DAKOTA REACH ADMISSION PACKET

Please complete and return to: Michelle Payne
Admissions 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 ______

South Dakota Division of Developmental Disabilities
Application for Services

Reason for Referral: _____

Applicant Name: ____
(First) (Middle) (Maiden) (Last)

Date of Birth: ________________ Sex: ☐ Female ☐ Male

Current Address: ____
(Street) (City) (State) (Zip)

Permanent Address: ____
(Street) (City) (State) (Zip)

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Email Address: ________________________________

Family Contact: ____
(First) (Middle) (Last) (Type of Relationship)

Address: ____
(Street) (City) (State) (Zip) (Email address)

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Additional Contact: ____
(First) (Middle) (Last) (Type of Relationship)

Address: ____
(Street) (City) (State) (Zip) (Email address)

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

SCHOOL INFORMATION – Check all that apply

☐ Currently attending school — Date school services projected to end: ________________

☐ Graduated with signed diploma — Date school services ended: ________________

☐ Received certificate of completion — Date school services ended: ________________

School: ________________ Contact Person: ________________ Phone: ________________

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old.

☐ Court Ordered Legal Representative and type (medical, limited, etc.): ________________

☐ Court Ordered Conservator and Name if different from Legal Representative: ________________

☐ Power of Attorney and type: ________________

☐ No Legal Representative in place. ☐ Copies of Legal Documents are attached.

Legal Representative's Name: ____
(First) (Middle) (Last)

Address: ____
(Street) (City) (State) (Zip) (Email address)

South Dakota Division of Developmental Disabilities
Application for Services

Home Phone:____________________ Work Phone:____________________ Cell Phone:______________

SERVICES REQUESTED – Check all that apply

☐ **Educational Services** Requested Start Date:______________________________
- ☐ Integrated Classroom
- ☐ Self-Contained Classroom

☐ **Employment Services** Requested Start Date:______________________________
- ☐ Day Services
- ☐ Own my Own Business
- ☐ Supported Employment
- ☐ Community Employment

☐ **Residential Services** Requested Start Date:______________________________
(i.e., independent living skills, community living skills, financial, personal living, etc.)
- ☐ Live with family
- ☐ Live alone
- ☐ Live with roommate
- ☐ Group Home
- ☐ Supervised apartment
- ☐ Rent apartment or home
- ☐ Buy house
- ☐ 24 hr. support needed
- ☐ Daily support needed
- ☐ Weekly support needed
- ☐ Other____________________

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply
(If available attach Psychological Evaluation) Please refer to evaluations for formal diagnosis:

IQ:
- ☐ Mild (52-70)
- ☐ Moderate (36-51)
- ☐ Severe (20-35)
- ☐ Profound (20 or below)
- ☐ Borderline (71-85)

- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Epilepsy/Seizure Disorder
- ☐ Autism
- ☐ Aspergers Disorder

- ☐ Fetal Alcohol spectrum Disorder
- ☐ Traumatic Brain Injury (prior to age 22)
- ☐ Cognitive Disability
- ☐ Other:____________________
- ☐ Other:____________________

FINANCIAL INFORMATION – Check all that apply
To assist in determining applicant's eligibility for services, please list sources and amounts of income:

☐ Medicare Number ______________________ ☐ Medicaid Number ______________________

☐ Social Security Number ______________________ Amount ________ Payee:______________

☐ Supplemental Security Income Amount ________ Payee:______________

☐ Social Security Disability Insurance Amount ________ Payee:______________

☐ Veteran's Administration Amount ________ Payee:______________

Other sources of Income and Amount: (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, CDs, wages, interest, property owned, etc.) ____

COMMUNICATION – Check primary means of applicant's expression

☐ Speaks ☐ Sign Language ☐ Gestures ☐ Communication Device
☐ Other (please specify): ____

ADAPTIVE EQUIPMENT – Check all of the adaptive devices or equipment the applicant uses:

