ADMISSION PACKET

Please complete and return to: **Michelle Payne**
Admissions and Aftercare Coordinator

Email: michelle.payne@auroraplains.com
Phone: 605.942.5437 Ext. 2402
Fax: 605.215.0342

Please include copies of the following:

- ☐ Medicaid card (copy)
- ☐ Private insurance card (copy)
- ☐ Birth Certificate (copy)
- ☐ Social Security card (copy)
- ☐ Court Order – adjudication
- ☐ Court Order – Custody/guardianship
- ☐ Certificate of Blood Degree
- ☐ Immunization Record
- ☐ Clothing sizes: Jeans _____, t-shirt _____, shoes _____

Department of Social Services
Child Protection Services

Department of Corrections
Group/Residential Referral Application

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

Date of Birth: _____ Social Security Number: _____

Male: ☐ Female: ☐ Race: _____ Height: _____ Weight: _____

Medicaid Number: _____ CID Number: _____

Discharge Plan: _____ Permanent Plan: _____

Level of Service – Please check the level of service that is being sought for the youth.

Community Based Services	NON-PRTF SERVICES	PRTF SERVICES
☐ Out of School Time	☐ Short Term Assessment	☐ Residential Treatment
☐ Independent Living	☐ Professional Foster Care	☐ Intensive Residential Treatment
☐ Crisis Stabilization	☐ Therapeutic Emergency Foster Care	
☐ Respite Care	☐ Group Care–Short Term (30 – 120 days)	
☐ Community Reintegration	☐ Group Care–Long Term (6 to 12 months)	

Has the Child been reviewed by the State Review Team (SRT)? Yes ☐ No ☐

Date that placement is needed:

Tribal Information

Tribe: _____ Enrollment Number: _____

Family Services Specialist

Name: _____ Office: _____

Email Address: _____

Work phone Number: _____ Fax Number: _____

Cell Phone Number: _____

Supervisor: _____

Group/Residential Referral Application (Continued)

Juvenile Corrections Agent

Name: _____ Office: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Supervisor: _____

Emergency Numbers

Mother's Name: _____ Father's Name: _____

Telephone Number: _____ Telephone Number: _____

Person to Contact in case of Emergency: Phone Number

_____

_____

Person or Relative child has been living with: _____

Siblings

Name	Age	Address

Group/Residential Referral Application (Continued)

Materials to be Included

- ☐ Removal/Commitment Order giving Custody to the State
- ☐ Latest Report to the Court
- ☐ Initial Family Assessment or Juvenile Offender Intake Summary
- ☐ Copy of the Social Security Card
- ☐ Copy of Birth Certificate
- ☐ Copy of Most Recent Psychiatric Evaluation
- ☐ Copy of Most Recent Psychological Evaluation
- ☐ Copy of Discharge Summaries From Prior Placements

School Record

☐ Current IEP Current Grade Level: _____ IQ Score (if available): _____

☐ Report Cards
☐ Other Services Provided

- ☐ Speech
- ☐ Language
- ☐ Counseling by School
- ☐ Behavior Issues

Medical Records

☐ EPSDT, Immunization Records, TB Test, Dental, Vision, Hearing

Dates Of Last:

TB Test: _____ Dental Visit: _____
Vision Test: _____ Hearing Test: _____
Physical Exam: _____

☐ **List Allergies:**

_____

_____

_____

☐ **Current Medications:**

_____

_____

_____

Group/Residential Referral Application (Continued)

☐ **Name & Phone Number of:**

Child's Doctor: _____ Telephone: _____

Child's Dentist: _____ Telephone: _____

Placement History:

Name of Facility	Dates of Service	Completed Successfully
	To	Yes ☐ No ☐
	To	Yes ☐ No ☐
	To	Yes ☐ No ☐
	To	Yes ☐ No ☐
	To	Yes ☐ No ☐

☐ **Abuse & Neglect History:**

_____

_____

_____

☐ **Drug / Alcohol History:**

☐ Child: _____

☐ Parents: _____

☐ **Fetal Alcohol Spectrum Disorder Information:** _____

Who Can Child Have Contact With:		
Name	**Relation to Student**	**Monitored**
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐
Should the person above be invited to meetings related to the student? Yes ☐ No ☐		Yes ☐ No ☐

Group/Residential Referral Application (Continued)

No Contact List		
Name	Relation to Student	

☐ **Discipline used in last Placement:** _____

What worked? _____

What did not work? _____

☐ **Last Monthly Reporting Form:** _____

☐ **Behaviors**

Aggression	☐ Yes ☐ No	Sexual Abuse	☐ Yes ☐ No	Sexual Behaviors	☐ Yes ☐ No
Fire Starter	☐ Yes ☐ No	Suicidal Ideation	☐ Yes ☐ No	Self Harm	☐ Yes ☐ No
Run Away	☐ Yes ☐ No	Huffing	☐ Yes ☐ No	Drug Use	☐ Yes ☐ No
Alcohol Use	☐ Yes ☐ No	Car Theft	☐ Yes ☐ No	Sexually Active	☐ Yes ☐ No

If Sexual Behaviors category is marked "yes":

Was sexual offender treatment recommended, and if so has the child completed? ☐ Yes ☐ No
If yes, where was sexual offender treatment completed at?

☐ **Please list any other behaviors that the child may need services for:**

_____

_____

☐ **Please describe or give examples of each item checked Yes or listed as other:**

_____

_____

_____

_____

_____

_____

_____

Group/Residential Referral Application (Continued)

Additional information that would be helpful to know to provide appropriate care for the child:

Reasons For Placement / Desired Treatment Outcome:

Discharge Plan. Please indicate in as much detail as possible what the discharge plan is for this student upon completion of this program:

Have Parents/Immediate family been notified of this possible placement? If No, please explain:

In order to maintain safety and security within the facility it may be necessary to utilize seclusion and/or restraint at times. The guidelines for the use of seclusion/restraint are enforced through licensing regulations.
Is the use of seclusion and restraint approved for this referral? Yes ☒ No ☐

Name of Person Completing This Form **Date**

A-2

Consent for Services

All youth placed in Residential Services at Aurora Plains Academy will have the opportunity to engage and participate in many types of services and activities. Please read below regarding services that are provided here at Aurora Plains Academy and then sign below to authorize youth to engage in services.

Mandatory Reporting. I understand that all staff at Aurora Plains Academy, (also referred to as the Academy), are mandatory reporters of abuse and neglect issues.

Permission for activities. I give permission for the youth to partake in any and all activities as offered by the Academy, including off campus activities. I understand I will be notified of off campus activities outside of Aurora County, either via email or telephone prior the scheduled activity.

Permission for photography. I give the Academy permission to photograph the youth upon admission; this photo will be used for identification purposes to ensure accuracy of provision of treatment services.

Room searches. I understand that the youths personal belongings and bedroom areas may be searched at any time.

Responsibility of belongings. I understand that the Academy is not responsible for lost, stolen or damaged items of the youth which are not in the direct possession of staff.

Transportation. I give permission for the Academy to transport the youth, locally for activities or community based health services, and potentially longer distances, such as home visits, court hearings or family therapy.

Religious services. I am aware that participation in religious services is not required by Aurora Plains Academy, however, a non-denominational Christian program is offered. I give permission for the youth to choose to participate in this service.

Cultural services. I am aware that participation in cultural services is not required by Aurora Plains Academy, however, a variety of cultural assemblies and/or ceremonies are offered. I give permission for the youth to choose to participate in these services.

I have received copies of the **Parent** and **Resident Handbook**, which include Aurora Plains Academy's **Privacy Statement,** information regarding **use of discipline, time out, isolation, emergency safety interventions,** a copy of the **Residential Rights and Grievance Procedures** and the **PQI Operational Plan.**

I give permission for Aurora Plains Academy to enact the behavior management program as outlined in the Parent and Resident handbook regarding Emergency Safety Interventions. The use of a **Safe Non-Violent Physical Intervention** is approved if this resident is a danger to himself or others.

I have received the above information regarding Consent for Services for Intensive Residential Treatment. I have had the opportunity to review the information and ask questions to my satisfaction. I agree to accept the terms and conditions of **placement and treatment at Aurora Plains Academy** for the above named youth. This Consent for Services is effective for twelve (12) months or ninety days past youths discharge from the Academy. I have the right to withdraw this informed consent, in writing, at any time.

Signature of Parent/Guardian: _____ Date: _____

Signature of Resident: _____ Date: _____

A-3

Medical Authorization

Practice of medicine. No medications are 100% safe for 100% of the people. I (We) do hereby agree to save, hold harmless and indemnify the Academy of and any and all claims, demands, and causes of action whatsoever on account of or in any way resulting from the authorizing by the facility of such medical services.

How we administer meds. Medications are given on an "as needed" basis by trained Academy staff according to standing orders approved by the physician. All medications are administered by Academy staff.

