

**Home On The Range  
Resident Information Sheet**

<b>Full Legal Name:</b>	<b>Date of Placement:</b>
<b>Nickname:</b>	<b>Religious Pref.:</b>
<b>Date of Birth:</b>	<b>Family Religious Pref.:</b>
<b>Place of Birth:</b>	<b>Height:</b>
<b>Gender:</b>	<b>Weight:        lbs.</b>
<b>Race:</b>	<b>Hair Color:</b>
<b>Complexion:</b>	<b>Eye Color:</b>
<b>Laundry No.:</b>	
<b>HOTR Reports Go To:</b>	
<b>Significant Physical Characteristics:</b>	

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**Insurance Information:**

**Company:**  
**Policyholder:**  
**Policy #:**

**Any other insurance?**

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<b>Court Order Date:</b>	<b>Court Order Expires:</b>
<b>Social Security #:</b>	<b>Grade in School:</b>
<b>Classification:</b>	<b>Last School:</b>
	<b>Financially Resp. School:</b>

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<b>Father:</b>	<b>Mother:</b>
<b>Address:</b>	<b>Address:</b>

<b>Home Phone:</b>	<b>Home Phone:</b>
<b>Work Phone:</b>	<b>Work Phone:</b>
<b>Cell Phone:</b>	<b>Cell Phone:</b>
<b>Date Of Birth:</b>	<b>Date Of Birth:</b>

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**Referring Agency:**  
**Address:**  
**Telephone:**  
**Contact Person:**

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**Agency Financially Responsible:**  
**Address:**  
**Telephone:**  
**Contact:**

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**Significant Others:**

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**Reason for Placement:**

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**Additional Information (contact restrictions, etc.):**

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**Social Skill Menu:**

**Behavior Management Techniques:**

**Restrictions: Yes \_\_\_ No \_\_\_ If Yes, list:**

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**Social Worker/Case Manager Assignment:**