- [ ] Needs Assistance Walking
- [ ] Needs Assistance on Stairs
- [ ] Hearing Aid
- [ ] Corrective Lenses
- [ ] Orthopedic Splints
- [ ] Manual Wheelchair
- [ ] Catheter
- [ ] Colostomy Bag
- [ ] Orthopedic Shoes/Braces
- [ ] Electric Wheelchair
- [ ] G-Tube
- [ ] Wears Helmet
- [ ] Walker
- [ ] Mechanical Lift
- [ ] J-Tube
- [ ] White Cane
- [ ] Gait Belt
- [ ] Other: ____________

MEDICAL INFORMATION and RELATED SERVICES – Check all that apply. If applicable, attach extra page(s)

- [ ] Speech/Language
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Counseling
- [ ] Psychiatric
- [ ] Medical Diagnosis: ____________
- [ ] Medications: 1. Name: ____________ Reason: ____________

2. Name: ____________ Reason: ____________

3. Name: ____________ Reason: ____________

Previous/Current Placements and dates-

____

____

____

____

____

____

____

____

Required documents to enclose with this application – Check and attach all that apply

- [ ] IEP (if applicable) (Multidisciplinary Team Assessment)
- [ ] Support Plan
- [ ] Diagnosis Documentation (Psychological Evaluation and MedicalInformation)

PORTS I NEED TO KEEP MYSELF & OTHERS SAFE – Check all that apply. (if applicable, attach extra page(s).

- [ ] Intentionally hurts self

Please describe: ____________

What appears to cause this? ____________

What is frequency? ____________

- [ ] Physically aggressive towards others

Please describe: ____________

What appears to cause this? ____________

What is frequency?

Is this potentially dangerous to others? ______________________
If yes, explain: ______________________

☐ Disruptive (such as frequent tantrums, screaming, other emotional outbursts)
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Sexual concerns
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Takes others possessions
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ______________________

☐ Any other concerns such as verbal or physical threats, difficulty relating to peers/authority, safety supports, etc.
Please describe: ______________________
What appears to cause this? ______________________
What is frequency? ________

Legal convictions/history ☐ No ☐ Yes
If yes, please describe: ______________________

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

APPLICANT SIGNATURE: ______________________
PARENT/LEGAL REPRESENTATIVE SIGNATURE: ______________________
DATE: ______________________

What do others like and admire about me:

Things I like to do and things I am good at:

Things that are important to me and make me happy:

Supports I need-what I am looking for to be successful:

Home & Community Based Service Providers (CSPs, FS 360)
Checklist

Name: ______________________________

INFORMATION REQUIRED FROM PARENTS:
Date Submitted:

- ____________ Completed Request for Services
- ____________ Completed Agency Application
- ____________ Authorization for Release of Information (current with in 12 months)
- ____________ Copy of Guardianship Order (if applicable)
- ____________ Copy of Certified Birth Certificate
- ____________ Copy of Social Security Card
- ____________ Copy of State-Issued Photo ID Card
- ____________ Copy of Medicaid/Medicare Card(s)
- ____________ Copy of Medicare D Card (if applicable)

INFORMATION REQUIRED FROM SCHOOL DISTRICT:
Date Submitted:

- ____________ Psychological Evaluation (Wechsler Adult Intelligence Test preferred)
- ____________ Current ICAP and Summary Printout (with in 12 months of enrollment)
- ____________ Most Recent 3-year Multidisciplinary Evaluation (if testing is included)
- ____________ Updated Medical/Social Assessment
- ____________ Current IEP

INFORMATION REQUIRED FROM PRIMARY PHYSICIAN:
Date Submitted:

- ____________ "Home Community-Based Services (Medicaid)
- ____________ Physical Examination (dated within 12 months of application)
- ____________ List of prescription medications signed by primary physician
- ____________ Current Vaccination Record
- ____________ TB Risk Assessment (dated within 12 months of application)