Emergency medical treatment. I understand that I will be contacted in cases of emergency, serious injury, or serious illness. In the event that I am unable to be contacted in a timely manner, in addition to any treatment given by Aurora Plains Academy staff, I hereby authorize their staff to give those emergency medical services. I authorize local hospitals and their staff to give those emergency medical services it determines appropriate to the above name youth and to discuss the medical condition of the above named youth with the Aurora Plains Academy staff.

Routine medical treatment. I understand that medical treatment and/or care is provided or coordinated by the Academy and do further authorize any doctor and/or medical facility selected by the Academy to render any and all necessary medical services. This includes, but is not limited to: diagnosis, medical treatment, dental treatment, medication treatment, hospital care, medical or dental x-ray, injections, lab services to include routine drug testing, urine analysis, blood draws and isolations from any contagious disease or condition. Parent/guardian and placing agency are contacted in case of medical/dental findings or medications needed for physical conditions which are not considered routine.

Vaccinations. Aurora Plains Academy will administer routine vaccinations as needed. Please check the yes box below to give consent for the youth to receive the vaccines while they are placed at the Academy. You will be notified when the vaccinations have occurred. If you do not wish for the youth to receive vaccines at any time while at Aurora Plains Academy, please check the no box and indicate the reason in the comments area.

☐ YES	NO	☐	INFLUENZA VACCINE
☐ YES	NO	☐	ROUTINE CHILDHOOD VACCINES
☐ YES	NO	☐	HPV
☐ YES	NO	☐	TB
☐ YES	NO	☐	COVID 19

Comments: _____

Psychotropic and non-prescription medication. Psychotropic medication is not a required part of residential treatment; however, it may be suggested by the treating psychiatrist. At admission, the parent/guardian consents to medical treatment and the administration of prescription medication, including psychotropic medications as prescribed by the treating physician.

Permission for occupational therapy. I hereby consent to Occupational therapy services as considered being necessary and appropriate by the clinical team. I authorize the occupational therapist to provide an evaluation and treatment in accordance to federal and state regulations. I consent to therapeutic treatments to improve fine-motor, gross motor, visual-perceptual, sensory processing, and/or other services which may be beneficial to the youth. Essential oils may be utilized on the units and/or individually for therapeutic purposes.

Please sign below to indicate that you have received the above information regarding Medical Authorization for Intensive Residential Treatment; have had the opportunity to review the information and ask questions to your satisfaction; and agree to accept the terms and conditions of placement / treatment at Aurora Plains Academy for the above named youth. This Medical Authorization is effective for twelve (12) months or ninety days past youths discharge from the Academy.

Signature of Parent/Guardian: _____ Date: _____

Signature of Resident: _____ Date: _____

Notice of Disclosure for Release of Information without a Consent

Permitted PHI Disclosures Without Authorization. The Privacy Rule permits a covered entity to use and disclose PHI, with certain limits and protections. Certain other permitted uses and disclosures for which authorization is not required follow.

Required by law. Disclosures of PHI are permitted when required by other laws, whether federal, tribal, state, or local.

Public health. PHI can be disclosed to public health authorities and their authorized agents for public health purposes including but not limited to public health surveillance, investigations, interventions, and to prevent a serious and imminent health risk.

Abuse, neglect, or domestic violence. PHI may be disclosed to report abuse, neglect, or domestic violence under specified circumstances.

Law enforcement. Covered entities may, under specified conditions, disclose PHI to law enforcement officials pursuant to a court order, subpoena, or other legal order, to help identify and locate a suspect, fugitive, or missing person; to provide information related to a victim of a crime or a death that may have resulted from a crime, or to report a crime.

Judicial and administrative proceedings. A covered entity may disclose PHI in the course of a judicial or administrative proceeding under specified circumstances.

Oversight. Covered entities may usually disclose PHI to a health oversight agency for oversight activities authorized by law. Oversight of the healthcare system, including licensing and regulation

Preventing a Serious and Imminent Threat. PHI may be disclosed as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public based on the health care provider's professional. The disclosure may be to anyone in a position to prevent or lessen the serious and imminent threat, including family, friends, caregivers, and law enforcement.

Treating the Patient. PHI may be disclosed as necessary to treat the patient, or to treat a different patient. Treatment includes the coordination or management of health care and related services by one or more healthcare providers and others, consultation between providers, and the referral of patients for treatment regarding life and safety.

Please sign below to indicate that you understand the above listed circumstances that may require Aurora Plains Academy to Release Information without written or signed Consent.

_____

Legal Guardian

_____

Date

STANDING ORDERS FOR AURORA PLAINS ACADEMY

Date: _____

MEDICATION	DOSE	DIRECTIONS	USE
Abreva		Apply per package instructions	Cold sores
Artificial Tears	2 drops	Insert 2 drops in affected eye(s) TID PRN	Dry eyes, Eye irritation
AYR Nasal Gel		Apply to nares TID PRN	Dryness, bloody nose
Benadryl	25 mg	1 cap po q 6 hours PRN x 5 days	Rash, itching
Claritan (loratadine)	10 mg	1 tab po q day x 1 week	Allergy symptoms
Bug spray with DEET		Apply ONLY as directed	Prevent bug bites
Bug spray without DEET		Apply per package instructions	Prevent bug bites
Ensure Supplement	1 can	Drink 1 can TID PRN x 1 week	Poor appetite
Head & Shoulders Shampoo		Use as directed	Dandruff
Imodium	2 mg	2 tabs initial dose, then 1 tab for each loose stool. Max dose 4 tabs in 24 hours	Diarrhea
Ibuprofen	200 mg	1-3 tabs po q 6 hours PRN with food	Pain, fever, inflammation
Melatonin	3 mg	1-2 tabs po q HS	Promote sleep
Milk of Magnesia	30 cc	30 cc po daily PRN	Constipation
Miralax	17 Gm	1 capful po daily PRN	Constipation
Mucinex	400 mg	1 tab po BID-TID x 3 or 5 days	Congestion
Mucinex DM		1 tab po BID x 3 or 5 days	Cough and congestion
Mylanta	30 cc	30 cc po q 4 hours PRN	Nausea, heartburn
Orageł or Ambesol		Apply per package instructions	Tooth or gum pain
Sunscreen	30-50 SPF	Apply as directed	Prevent sunburn
Aloe Vera Gel		Apply per package instructions	Sunburn, burns
Tylenol	325 mg	1-2 tabs po q 4-6 hours PRN (Not to exceed 4000 mg in 24 hours)	Pain, fever

Please review and sign if this resident is safe to take these medications upon admission to Aurora Plains Academy. If there are any medications on this list that should not be administered, please indicate below. Thank you,

Debra High, RN

Medications to avoid from above list: _____

_____

_____

Resident: _____

Physician: _____
Signature

Legal Guardian: _____
Signature

A-6

1400 East 10th Street – Plankinton, South Dakota 57366
Phone: (605)942-KIDS(5437) – Fax: (605)942-5438

CONFIDENTIAL STUDENT RECORDS
RELEASE OF STUDENT INFORMATION

Name of Student _____ Date of Birth _____

I hereby authorize the following School District to release the school records of the above named student to Aurora Plains Academy and/or Plankinton School District: Please specify School(s), Agency(s) or Organization(s).

_____

_____

Signature of Parent/Guardian _____ Date _____

Date: _____

Aurora Plains Academy hereby requests information/school records for the above listed student. Please Send:

- Special Education files (including current IEP and 3 year eligibility determination assessment)
- Official Transcript
- Student Records
- Health and Immunization Information
- Report Cards (including all other schools attended)
- Academic Testing
- Other Pertinent Information

Please fax/mail the student information to: Fax #: (605) 942-5438; or
Aurora Plains Academy; Attn: Education Department; 1400 East 10th Street; Plankinton, SD 57368

A-6

1400 East 10th Street – Plankinton, South Dakota 57366
Phone: (605)942-KIDS(5437) – Fax: (605)942-5438

CONFIDENTIAL STUDENT RECORDS
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_____

_____

_____ _____
Signature of Parent/Guardian Date

Date:_____

Aurora Plains Academy hereby requests information/school records for the above listed student. Please Send:

- Special Education files (including current IEP and 3 year eligibility determination assessment)
- Official Transcript
- Student Records
- Health and Immunization Information
- Report Cards (including all other schools attended)
- Academic Testing
- Other Pertinent Information

Please fax/mail the student information to: Fax #: (605) 942-5438; or
Aurora Plains Academy; Attn: Education Department; 1400 East 10th Street; Plankinton, SD 57368

genesight

GeneSight® Patient Consent

By signing below, you agree to the following:

- I give consent for GeneSight testing. I understand this is a genetic test that will examine my DNA. Specifically, the GeneSight panels will test for genetic variants related to the metabolism or action of medications classified as psychotropic and for MTHFR.
- This test is intended to be used by my clinician to assist in medication treatment decision-making. By taking this test, I understand that this is not a substitute for the professional decision-making of my clinician. Any concerns I have about medication changes as a result of this test should be discussed with my clinician.
- Once my test results are provided, Myriad Neuroscience removes all personal identifiers on my sample and may use the sample and information derived from the sample for the purposes of test validation, education, and research and development of new products. Samples from New York patients are disposed after 60 days.
- I understand I can withdraw my consent at any time and have my sample destroyed by contacting Myriad Neuroscience at 866.757.9204.
- If I am covered by insurance, I authorize Myriad Neuroscience to give my designated insurance carrier, health plan, or third-party administrator the information necessary or reasonably requested for reimbursement. I understand Myriad Neuroscience can appeal to my health insurance plan if the service is either partially paid or denied, and release all relevant medical records, only for the purpose of health insurance plan coverage.
- I authorize and direct that benefits under this claim be paid directly to Myriad Neuroscience. If I receive payment directly from my health insurance plan, I will contact Myriad Neuroscience and promptly send the payment to Myriad Neuroscience.
- I understand that $330 is an estimate of a typical patient financial responsibility for the GeneSight test. I understand that Myriad Neuroscience will contact me prior to processing my test if my total financial responsibility could be more than $330.
- I authorize Myriad Neuroscience to obtain a consumer credit report on me from a consumer reporting agency selected by Myriad Neuroscience. I understand and agree that Myriad Neuroscience may use my consumer report to confirm whether my income qualifies me for financial assistance. I understand that this inquiry will not affect my credit score.
- I agree to appoint Myriad Neuroscience to file a complaint or appeal regarding the processing or pricing of my claim to any insurer, including: CMS or their agent, any Medicare Part C plan or their agent, or any private insurer or regulatory body.
- By providing my email address and phone number below, I consent to receive secure communication from Myriad Neuroscience. I understand Myriad Neuroscience cannot guarantee the security and confidentiality of communication I may send/initiate and I am aware of the risks of communicating in this fashion. I understand that I may revoke this consent at any time by contacting Myriad Neuroscience at 866.757.9204.

I agree that I have read and understand the terms listed above. I understand that Myriad Neuroscience will send me a statement for any balance due after my health insurance plan has processed the claim. I understand and agree that I will pay the full amount of this statement to Myriad Neuroscience within 30 days of receiving the statement. If there is a balance due, I understand that Myriad Neuroscience will provide applicable patient financial assistance program information. If I qualify for financial assistance, I agree to provide Myriad Neuroscience with any additional information or documentation that may be needed to confirm my qualification for the financial assistance program.

By signing below I attest that I am the patient or someone who is designated and authorized to sign and provide consent on behalf of the patient for healthcare and financial matters. If the healthcare provider/facility allows for a verbal consent for testing (including financial responsibility), please provide in the spaces below the printed name of the authorized person giving consent and the name of the representative verifying consent. Identify each name provided.

I hereby appoint _____ as my "Personal Representative," effective on this date. This appointment shall entitle my Personal Representative to all rights pursuant to HIPAA including the right to request, receive, and review any information regarding my GeneSight test. This appointment shall remain in effect until such time as I revoke it by contacting Myriad Neuroscience at 866.757.9204.

Patient, Legal Guardian, or Other Authorized Signature _____

(signer must be 18 years or older)

Printed Name _____ Date _____

Printed Patient Name _____ Relationship to Patient _____

Email _____ Phone (mobile preferred) _____

Upon completion, fold and place this document inside the prepaid Return Envelope.
We cannot process test(s) without a signed consent form.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with:

Dr. Stephen D. Gullings, DDS; 205 E. 4th Avenue; Mitchell, SD 57301; Ph: 605-996-2411; Fax: 605-996-2411

INFORMATION TO BE RELEASED:

_X_ Dental records _X_ Verbal Exchange of Information

Other: _____

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

This authorization will terminate one year from date of signature unless otherwise specified: _____

(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

Use or disclosure of this information will not result in a financial gain for Aurora Plains Academy. The information being disclosed to you is from records whose confidentiality is protected by Federal Law. Federal Law regulations (42 CFR Part 2) prohibits you form making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with:

Kelly McDermott, PMHNP-BC

INFORMATION TO BE RELEASED:

_X_ Complete record and history	_X_ Verbal Exchange of Information	
_X_ Current and past medications	_X_ Labs and x-rays	_X_ Immunizations/vaccinations
_X_ Psychiatric Evaluation	_X_ Psycho-educational Report	_X_ Psychological Evaluation
_X_ Clinical assessments and screenings	_X_ Discharge Summary	_X_ Education Records

Other: _____

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

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(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

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A-10

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with: **Avera Medical Group(s); Mitchell and Sioux Falls, South Dakota**

___ **Optometry**	___ **Nephrology**	____ **Opthamology**
___ **Orthopedic**	___ **Neurology**	____ **Surgical**

INFORMATION TO BE RELEASED:

_X_ Clinical assessments and screenings	_X_ History and Physical records	_X_ X-rays and results
_X_ Current and past medications	_X_ Immunization Record	_X_ Lab results
_X_ Discharge/ treatment Summary	_X_ Verbal Exchange of Information	

Other: _____

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

This authorization will terminate one year from date of signature unless otherwise specified: _____

(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

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A-11

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with:

Plankinton School District 1- 1; 404 Davenport Street; Plankinton, SD 57368

INFORMATION TO BE RELEASED:

X Complete record and history	X Verbal Exchange of Information	
X Current and past medications	____ Labs and x-rays	X Immunizations/vaccinations
X Psychiatric Evaluation	X Psycho-educational Report	X Psychological Evaluation
X Clinical assessments and screenings	X Discharge Summary	X Education Records

Other: IEP and Special Education services

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

This authorization will terminate one year from date of signature unless otherwise specified: _____

(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

Use or disclosure of this information will not result in a financial gain for Aurora Plains Academy. The information being disclosed to you is from records whose confidentiality is protected by Federal Law. Federal Law regulations (42 CFR Part 2) prohibits you form making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with:

Hometown Family Health, PLLC; 104 W Commerce; PO BOX 35; Plankinton, SD 57368; Ph: 605-299-8234; Fax: 605-799-1165

INFORMATION TO BE RELEASED:

_X_ Complete record and history	_X_ Verbal Exchange of Information	
_X_ Current and past medications	_X_ Labs and x-rays	_X_ Immunizations/vaccinations
_X_ Psychiatric Evaluation	_X_ Psycho-educational Report	_X_ Psychological Evaluation
_X_ Clinical assessments and screenings	_X_ Discharge Summary	_X_ Education Records

Other: _____

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

This authorization will terminate one year from date of signature unless otherwise specified: _____

(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

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HOMETOWN FAMILY HEALTH

Hometown Family Health PLLC
104 W Commerce St/PO Box 35
Plankinton SD, 57368
605.299.8234 (P) 605.799.1165 (F)

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Patient Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone: _____ **Date of Birth:** _____/_____/_____ **Social Security:** _____

I hereby authorize the release of my protected health information as indicated below:

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
Provider/Facility: Horizon Healthcare	Provider/Facility: Hometown Family Health PLLC
Address: 106 S Main St/ PO Box 250	Address: 104 W Commerce St/PO Box 35
City/State/Zip: Plankinton, SD 57368	City/State/Zip: Plankinton, SD 57368
Phone: 605.942.7711 Fax: 866.423.6811	Phone: 605.299.8234 Fax: 605.799.1165

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

- ☐ **ENTIRE RECORD** ☐ **PROGRESS NOTES** ☐ **DIAGNOSTIC IMAGING** ☐ **IMMUNIZATIONS**
- ☐ **FAMILY PLANNING** ☐ **DENTAL RECORDS** ☐ **MENTAL HEALTH RECORDS** ☐ **LAB RESULTS**
- ☐ **OTHER (PLEASE SPECIFY):** _____
- ☐ **I do NOT wish to release records containing any information related to the treatment or diagnosis of these specified conditions:** _____

PURPOSE OF DISCLOSURE (Changing physicians, continuation of care etc.): _____

REQUESTED DATES OF INFORMATION: _____ **to** _____

(records from the past 5 years will be released if not further specified)

- **I acknowledge that I have the right to revoke authorization at any time, except for information that has already been released under receipt of my previously given authorization. I understand I must revoke this authorization in writing, and both documents will be kept on file by Hometown Family Health**
- **My authorization is valid for 365 days from date of my signature unless specified below**
- **A photocopy or faxed copy of this authorization shall be treated as valid by all parties**
- **Hometown Family Health and all of its representatives are hereby released from any liability or responsibility for disclosure of the above specified information in the designated timeline in accordance with HIPAA**

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient

HOMETOWN FAMILY HEALTH
104 W Commerce St/PO Box 35 Plankinton, SD 57368
605.299.8234 (P) 605.799.1165 (F)

New Patient Registration

Current Patient Information – Please Print

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

_____

City: _____ State: _____

Zip: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Patient Email: _____

Preferred Contact Method: _____

Sex at Birth: _____ Current: _____

Date of Birth: _____

Social Security #: _____

Language: _____

Translation Required: _____

Special Communication Needs (Impaired Hearing, Vision Loss etc.): _____

Race: _____

Ethnicity: _____

Marital Status: _____

Employer: _____

Preferred Pharmacy: _____

Online Portal Registration

- ○ Yes, I give Hometown Family Health authorization to establish an online portal for myself or for my 0-11 aged child
- ○ No, I would not like to have a portal account set up at this time

Guarantor Information (party responsible for payment on account)

Name: _____

Address: _____

_____

Relationship to Patient: _____

Date of Birth: _____

Social Security #: _____

Phone: _____

Insurance Information

Insurance Plan Name: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____

Birthdate of Policy Holder: _____

Relationship to Patient: _____

Emergency Contact Information

I approve the below contact to have access to my private medical information in its entirety, unless specified in writing below.

