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 April of 2015 we opened a similar 12-bed Independent Living Program for adolescent males in Rochester, Minnesota. In November of 2016 we opened a residential program for girls 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

Village Ranch, Inc. provides the following outpatient services: in-home individual and family skills-based therapy services, outpatient individual and family therapy, and diagnostic assessment services. We also offer residential group home and foster care placement which works in tandem with our 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 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. Please note, skills-based therapy services are not available to those individuals over the age of 18.

Our philosophy is that every family system is unique, important, and has strengths. We believe that working as partners through relationships, support, and caring, families are

strengthened and experience greater success. The services provided, areas covered, and goals established are mutually agreed upon between client, family and provider.

FINANCIAL RESPONSIBILITY (OUTPATIENT THERAPY SERVICES ONLY)

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.

If the client is a child/adolescent involved with skills-based therapy services, please complete all the paperwork in a timely manner as we cannot hold the skills-based therapy spot longer than three (3) weeks due to our current waiting list for these services.

VILLAGE RANCH
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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 Ext. 202. 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.
- To be contacted by a client only 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 responsicility 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 not to 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.

_____	___/___/20___	_____	___/___/20___
Client Signature	Date	Legal Guardian Signature	Date
_____	___/___/20___	_____	___/___/20___
Therapist/Mental Health Practitioner	Date	Clinical Supervisor	Date

_____ (Client/Parent/Guardian initial)

VILLAGE RANCH
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VILLAGE RANCH APPLICATION FOR SERVICES

Today's Date: ___/___/_____

A. CLIENT INFORMATION:

_____ ____ _____ ____/____/_____
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 ❒ Anoka

SERVICES REQUESTED:

❒ CTSS Services: ❒ Individual Skills ❒ Family Skills ❒ Group Skills
❒ Individual Therapy ❒ Family Therapy ❒ Group Therapy ❒ Family Focus
❒ Adolescent Sexual Health Curriculum ❒ Sexuality-Specific Treatment ❒ RISE ❒ CLIMB

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 Diagnostic Assessment (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:

_____
_____
_____

(Continued on next page)

VILLAGE RANCH
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D. REFERENT:

❒ Self ❒ Therapist ❒ Social Worker ❒ Probation Officer ❒ Foster Parent ❒ Other: _____

_____ _____
First Name/Last Name Agency

_____ _____ _____ _____ (____) ____-_____
Street Address City State Zip Code Phone

(_____) ____-_____ (_____) _____-_____ _____
Phone Alternate Phone Email Address

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

E. CUSTODIAL (LEGAL) GUARDIANSHIP:

_____ _____
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

VILLAGE RANCH
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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):

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

SIBLING(S):	DATE OF BIRTH:	ADDRESS:
_____	___/___/_____	_____
_____	___/___/_____	_____
_____	___/___/_____	_____
_____	___/___/_____	_____

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): _____

III. PAYMENT INFORMATION FOR CLIENT: _____

PARTY RESPONSIBLE FOR PAYMENT:

❒ County of Residence
❒ County Different than County of Residence
❒ Self-Pay
❒ Other: _____
❒ Primary Insurance Company
❒ Secondary Insurance Company

Responsible Party: _____ Relation: _____

Social Security Number: _____-____-_____ Date of Birth: ____/____/_____

Employer: _____ Work Phone: (____) ____-_____

Employer: _____ Work Phone: (____) ____-_____

Primary Insurance Company: _____ Group #: _____

Policy/Contract #.: _____ ID #.: _____

RXBIN#: _____ Phone: _____

Claims Address: _____ City, State, Zip: _____

Insurance Coverage: ❒ Dental Eye ❒ Exams/Glasses ❒ Prescriptions ❒ Others _____

Secondary Insurance Company: _____ Group #: _____

Policy/Contract #.: _____ ID #.: _____

RXBIN#: _____ Phone: _____

Claims Address: _____ City, State, Zip: _____

Insurance Coverage: ❒ Dental Eye ❒ Exams/Glasses ❒ Prescriptions ❒ Others _____

FOR RESIDENTIAL AND GROUP HOME ONLY:

Placement funded by: ❒ DOC ❒ DHS

Agency Responsible for Payment: _____

VILLAGE RANCH
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IV. 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

VILLAGE RANCH, INC. RELEASE OF INFORMATION

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

Village Ranch Cokato Outpatient
13637 60th St. SW, Cokato, MN 55321
Phone: (320) 286-2922 Fax: (320) 286-5140