ADDITIONAL RECOMMENDATIONS:

- ____________ Tour of agency
- ____________ Tour of available residential services (when applicable)
- ____________ Meet with provider
- ____________ Complete one page profile

COMMUNITY SUPPORT PROVIDERS

Ability Building Services (ABS)
909 West 23rd
Yankton, SD 57078-1510
Telephone: (605) 665-2518 / FAX: (605) 665-0206
Executive Director: Beth Kathol
Admissions: Gigi Healy

ASPIRE
607 North Fourth Street
Aberdeen, SD 57401-2733
Telephone: (605) 229-0263 / FAX: (605) 225-3455
Web Site: http://www.aspiresd.org
Executive Director: Jennifer Gray
Admissions: Arlette Keller

ADVANCE (ADV)
301 Division Ave.
Brookings, SD 57006-0810
Telephone: (605) 692-7852 / FAX: (605) 692-6169
President/CEO: Brian Ardry
Admissions: Marilyn Kruse

Black Hills Special Services Cooperative (BHSSC)
PO Box 218
Sturgis, SD 57785-0218
Telephone: (605) 347-4467 / FAX: (605) 347-5223
Web Site: http://www.bhssc.org
Executive Director: Joe Hauge
Admissions: Shirley Halverson

Black Hills Special Services Cooperative - Hot Springs
737 University Avenue
Hot Springs, SD 57747
Telephone: (605) 745-3408 / FAX: (605) 745-4474
Executive Director: Joe Hauge
Admissions: Shirley Halverson

Black Hills Works
PO Box 2104
Rapid City, SD 57709-2104
Telephone: (605) 343-4550 / FAX: 343-0879
Web Site: http://www.bhws.com
CEO: Brad Saathoff
Admissions: Kathy Staton

Community Connections, Inc. (CCI)
PO Box 742
Winner, SD 57580-0742
Telephone: (605) 842-1708 / FAX: (605) 842-0309
Web Site: http://www.winnercommunityconnections.com
Executive Director: Melony Bertram
Admissions: Melony Bertram

DakotAbilities (DA)
3600 South Duluth
Sioux Falls, SD 57105-6494
Telephone: (605) 334-4220 / FAX: (605) 334-7976
Web Site: http://www.dakotabilities.com
Executive Director: Robert Bohm
Admissions: Shelley Graham

Dakota Milestones (DM)
PO Box 248
Chamberlain, SD 57325-0248
Telephone: (605) 734-5542 / FAX: (605) 734-4260
Web Site: http://www.dakotamilestones.org
Executive Director: Ronda Schelske
Admissions: Rhonda Schelske

Every Citizen Counts Organization, Inc. (ECCO)
PO Box 450
Madison, SD 57042-0450
Telephone: (605) 256-6628 / FAX: (605) 256-2060
Executive Director: Vicki Kommes
Admissions: Karla Kessler

Huron Area Center for Independence (HACFI)
258 3rd Street SW
Huron, SD 57350
Telephone: (605) 352-5698 / FAX: (605) 352-1013
Web Site: http://www.cfindependence.com
Executive Director: Randy Meendering
Admissions: Lisa Tschetter

LifeQuest (LQ)
804 North Mentzer
Mitchell, SD 57301-2198
Telephone: (605) 996-2032 / FAX: (605) 996-0972
Web Site: http://www.lifequestsd.com
Executive Director: Pam Hanna
Admissions: Paul Engen

LifeScape (LS)
2501 W 26th Street
Sioux Falls, SD 57105-6699
Telephone: (605) 336-7100 / FAX: (605) 338-0259
Web Site: http://www.achievesd.org
President/CEO: Anne Rieck McFarland
Admissions: Melanie DeBates

LIVE Center, Inc. (LIVE)
PO Box 59
Lemmon, SD 57638-0059
Telephone: (605) 374-3742 / FAX: (605) 374-3238
Executive Director: Julie Peterson
Admissions: Julie Peterson

