Our Home, Inc.
Caring for Kids and Families

Admission Packet

PRTF Parkston (All Female Facility)	PRTF Huron (All Male Facility)	PRTF Rediscovery (Co-ed Drug & Alcohol Facility)
Return to: **Jade Hamilton** 103 W. Maple St. Parkston, SD 57366 Phone: 605-928-7907 Extension 1418 Fax: 605-928-7910 jhamilton@ourhomeinc.org	**Return to:** **Kristen Schroeder** 40354 210th St. Huron, SD 57350 Phone: 605-352-9098 Extension 1306 Fax: 605-352-0550 kschroeder@ourhomeinc.org	**Return to:** **Oran Williams** 40354 210th St. Huron, SD 57350 Phone: 605-353-1025 Extension 1205 Fax: 605-353-1061 owilliams@ourhomeinc.org

Required Admission Information & Documents

- ✓ **Social Security Card**
- ✓ **Title 19 (Medicaid) Card**
- ✓ **Birth Certificate**
- ✓ **Court Order** (if applicable)
- ✓ **Custody Order** (if applicable)
- ✓ **Interstate Compact** (if applicable)
- ✓ **Social History**
- ✓ **Psychological/Psychiatric Evaluation** (if available)
- ✓ **Drug & Alcohol Evaluation** (if applicable)
- ✓ **Immunizations**
- ✓ **School Transcript**
- ✓ **Individualized Education Plan/504 Plan copy** (if applicable)
- ✓ **Completed Admission Packet**
- ✓ **Signed Consents & Releases**
- ✓ **Allergy Information**
- ✓ **Authorization for Tuition Cost** (if applicable)
- ✓ **Insurance Card Copies**

Referred By:

Name: _____ Agency: _____

Address: _____

Phone: _____ Emergency Phone: _____ Fax: _____

Email: _____

Youth:

Name: _____ Sex: _____

Race: _____ Age: _____ Birthdate: _____

Social Security Number: _____ Medicaid Number: _____

Present Address: _____

Is youth living with parent? ☐ Yes ☐ No

If not, where and with whom? _____

Has the child received professional counseling? ☐ Yes ☐ No

If yes, by whom? _____

Family:

Parent 1: ☐ Has custody of youth ☐ Rights Terminated ☐ Other: _____

Name: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Has this parent received any type of counseling? ☐ Yes ☐ No

If yes, by whom? _____

Parent 2: ☐ Has custody of youth ☐ Rights Terminated ☐ Other: _____

Name: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Has this parent received any type of counseling? ☐ Yes ☐ No

If yes, by whom? _____

Marital Status of parents:
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Legal Guardian *(if other than parent)*: ☐ Custody of youth

Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Education: _____

Sibling Information:

	Name	Age	Living in home or elsewhere
1.			
2.			
3.			
4.			
5.			
6.			

List any persons who contact with might be damaging for youth: _____

_____

Describe any family problems affecting the youth: _____

_____

_____

Describe how youth gets along with his/her siblings: _____

_____

Health:

Describe the youth's general health: _____

_____

Describe any psychological or psychiatric problems youth has had: _____

_____

Has youth received psychological/psychiatric care for the problems above? ☐ Yes ☐ No

If yes, identify provider seen: _____

List current diagnoses: _____

_____

Does the youth have any physical limitations? ☐ Yes ☐ No

If yes, please describe: _____

Does the youth currently take any medications ☐ Yes ☐ No

If yes, list medications and dosage: _____

_____

_____

Prescribed by: _____ Date: _____

Has youth ever been on medication in the past that he/she is no longer taking? (i.e.: for depression, anxiety, mood stabilizer, etc.) ☐ Yes ☐ No

If yes, list medications: _____

_____

Name of youth's primary physician: _____

Address: _____ Phone: _____

Date of last physical exam: _____

Allergies and symptoms: _____

_____

Name of youth's dentist: _____

Address: _____Phone: _____

Date of last dental exam: _____

Name of youth's optometrist: _____

Address: _____Phone: _____

Date of last vision exam: _____

Education:

Last grade completed: _____ Current grade: _____

Last school attended: _____

Address: _____

Has youth obtained a GED? ☐ Yes ☐ No If yes, date completed: _____

Does youth have an Individualized Education Plan (IEP) or 504 Plan? ☐ Yes ☐ No

If yes, please provide a copy. Next review date: _____

Name of school who developed plan: _____

Is youth presently in school? ☐ Yes ☐ No If not, why? _____

Has youth ever been suspended/expelled or given detention? ☐ Yes ☐ No

If yes, explain: _____

_____

Describe youth's attitude and performance towards school: _____

_____

Describe youth's relationship with peers and teachers: _____

_____

Legal History:

Describe youth's legal history (include arrests, charges, etc.): _____

_____

_____

Is youth on probation/DOC? ☐ Yes ☐ No

If yes, name of probation officer or JCA: _____ Phone: _____

Is youth court ordered to treatment? ☐ Yes ☐ No *If yes, please provide a copy of court order.*

Is youth required to register as a sex offender? ☐ Yes ☐ No

Placement History:

Please list all past placements (treatment centers, JDC, jail, behavioral health, etc.)

	Placement Name	Dates Attended	Completed Program?
1.	_____		☐ Yes ☐ No ☐ N/A
2.	_____		☐ Yes ☐ No ☐ N/A
3.	_____		☐ Yes ☐ No ☐ N/A
4.	_____		☐ Yes ☐ No ☐ N/A
5.	_____		☐ Yes ☐ No ☐ N/A

Substance Use History:

Describe to the best of your ability the substance (including alcohol) you know the youth has used and how long the youth has been using: _____

_____

_____

Describe, if possible, how much the youth uses in terms of quantity: _____

_____

Describe how the youth gets money and how much money the youth is accustomed to having in an average week: _____

If possible, describe any unsuccessful attempts the youth has made to cut down or stop using substances (for example, prior drug and alcohol counseling treatment, promising not to use anymore, etc.): _____

_____

Do you believe the youth has ever been intoxicated or high over the course of an entire day?

☐ Yes ☐ No If yes, describe the incident(s) of this that you can recall: _____

_____

Do you have any reason to believe the youth has had a blackout or loss of memory of events that took place while under the influence of substance? ☐ Yes ☐ No

If yes, describe: _____

_____

Does the youth's personality seem to have changed? ☐ Yes ☐ No

If yes, describe: _____

_____

Has the youth ever missed or had difficulties at school or work due to their substance use?

☐ Yes ☐ No If yes, describe: _____

_____

Describe any legal problems resulting from drug and alcohol use: _____

_____

Have any medical problems or injuries occurred because of substance use? ☐ Yes ☐ No

If yes, describe: _____

Describe any family arguments or difficulties because of youth's substance use: _____

_____

Describe any difficulties the youth may have with friends due to substance use: _____

_____

Do any other members of the youth's family have a history of drug and/or alcohol use?

☐ Yes ☐ No If yes, describe: _____

Has a Drug & Alcohol Evaluation been completed? ☐ Yes ☐ No

If yes, by whom: _____ *Please provide a copy of the evaluation.*

Religion:

Denomination: _____

Does religion play a ☐ *large*, ☐ *average*, ☐ *small* part in youth's life?

Additional Information:

Provide any additional information you feel is important to know about the youth:

_____

_____

_____

_____

_____

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_____

_____

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_____

Financial Responsibility for Medical Costs

As a parent/guardian of a youth receiving treatment services at Our Home, Inc. programs, I acknowledge that I have been provided with a copy of the Our Home, Inc. Medical Care Policies and Procedures. I also acknowledge that the costs of medical care are my responsibility.

☐ DSS ☐ DOC ☐ Private Guarantor Name: _____
Address: _____
Phone: _____

If a third party is to be used for expense incurred, please identify below:

☐ Medicaid Number: _____

☐ Indian Health Services Location: _____

☐ Private Health Insurance *(copy of insurance card required)*

Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____

Policy Holder Name: _____

Address: _____

Phone Number: _____

Employer: _____

Social Security Number: _____

Date of Birth: _____

Medical Consent

As parent/guardian of _____, I authorize Our Home, Inc. to procure emergency medical treatment, surgery, hospitalization, and other routine medical care, including recommended vaccinations, determined necessary for the youth identified. Additionally, I authorize the administration of urinalysis for the detection of drugs and alcohol when deemed necessary.

I acknowledge that this authorization is given even though circumstances may not allow for proper notification, to you as parent/guardian, of the need for the procurement of emergency medical care.

I further acknowledge that this consent form is valid in the event that the youth identified above is transferred to another Our Home, Inc. program.