Village Ranch Foster Care
13637 60th St. SW. Cokato, MN 55321
Phone: (320) 286-2922 Fax: (320) 286-5140

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) 258-3447

Village Ranch Anoka Outpatient
12 Bridge Square, Suite 207, Anoka, MN 55303
Phone: (763) 712-9209 Fax: (763) 712-9200

Village Ranch Hutchinson Group Home
851 Dale St SW, PO Box 305 Hutchinson, MN
Phone: (320) 587-3447 Fax: (320) 286-2875

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

1. **I would like Village Ranch, Inc. to:** ❒ Exchange information with ❒ Release my records to ❒ Obtain my records from

   Person, Clinic, Organization Name: _____

   Address: _____ City, State, Zip: _____

   Phone: (____) _____-_____ Fax: (____) _____-_____

2. **I would like the following records released:** All pertinent records, or check all that appy 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: _____

_____ (Client/Parent/Guardian initial)

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: In regards to Foster Care Providers:

☐ I understand that 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
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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

_____ (Client/Parent/Guardian initial)

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

CONSENT FOR MEDICAL TREATMENT

I hereby authorize the 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 the 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**
ADMINISTER RECOMMENDED MN DEPT. OF HEALTH LAB SCREENINGS	**❒ YES**	**❒ NO**
ADMINISTER RECOMMENDED CDC VACCINES	**❒ 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

_____ (Client/Parent/Guardian initial)

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

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. ("Village Ranch")
13637 60TH STREET SW, COKATO, MN, 55321

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

_____ (Client/Parent/Guardian initial)

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

VILLAGE RANCH VISITATION SCHEDULE

It is the desire of the Village Ranch to ensure communication continues between our residents and supportive family members. Village Ranch wants to accommodate you in providing a Visitation Schedule that fits into your work schedule.

- **VILLAGE RANCH OFFERS TWO (2) VISITATION OPTIONS:**
  - SATURDAYS: 10:00 a.m. – 1:00 p.m.
  - SUNDAYS: 10:00 – 1:00 p.m.
- **VILLAGE RANCH OFFERS TWO (2) PHONE COMMUNICATION OPTIONS:**
  - THURSDAYS: 5:00 – 8:00 p.m.
  - SUNDAYS: 10:00 – 1:00 p.m.

If these accommodations do not fit into your schedule, please let us know and other arrangements can be made.

There are some situations which require calls and visits to be supervised by a staff member. In this case, the client and the individual(s) involved will be notified by a staff. All supervised phone and visitation are set up on a case-by-case basis. Again, **ALL CALLS must be initiated by individuals on the client's contact list.**

NOTE: IT IS REQUIRED THAT FAMILY THERAPY BEGIN PRIOR TO ANY OFF-GROUND VISIT, UNLESS OTHERWISE SPECIFIED BY THE CLIENT'S THERAPIST.

We apologize for any inconvenience this may cause. Please feel free to contact the office at (320) 286-2922 if you have any questions.

_____ ___/___/_____

Client/Legal Guardian Signature **Date**

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

VILLAGE RANCH
A CONTINUUM OF FAMILY SERVICES

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 Date

_____
Print Name

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

_____ (Client/Parent/Guardian initial)

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 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 of Directors 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 of Directors.
4. The Residential Care Staff will cooperate with the Grievance Committee in order to resolve the grievance issues.

_____ ___/___/_____

Client/Legal Guardian Signature Date

Last printed 10/9/2017 11:44:00 AM

Hutchinson HEALTH

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION FORM 1754

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____
Clinic/Hospital/Health Care Provider – (*Who* has the information you want released?) **Please list the specific Hospital and/or clinic.**	NAME: Hutchinson Health X Information Exchange Address: Mental Health 1071 Hwy 15 S Day Phone: _____ City: Hutchinson State MN Zip: 55350
Receiving Party (*Where* do you want the information sent? *Who* may have the information?)	NAME: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____ Fax Number (URGENT PATIENT CARE ONLY) _____
Information to be Released (*What* do you want sent or released? Check the appropriate box.)	Routine Record Sets (indicate date(s) of service _____) ☐Clinic (office visit, lab, radiology, medicines, immunizations) ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) ☐Billing Records ☐ Copies of Films/Images ☐Any and all records (includes ALL types of record listed below, excluding behavioral health and substance abuse. If you want to include images and billing records, check those boxes.) Only records types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Medication records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Chemical dependency ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Substance abuse records ☐ Consultations ☐ Progress notes/clinic notes ☐ Mental health records ☐ Pathology slides/blocks ☐ Psychiatric Evaluation ☐ Other records specify record type(s) _____ OPTIONAL Limits - Disclose only records related to following: Date(s) of service: _____ Injury or illness: _____
Release Instructions (*How* and *When* do you want the information?)	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) Release Method / Format requested: (check one) ☐ *Paper* ☐*CD/DVD* ☐*Fax* (patient care only) ☐*Verbal* Continuing Care Information released by Nursing Station/Department (verbal and paper) ☐ Yes ☐ No
Purpose of Release (*Why* is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social security appeal * ☐ Insurance application * ☐ Personal use or review * ☐ Social security disability determination * ☐ Insurance payment/claim ☐ Litigation/legal * ☐ Other* _____ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Hutchinson Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Hutchinson Health will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Hutchinson Health cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Hutchinson Health from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Forward Release of Information form to HIS for (check one) ☐ HIS to complete request ☐ HIS to file in patient chart