New Horizons
c/o Human Services Agency
PO Box 1030
Watertown, SD 57201-6030
Telephone: (605) 886-0123 / FAX: (605) 886-5447
Web Site: http://www.humanserviceagency.org
HSA President/CEO: Dr. Charles L. Sherman; ATCO Executive Director: Jodie Marotz
Admissions: Haley Moeller

Northern Hills Training Center (NHTC)
625 Harvard Street
Spearfish, SD 57783-9730
Telephone: (605) 642-2785 / FAX: (605) 642-5069
Web Site: http://www.nhtc.org
Executive Director: Rich Mulholland
Admissions:

OAHE, Inc. (OAHE)
PO Box 503
Pierre, SD 57501-0503
Telephone: (605) 224-4501 / FAX: (605) 224-9619
Web Site: http://www.oaheinc.com
Executive Director: Ann Hoye
Admissions:

Southeastern Directions for Life (SE)
2000 South Summit
Sioux Falls, SD 57105
Telephone: (605) 336-0510 / FAX: (605) 338-9385
Web Site: http://www.southeasternbh.org
Executive Director: Clark Guhin
Admissions: Debbra Anderson

SESDAC, Inc (SESDAC)
1314 East Cherry
Vermillion, SD 57069-1606
Telephone: (605) 624-4419 / FAX: (605) 624-7375
Web Site: http://www.sesdac.org
Executive Director: Gerry Tracy
Admissions: Jenna Gobel

Volunteers of America/West Oak (VOA)
3520 S Gateway Lane
Sioux Falls, SD 57106
Telephone (VOA): (605) 334-1414 / FAX: (605) 335-3121
Telephone (WO): (605) 367-4293 / FAX: (605) 367-5714
CEO/Director: Dennis Hoffman; West Oak Director:
Admissions: Kurt Schiferl

South Dakota Department of Human Services

Division of Developmental Disabilities
Hillsview Properties Plaza
East Highway 34, c/o 500 East Capitol
Pierre, SD 57501
Telephone: (605) 773-3438

South Dakota Developmental Center
17267 W 3rd Street
Redfield, SD 57469
Telephone: (605) 472-2400

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: ______________

Revised 05/20/2021mp

A-4

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

AURORA PLAINS ACADEMY / DAKOTA REACH

1400 East 10th Street - Plankinton, South Dakota 57368
Phone: (605)942-5437 - Fax: (605)942-5438

Information requested before a person is admitted to Dakota Reach.

Benefits being received

Supplemental Security Income (SSI) amount: ______________________

Social Security Disability Income (SSDI) amount: ______________________

Child Support amount: ______________________

Veterans Administration Benefits amount: ______________________

Other type of benefit amount: ______________________
(Ex: Adoption subsidies?)

Who is representative payee for these benefits?

Bank Accounts

Checking Account: ______________________

Savings Account: ______________________

Other type of Account: ______________________

Name, telephone number and address of the person or agency that Dakota Reach may send a bill or request funds: ______________________

____

Medical Insurance

Medicare #: ______________________ Medicaid #: ______________________

Private Insurance, name and policy number: ______________________

____

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

1400 E. 10th Street; Plankinton, SD 57368 *phone:* (605)942-KIDS (5437) *fax:* (605)942-5438

AURORA PLAINS ACADEMY / DAKOTA REACH
APPROVED CALLING/WRITING LIST

NAME OF YOUTH______________________________

NAME______________________________ Relationship to Youth____________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

____

NAME______________________________ Relationship to Youth____________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

____

NAME______________________________ Relationship to Youth____________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

____

NAME______________________________ Relationship to Youth____________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

____

NAME________________________________ Relationship to Youth________________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

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NAME________________________________ Relationship to Youth________________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

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NAME________________________________ Relationship to Youth________________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

