, complete the Enrollment Options Form.

Primary Parent / Guardian - #1

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ Gender: M or F Relationship to Student:_____

Email:_____ Cell #:_____ Work #:_____

Employer:_____ Legal Guardian? Yes or No

Student Information

Enter the student's full legal name as it appears on their birth certificate.

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ Current Age:_____ Gender: M or F Enrolling in Grade:_____

Student's Preferred Name:_____

Has this student attended Hutchinson Public Schools in the past? Yes or No

Name of Previous School Attended:_____ Dates Attended:_____

Previous School City and State:_____

Special Services

Does this student currently receive specialized services on an Individual Education Plan (IEP)? Yes or No

If Yes, identify the areas of service or primary disability area from the options below:

- ❑ Autism Spectrum
- ❑ Blind-Visually Impaired
- ❑ Deaf and Hard of Hearing
- ❑ Developmental CognitiveDisabilities
- ❑ Developmental Delay
- ❑ Emotional or Behavioral Disorders
- ❑ Learning Disabilities
- ❑ Other Health Disabilities
- ❑ Physically Impaired
- ❑ Speech or Language Impairments
- ❑ Traumatic Brain Injury
- ❑ Uncertain

Do you have a copy of the IEP with you today? Yes or No

Does this student currently receive accommodations through a 504 plan? Yes or No

Does this student currently receive Gifted and Talented services? Yes or No

Do you give permission for your child to be tested and possibly placed in Title I programming? Yes or No

Does your student currently receive English as a Second Language (ELL) services? Yes or No

Additional Student Information

Is the student a teen parent? Yes or No

Is the student in foster care? Yes or No

Is the student a ward of the county or state? Yes or No

Is the student a Military Connected Youth? Yes or No

Military personnel's relationship to student:_____

_____

Has the student moved across district or state lines within the last 35 months? Yes or No

Has your family moved to seek or obtain agricultural related work? (Ex. meat, poultry, fish) Yes or No

Is the student homeless? Yes or No

A student may be homeless if:

- ❑ Shared housing (doubled up) due to loss of housing, economic hardship, or similar reason
- ❑ Living in cars, parks, public spaces, abandoned buildings, not a regular sleeping place.
- ❑ Hotels or motels
- ❑ Emergency/transitional shelters; awaiting foster care

Acknowledgement

I certify the information given above it true and complete to the best of my knowledge.

Parent/Legal Guardian Signature:_____ Date:_____

Authorization for Release of Information

Section I. [1]

Student's Name: _____ **Date:**_____

Date of Birth: ____/____/____ (mm/dd/yy) **ID:** _____ **Grade:**_____

School:_____

Section II [2]

Parent/Guardian Name: _____

Authorizes: _____ _____

District Name / Number | Staff Person Responsible

_____ _____

School Responsible | Address

☒ to release the specific information identified below ***to***: ISD # 0423

☐ to obtain specific information identified below ***from***:

Name of individual or entity, Title: _____ Organization: _____

Address: _____

☒ Health Records	Created between ____/____/____ (mm/dd/yy) and ____/____/____(mm/dd/yy)
☒ Medical Reports	Created between ____/____/____ (mm/dd/yy) and ____/____/____(mm/dd/yy)
☒ Chemical Abuse/ Dependency Report	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Psychological Reports	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Psychiatric Report	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Teacher, Counselor, Staff Observations	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Special Education Records	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Social Work Report	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)
☒ Others *(specify)*	Created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy)

For the purpose of :

Educational Planning

Section III [3]

I understand this authorization:

- takes effect the day I sign it,
- cannot exceed one year, and expires either:
  - ☐ on ___/___/___ (mm/dd/yy), or
  - ☒ one year from the date of my signature,
- can be stopped any time by sending a written request to:

Cornerstone School

Hutchinson Public School

145 Glen Street

Hutchinson, MN 55350

I further understand:

- I may refuse to sign this authorization and it will not affect my child's ability to receive educational services,
- the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose this information, but only as permitted by law Health Insurance Portability and Accountability Act [HIPAA], Family Educational Rights & Privacy Act [FERPA], Minnesota Government Data Practices Act [MGDPA or Chapter 13]),
- a copy of this release form is as valid as an original, and
- I will receive a copy of this authorization.

Signature: _____ **Date:**_____

Parent, legal representative or student | (mm/dd/yy)

References to regulations [4]

MDE -06/14/06

DEPARTMENT OF EDUCATION

Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions **(in bold)** for their children. If you choose not to answer the federal questions **(in bold)**, federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as "Optional" and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our *Frequently Asked Questions: Ethnic and Racial Designation Form.*

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[1]

[You must select "yes" or "no" to this question.]