_____ _____ _____

Patient/Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)

Hutchinson Health is an Equal Opportunity Provider and Employer

Hutchinson Health
ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned and operated by Hutchinson Health, including physician services, or by any provider under contract with Hutchinson Health or participating in a provider network in which Hutchinson Health participates.

Important Information for Patients: I received the material on each line initialed below.

_____ Notice of Privacy Practices (unless received during previous visit)
_____ Federal and State Patient Rights Information
_____ Important Message from Tricare/Champus (inpatient visit only)

_____ _____
Signature of Patient, or if Patient is unable to sign, a Representative of the Patient — Date/Time

_____ _____
Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

Guarantee and Agreement to Pay

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document).

_____ _____
Patient, Legal Representative or Guarantor Signature — Date/Time

☐ **Directed by Patient to sign on their behalf (having read this document to them)**

_____ _____
PRINTED Patient Name — Patient Date of Birth

1/30/2013

ASSIGNMENT OF BENEFITS FORM 3500	Hutchinson HEALTH	*Patient Label*

_____ (Client/Parent/Guardian initial)

Hutchinson Health
Electronic Health Record

Health Information is stored, viewed and shared by health care providers in a secure electronic health record (EHR) system. Hutchinson Health uses an EHR that helps providers coordinate care exchange treatment information and provide complete and current information to any provider who uses the EHR. Several other health care providers in the area, including our organization use the same electronic medical record system to document and review the health care services they provide to you. A list of organizations that use Allina Health's EHR system is available when requested.

I authorize all the information about my treatment with these providers to be released and put into one EHR. The EHR will be used by all these providers for treatment, payment and health care operations purposes.

This consent will continue indefinitely unless I cancel it in writing at: Hutchinson Health, Attention: Health Information Services, 1095 Highway 15 South, Hutchinson, MN 55350

If I cancel my consent, it will not change releases that have already been made.

Patient or Legal Representative Signature	Date/Time
Legal Representative Printed Name (if signing for patient)	Authority to sign for patient (Attach Documentation)
PRINTED Patient Name	Patient Date of Birth

08/30/2017, TG & PAT/DocMan

ELECTRONIC HEALTH RECORD FORM 4760	Hutchinson HEALTH	*Patient Label*

4760 (10/17) Page 1 of 1

_____ (Client/Parent/Guardian initial)

Hutchinson Health

CONSENT FOR USE AND RELEASE of HEALTH INFORMATION

1. **Treatment, Payment and Operations:** I authorize Hutchinson Health, any other health care providers, entities that pay for my health care, and anyone affiliated with or authorized by them to: release and receive my health records and other information about my health care for treatment, payment and health care operations purposes as described in Hutchinson Health's Notice of Privacy Practices. I understand that information received by or created in a drug, alcohol, or mental health treatment service area may require another authorization before it can be released for some or all of these purposes.

2. **Provider Record Locator or Patient Information Services**: A health record locator or patient information service helps my health care providers know where I have received care and get information about my health to help treat me. Hutchinson Health and other providers who participate in a record locator or patient information service may access my information in a record locator or patient information service to help provide care and services to me. Hutchinson Health may share my identifying information and location of my health records with a health record locator or patient information service, unless I check here. ☐

3. **Consent for Use and Disclosure of Medical Records in Research:** I authorize Hutchinson Health to use or disclose my medical records for research. This includes health records created by Hutchinson Health and any records Hutchinson Health receives from other health care providers while treating me, unless I check here. ☐

This consent will continue indefinitely unless I cancel it in writing at: Hutchinson Health, Attention: Health Information Services, 1095 Highway 15 South, Hutchinson, MN 55350. If I cancel my consent, it will not change releases that have already been made.