Name: _____

Relationship: _____

Phone: _____

Additional Contacts

I approve the below contacts to have access to my private medical information in its entirety, unless specified in writing below.

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

HOMETOWN FAMILY HEALTH
104 W Commerce St/PO Box 35 Plankinton, SD 57368
605.299.8234 (P) 605.799.1165 (F)

ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

Patient Name: _____ DOB: _____

- o I have read the Acknowledgement and Consent Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff). I request, agree, and consent to the evaluation and treatment of myself and/or child(ren) or dependent as set forth above, including any studies or procedures deemed necessary/appropriate for proper diagnosis or treatment by Hometown Family Health staff

Signed: _____

Date: _____

- o I have read and understand the HIPAA/Privacy Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff)

Signed: _____

Date: _____

- o I hereby assign my insurance benefits to be paid directly to Hometown Family Health

Signed: _____

Date: _____

- o I authorize Hometown Family Health to release medical information required to process my claim with my insurance

Signed: _____

Date: _____

- o I have read and understand the Financial Policy for Hometown Family Health (found on our website www.hometownfamilyhealth.org or hard copy available from staff)

Signed: _____

Date: _____

- o I authorize Hometown Family Health to obtain/have access to my medication history

Signed: _____

Date: _____

- o I authorize my provider's office to contact me by mobile phone via text or call

Signed: _____

Date: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, being the legal guardian of:

_____

(Name) (Date of Birth)

authorize Aurora Plains Academy to disclose and/or release information with:

Horizon Health Care Inc.; 106 South Main; Plankinton, SD 57368; Ph: 605-942-7711; Fax: 605-942-7713

INFORMATION TO BE RELEASED:

X Complete record and history	X Verbal Exchange of Information	
X Current and past medications	X Labs and x-rays	X Immunizations/vaccinations
X Psychiatric Evaluation	X Psycho-educational Report	X Psychological Evaluation
X Clinical assessments and screenings	X Discharge Summary	X Education Records

Other: _____

This disclosure is being made for the following purpose(s): continuity of care and coordination of services.

I understand that I may revoke this authorization in writing at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date I have indicated below. I also understand I may inspect and request a copy of the material to be disclosed.

This authorization will terminate one year from date of signature unless otherwise specified: _____

(date or condition)

_____

(Signature of Parent/Authorization Guardian) (Date)

Use or disclosure of this information will not result in a financial gain for Aurora Plains Academy. The information being disclosed to you is from records whose confidentiality is protected by Federal Law. Federal Law regulations (42 CFR Part 2) prohibits you form making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

FOR INTERNAL USE ONLY
Insurance Cards Received ☐
Date: _____

HORIZON Health Care, Inc.

NEW PATIENT REGISTRATION

PATIENT'S PERSONAL INFORMATION

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

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____ Country of Birth:_____

Social Security #:_____ Date of Birth: ____/____/_____ Former name(s):_____

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

E-mail Address:_____

Employer/Name of School_____ Part-time_____ Full-time_____

Are you a veteran? ☐ Yes ☐ No

Marital Status: S M D W

Spouse's Name:_____ Spouse's Work Phone:_____

RESPONSIBLE PARTY (Who is responsible for payment for services?)

Please note that the responsible party will receive an itemized list of services provided during your visit.

☐ Self ☐ Spouse ☐ Parent ☐ Other (specify relationship) _____

Please complete information below if you did not mark "self" as responsible party:

Responsible Party Name:_____

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____

Social Security #:_____ Date of Birth: ____/____/_____

Home Phone:_____ Cell Phone:_____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

HEALTH INSURANCE and PHARMACY INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No

Name of Insurance:_____

What pharmacy do you currently use? _____

City of Pharmacy: _____

HORIZON
Health Care, Inc.

INTERPRETIVE SERVICES

Do you need interpretive services? ☐ Yes ☐ No

If so, what language? _____

COMMUNICATION NEEDS

Do you have any communication needs that we should be aware of, such as hearing loss or vision impairment?

☐ Yes, please specify: _____

☐ No

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against applicants seeking to participate in this program. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race, ethnicity and sex of applicants on the basis of visual observation or surname.

RACE/ETHNICITY (*Mark all that apply*)

☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown or refuse to report

Do you consider yourself? (*Please check one*)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

SEX AT BIRTH (*Please check one*)

☐ Male ☐ Female

**While Horizon recognizes a number of genders, many insurance companies and legal entities unfortunately do not.*

Horizon realizes that every patient has a unique set of health needs. We feel that it is most important to resect an individual's choice about how to identify. These questions are asked of all patients and are completely voluntary to complete.

WHAT IS YOUR SEXUAL ORIENTATION? (*Please check one*)

☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Lesbian or Gay ☐ Other ☐ Unknown

☐ I would prefer not to disclose

WHAT IS YOUR CURRENT GENDER IDENTITY? (*Please check one*)

☐ Male ☐ Female ☐ Transgender male/female-to-male ☐ Transgender female/male-to-female

☐ Other ☐ I would prefer not to disclose

HORIZON
Health Care, Inc.

HOUSEHOLD INCOME

Horizon Health Care is a Federally Qualified Health Center (FQHC) which means we receive Federal Grant funds that allow us to provide discounted fees to patients who qualify. We are required to collect income information on the patients we serve. We respect that this information is personal and confidential.

Using the table provided below, please circle the income that most closely represents your total family or household income based on your household size. If your income falls into the shaded area on the table, please ask about our sliding fee program.

Please indicate your current household size and approximate family income level.

Household Size	Less than or equal to	Between	Between	Equal to or greater than
1	12,140	12,141 – 18,210	18,211 – 24,280	24,281
2	16,460	16,461 – 24,960	24,591 – 32,920	32,921
3	20,780	20,781 – 31,170	31,171 – 41,560	41,561
4	25,100	25,101 – 37,650	37,651 – 50,200	50,501
5	29,420	29,421 – 44,130	44,131 – 58,840	58,841
6	33,740	33,741 – 50,610	50,611 – 67,480	67,481
7	38,060	38,061 – 57,090	57,091 – 76,120	76,121
8	42,380	42,381 – 63,570	63,571 – 84,460	84,461

HORIZON HEALTH CARE PATIENT PORTAL – MY HORIZON CHART

Horizon Health Care, Inc. is pleased to offer My Horizon Chart – an easy, secure and convenient way to access your health records 24/7! My Horizon Chart allows you to communicate with your care team online, when it's convenient for you. Communication sent through My Horizon Chart does not replace any of the other ways in which you can communicate with your provider – it's an additional option and not a replacement!

Your Horizon care team will complete the registration process for you while you are in the clinic; you will then receive an e-mail containing your username, temporary password, and a link to My Horizon Chart.

☐ YES, I give Horizon Health Care, Inc. permission to set up an account in My Horizon Chart.

Email Address: _____

☐ NO, I am not interested in My Horizon Chart at this time.

HORIZON
Health Care, Inc.

AUTHORIZATIONS and ASSIGNMENT OF BENEFITS

- I understand that if I carry health/dental insurance, all services furnished are charged directly to me and that I am personally responsible for payment of all services whether or not they are covered by insurance. This office will help prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account.

- I understand that if I do not make acceptable payments on my account as defined by Horizon Health Care, Inc. (Horizon) policy, I may be placed on a scheduling restriction until my balance is current or until payment arrangements have been made.

- I hereby give authorization for payment of insurance benefits to be made directly to Horizon for services until I revoke such authorization. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. The information I have given is correct. I agree that a photocopy of this agreement shall be as valid as the original. I have read the above conditions of treatment and payment and agree to their content.

- I hereby grant permission to Horizon's dental / medical staff to perform simple and common procedures they deem necessary. I understand that I will be told the reasons for the treatment / procedure(s), the benefits or risks with it, and other treatment options. I further understand that there are risks associated with simple and common procedures and that the healthcare provider cannot guarantee success.