**Completed By:** \_\_\_\_\_

**Michelle Swanson, LSW  
Administrative Services Director**

Form Date: 08/13/09

**NORTH DAKOTA APPLICATION FOR RESIDENTIAL SERVICES**

**DATE OF REFERRAL:** **COMPLETED BY:**  
(Signature)

**NAME OF PERSON MAKING REFERRAL:**

**AGENCY NAME & ADDRESS:**

**TELEPHONE NUMBER:**

**FAX NUMBER:**

\*\*\*\*\*

**CLIENT'S NAME:** **DOB:** **AGE:**

**PLACE OF BIRTH:** **HEIGHT:** **WEIGHT:**

**SSN:** **GENDER:** **RACE:**

**RELIGION:**

**CURRENT PLACEMENT OF CHILD:**

**ADDRESS & PHONE #:**

**MEDICAID ELIGIBLE: YES { } NO { } SSI ELIGIBLE: YES { } NO { }**

**MEDICAID (MA) #:**

**COUNTY ISSUING MA#:**

**THIRD PARTY INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER:**

**POLICY HOLDER'S NAME:**

**ADDRESS:**

**PHONE NUMBER:**

**LEGAL CUSTODY WITH:**

**PROBATION OFFICER:**

**COURT ORDER DATE:**

**PHONE NUMBER:**

**LEGAL CUSTODIAN NAME:**

**PHONE NUMBER:**

**FAX NUMBER:**

**ADDRESS:**

**COUNTY OF FINANCIAL RESPONSIBILITY:**

**ADDRESS:**

**CONTACT PERSON:**

**PHONE NUMBER:**

\*\*\*\*\*

**BRIEF DESCRIPTION OF PRESENT TREATMENT ISSUES & CURRENT REASON FOR REFERRAL:**

**CURRENT ASSESSMENT OF RUNAWAY RISK, DANGER TO SELF AND OTHERS:**

**BRIEF DESCRIPTION OF PRESENT THERAPY:  
LOCATION:  
NAME OF PROVIDER:**

**BRIEF DESCRIPTION OF FAMILY THERAPY:  
LOCATION:  
NAME OF PROVIDER:**

**MOST RECENT DIAGNOSIS:**

**AXIS I:**

**AXIS II:**

**AXIS III:**

**AXIS IV:**

**AXIS V:**

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**FAMILY ORIGIN:**

**FATHER'S NAME:**

**AGE:**

**ADDRESS:**

**PHONE #: (W)**

**(H)**

**LEVEL OF EDUCATION:**

**EMPLOYED: { } YES { } NO**

**OCCUPATION:**

**RACE:**

**BIRTH DATE:**

**RELIGION:**

**MOTHER'S NAME:**

**AGE:**

**ADDRESS:**

**PHONE #: (W)**

**(H)**

**LEVEL OF EDUCATION:**

**EMPLOYED: { } YES { } NO**

**OCCUPATION:**

**RACE:**

**BIRTH DATE:**

**RELIGION:**

**SIBLINGS:**

<b>NAME</b>	<b>SEX</b>	<b>AGE</b>	<b>ADDRESS</b>	<b>RELATIONSHIP</b>
<b>OTHER SIGNIFICANT PEOPLE IN CHILD'S LIFE</b>				

**DOES EITHER PARENT CURRENTLY HAVE A SIGNIFICANT OTHER LIVING WITH THEM? IF YES, PLEASE SPECIFY WHICH PARENT, AND IF THE SIGNIFICANT OTHER HAS CHILDREN LIVING WITH THEM IN THE HOME:**

**FAMILY HISTORY (Divorce, history of physical, verbal, emotional, or sexual abuse or neglect, domestic violence, family dynamics, etc.):**

**FOSTER CARE ENTRY AND DISCHARGE DATES (most current first):**

<b>ENTRY</b>	<b>DISCHARGE</b>	<b>PROVIDER NAME/ADDRESS</b>	<b>TYPE</b>

**IF THE CHILD IS NOT PRESENTLY PLACED IN THE BIOLOGICAL HOME,  
PLEASE COMPLETE:**

**NUMBER OF CHILDREN IN CURRENT FOSTER HOME, IF APPLICABLE: \_\_\_\_\_**

<b>NAME</b>	<b>SEX</b>	<b>AGE</b>	<b>RELATIONSHIP TO FOSTER PARENT(S)</b>

**HISTORY OF CLIENT'S BEHAVIOR:**

- 1. DESTRUCTIVENESS (include fire-setting):**
- 2. AGGRESSIVENESS/SEXUAL OFFENDING:**
- 3. SOCIAL STRENGTHS AND WEAKNESSES:**
- 4. RELATIONSHIP WITH PEERS:**
- 5. RELATIONSHIP WITH ADULTS:**
- 6. RELATIONSHIP WITH AUTHORITY:**
- 7. VIOLENCE TO SELF/SIB/PIERCING/TATTOOS:**
- 8. VIOLENCE TO OTHERS (include animals):**
- 9. EATING AND SLEEPING HABITS (eating and sleeping disorder symptoms):**
- 10. SUICIDE ATTEMPTS/IDEATION (child):**
- 11. MENTAL ILLNESS HISTORY (family):**
- 12. HISTORY OF SEXUALITY (sexually active, STD's, pregnancy, etc.):**
- 13. ALCOHOL AND DRUG USAGE, INCLUDING SMOKING, HUFFING (child) - Treatment?**

**Parental/Other Members - Treatment?**

Has client been assessed for Fetal Alcohol Syndrome/Fetal Alcohol Effects? { } Yes  
( ) No

If yes, what were the results? \_\_\_\_\_

14. LEGAL HISTORY:

15. RUNAWAY HISTORY (Who he/she ran with? What does he/she do on run?):

16. THOUGHT DISORDER:

17. OTHER:

**ABUSE/NEGLECT HISTORY:**

**VICTIM OF ABUSE**

TYPE OF ABUSE	KNOWN PERPETRATOR (NAME)	WHEN AND HOW LONG	INVESTIGATED	SUBSTANTIATED

**CURRENT CONTACT, IF ANY, WITH KNOWN PERPETRATORS(S):**

**CLIENT'S NAME:**

**PERPETRATOR OF ABUSE:**

TYPE OF ABUSE	RELATIONSHIP OF VICTIM TO CLIENT	WHEN AND HOW LONG	INVESTIGATED	SUBSTANTIATED

**MEDICAL HISTORY:**

1. **KNOWN MEDICAL PROBLEMS/DISABILITIES/HEAD INJURIES**  
(include allergies: meds, food, insects, etc.):
2. **MEDICATIONS** (current and past):
3. **PRENATAL, INFANCY, AND CHILDHOOD DEVELOPMENT:**
4. **ADOLESCENT DEVELOPMENT:**
5. **IMMUNIZATION RECORD:**