Patient or Legal Representative Signature	Date/Time
Legal Representative Printed Name (if signing for patient)	Authority to sign for patient (Attach Documentation)
PRINTED Patient Name	Patient Date of Birth

8/31/2016; 8/30/2017 TG/smg

CONSENT FOR USE AND RELEASE OF INFORMATION FORM 3498	Hutchinson HEALTH	*Patient Label*

3498 (10/17)

Page 1 of 1

_____ (Client/Parent/Guardian initial)

Village Ranch Alternative Program (VRAP)

13637 60th Street SW, Cokato, MN 55321
Phone: (320) 286-2922 • Fax: (320) 286-3274

MULTIPLE AGENCY RELEASE OF PRIVATE STUDENT INFORMATION

Student Name: _____ DOB: __/___/____Grade: _____

Parent Name/Address: _____

Parent Phone: (____) _____-_____ County of Residence: _____

Resident School District: _____

Student's Current Address: _____

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I hereby give permission for representatives from the following agencies to release and exchange verbal, printed, and electronic information which will assist in the development of an educational and/or individual treatment plan for this program.

- ☑ Village Ranch Alternative Program Staff
- ☑ Village Ranch, Inc.
- ☑ County
- ☑ School District Staff:
- ☑ Mental Health Agency Staff:
- ☑ **My email address:** _____

THE INFORMATION TO BE RELEASED/EXCHANGED WILL BE THE FOLLOWING:

- ☑ Educational Assessment, Individual Education Plans, Staff Observations
- ☑ Psychological Reports (including test scores)
- ☑ Health/Medical Reports
- ☑ Other School Records (attendance, grades, etc.)
- ☑ County Social Worker/Court Reports on Student
- ☑ Chemical Abuse Reports

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically as described below. I understand that information maintained by the organization named above is limited to staff whose work assignments reasonably require access to such information within the purpose specified in the services provided. I further understand that unless specified otherwise below, this Informed Consent will continue in effect during my participation or within one year, whichever is less, within the program for which disclosures of the above-described data is made. A copy of the original is as valid as the original.

_____ ___/___/_____

Client/Legal Guardian Signature Date

**Obtain a new signed release one year from this date, if needed.*

Village Ranch Alternative Program (VRAP)

The collection of the following information is in cooperation with U.S. Department of Education's guidance on school district data collections.

PART A. ETHNICITY

Is this Student (or are you) Hispanic/Latino? (*Choose only one)*

❒ **NO,** not Hispanic/Latino

❒ **YES,** Hispanic/Latino
(A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race.)

PART B. RACE

What is this Student's (or your) Race? (*Choose one or more)*

❒ **American Indian or Alaska Native**
(A person having origins in any of the original peoples of North and South America (including Central American), and who maintains tribal affiliation or community attachment.

❒ **Asian**
(A person 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.)

❒ **Black or African American**
(A person having origins in any of the black racial groups of Africa.)

❒ **Native Hawaiian or Other Pacific Islander**
(A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)

❒ **White or Caucasian**
(A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

Village Ranch Alternative Program (VRAP)

ACCEPTABLE USE GUIDELINES FOR STUDENT ACCESS TO TECHNOLOGY AND NETWORKED INFORMATION RESOURCES

The goal in providing instructional technology to teachers, staff, and students is to promote educational excellence at VRAP by facilitating resource sharing, innovation, and communication. The Internet, as one component of instructional technology, is an electronic communications network which provides vast, diverse, and unique resources. This electronic highway, connecting millions of computers, individual subscribers, and databases throughout the world, is a realistic tool of the information age.

LEARNER SECTION

We believe that learners should have the OPPORTUNITY to:

- Examine a broad range of opinion and ideas in the learning process, including the opportunity to locate, use, and exchange ideas and information.
- Examine and use all information formats, including interactive formats (i.e. internet).
- Communicate with other individuals on the network as it pertains to their learning.
- Utilize network resources that pertain to their learning.

RIGHTS AND RESPONSIBILITIES FOR ELECTRONIC LEARNERS

As electronic information plays an integral role in education and lifelong learning, the empowerment of individuals and organizations bring new levels of rights, privileges, and responsibilities.

Individuals have RIGHTS to:

- Access computing and information sources within VRAP guidelines.
- Appropriate training and tools to ensure access.
- Be informed, review, and give permission about collected personal information
- Ownership over their own intellectual works.