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NAME________________________________ Relationship to Youth________________________

ADDRESS____

TELEPHONE NUMBER: ____

Level of Supervision (circle): Staff supervised visit on campus;
Unsupervised visit on campus; Unsupervised off campus in Plankinton/Mitchell area;
Staff supervised day visit to home; Unsupervised day visit to home;
Unsupervised overnight visit to home; Unsupervised overnight home visit > 1 day

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AURORA PLAINS ACADEMY / DAKOTA REACH

1400 East 10th Street – Plankinton, South Dakota 57368
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 Districts 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 / Dakota Reach 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
Attn: Education Department; 1400 East 10th Street; Plankinton, SD 57368

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

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)

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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_ Current and past medications
_X_ Psychiatric Evaluation
_X_ Clinical assessments and screenings
_X_ Verbal Exchange of Information
_X_ Labs and x-rays
_X_ Psycho-educational Report
_X_ Discharge Summary
_X_ Immunizations/vaccinations
_X_ Psychological Evaluation
_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.

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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)

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.

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 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 ____________

FOR INTERNAL USE ONLY
Insurance Cards Received ☐
Date: ____________________

NEW PEDIATRIC 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: ____

Name of School ____

Mother's Name: ____ Contact Phone Number: ______________

Father's Name: ____ Contact Phone Number: ______________

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: ____

EMERGENCY CONTACT INFORMATION (*Not living at your current address*)

Name: ____ Relationship to Patient: ______________________________

Home Phone: _______________________ Work Phone: _____________________ Cell Number: ____________________

HORIZON
Health Care, Inc.

INTERPRETIVE SERVICES

Do you need interpretive services? ☐ Yes ☐ No

If so, what language? ____________________

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

☐ Other Pacific Islander ☐ More than one race ☐ 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 ☐ Other ☐ I would prefer not to disclose

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 hereby give authorization for payment of insurance benefits to be made directly to Horizon Health Care, Inc. (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'S PERSONAL INFORMATION

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

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. *Complete the below portion of this form only if you want to list family members or other people we can contact about your child/minor's health care.*

ADDITIONAL CONTACTS

Who else may we speak to about your child/minor's care?

☐ Please do not speak with anyone but me.

☐ I give my permission to speak with:**

Name: ______________________________ Relationship: ______________ Phone Number: __________

Name: ______________________________ Relationship: ______________ Phone Number: __________

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

- ☐ To remind the patient is due for a test or appointment.
- ☐ To give details about dates and/or preparations for a test or appointment.
- ☐ To discuss test results, condition, and/or medical care.

Patient or Responsible Party Signature:____

Date:________/_________/____________

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.*

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: ____________________________________

____

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,*

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

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

Grievance Procedures

Policy #CR-3

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
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 Clinical Operations 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 Clinical Operations 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 Clinical Operations 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 Clinical Operations 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 Clinical Operations 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 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

14. The policy and procedure will be signed and explained on a yearly basis.

PARENT/GUARDIAN/CONCERNED PERSON/LEGAL REPESENTATIVE GRIEVANCE PRODCEDURE

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 Clinical Operations 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 Clinical Operations or designee will forward the findings to the Department Head Team for review.
7. The Clinical Operations 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 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

SD Department of Human Services (605) 773-5990

SD Division of Developmental Disabilities (605) 362-4857

APPROVED BY: [signature] ____________________
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

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: Annette Biggers
EXECUTIVE DIRECTOR

DAKOTA REACH

THE RIGHTS OF PERSONS WITH DEVELPMENTAL DISABILITIES

CR-4

Effective date: 1/14/2019
Review Date:
Revision Date:
Policies/standards meet: COA CR 4; ARSD 46:11:03:00, ARSD 46:17:02:01, ARSD 46:17:06:07

POLICY

Dakota Reach is an Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID) and operates 24 hours a day. Every youth receives services helping them achieve full integration and inclusion in society, make choices, exert control over their lives, and fully participate in, and contribute to their communities. Every youth is the primary source of information about their need for service and any information gathered for assessment.