TYPE	DATE	TYPE	DATE

DOCTOR'S NAME	CLINIC/ADDRESS	PHONE #	LAST EXAM
DENTIST:			
OPTOMETRIST:			
FAMILY DOCTOR:			
PSYCHOLOGIST:			

\*\*\*\*\*

**EDUCATION:**

**HOME SCHOOL DISTRICT:**  
**SUPERINTENDENT'S NAME:**  
**ADDRESS/PHONE #:**

**PRESENT GRADE LEVEL:      LAST GRADE COMPLETED:      ED:      GED:**  
**GED COMPLETED:      GED WAIVER:      FULL SCALE IQ:**  
**PERFORMANCE IQ:      VERBAL IQ:      ED:      LD:**

**EDUCATIONAL DEVELOPMENT (History of learning or perceptual problems, sensory handicaps, dyslexia, etc.):**

**RECEIVING SPECIAL EDUCATION? WHAT NEEDS?**

**SPECIAL EDUCATION DISTRICT:**

**ADDRESS/PHONE #:**

**TRUANCY:**

**PEER RELATIONSHIPS (in school):**

**RELATIONSHIP WITH TEACHERS/COUNSELORS:**

**PAST YEAR AND PRESENT YEAR PERFORMANCE (average grades):**

**INDEPENDENT LIVING SKILLS CURRICULUM:**

**HAS SCHOOL BEEN INFORMED OF REFERRAL?**

**CURRENT ED IEP DATE:**

**CHILD'S INTEREST/SKILLS IN AREA OF VOCATION/WORK:**

**SCHOOL PLACEMENT HISTORY:**

SCHOOL NAME/ADDRESS	DATE ATTENDED

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**PAST PLACEMENTS (hospitalizations, group home, out-patient services, etc.) OR**

**FOSTER CARE:**

AGENCY NAME/ ADDRESS	DATE OF PLACEMENT	REASON FOR PLACEMENT	DATE OF DISCHARGE



**HOME ON THE RANGE  
CONTRACT FOR SERVICES**

**A. Service To Be Provided By - (Contractor):**

Home On The Range  
16531 I-94  
Sentinel Butte, ND 58654

**B. At The Request Of - (Referral Source):**

Referring Agency:  
Address:  
City/State/Zip:  
Agency Representative:

**C. Service To Be Provided To - (Client):**

Youth's Name:  
Date Of Birth:  
Medical Assistance #:  
Private Insurance Co.:  
Policy #: Group#:  
Policy Holder's Name:

**D. Services To Be Provided:**

Therapeutic Residential Child Care - all applicable services and care

**E. Payment Plan / Procedure:**

Fee Schedule - all fees are established by the licensing body of the facility (ND Dept. of Human Services) and are subject to change. **Consult current ND Dept. of Human Services manual letter defining applicable rates, or contact Home On The Range admissions office.** Billing for services is based on units of service, with one unit equaling one calendar day of actual care. Statements are provided monthly to the agency listed as the financially responsible agency.

**\* Note - this fee does not include educational costs.** All applicable educational tuition, etc. is billed by the public school providing service directly to the agency of financial responsibility.

\*\* All placement payments are payable to :

Home On The Range  
16351 I-94  
Sentinel Butte, ND 58654

**F. Financial Responsibility:**

Agency:  
Address:  
City/State/Zip:

**G. Method For Resolution Of Dispute or Termination:**

This contract may be terminated by either party by providing reasonable notice of the dissolution of these terms. The CONTRACTOR may terminate service based on the CLIENT's failure to cooperate with provided services and/or the stated expectations of the placement. The REFERRAL SOURCE, upon finding that the CONTRACTOR is not in compliance with any law or regulation, or applicable licensure and certification requirement, may terminate this contract upon written notice to the CONTRACTOR. Upon the termination or expiration of this contract, the CONTRACTOR shall cooperate in the orderly transition of client service and records and will grant, upon receipt of a signed release of information, copies of all requested client records generated by the CONTRACTOR.

**H. Statement Of Confidentiality:**

The REFERRAL SOURCE and the CONTRACTOR agree to comply with all client confidentiality requirements of the CONTRACTOR as well as state and federal law requirements.