Signed this _____day of _____, 20_____.

_____
Parent/Guardian Signature

_____
Print Parent/Guardian Name

_____
Referral Agent Signature

Janise Pischel, MSE
_____
Administrator of Our Home, Inc.

Media Consent

As the parent/legal guardian of _____,
Name of Youth

a resident of _____, _____, I ☐ **DO** or ☐ **DO NOT** consent to Our Home,
City State

Inc. to use, for the publication thereof, information relating to the residency and activities of said youth at Our Home, Inc. Consent includes, but is not limited to, the use of youth's name, photograph, stories concerning the youth's residency and activities at Our Home, Inc.

_____ _____
Parent/Guardian Signature Date

Ukeru Acknowledgement

It is Our Home, Inc's objective to create an environment where staff have a proven prevention alternative to the use of restraint and or seclusion to de-escalate youth safely and effectively that is safer for both staff and youth, thus creating an environment where the youth can remain forward focused on their treatment planning.

Using its own experience as a model, Grafton developed Ukeru®(Japanese for "receive"), the first crisis-training program to offer a physical alternative to restraints and seclusion. Today, Ukeru is used in 36 states and Canada, and in more than 251 private day and residential programs, private and public schools, psychiatric hospitals and forensic units.

Through trauma informed training, Ukeru helps providers explore and understand the effects of trauma on behavior and functioning. Participants will learn how to assess the impact of trauma and grow a greater understanding of trauma symptoms.

- Introduces the importance of creating a trauma-Informed treatment environment.
- Explores the effects of trauma on the brain and subsequent behavioral, emotional, and adaptive functioning.
- Provides a better understanding of why individuals may exhibit behaviors that are considered "maladaptive" but may be quite "adaptive" in protecting the individual from real or perceived threat.
- Presents cultural and environmental factors associated with "trauma-informed" and "trauma-uninformed" settings.
- Reviews specific information to consider when assessing the impact of trauma and developing a support plan to minimize traumatic stress in the future.

Physical techniques are taught by practicing effective use of protective equipment and soft, cushioned blocking materials — custom made specifically for use with the Ukeru model— that keep both the employee and client safe. These techniques include:

- Physical release techniques
- Physical re-direction
- Blocking techniques

By signing below, I acknowledge that I have read and understand the use of Ukeru as an alternative to seclusion and restraint used within Our Home, Inc.'s treatment facilities.

_____ _____

Parent/Guardian Signature Date

Seclusion And Personal Restraint Consent

Our Home, Inc. maintains a Seclusion and Personal Restraint policy that includes procedures for the implementation of seclusion and personal Restraint interventions. These interventions are only used as a last resort to unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs. Parents/guardians are provided with a copy of the policy.

Safety measures of the policy include, but are not limited to:

- Continuous observation, assessment, and monitoring to evaluate the well-being of the resident.
- Staff interaction and support as an effort to deescalate the situation.
- Time limited order not to exceed one hour.
- Face to face assessment conducted by a physician, licensed practitioner, or registered nurse withing one hour of the initiation of the seclusion or personal restraint.

To place a resident in seclusion or personal restraint, Our Home, Inc. must have written permission from the resident's placement agency. If the resident is placed by the parent or guardian, the parent or guardian must approve the use. If you have no questions regarding the use or procedures of seclusion or personal restraint, please sign below. The placement worker's signature or the parent/guardian signature is required. If you have any questions or concerns, please contact the Program Coordinator at the Our Home, Inc. program where your child is being referred.

As the parent/legal guardian of _____, I hereby
Name of Youth

consent to the use of monitored seclusion and personal restraint by Our Home, Inc. for the purpose of personal safety.

_____ _____

Parent/Guardian Signature Date

Evacuation Acknowledgement

Our Home, Inc. developed an Emergency Preparedness Plan as a comprehensive approach to meeting the health and safety needs of the residents served in the event of a disaster/emergency situation. In the event of a disaster/emergency situation the Executive Director will make a determination based on structural and operating integrity of the campus with safety and well-being serving as top priority to determine if a move to an alternate site is needed.

Parents/guardians of residents will be notified immediately upon determination of a need to move residents to a secondary location. Parents/guardians have the option of approving the move to the secondary site or will need to make plans to immediately come and taky physical custody of the resident. If a parent/guardian is unable to be reached, the resident will remain in the care of Our Home, Inc. and will be transported to the secondary location by Our Home, Inc. staff.