Human relationships are the basis for all personality growth, change and self-determination. Relationships include both giving and receiving in proportion to the needs of each person involved. Each and every youth is provided fair treatment and are given information about our program in order to make choices about utilizing our services. Dakota Reach youths do not participate in experimental research nor do they perform labor or services for the facility.

PROCEDURE

<u>CLIENT RIGHT PROVISIONS</u>

A supportive environment will include services and experience in the following areas:

PHYSICAL CARE We provide access to a nutritious diet, drinking water, shelter, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, fresh air, adequate exercise, and necessary clothing.

GROUP LIVING Living and leisure time activities is provided by a group of direct youth care specialists who offer skilled supervision and services. They provide the support basis for the implementation of strength-based, person-centered activities and interventions.

SOCIOLOGICAL SUPPORT Staff, utilizing knowledge from social class behaviors, family relationships, dynamics, and cultural differences provide experiences in group living where social behaviors, differences and similarities can be explored and understood.

MEDICAL & PSYCHIATRIC Based upon medical, nursing and other specialists' evaluations and recommendations, participants receive appropriate health services,

INSIGHTS	medical care, attention to growth and wellness, and 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 observed medical problem areas.
PSYCHOLOGICAL SERVICES	Every participant will receive the services and/or a clinical review of psychologist's observations and test results.
CLINICAL SERVICES	Every participant shall have regular individual, group, and/or family therapy experiences as an integral part of the services offered in residential care. The therapist will provide insight and mental health services based upon goals identified in the individual support plan.
SPECIAL EDUCATION	Every participant is entitled to special and individualized education courses, instruction. Which is 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.
DAILY AND SPECIAL ACTIVITIES	Every youth will have individual and group activities provided in free time, recreation and in some cases utilize community facilities for social and cultural development. Self-development, cooperation, unity of purpose, and the need to compete successfully is also recognized. Spiritual, moral and ethical behavior are emphasized within cultural backgrounds.
COMMUNITY TIES	Every youth has help with understanding their family as well as help with relationships at the community level increasing a sense of belonging, in an extended social system. Dakota Reach does not restrict the visitation rights of the parents/guardian of a child beyond limitations imposed by the court, and does not place restrictions on a child's communication rights beyond limitations specified in the support plan.
Individual Support Plan (ISP)	Dakota Reach works in partnership with the youth and their team to develop and implement a support plan that promotes self-determination and enables the fullest and most independent life possible. Quarterly reviews are completed on these support plans to assess their helpfulness and appropriateness from the standpoint of participants' rights.
GRIEVENCE	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 Performance Quality Improvement personnel or designee.

LIMITATION OR DENIAL OF RIGHTS

Good cause for denial or limitation of a right exists only when the Human Rights Committee has reason to believe the exercise of the right would create a security problem, adversely effect the youth's progress or seriously interfere with the rights or safety of themselves and/or others. (Refer to policy CR-5)

CLIENT RIGHTS

Dakota Reach supports and protects the fundamental human, civil, constitutional, and statutory rights of each youth. Written notice and training is provided to the youth in an accessible format upon admission and yearly thereafter. The notice shall also be provided to the youth's parent or guardian as well as their advocate upon the youth's request.

All youths are entitled to equal treatment regardless of race, gender, ability, age, creed or national origin. Any youth who feels that they have been denied equal treatment should file a written or verbal grievance with the participant ombudsman (Performance and Quality Improvement or designee) using the Resident Grievance/Complaint form.

Any rights that may be limited or restricted because of supports or security needs will have gone through the Human Rights Committee and a restoration plan will be implemented. This will be explained to the participant and specified in their ISP.