Individuals have RESPONSIBILITIES to:

- Find, evaluate, and effectively use information resources.
- Recognize and honor the intellectual property and privacy of others.
- Question the integrity and authenticity of information utilized.
- Share and conserve resources.

Individuals have PRIVILEGES to:

- Access the network.
- Reasonable access to the printing of educational materials.
- A network account.

GENERAL

- School officials may review all files and communications to maintain system integrity and to ensure that users are using the system responsibly.
- Illegal activities are strictly forbidden.
- VRAP vandalism and harassment policies apply to technology.
- VRAP technology may not be used for personal gain.
- Attempting to gain unauthorized access to the network is not permitted.
- Do NOT send out personal address or phone numbers of students or colleagues.

CONSEQUENCES

Any misuse or illegal activities may result in communication with parents/guardians, suspension, and/or cancellation of privileges and in contact with authorities if a violation of law has occurred. All other policies of VRAP relating to harassment, appropriate use of own time and district resources, and all others as outlined in VRAP policies relating to students will apply as well. Any student, staff members, or parent can report infractions. VRAP administration will follow through on consequences.

DISCLAIMER

VRAP makes no warranties of any kind, whether expressed or implied, for the service it is providing. VRAP will not be responsible for any damages a user may suffer, including loss of data. VRAP will not be responsible for accuracy or quality of information obtained in violation of the above guidelines.

NOTE: INAPPROPRIATE USE MAY RESULT IN THE CANCELLATION OF COMPUTER/INTERNET PRIVILEGES.

STUDENT TECHNOLOGY AND NETWORKED INFORMATION AGREEMENT

I understand and will abide by Village Ranch Alternative Program (VRAP) Acceptable Use Guidelines for technology and networked information. My access privileges may be revoked, school disciplinary action may be taken and/or appropriate legal action if I choose to disregard VRAP guidelines. I further understand that failure to comply with these guidelines may constitute a criminal offense.

X _____

Student Signature Date

X _____

Legal Guardian Signature Date

MAWSECO
MEEKER AND WRIGHT SPECI
CO-OPERATIVE - #
PO Box 1010
720 9th Avenue
Howard Lake, MN 55349

Janell Bullard
Director of Special Education
(320) 543-1122 Voice or TDD
Fax (320) 543-1121
E-mail:
jbullard@mawseco.k12.mn.us

Dear Parent/Guardian,

MAWSECO programs provide vision and hearing screenings that meet the recommendations of the Minnesota Department of Health. These recommendations include **annual vision and hearing screening** for grades K-3, 5, 7, 10 and for any students who are referred to us by a parent, teacher, or the students themselves.

The health service of MAWSECO is staffed by a Licensed School Nurse who will conduct these screenings, usually in the spring of each school year. An audiologist is also on staff and is available for assessment of students who have hearing loss. Students will not be included in these screenings if they have recently been assessed for a 3-year re-evaluation.

School health screenings are an important public health practice that identifies problems early. Early identification of problems leads to more effective treatment and prevention of more serious issues.

☐ I **do** want my child to be included in the annual vision and hearing screenings
mentioned in the letter above.

☐ I **do not** want my child to be included in the annual vision and hearing screenings mentioned in the letter above.

_____ _____
Signature Date

_____ (Client/Parent/Guardian initial)

MAWSECO

MEEKER AND WRIGHT SPECIAL EDUCATION COOPERATIVE #0938-52
PO Box 1010
720 9th Avenue

Janell Bullard
Director of Special Education
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Serving the following programs:
Cornerstones Program * Eastern Wright Program * Journeys Program * Sholund School * STEP Program
TREK Program * Village Ranch Alternative Program * Westside Program * Wings Program

Email Authorization Form

(Permission to communicate via email)

YES, I authorize the use of email for communication relating to my child's education including but not limited to: due process documents (Individual Education Plan, Prior Written Notice, Evaluation Report, etc.), educational reports, discipline or behavior reports and/or general communication regarding my child's progress.

_____
(Child's Name)

I wish to receive email at: _____
(Please provide email)

Parent Name: _____

Parent Signature: _____

Date: _____

Expiration Date: _____
Please Note: this authorization will expire after one year or with written withdrawal of permission to use email from a parent/guardian.

If you have any questions regarding this release or form, please contact your child's special education teacher.

_____ _____
Teacher Phone

Or the Director of Special Education, Janell Bullard at 320-543-1122 ext. 2103

Original Release Placed in Due Process File.