○ **Yes** *[If yes, go to Question A.]* ○ **No** *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Guatemalan	☐ Salvadoran	☐ Other Hispanic/Latino
☐ Colombian	☐ Mexican	☐ Spaniard/Spanish/ Spanish-American	☐ Unknown
☐ Ecuadorian	☐ Puerto Rican		

Go to Question 1.

[Select "yes" to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

○ **Yes** *[If yes, go to Question 1a.]* ○ **No** *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Cherokee	☐ Other North American Indian Tribal Affiliation
☐ Anishinaabe/Ojibwe	☐ Dakota/Lakota	☐ Unknown

Go to Question 2.

[1]Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

○ **Yes** *[Go to Question 3.]* ○ **No** *[Go to Question 3.]*

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.[1]

○ **Yes** *[If yes, go to Question 3a.]* ○ **No** *[If no, go to Question 4.]*

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Chinese	☐ Karen	☐ Other Asian
☐ Asian Indian	☐ Filipino	☐ Korean	☐ Unknown
☐ Burmese	☐ Hmong	☐ Vietnamese	

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.[1]

○ **Yes** *[If yes, go to Question 4a.]* ○ **No** *[If no, go to Question 5.]*

Optional Question 4a**.** If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Ethiopian-Other	☐ Somali
☐ African-American	☐ Liberian	☐ Other black
☐ Ethiopian-Oromo	☐ Nigerian	☐ Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[1]

○ **Yes** *[Go to Question 6.]* ○ **No** *[Go to Question 6.]*

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.[1]

○ **Yes** ○ **No**

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has consistent interaction in:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

Hutchinson School District
Student Health Information Form

Office Only:
School Year in effect:

Student Name: _____Grade_____

**Please note: Health Staff will alert the bus company of any health concerns the student may have. **

Privacy statement: In accordance with the Minnesota Government Data Privacy Act, the information you provide *may* be shared with district staff involved with your child based on an educational need. Any information shared with others cannot be done so without your permission. School personnel are mandated reporters for suspected child abuse/neglect as well as suspected excessive/habitual use of illegal drugs by a parent or guardian. You have the right to withhold health information however, in doing so the school may not be able to provide the safest environment for your child.

Check ALL that apply

☐ My Child has NO known Medical Concerns

☐ Asthma
- ☐ I have completed a plan for this school year
- ☐ I need a plan for this school year.

Medication Used: _____
- ☐ Kept in Health Office ☐Carried on Self (signed off by MD)

**Action Plan and Prescription Medication Form Need to be completed Yearly. Signed by MD, Guardian, LSN

☐ ADD/ADHD
- ☐ I have completed the Prescription Medication Form for this School Year.
- ☐ I need a Prescription Medication form for this School Year.
- ☐ Student takes medication at home

** Prescription Medication form needs to be completed Yearly and with every medication change. Signed by MD, Guardian, LSN

☐ Allergies

List: _____

_____

Special Diet Statement on File: ☐ Yes ☐ No (only once)
(if we do not have it we will contact you)

☐Emergency Medication
- ☐ Benadryl ☐ Epi-Pen

**Emergency Care Plan needs to be completed by MD Yearly. If medication required: Prescription Medication form needed Yearly. Signed by MD, Guardian, LSN

☐Bleeding Disorders: (i.e: ITP, Hemophilia)

Describe: _____

Precautions: _____

**Health staff may ask for an Emergency Care Plan from MD.

☐Cancer:

Type: _____
- ☐ Actively Receiving Treatment

Frequency: _____
- ☐ In Remission (Date): _____

**Health staff may ask for an Emergency Care Plan from MD.

☐Seizures: Type(s): _____

Medication: _____
- ☐ I have completed an Emergency Care Plan for the School Year and Prescription Medication form for the School Year.
- ☐ I need an Emergency Care Plan and Prescription Medication form for this School Year.

**Emergency Care Plan needs to be completed by MD Yearly. If medication required: Prescription Medication form needed Yearly. Signed by MD, Guardian, LSN

☐Diabetes: Type 1: _____ Type 2: _____
- ☐ I have a completed Diabetic School Plan from the MD for the School Year.
- ☐ I have completed an Emergency Care Plan for the School Year.
- ☐ I need to have the MD complete a Diabetic School Plan and Emergency Care Plan

☐Student Requires Blood Glucose Monitoring at School

☐Student is able to self-monitor/administer BG and injections.
- ☐ Unsupervised (Signed by MD) ☐Supervised (Signed by MD)
- ☐No

*Supplies needed for school:

Glucose monitor, strips, lancets/pen needles, glucose tabs, glucagon injection, extra snacks.