As the parent/legal guardian of _____,
Name of Youth

I acknowledge that I have been informed of Our Home, Inc.'s procedures when a determination of need for evacuation to a secondary location has been made. I understand that in the event of an evacuation to a secondary site that I will need to make plans to immediately come and take physical custody or the resident will remain in the care of Our Home, Inc. and will be transported to a secondary location.

_____ _____
Parent/Guardian Signature Date

Acknowledgement of Receipt & Notification of Selected Agency Policies

It is the responsibility of Our Home, Inc. to provide the parent/guardian of a resident in our care, copies or notification of specific agency policies and listing of agencies to whom required reports must be made.

Provision of Agency Policies: We are required to provide you with copies of some agency policies. Those policies listed below are being provided for your review:

- Seclusion & Personal Restraint
- Notice of Privacy Practices

Notification of Agency Policies: We are also required to let you know of policies established by Our Home, Inc. to ensure the health, safety, and care of each resident. Copies of these policies are available upon request.

- Admission
- Written Treatment Plan
- Scope of Services
- Case Management
- Counseling
- Discharge
- Resident Discipline
- Confidentiality of Information
- In-house Abuse and/or Neglect Prevention & Intervention
- Access to Health Care
- Collections & Recording of Health Appraisal Data
- Medical Emergency Plan
- Immediate Medical Examination & Treatment

Prohibition of firearms or other dangerous weapons: Our Home, Inc. prohibits the presence of firearms or other dangerous weapons (knives, CD gas, chemical agents, etc.) in our facilities or on Our Home, Inc. property.

Reporting Requirements: Regarding the policies listed above, we are required to advise you of our reporting obligations. Reports must be made to the following individuals or agencies as required on a monthly and/or quarterly basis or if a specific event occurs:

- Placement Agency/Worker
- Department of Social Services Office of Child Protection Services
- Department of Social Services Division of Medical Services
- South Dakota Advocacy Services
- Centers for Medicare & Medicaid Services – Regional Office
- State Certification Team

Questions, Concerns, or Complaints: Our Home, Inc. uses a collaborative team and person-centered approach to treatment. If you have any questions, concerns, or complaints, please contact the resident's assigned Counselor/Group Leader.

By signing below, I acknowledge that I have been provided with and understand the listed policies.

_____ _____

Parent/Guardian Signature Date

_____

Resident Name

Our Home, Inc.
Caring for Kids and Families

Authorization to Release Information

I certify that I am the parent/guardian of the person described in this report and that my right to the custody of said person has not been terminated or limited by the order or decree of any court of law. I hereby authorize my local law enforcement agency and any other officer or employee thereof, or an officer or employee of any other criminal justice agency, to collect and/or disseminate the information provided by me, including photographs, dental, and medical information, to any person or organization engaged directly or indirectly in any effort to assist in the location of missing persons.

I certify the information I have provided is true and correct to the best of my knowledge.

_____
Name of Youth

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Youth

_____ _____
Address Phone Number

_____ _____
Police Officer's Name Badge No.

_____
Agency

Please note that Our Home, Inc. is not responsible for the cost if the above-named youth is placed at a detention center. Please identify who would be the responsible party for payment.

_____ _____
Responsible Party Date

_____ _____
Referral Worker/Agency Date

Removal of Youth from the Treatment Facility

In cases where a private placement resident demonstrates serious and/or high-risk assaultive behavior that presents a high level of danger to themselves or others, the Program Coordinator of the Our Home, Inc. treatment facility may need to have the resident removed from the facility as a behavioral intervention. Removal of a resident from the treatment facility will only be considered after other behavioral interventions have been unsuccessful and will at no time be initiated as punishment for the resident.

Parent/Guardian Responsibility

When removal from the treatment facility is chosen as a behavioral intervention, the parents/guardians of a privately placed resident are responsible for the transport of the youth from the treatment facility. Arrangements for transport will be made in consultation with the Program Coordinator of the Our Home, Inc. treatment facility.

Parent/Guardian Acknowledgement of Responsibility

As the parent/legal guardian of _____,
Name of Youth

I acknowledge that I have been informed of my transporting responsibility in the event of removal from the treatment facility as a behavioral intervention if needed during my youth's stay at Our Home, Inc. and I agree to honor that responsibility.

_____ _____
Parent/Guardian Signature Date