RIGHTS

Copies of Client Rights are posted in the reception area as well as the living area. All participants of Dakota Reach have the following rights:

1. You have the right to humane non-discriminating care that provides privacy, dignity, respect, and confidentiality.
2. You have the right to be free from bias and harassment regarding race, gender, age, disability, spirituality and sexual orientation.
3. You have the right to be free from abuse, neglect, inhumane treatment and exploitation.
4. You have the right to communicate in private; in your primary language; in your mode of communication.
5. You have the right to be free from retaliation for making a complaint, voicing a grievance, recommending changes in policies or procedures, or for exercising your legal rights.
6. You have the right to receive an education.
7. You have the right to nutritious and sufficient meals.
8. You have the right to sufficient clothing and housing.
9. You have the right to live in clean, safe surroundings.
10. You have the right to maintain contact with family and friends, unless contact has been legally restricted.
11. You have the right to refuse or discontinue services.

12. You have the right to access, read, and challenge any information contained in your record.
13. You have the right to an advocate or an employee of the State's designated protection and advocacy system.
14. You have the right to be provided choices among services and providers.
15. You have the right to be informed of and use the grievance procedure and receive a fair response from the facility within a reasonable amount of time.
16. You have the right to appropriate support in the least restrictive setting available with reasonable regularity and continuity of staff assignment that meets your needs.
17. 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.
18. You have the right to daily bathing or showering and reasonable use of materials, including culturally specific product.
19. You have the right to retain and use a reasonable amount of personal property.
20. You have the right to reasonable observance of cultural and ethical practice and religion.
21. You have the right to supportive management of personal financial affairs. A record will be kept documenting any transactions of any personal money at Dakota Reach.
22. 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.
23. You have the right to be told before admission: 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.
24. You have the right to not receive unnecessary or excessive medication.
25. 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 may lead to termination of services.
26. You have the right to change your mind regarding your treatment at any time, unless specifically restricted by law.
27. You have the right to an individual support plan that is designed to meet your needs. You have the right to take part in developing and reviewing said plan on a regular basis. You have the right to request, at any time, an in-house review of your care and treatment. You have the right to choose who you want in the development of your plan, as appropriate.
28. You have the right to be free from restraint used for a purpose other than to protect yourself or others from imminent danger. (Dakota Reach does not do seclusions).
29. You have the right to reasonable communication and visitation with approved people outside the facility including: family members, legal guardian, case worker/manager, attorney, therapist, physician, religious advisor, as well as the Department of Human

Services, Department of Social Services, Disability Rights South Dakota, at any reasonable time.

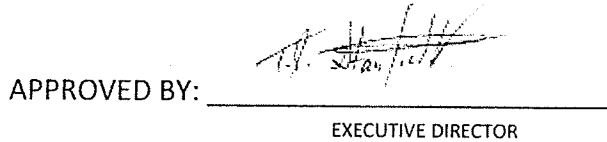
30. You have the right to communicate directly to the State of South Dakota Child Protection Service (CPS) (877-244-0864) or to Long Term Services and Supports (LTSS) (833-663-9673) at any reasonable time.
31. You have the right to not be arbitrarily transferred or discharged.
32. You have the right to be told about the program's rules and regulations before you are admitted.
33. 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.
34. You have the right to get a copy of these rights before you are admitted.

PROGRAM EXPECTATIONS

You are expected to work towards becoming a productive member of your community. This means:

- You understand that you have strengths and weaknesses with how you handle your thoughts, emotions, and behaviors.
- You have the responsibility to be honest with the information you provide into your program.
- You will respect yourself, others, and the environment. Not respecting yourself, others and environment could lead to termination of services.

Your individual support plan always takes precedence if there is a conflict.



APPROVED BY: ______________________

EXECUTIVE DIRECTOR

I have read, received a copy, an explanation and I understand these rights, rules and responsibilities.

______________________________ ____________

Resident Signature Date

______________________________ ____________

Guardian Signature Date

______________________________ ____________

Staff Member Providing Explanation 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
Oragel 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