**Emergency Care Plan needs to be completed by MD Yearly. If medication required: Prescription Medication form needed Yearly. Signed by MD, Guardian, LSN

☐ Vision ☐Hearing Impairment
- ☐ Wears Glasses ☐ Has Hearing Aide(s) ___R ___L

Accommodations Needed: _____

_____

☐ Heart Condition
- ☐ Murmur without restrictions/limitations
- ☐ Other: (describe)_____

_____

**Health staff may ask for an Emergency Care Plan from MD.

☐ Mental Health
- ☐ Anxiety ☐ Depression ☐ Panic ☐ Bi-Polar Disorder
- ☐ Other: _____
- ☐ I have completed the Prescription Medication Form for this School Year.
- ☐ I need a Prescription Medication form for this School Year.
- ☐ Student takes medication at home

** Prescription Medication form needs to be completed Yearly and with every medication change. Signed by MD, Guardian, LSN

☐Other (ie: activity restrictions, neurological, mobility, special dietary needs, orthopedic concerns, migraine/headaches)

Describe: _____

_____

_____

_____

**Health staff may ask for an Emergency Care Plan from MD.

PLEASE NOTIFY THE SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE YEAR!

Complete Both Sides

Hutchinson School District
Student Health Information Form

Office Only:
School Year in effect:

Student Name: _____Grade_____

Prescription medications

- The medication permission form is part of the care plan and must be signed by the parent and physician.
- Medication form must be renewed annually.
- Medication container must be labeled by the pharmacy with the medication name, dose and physician's name.
- Medication are to be brought to the health services office by a parent or responsible adult.
- A new Prescription Medication form is needed with any medication changes including dose.

Nonprescription or over-the-counter medications

- Nonprescription medications are to come to school in the original unopened container.
- Sample sized are recommended.
- Nonprescription medications sent to school in a plastic bag and/or mixed with other medications will be returned.
- Nonprescription medications can only be given according to manufacturer's instructions.
- Inappropriate age or dose will not be given without a physician's order.
- Parent must complete the nonprescription medication form with the name of the medication, dosage requirements, and student's name.
- The health service office does stock or dispense any nonprescription medications that have not come from home with appropriate documentation.

Children should not transport medications to and from school. Medications must be brought to the school health office when the health staff is on duty, by a parent or trusted adult.

If you have questions about your child's health, please contact the school health office. Health information is confidential. Pertinent health information regarding your child may be shared with appropriate school staff at the discretion of the nurse.

***Parent/Guardian Initials stating you understand the medication requirements. _____ ***

Is your child covered by a health insurance plan or medical assistance? Yes No

Please list any additional information that may be helpful to meet the health needs of your child

_____

_____

_____

_____

Health information is confidential, protected information. Pertinent health information regarding your child's health may be shared with appropriate school staff at the discretion of the school nurse/ building health staff. If your child has received immunizations since last school year, please let the health office know. If you have any questions, please contact the Licensed School Nurse at 320-234-2731. ***If your phone numbers have changed, please contact Central Office at 320-587-2860 to have the information updated. Thank you.***

Parent/Guardian Signature _____ Date _____

PLEASE NOTIFY THE SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE YEAR!

Complete Both Sides

Hutchinson Public Schools

Excellence in Academics, Activities, and Character

Dear Parent/Guardian:

Our school offers healthy meals each day. Starting school year 2023-24, we are joining Minnesota's Free School Meals Program. All students can get one breakfast and one lunch free of charge each day at school. Although no application is required to receive this free meal benefit, filling out the Application for Educational Benefits is still important! Your child(ren) may qualify for other benefits like reduced fees at school. Your application may also help the school qualify for education funds, discounts, and other meal programs.

To apply, complete the enclosed Application for Educational Benefits and return it to:

30 Glen St. NW
Hutchinson, MN 55350

Who should complete this application? Children in households participating in the Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP) or Food Distribution Program on Indian Reservations (FDPIR), and foster, homeless, migrant and runaway children qualify without reporting household income. Alternatively, children can qualify if their household income is within the maximum income shown for their household size on the instructions.

COMMON QUESTIONS:

I get WIC or Medical Assistance. Can my children qualify? Children in households participating in WIC or Medical Assistance do not automatically qualify. Children may be eligible depending on other household financial information. Please fill out an application.

Who should I include as household members? Include yourself and all other people living in the household, related or not (such as grandparents, other relatives, or friends).

May I apply if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens for you to complete an application.