- I understand that Horizon will protect the confidentiality of my protected health information and will release my protected information for the purposes stated in the Horizon Notice of Privacy Practices, and as I have indicated on the "Preferred Communication Form".

I have read and understand the above authorizations and hereby certify that no guarantee of assurance has been made as to the results that may be obtained.

Patient or Responsible Party Signature: _____

**Signature here indicates consent to all of the above*

Date:_____/_____/_____

HORIZON Health Care, Inc.

PREFERRED COMMUNICATION FORM

Patient Name:_____ Date of Birth:_____/_____/_____

PREFERRED COMMUNICATION METHODS

How would you like to receive information from our practice? (*Check all that apply*)

- ☐ Phone Call
  - ☐ Cell Phone: _____
  - ☐ Home Phone: _____
  - ☐ Work Phone: _____ During what hours? _____
- ☐ Text Message
- ☐ Mail Reminder
- ☐ Patient Portal Message

PLEASE NOTE: *We may need to contact you by mail for certain purposes. If you have special requests regarding mail, please talk to the receptionist regarding confidential communications.*

WE ARE COMMITTED TO PROTECTING OUR PATIENT'S PERSONAL HEALTH INFORMATION. IN AN EMERGENCY, HORIZON WILL CONTACT THE INDIVIDUAL LISTED BELOW TO INFORM THEM OF YOUR LOCATION AND GENERAL CONDITION.

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Patient:_____

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

WE ARE COMMITTED TO PROTECTING OUR PATIENT'S PERSONAL HEALTH INFORMATION. WE WILL DISCLOSE RELEVANT MEDICAL INFORMATION TO FAMILY MEMBERS OR OTHER PEOPLE THAT ARE LISTED BELOW AS INDICATED.

ADDITIONAL CONTACTS

Who else may we speak to about your care?

- ☐ Please do not speak with anyone but me.
- ☐ I give my permission to speak with:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Please indicate below what we can speak with the contact about. This applies to HIPAA/Confidentiality Law.

- ☐ To remind me that I am due for a test or appointment.
- ☐ To give details about dates and/or preparations for a test or appointment.
- ☐ To discuss my test results, condition, and/or medical care.

Patient or Responsible Party Signature: _____ Date:_____/_____/_____

HORIZON Health Care, Inc.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law.

The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I,_____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Horizon Health Care, Inc.

Signature: _____

Date: _____/_____/_____

Signature of Parent or Patient's Authorized Representative *(if applicable)*: _____

Date: _____/_____/_____

Description on Legal Authority to Act on Behalf of Patient: _____

_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
DELTA DENTAL OF SOUTH DAKOTA

I, _____(print name) hereby authorize the use and disclosure of my health information by Delta Dental of South Dakota as described in this authorization.
Subscriber ID#: _____

1) *Specific person/organization (or class of persons) authorized to receive and use the information:*
Aurora Plains Academy; 1400 E. 10th; Plankinton, SD 57368

2) *Specific description of the information you are authorizing us to release:*
(For example, relevant dental information associated with claims received by Delta Dental of South Dakota.)
Date of last dental exam; recommendations and/or diagnosis of last dental examination

3) *Purpose of the request:*
(Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual.")
Continued dental treatment as recommended

4) I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

5) I understand that I am entitled to receive a copy of this authorization.

6) I understand that this authorization will expire when I am no longer a subscriber with Delta Dental of South Dakota.

7) Payment, enrollment or eligibility will not be conditioned on obtaining an authorization.

8) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying in writing, Attn: Privacy Officer, Delta Dental of South Dakota; 720 N. Euclid, PO Box 1157; Pierre, SD 57501. I understand that the revocation is only effective after it is received and logged by Delta Dental of South Dakota. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

Personal Representatives Section

If a Personal Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the basis of: Guardianship

Signature of Guardian _____ Date _____

ASSIGNMENT OF BENEFITS FORM

Assignment of benefits

I hereby assign all psychiatric residential treatment benefits, to include benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Aurora Plains Academy for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or placing agency.

Financial Responsibility

All residential services rendered are charged to the parent/placing agency unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments in conjunction with the placing agency.

Authorization for Release of Information

I hereby authorize Aurora Plains Academy to: (1) release any information necessary to insurance carriers regarding treatments; (2) process insurance claims generated in the course of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of treatment. This order will remain in effect until revoked by me in writing.
I have requested medical services from Aurora Plains Academy on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Patient Name

_____ _____
Guardian Signature Date
Rev. 06/09/2021mp

AURORA PLAINS ACADEMY
BINDING ARBITRATION AGREEMENT

Name of Youth (First, Middle, Last): _____

A. **The Parties.** *This Arbitration Agreement is entered into by and between the following parties (hereinafter referred to collectively as "the Parties"): (a) the Clinicare Corporation, the Aurora Plains Academy, on behalf of themselves, as well as their owners, officers, directors, shareholders, members, managers, employees, agents, servants, representatives, insurers, attorneys, accountants, predecessors, successors, assigns, parent companies, subsidiaries, management companies, partners, divisions, affiliates, all persons and entities who provided services, supplies, or equipment to or on behalf of the above-named youth, and all persons and entities acting, or purporting to act, on their behalf (hereinafter referred to collectively as "the Academy"); and (b) The parent(s)/agency of the above-named youth on behalf of the above-named youth and themselves, as well as their heirs, executors, administrators, agents, servants, assigns, designees, trustees, personal representatives, successors, spouses, children, next of kin, guardians, legal representatives, third party beneficiaries, health care proxies, health care surrogates, insurers, attorneys, guardians ad litem, accountants, all persons and entities whose claim is derived through or on behalf of them, all persons and entities who previously assumed responsibility for providing the above-named youth with necessary services such as food, shelter, clothing, or medicine, etc., all persons and entities who executed this Arbitration Agreement or the Admissions Packet, and all persons and entities acting, or purporting to act, on their behalf (hereinafter referred to collectively as "the Youth").*

B. **What is Arbitration?** *Arbitration is a cost effective and time saving method of resolving disputes without involving the courts. In arbitration proceedings, disputes are heard and decided by private individuals called arbitrators. The Parties are not waiving the right to sue by agreeing to arbitrate disputes within the scope of this Arbitration Agreement. However, the dispute will not be heard or decided by a judge or jury, as the Parties desire and expressly agree that any dispute between them be resolved outside of the court system.*

C. **Agreement to Arbitrate.** *The Parties agree that any and all claims or controversies arising out of or in any way relating to this Arbitration Agreement, the Admissions Packet, any services provided by the Academy, and/or the Youth's stay at the Academy, whether arising out of State or Federal law, whether now existing or arising in the future, whether sounding in breach of contract, tort (i.e., negligence or wrongful death), breach of statutory duties, irrespective of the basis for the duty or of the legal theories upon which the claim is asserted, etc., SHALL BE SUBMITTED TO FINAL BINDING ARBITRATION.*

D. **Arbitrators are Sole Decision Makers.** *A panel of Arbitrators will be chosen as described below in* **Section I** *("The Arbitration Panel") of this Arbitration Agreement. The Arbitrators are empowered to, and shall, resolve all disputes, including without limitation, any disputes regarding the making, execution, validity, enforceability, voidability, unconscionability, severability, scope, arbitrability, interpretation, waiver, duress, preemption or any other defense to enforceability of this Arbitration Agreement, as well as resolve the Parties' underlying disputes, as it is the Parties' intent to completely avoid the court system.*

E. **Waiver of Trial by Judge or Jury.** *By entering into this Arbitration Agreement, the Parties are giving up and waiving their right to have any claim decided in a court of law before a judge and/or jury. In the event this Arbitration Agreement is found to be void, invalid, or unenforceable for any reason, the Parties hereby agree to waive their right to a jury trial and agree to have their disputes resolved by a judge via a bench trial.*

F. **Binding on Parties and Others.** *It is the intention of the Parties that this Arbitration Agreement shall inure to the direct benefit of, and bind, the Academy and the Youth. The Parties agree that all aspects of a controversy, including claims, cross-claims, and counterclaims, and any or all demands for damages, made by or against any person or entity bound by this Agreement shall be included and exclusively adjudicated through Binding Arbitration, except as otherwise stated herein.*

Name of Youth (First, Middle, Last): _____

G. **Third-Party Beneficiaries.** *In all circumstances, including but not limited to, if no one signs this Arbitration Agreement or the legality of the signature of a person signing this Arbitration Agreement is challenged, it is the intention of the Parties that this Arbitration Agreement is for the direct benefit of the Youth and that the Youth's representatives, relatives, spouse, and children, if any, or next of kin, are also directly benefited by the provisions of this Arbitration Agreement.*

H. **The Arbitration Hearing.** *The arbitration hearing shall take place in Wisconsin within 100 miles of the Academy at which the Youth is/was admitted.*