**I. Signature Block:**

**REFERRAL SOURCE:**

\_\_\_\_\_  
Referring Agency

\_\_\_\_\_  
Date

**CONTRACTOR:**

\_\_\_\_\_  
Executive Director  
Home On The Range

\_\_\_\_\_  
Date

## HOME ON THE RANGE PLACEMENT AGREEMENT

Name of Child: \_\_\_\_\_  
(Print or Type)

Youngsters who are referred to Home On The Range (hereinafter referred to as HOTR) for placement are those having difficulty in their home, school and/or community. Any youth who is referred will be considered for placement at HOTR. The goal of HOTR is to offer youth a program of service and care to meet their individual needs. If a youth is accepted, efforts will be made to help the child learn social, academic, self-maintenance and similar skills to aid him/her in a better adjustment to family, teachers, peers and members of the community. Efforts are made to return the resident to a community placement as soon as possible. Exact plans depend on the child's needs and family situation.

I have decided that the problems of my child are serious enough to warrant placement at HOTR. I understand my child will be considered for residence in the HOTR program. With this understanding, I agree to the condition of this consent form, as indicated.

I understand that I am not, nor will be, deprived of my parental rights. However I agree to extend these parental rights to the staff at HOTR. This includes signing official documents, school permission forms, medical forms, etc.

I understand at the discretion of HOTR personnel, in accordance with the treatment plan, that my child will be able to spend holidays and vacation time with me. I agree to accept responsibility for my child during such periods and will notify the staff of HOTR immediately if any evidence of difficulty should appear. For example, if my youngster runs away or becomes physically abusive or is arrested, I would agree to contact the HOTR staff immediately to inform them of such happenings. I agree to return the child "on time" in accordance with plans made with HOTR staff.

I give my permission to the staff of HOTR to use physical restraint in the event that it is necessary to protect the health or safety of him/herself or others. It is understood that physical restraint in this context means holding the arms or legs of the child to prevent damage to oneself and/or other people. I understand the Ranch has a policy of never physically abusing (hitting, spanking, kicking, etc.) a child for discipline or punishment.

I understand the HOTR provides an "All Faiths" chapel service for all youth. I also understand that youngsters other than Christian youth are never excluded from the HOTR program because of their religious preferences and that special arrangements will be made for those youth to attend community services in accordance with their personal belief. I am aware that, regardless of my child's religious preference, my child, as well as all other HOTR residents, are expected to attend a religious service each week unless they have a legitimate reason for not attending.

I understand that the HOTR program includes physical activities such as football, basketball, soccer and similar vigorous activities. Unless my child has some physical limitations that make it medically unwise to participate if he/she so desires, I authorize such participation. I also will allow him/her to travel with teams and similar groups for such participation.

I understand that HOTR is a working ranch and that it operates a farm/ranch and vocational program. I understand that while my child is at HOTR he/she may at one time or another operate machinery, equipment or vehicles as part of his/her work experience, which is a part of the HOTR program. I understand that he/she will be given proper instruction in both the use of machinery and safety procedures associated with their use and that he/she will not be allowed to operate such equipment until he/she has demonstrated competency in the operation of such equipment and machinery.

Thus, in general, I agree to the cooperative relinquishment of the control and management of my child to engage in any activity that the staff deems appropriate for my child's benefit.

I understand that, given the problems of my child, placement at HOTR is the least restrictive alternative placement.

Parent: \_\_\_\_\_

Parent: \_\_\_\_\_

Resident: \_\_\_\_\_

Referring Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**HOME ON THE RANGE**  
**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, the undersigned, hereby freely and voluntarily authorize

Name of Person/Hospital/Agency	Address	City/State/Zip
to release the following information concerning _____		
	Name of Client	Date of Birth
to _____		
Name of Person/Hospital/Agency	Address	City/State/Zip

Information to be released:

\_\_\_\_\_  
\_\_\_\_\_

This information is necessary for (circle): Diagnosis and Treatment / Follow-Up

Other: (specify) \_\_\_\_\_

**I understand that I do not have to give this authorization to receive treatment services and that I may revoke this authorization to release information at any time by giving written notice to Home On The Range. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my Right of Confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire \_\_\_\_\_ days from the date of the authorizing signature below.**

Client Signature	Date	Witness	Date
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**If the client is a minor (under the age of 18 in the state of North Dakota) or has a legal guardian appointed by the court, this authorization to release information must be signed by the client's responsible parent or legal guardian and must be signed by the client if the client is over age 12.**