What if my income is not always the same? List the amount that you normally get. If you normally get overtime, include it, but not if you get overtime only sometimes. For seasonal work, write in the total annual income.

Will the income information or case number I give be checked? It may be. We may also ask you to send written proof.

How will the information be kept? Information you provide on the form, and your child's approval, will be protected as private data. For more information, see the back page of the Application for Educational Benefits.

If I don't qualify now, may I apply later? Yes. Please complete an application at any time if your income goes down, your household size goes up, or you start getting SNAP, MFIP or FDPIR benefits.

If you have other questions or need help, call [*phone number*].

Sincerely,

Lesli Mueller
Director of Food and Nutrition Services
320-234-2607

Hutchinson Public Schools

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How to Complete the Application for Educational Benefits

Complete the Application for Educational Benefits form for school year 2023-24 if any of the following applies to your household:

- Any household member currently participates in the Minnesota Family Investment Program (MFIP), or the Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR) or
- The household includes one or more foster children (a welfare agency or court has legal responsibility for the child) or
- The total income of household members is within the guidelines shown below (**gross earnings before deductions**, not take-home pay). Do not include as income: foster care payments, federal education benefits, MFIP payments, or value of assistance received from SNAP, WIC, or FDPIR. Military: Do not include combat pay or assistance from the Military Privatized Housing Initiative. The income guidelines are effective from July 1, 2023 through June 30, 2024.

Maximum Total Income

Household size	$ Per Year	$ Per Month	$ Twice Per Month	$ Per 2 Weeks	$ Per Week
1	26,973	2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
Add for each additional person	9,509	793	397	366	183

Step 1: Children

List all infants and children in the household, their school and grade if applicable, and birthdate. Attach an additional page if needed to list all children. Check the box if a child is in foster care (a welfare agency or court has legal responsibility for the child).

Step 2: Case Number

If any household member currently participates in SNAP, MFIP or FDPIR, write in the case number and then go to Step 4. If you do not participate in any of these programs, leave Step 2 blank and continue on to Step 3.

Step 3: Adult and Child Incomes / Last 4 Digits of Social Security Number

- **Social Security Number/Total Household Members.** An adult household member must provide the last four digits of their Social Security number or check the box if they do not have a Social Security number. Report the total number of household members and ensure all household members are listed individually on the application in the child or adult section as applicable.
- **Child Income**. If any children in the household have regular income, such as SSI or part-time jobs, list the total amount of regular incomes received by all children, and check the box for the frequency: weekly, bi-weekly, twice a month, or monthly. Do not include occasional earnings like babysitting or lawn mowing.
- **Adult income.** Report the names of adult household members and income earned in this section.
    - List all adults living in the household not listed in Step 1, whether related or not, such as grandparents, relatives, or friends.
    - **Gross Earnings from Work**. This is usually the money received from working at jobs where a paycheck is received. For each income, check the box to show how often the income is received: weekly, bi-weekly, twice per month, or monthly.
    - List gross incomes before deductions, not take-home pay. Do not list an hourly wage rate. For adults with no income to report, enter a '0' or leave the section blank. For seasonal work, write in the total annual income.
    - **Are you Self-Employed or a Farmer?** List the net income per month or year after business expenses. Do not list the same income twice on the application. A loss from farm or self-employment must be listed as 0 income and does not reduce other income.
    - **Any Other Gross Income**. List gross incomes before deductions from all other sources, such as SSI, unemployment, child support, public assistance, social security, rental income or annuities.

Hutchinson Public Schools

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Step 4: Signature and Contact Information An adult household member must sign the form. If you do not want your information to be shared with Minnesota Health Care Programs, check the “Don’t share” box in Step 4.

Optional: Please provide the information on ethnicity and race that is requested on the second page of the form. This information is not required and does not affect approval for school meal benefits. The information helps to ensure we are meeting civil rights requirements and fully serving our community.

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DEPARTMENT OF EDUCATION

2023-24 Application for Educational Benefits

Complete one application per household for all children. Please use pen (not a pencil). **Mail or return completed form to: 30 Glen St. NW, Hutchinson, MN 55350**

STEP 1: **List ALL Household Members who are infants, children, and students** up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

Definition: A Household Member is "Anyone living with you and shares income and expenses, even if not related." Read *How to Complete the Application for Educational Benefits* for more information. Adults over grade 12 living in the same household should be reported in Step 3. If your children attend different districts or charter/nonpublic schools, return an application at each one.