I. **The Arbitration Panel.** *The arbitration panel shall be composed of three (3) arbitrators ("Arbitrators"). Within thirty (30) days after a demand for arbitration is made, each side shall select an arbitrator. Within twenty (20) days of being selected, the two arbitrators shall choose a third "neutral" arbitrator to be the remaining arbitrator on the panel. If the two arbitrators cannot agree on selection of a third "neutral" arbitrator within twenty (20) days of being selected, the American Arbitration Association shall select such arbitrator in accordance with the terms of this Arbitration Agreement.*

J. **The Arbitration Award.** *Once the Arbitrators issue an award, it is final. An arbitration award must be based on the vote of a majority of the Arbitrators; a unanimous decision is not required. An arbitration award shall be in writing and signed by the Arbitrators or by a majority of them, and shall be accompanied by a statement of the reasons upon which the award is based. If an arbitration award is not unanimous, the dissenting arbitrator shall draft a separate statement that shall be attached to the arbitration award. Once an arbitration award is issued, the arbitration panel is functus officio and does not have authority to hear re-argument. It may, however, correct inadvertent clerical or arithmetical errors which are apparent on the face of the award.*

K. **Procedural Rules and Substantive Law.** *Except as otherwise stated herein, the Arbitrators shall apply the procedural rules and the substantive laws of Wisconsin, without regard to principles of conflict of laws. A claim that is not served and filed within the statute of limitations period that would apply to the same claim under Wisconsin law shall be waived and forever barred.*

L. **Scope of Discovery.** *Discovery shall be limited to that discovery provided in Chapter 788 of the Wisconsin Statutes. There shall be no interrogatories, requests for production/inspection of documents, or requests to admit or deny, unless expressly agreed to by the Parties. Subject to these limitations on discovery, the Arbitrators shall have authority to resolve any discovery disputes with a view to achieving an efficient and economical resolution of the dispute, while at the same time promoting equality of treatment and safeguarding each party's opportunity to fairly present its claims and defenses.*

M. **Limitation on Liability; Waiver of Punitive and Exemplary Damages.** *The Arbitrators shall have no authority to award punitive or exemplary damages. By entering into this Arbitration Agreement, the Parties expressly waive any right or claim to punitive or exemplary damages they may have or which may arise in the future, whether the dispute is resolved by arbitration, mediation, judicially, or otherwise.*

N. **Fees and Costs.** *The Arbitrators' fees and costs associated with the arbitration shall be divided equally among the Parties and the Parties shall bear their own attorneys' fees and costs.*

O. **Judgment on the Arbitration Award.** *The Parties agree that a judgment of any court having jurisdiction may be entered on the arbitration award as provided in Chapter 788 of the Wisconsin Statutes.*

P. **Survival Clause.** *Except as noted below in* **Section W** *("Right to Change your Mind") of this Arbitration Agreement, the terms and conditions recited herein shall survive and remain in full force and effect notwithstanding the death of the Youth, the discontinuation of operations at the Academy,*

Name of Youth (First, Middle, Last): _____

or the termination, revision, cancellation or natural expiration of the Admissions Packet or any other contract between the Parties.

Q. **Integration Clause.** *This Arbitration Agreement represents the Parties' entire agreement regarding disputes, and it may only be changed in a writing signed by all Parties.*

R. **Severability Provision.** *Any clause, term, phrase, provision or part thereof contained in this Arbitration Agreement is severable, and in the event any of them shall be found to be invalid for any reason, this Arbitration Agreement shall be interpreted as if such invalid clause, term, phrase, provision or part thereof were not contained herein, and the remaining clauses, terms, phrases, provisions or parts thereof, of this Arbitration Agreement shall not be affected by such determination and shall remain in full force and effect. This Arbitration Agreement shall not fail because any clause, term, phrase, provision, or part thereof shall be found void, invalid, or unenforceable. No part of this Arbitration Agreement will be construed against any Party because that Party wrote the Arbitration Agreement.*

S. **Right to Consult with Attorney.** *Please read this Arbitration Agreement very carefully and ask any questions that you may have. You should also feel free to consult with an attorney of your choice before agreeing to the terms and conditions of the Admissions Packet, including but not limited to the terms and conditions of this Arbitration Agreement.*

T. **Confidentiality.** *The Parties shall maintain the confidential nature of the arbitration proceeding and the Award, including the Hearing, except as may be necessary to prepare for or conduct the arbitration hearing on the merits, or except as may be necessary in connection with a court application for a preliminary remedy, a judicial challenge to an Award or its enforcement, or unless otherwise required by law or judicial decision.*

U. **Opportunity to Read.** *The Parties understand and agree that each has received a copy of this Arbitration Agreement and has had an opportunity to read and ask questions about this Arbitration Agreement.*

V. **Manner of Acceptance.** *Acceptance of this Arbitration Agreement can be accomplished by signing below, by the Youth's continued residency at the Academy after the admission date, or by any other manner of acceptance recognized by contract law or equity.*

W. **Right to Change Your Mind.** *This Arbitration Agreement may be rescinded (i.e., canceled) by written notice, sent certified mail, by any Party within seven (7) business days from the date of the Youth's admission to the Academy. If alleged acts underlying a dispute governed by the Arbitration Agreement are committed prior to the rescission date, this Arbitration Agreement shall be binding with respect to said alleged acts. The Parties expressly agree that the rescission of the Arbitration Agreement will also serve as a rescission of the Admissions Packet, and the Youth's Parent or Agency Representative will cooperate in arranging for the Youth's immediate discharge and/or transfer from the Academy, as well as arranging for payment of any outstanding financial obligations to the Academy. The Client's Parent or Agency Representative's failure to cooperate in the Youth's discharge/transfer will render the rescission of the Arbitration Agreement a nullity and of no legal effect whatsoever.*

_____ _____
Date Signature of Parent or Agency Representative*

* Parent or Agency Representative understands and agrees that, by signing this Binding Arbitration Agreement, he/she is signing in both a representative and individual capacity.

_____
Printed Name

AURORA PLAINS ACADEMY

INFORMED CONSENT FOR COVID-19 TESTING

Please carefully read the following informed consent:

a. I authorize Aurora Plains Academy to conduct collection and testing for COVID-19 through a nasal swab, as ordered by an authorized medical provider or public health official.
b. I authorize my test results to be disclosed to the SD Department of Health, county, state, or to any other governmental entity as may be required by law.
c. I acknowledge that a positive test result is an indication that I must continue to self-isolate to avoid infecting others.
d. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
e. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I voluntarily agree to testing for COVID-19.

_____ _____

Signature of Patient and/or Guardian Date

_____

Printed name of Patient and/or Guardian

Aurora Plains Academy Requested Contact List

*To be discussed and potentially approved/denied during Initial Clinical Staffing

NAME OF YOUTH_____

NAME_____ Relationship to Youth_____

ADDRESS_____

TELEPHONE NUMBER: _____

_____

NAME_____ Relationship to Youth_____

ADDRESS_____

TELEPHONE NUMBER: _____

_____

NAME_____ Relationship to Youth_____

ADDRESS_____

TELEPHONE NUMBER: _____

_____

NAME_____ Relationship to Youth_____

ADDRESS_____

TELEPHONE NUMBER: _____

_____

NAME_____ Relationship to Youth_____

ADDRESS_____

TELEPHONE NUMBER: _____

AURORA PLAINS ACADEMY

DISCHARGE AGAINST MEDICAL / CLINICAL ADVICE

Policy #RTX-25

Effective date: 7/20/15
Revision Date: 10/24/19
Policies/standards meet: APA

POLICY

COMPLETE UPON ADMISSION

The Academy may provide services for residents 10 years of age up to 20 years of age. In the event the Parent/Guardian chooses to remove the youth from treatment against Medical / Clinical advice, Aurora Plains Academy requires 2 business day notice prior to the youth leaving the facility. This is required for proper preparation of an orderly discharge.

I, _____, the guardian, the undersigned, fully understand that the medical/clinical team who provides treatment for _____ at Aurora Plains Academy recommends that he/she complete the full course of treatment offered at Aurora Plains Academy.

_____ _____

Signature Date

COMPLETE UPON DISCHARGE

I request to refuse further treatment and care at Aurora Plains Academy. I hereby give my notice of 2 business days. I will not hold Aurora Plains Academy at any fault and absolve them from any liability for my actions.

My signature denotes an understanding of the statement above.

_____ _____

Signature Date

APPROVED BY: _____

EXECUTIVE DIRECTOR

AURORA PLAINS ACADEMY

Protection of Rights and Ethical Obligation
CR-1

Effective date: 1/7/07
Revision Date: 8/27/15, 1/21/2016, 9/15/16, 2/22/17, 7/25/18, 1/23/20
Policies/standards meet: CR1; CR2; SD 67:42:07

POLICY

Aurora Plains Academy (APA) is an Intensive Residential Treatment Facility and operates 24 hours a day. Every youth admitted to the Academy is entitled to a safe and therapeutic milieu made up of numerous components provided by several professionals across the scope of treatment. Every staff member has the responsibility to maintain an appropriate relationship with all youth. Healthy relationships are the catalyst for personal growth and change. Each youth is provided fair and equitable treatment and is informed about our program in order to make choices about utilizing our services. Aurora Plains Academy residents do not participate in experimental research nor do they perform labor or services for the academy.

PROCEDURE

A therapeutic milieu will include services and insights in the following areas:

PHYSICAL CARE	Food, clothing, shelter and hygiene. Restricting a child's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, school, fresh air, adequate exercise, and necessary clothing is not allowed.
GROUP LIVING	Living and leisure time are provided by a group of skilled direct youth care specialists who offer supervision and services.
PSYCHOLOGICAL SUPPORT	All staff provide opportunities for recognition, acceptance and support. These ways can differ from family and may provide influence and authority that is different from parents.
SOCIOLOGICAL SUPPORT	Trauma informed staff utilize knowledge from trainings that cover social class behaviors, family relationships, dynamics, and cultural influences will provide experiences in a group living milieu where these social behaviors, differences, and similarities can be explored and understood.
MEDICAL & PSYCHIATRIC INSIGHTS	Based upon medical and other specialists' evaluations and assessments, youth will receive appropriate health and medical care. All staff will provide attention to adequate growth and wellness, which includes psychiatric services at primary, secondary, and tertiary levels. Basic physical exams, eye, ear and dental exams, lab x-rays, emergency services, nutrition, speech and other special assessments are arranged either routinely or based upon need.
PSYCHOLOGICAL SERVICES	Every youth will receive psychological services and/or ongoing clinical review of psychologist's observations and test results.

CLINICAL SERVICES

Every youth shall have regular individual, group, and family therapy as an integral part of the 24 hour services offered at APA. The therapist provides the youth knowledge about both the agency and the community resources for their own or family benefit.

SPECIAL EDUCATION

Every youth is entitled to special and individualized education courses, instruction, based upon educational strengths and weaknesses, alternative education, vocational or pre-vocational instruction as well as physical education which meets individual needs for play and for developing play skills. Every student will learn about the world of work and the role of the family in the attainment of work goals.

DAILY AND SPECIAL ACTIVITIES

Every youth will be provided with individual and group activities that occur at the academy and in community. These activities incorporate social, cultural, and self-development. Responsible, moral, and ethical decision-making is encouraged. Youth are given the opportunity to participate in a spiritual service to express their religions or spiritual beliefs.

COMMUNITY TIES

Every youth will have help with understanding their family dynamics to help with relationships at the community level. This adds to a sense of belonging in an extended social system. Restricting the visitation rights of the parents of a child beyond limitations imposed by the court, and placing restrictions on a child's communication rights beyond limitations specified in the treatment plan is not allowed.

TREATMENT PLAN

Every youth will have a treatment plan that incorporates all of the above areas with emphasis upon:

a. Individualized assessments based on social, intellectual, psychological and educational developmental levels.
b. Short and long-term goals for accomplishment in each area of need.
c. Individual deficits, personality categories, character structure, affect states, and capacity to relate and to understand what he/she must work on to change.
   Clinical reviews on a monthly basis to evaluate these treatment plans to assess their effectiveness.

GRIEVANCE

Every youth shall have the right to a fair, simple, and timely resolution of grievances. The youth shall have access to both the written grievance form and the Grievance monitors. (Policy CR2 Resident Grievance Policy)

CHILD CARE & DEVELOPMENT

The Academy will meet all requirements in regard to child care and development as is stated in Administrative Rules: Department of Social Services: Article 67:42 Regulatory Administration: Group care centers for minors: 67:42:07

The Academy will:

a. Develop programs that encourage the development of independence through avoiding regimentation of scheduling.
b. Whenever possible integrate the agency program with community activities so that children have the opportunities to participate in normal community living patterns.
c. Provide for the development and maintenance of constructive relationships with parents, brothers and sisters, relatives, staff and friends.
d. Responsible, moral, and ethical decision-making is encouraged across all aspects of programing.

e. Utilization of therapeutic and psychoeducational groups to help the child obtain a sense of personal identity.
f. Empower youth to make personal choices in their routine and environment along with providing for a variety of experiences.
g. Issuing consequences to one child for the behavior or action of another, is not allowed.
i. Use of restrictive techniques as punishment, for the convenience of staff, to compensate for not having adequate staff, to enforce program rules, or to substitute for program services is not allowed.

LIMITATION OR DENIAL OF RIGHTS

Good cause for denial or limitation of a right exists only when the director or designee of the treatment facility has reason to believe the exercise of the right would create a security problem, adversely effect the patient's treatment or seriously interfere with the rights or safety of others.

PROCEDURE

1. Upon receiving information gathered and reviewed by the multi-disciplinary treatment team, the Executive Director (or designee) will determine the appropriateness of a denial or limitation of a resident's rights.

2. A special treatment plan will be developed by the therapist. The treatment plan will clarify the following:

- specific reason for the denial or limitation of right and correlation of that reason to the resident's treatment
- expected duration of time of denial or limitation
- conditions required for restoring the right
- notice to the youth of the right to an informal meeting with the decision maker

RESIDENT RIGHTS

INTRODUCTION

Aurora Plains Academy supports and protects the fundamental human, civil, constitutional, and statutory rights of each resident.

All youth are entitled to equal treatment regardless of race, gender, age, creed or national origin. Any youth who feels that they have been denied equal treatment should file a written grievance with the resident ombudsman (Grievance Monitor) using the Resident Grievance/Complaint form.

Some rights may be limited because of the youths' treatment or security needs. This will be explained further in the individual treatment plan.

RIGHTS

Copies of Resident Rights are posted in the reception area and on all living units. All treatment clients of Aurora Plains Academy have the following rights:

1. You have the right to humane non-discriminating environment that provides reasonable protection from harm and appropriate privacy for your personal needs.

2. You have the right to be free from bias and harassment regarding race, gender, age, culture, disability, spirituality, sexual orientation and linguistic differences.

3. You have the right to be free from abuse, neglect, inhumane treatment and sexual exploitation.

4. You have the right to be treated courteously, with dignity and respect.

5. You have the right to receive service in a manner that is non-coercive and that protects your right to self-determination.

6. You have the right to appropriate treatment in the least restrictive setting available with reasonable regularity and continuity of staff assignment that meets your needs.

7. You have the right to appropriate medical care. This includes, but not limited to, receiving information about your current treatment, diagnosis, alternatives, risks, and prognosis. You have the right to be told or given in writing the physician's identity as well as any outside health care services information including name, business address, telephone number, and specialty.

8. You have the right to receive an education.

9. You have the right to nutritious and sufficient meals.

10. You have the right to sufficient clothing and housing.

11. You have the right to live in clean, safe surroundings.

12. You have the right to daily bathing or showering in 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.

13. You have the right to retain and use a reasonable amount of personal property.

14. You have the right to reasonable observance of cultural and ethical practice and religion.

15. You have the right to manage personal financial affairs. At a minimum, a quarterly statement documenting any transactions of any personal money at the Academy will be provided.

16. You have the right to positive and proactive adult guidance, support, and supervision. This includes the right to a prompt and reasonable response to questions and requests.

17. You have the right to be informed of the program's rules and regulations before you are admitted.

18. You have the right to informed before admission and upon changes of: the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
    A. The condition to be treated
    B. The proposed treatment
    C. The risk, benefits, and side effects of all proposed treatment and medication
    D. The probable health and mental health consequences of refusing treatment
    E. Other treatments that are available and which ones, if any might be appropriate for you.

19. You have the right to accept or refuse treatment after receiving this explanation unless you are court ordered for treatment. Consequences of refusing treatment or medication can lead to termination of services.

20. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).

21. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan. You have the right to request an in-house review of your care and treatment. You have the right to have a parent/guardian, agency worker, and if applicable, other care providers including extended family or significant others as appropriate and with consent from the resident take part in developing your plan.

22. You have the right to meet with staff to review and update the plan on a regular basis.

23. You have the right to refuse to take part in research without affecting your regular care. (APA does not participate in experimental research.)

24. You have the right not to receive unnecessary or excessive medication.

25. You have the right not to be free from restraint used for a purpose other than to protect the resident from imminent danger to themselves or other. (APA does not do seclusions).

26. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.

27. You have the right to authorize disclosure of your presence in a facility.

28. You have the right to reasonable communication and visitation with approved people outside the facility which may include: parent(s), extended family members, siblings, legal guardian, case worker/manager, attorney, therapist, physician, religious advisor, as well as the Department of Social Services, Department of Corrections, Disability Rights South Dakota, MN State appointed ombudsman at any reasonable time. MN residents and their families have the right to organize, maintain, and participate in resident advisory and family councils.

29. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.

30. You have the right to purchase or rent goods and services that are not included in the per diem rate from a supplier of your choice unless provided by law.

31. If you consented to treatment, and are 18 years old and your own guardian, you have the right to leave the facility within 2 business days of requesting release unless a physician determines that you pose a threat of harm to yourself and others.

32. Married MN residents have the right to privacy during visits with their spouses and, if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records.

33. You have the right to be informed of and to use a grievance procedure and receive a fair response from the facility within a reasonable amount of time.

34. You have the right to complain directly to the South Dakota Child Protection Service (CPS) (605-773-3227) at any reasonable time.

35. You have the right to get a copy of these rights before you are admitted, including the CPS's address and phone number.

36. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of being admitted.

37. You have the right to not be arbitrarily transferred or discharged. You must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. The notice period may be shortened in situations outside APA's control, such as a determination by utilization review, the accommodation of newly admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare. APA shall make a reasonable effort to accommodate new residents without disrupting room assignments.

38. Have all special needs communication met either in writing or orally, as well in languages of the major population, with arrangements being made with consideration of literacy level. The Aurora Plains Academy will make arrangements for interpreters or translators or the use of assistive technologies which may include telephone amplification.

You are expected to work towards becoming a 'safe' person if you are not one already. This means:

You understand that you have problems with how you handle your thoughts, emotions, and behavior. As a client in our program, you have the responsibility to provide relevant information as a basis for receiving treatment.

You are responsible for your emotions and behavior.

You will respect yourself, others, and the environment by:

- ..... not hurt yourself or others, or be violent in any way.
- ..... not smoking or using drugs or alcohol.
- ..... not engaging in any sexual activity.

Not respecting yourself, others and environment could lead to termination of services or unsuccessful discharge from the Academy.

Your individual treatment plan always takes precedence over these rules of conduct if there is a conflict.

APPROVED BY: _____
EXECUTIVE DIRECTOR

_____ _____
Youth Signature Date

_____ _____
Guardian Signature Date

_____ _____
Staff Providing Information Signature Date

AURORA PLAINS ACADEMY
DAKOTA REACH
Grievance Procedures
Policy #CR-3

DAKOTA REACH

Effective date: 1/7/07
Revision Date: 8-27-15, 1-28-16, 9/7/16, 2-22-17, 1/14/2019, 7/23/19, 5/19/2022, 7/28/2022
Policies/standards meet: CR 3; CR 1.01; RPM 2.02 ARSD 46:17:02:02

POLICY

Youth Complaint/Grievance forms shall be available throughout the facility including a central area within each living unit. The Youth is to complete this form, detach the bottom to give to staff, place the top part in the locked mailbox located in the Cafeteria by the water fountain or School hallway. The Program Coordinator or designee will have the only keys to the mailbox and will retrieve grievances on business days. The bottom half of the page will be given to the overnight Shift Supervisor to place the Grievance Reference # on the night report alerting there is a Grievance that needs reviewed.

The youth may be assisted by a staff member in completing the form if the youth requests assistance, however, the youth needs to be in possession of it until they place it themselves in the grievance box. The youth has the opportunity to obtain an advocate to assist in this process if the youth so chooses. The Program Coordinator or designee shall review each completed form to determine if the issue appears to compromise the therapeutic rights of the youth.

The youth, youth's parent or legal representative, a guardian, or a concerned person in the youth's life may make a formal complaint or suggestion or express a concern about any aspect of the youth's care during the youth's stay in the facility. They also may grieve any decision that affects the youth's eligibility, modification or termination of service or supports.

By signing on the bottom of the Policy and Procedure acknowledges you have read, been given an explanation that you understand, and have received a copy of this grievance procedure. The staff signature verifies the youth has been given a copy and assisted the youth if requested.

YOUTH PROCEDURE

1. All staff shall be aware of a youth's needs and shall pay close attention to those situations that could lead to a grievance situation. Youth may grieve about any violation of youth's' rights. Youth may express their grievance to any staff member, but using the form and process maintains accountability, confidentiality and resolution within specific time frames.
2. Staff must not attempt to influence a youth's statement about the facility in the grievance document or during an investigation resulting from the grievance.
3. Staff who are sited in the grievance will not be involved in acceptance, investigation or decision-making concerning the grievance. Their involvement will consist of participation in an interview from the Program Coordinator or designee when applicable.
4. Forms are located in central living areas within each living unit. Staff will provide pencil, paper, envelopes, postage and/or access to a telephone upon request in order to file a grievance. Staff will provide assistance to youth who cannot read or write or have difficulty reading or writing.
5. The bottom portion of the completed form will be given to staff so the Overnight shift supervisor can place the Grievance Reference # on the night report. The top portion of the form will be placed in a confidential locked grievance boxes located in the Cafeteria by the water fountain or in the school hallway by the youth. The Clinical Operations or designee will pick up grievances daily excluding weekends and holidays.
6. The Program Coordinator or designee will investigate the grievance in conjunction with the applicable departments and update the youth on the process. If the grievance appears to be a complaint/concern rather than a grievance, the Program Coordinator or designee will write a response for the youth.
7. A written response of the investigation and initial disposition shall be made available to the youth within five (5) days from when the grievance was filed.
8. A youth who is dissatisfied with the grievance conclusion may appeal the decision to the Clinical Director. The investigation process will be conducted in the same fashion and time frame.
9. If the youth remains dissatisfied with the appeal decision, he/she may appeal to the Executive Director.
10. If the youth is still dissatisfied with the appeal decision, he/she may appeal to the Department of Social Services, the Department of Corrections, Department of Human Services, and/or the Division of Developmental Disabilities directly. A report of the decision will be given to the youth within thirty (30) calendar days of receipt of the complaint.
11. There shall be no interference or retaliation, formal or informal, against a grievant.
12. Aurora Plains Academy/Dakota Reach shall retain full records of all grievances in a centrally located confidential file for seven (7) years.

13. Youths may submit their grievance at any time directly to:
    - SD Department of Corrections: (605) 773-3478
    - SD Department of Social Services: (605) 773-3227
    - SD Department of Human Services: (605) 773-5990
    - SD Division of Developmental Disabilities: (605) 362-4857
    - MWI Health (Grievance Monitor): (605) 573-2000 or online at https://www.mwihealth.org/youth-services-grievance/
14. The policy and procedure will be signed and explained on a yearly basis.

PARENT/GUARDIAN/CONCERNED PERSON/LEGAL REPESENTATIVE GRIEVANCE PROCEDURE

All staff shall be aware of a youth's needs and shall pay close attention to those situations that could lead to a grievance situation. Youth, parents/guardians may submit a written grievance about any violation of youth's rights.

1. Parents/guardians or agency worker will attempt to resolve their concern with the youth's therapist or case manager.
2. If the grievance could not be resolved adequately, the interested party will request a grievance form from the youth's case manager or therapist. They may also use a letter stating within that it is a formal grievance if not on a provided form.
3. The case manager will forward the grievance form to the interested party via mail or email within 24 hours of the request.
4. The interested party will mail or email their grievance to the Clinical Operations or designee. The address and email address is listed below.
5. The Program Coordinator or designee will review the grievance, forward a copy to the Executive Director, and conduct an investigation with members of the appropriate department.
6. The Program Coordinator or designee will forward the findings to the Department Head Team for review.
7. The Program Coordinator or designee will respond to the grievance within 5 calendar days of receiving the grievance.
8. If the interested party does not feel the issue is adequately resolved, the interested party will forward a grievance directly to the Executive Director or their designee, following the same procedure listed above.
9. The Executive Director or their designee will investigate the grievance with appropriate departments and respond in writing to the interested party within 5 calendar days.
10. If the parent/guardian or agency worker is still dissatisfied with the appeal decision, he/she may appeal to the Department of Social Services, the Department of Corrections, Department of Human Services, and/or the Division of Developmental Disabilities directly. A report of the decision will be given to the youth within thirty (30) calendar days of receipt of the complaint.
11. There shall be no retaliation, formal or informal, against a grievant.
12. Aurora Plains/Dakota Reach shall retain full records of all grievances in a centrally located confidential file for seven (7) years.
13. Parents/guardians, agency workers may submit their grievance at any time directly to:
    - SD Department of Corrections: (605) 773-3478
    - SD Department of Social Services: (605) 773-3227
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    - SD Division of Developmental Disabilities: (605) 362-4857
    - MWI Health (Grievance Monitor): (605) 573-2000 or online at https://www.mwihealth.org/youth-services-grievance/

APPROVED BY: Annette Boggess
EXECUTIVE DIRECTOR

I acknowledge that I have read, been given an explanation that I understand, and have received a copy of this grievance procedure. The staff signature verifies the youth has been given a copy and assisted the youth if requested.

_____ _____
Youth Signature Date

_____ _____
Staff Providing Information Signature Date

_____ _____
Guardian/Advocate Date