Child's First Name (list all children in household)	MI	Child's Last Name	School	Grade	Birthdate	Foster Child (v)
						☐
						☐
						☐
						☐
						☐

STEP 2: Do Any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, MFIP or FDPIR? Medical assistance **does not** qualify. **If NO** > Go to STEP 3.
If YES >Enter SNAP, MFIP or FDPIR Case Number (between 4-9 digits, do not report EBT card number) ___ ___ ___ ___ ___ ___ ___ ___ ___ then go to STEP 4 (Do not complete STEP 3)

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A. **Last Four Digits of Social Security Number (SSN)** of Adult Household Member: **XXX-XX-** ☐ ☐ ☐ ☐ Or Check if Adult has **No SSN**: ☐ **Total Number of All Household Members** (Children + Adults) ☐

B. **Child Income.**
Sometimes children in the household earn or receive income, such as from a part time job or SSI. Please include the TOTAL income received by all children listed in STEP 1. Do not include income received by adults in the box to the right.

Total Income Received by All Children	Weekly	Bi-weekly	2x Month	Monthly
$	☐	☐	☐	☐

C. **All Adult Household Members (including yourself).** For each Household Member listed, if they do receive income, report total gross income only. If they do not receive income from any source, write '0' or leave any fields blank. You are certifying (promising) that there is no income to report. Not sure what income to include here? Flip the page and review "Sources of Income" for information. "Sources of Income" will help you with the Child Income section and All Adult Household Members section.

Names of All Adult Household Members (First and Last)	Gross Earnings from Working at Jobs					Are you Self-Employed or a Farmer?			Any Other Gross Income				
List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.	Weekly	Bi-weekly	2x Month	Monthly	Report income **before deductions or taxes** in whole dollars (no cents).	Monthly	Yearly	**Net income** from Farm or Self-Employment. Do not duplicate elsewhere.	Weekly	Bi-weekly	2x Month	Monthly	SSI, Unemployment, Public Assistance, Child Support, and others on Page 2
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$

See Page 2 for Additional Information. Return completed form to the school at the address listed at the top of the form. Do not mail to the Minnesota Department of Education or United States Department of Agriculture.

Hutchinson Public Schools

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STEP 4: Contact information and adult signature. "I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is give in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

☐ I have checked this box if I *do not* want my information shared with Minnesota Health Care Program as allowed by state law.

Printed name of adult signing form _____ Daytime Phone _____

Address (if available) _____ Apt# _____ City _____ Zip _____

SIGN HERE: Signature of Household Adult _____ Date _____

OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility. Respond to both Step One, *Ethnicity* and Step Two, *Race*.

Step One: Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Step Two: Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

INSTRUCTIONS: Sources of Income

Sources of Income for Children

Sources of Child Income	Examples
• Earnings from work • Social Security a. Disability Payments b. Survivor's Benefits • Income from person outside the household • Income from any other source	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security • A Parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	All Other Income
• Salary, wages, cash bonuses (before deductions or taxes) • Net income from self-employment (farm or business) • If you are in the U.S. Military: a. Basic pay and cash bonuses (do NOT include combat pay, FSSA	• Cash Assistance from State or local government • Supplemental Security Income • Unemployment benefits • Worker's compensation • Alimony payments • Child support payments	• Social Security • Disability benefits • Regular income from trusts or estates • Annuities • Investment income • Rental income

Do Not Fill Out: For School Office Use Conversions to Annualize All Income:	X52	X26	X24	X12	X1	☐ **Verified? Attach Tracker**	No change ☐	Free After Verified ☐	Reduced After Verified ☐	Denied After Verified ☐
All Total Income (Include child and adult income)	Weekly	Bi-weekly	2X Month	Monthly	Annualize	**Household Size:**	Categorical Eligibility	Free	Reduced	Denied
$	☐	☐	☐	☐	☐		☐	☐	☐	☐
Determining Official Signature:								**Date:**		
Confirming Official Signature:								**Date:**		

Hutchinson Public Schools

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Sources of Child Income	Examples
	• A child receives regular income from a private pension fund, annuity, or trust

Earnings from Work	Public Assistance / Alimony / Child Support	All Other Income
or privatized housing allowances) b. Allowances for off-base housing, food and clothing	• Veteran's benefits • Strike benefits	• Regular cash payments from outside household

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

At public school districts, each student's school meal status also is recorded on a statewide computer system used to report student data to MDE as required by state law. MDE uses this information to: (1) Administer state and federal programs, (2) Calculate compensatory revenue for public schools, and (3) Judge the quality of the state's educational program.

Nondiscrimination statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) **mail:** U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
(2) **fax:** (833) 256-1665 or (202) 690-7442; or
(3) **email:** program.intake@usda.gov

This institution is an equal opportunity provider.