Parent/Guardian Signature	Date	Witness	Date
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\_\_\_\_\_  
Relationship to Client

**\_\_ CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records, the confidentiality of which is protected by federal law. Federal regulations (42CRF Part 2) prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.**

## HOME ON THE RANGE DOCUMENTATION OF COMMUNITY / FAMILY SERVICES

Licensing guidelines for group and residential care facilities in North Dakota, specifically Section 75-03-16-16, #4 states:

- "e. The facility shall request documentation of the services the parents or custodian will receive in the home community while the child is receiving services in the facility.**
- f. The facility shall request quarterly progress reports from the agency providing services to the parents or custodians."**

Below is a simple form for your convenience with which to document family services. Please complete and return as soon as possible.

\*\*\*\*\*

Youth's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Referring Agency: \_\_\_\_\_  
Referring Case Manager: \_\_\_\_\_

\*\*\*\*\*

Community Service Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Agency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Brief description of services provided:

Comments:

\_\_\_\_\_  
Referring Case Manager

\_\_\_\_\_  
Date

# HOME ON THE RANGE COLLATERAL INFORMATION - PARENT WORKSHEET

## **I. Identifying Information** -

Youth's Name:

DOB:

Sex: M F Race:

Address:

City:

State:

Informant(s):

Relationship:

**II. History of Previous Intervention** - list previous placements / interventions including counseling, foster care, group homes, residential care, psychiatric hospitalizations, etc.

Therapist/Facility

From-To

Reason For Termination

**III. Presenting Problem** - list a description of the precipitating events and circumstances that lead to the referral for placement

## **IV. Family History** -

A. Youth's Biological Father:

Birthplace:

Age/DOB:

Last grade or education completed:

Occupation:

If deceased, state date and cause of death:

B. Youth's Biological Mother:

Birthplace:

Age/DOB:

Last grade or education completed:

Occupation:

If deceased, state date and cause of death:

Date of parent's marriage:

C. Father's previous and/or subsequent marriages (list names and dates)

Name of ex-spouse

Date of Marriage

Date of Divorce

D. Mother's previous and/or subsequent marriages (list names and dates)

Name of ex-spouse

Date of Marriage

Date of Divorce

E. Name and relationship of relative or other person(s) important in rearing the youth and age of the youth.

F. List all of the youth's siblings, step-siblings, etc:

Name:

Age:

Location:

G. List any history of mental illness, emotional problems, substance abuse, etc. in siblings or parents:

**V. Youth's Birth / Developmental History -**

A. Date of birth:

B. Place of birth:

C. Adopted?: Y N                      D. If yes, at what age?:

E. Any medical complications during the mother's pregnancy or delivery (premature, Cesarean, etc.):

F. What was the parent's attitude toward the birth? (sadness, joy, frustration, etc.)

G. Hospitalizations, surgery, significant illness or severe accidents during:

0 - 18 mos.:

18 mos. - 18 yrs.:

Other:

H. Developmental Milestones (Check or fill-in the following):

1. Feeding difficulty

2. Weaned at age?

3. Age resident began to walk:

4. Age resident began to talk:

5. Age resident was toilet trained:

6. During the resident's childhood, were there any problems in the following areas:

unusual fears	age?
projectile vomiting	age?
head banging	age?
temper tantrums	age?
runaway	age?
sleep disturbance	age?
eating disturbance	age?
speech difficulty	age?

**VI. School History -**

A. Attended pre-school / nursery school? :

Any apparent difficulties? :

B. List all schools attended:

School	Grade Attended	Location
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C. Special Education? At what age?

D. Behavioral difficulties? (Describe):

E. Achievements? :

**VII. Religious / Cultural History -**

A. Current church preference:

B. Baptized?: Confirmed ?:

C. Any specific religious needs? :

D. If Native American, is the youth active in cultural activities? :

E. Enrolled tribal member?: Tribe?:

**VIII. Social Patterns -**

A. Does the youth have many friends?:

B. Is the youth a follower or a leader?:

C. Does the youth have any particular difficulties with peers?: (shy, aggressive, etc.):

D. Has the youth begun dating?: At what age ?:

E. Is the youth sexually active? : At what age?:

F. Are you aware of any problems directly related to the youth's dating or sexual activity?:

**IX. Substance Abuse History -**

A. Does the youth have a history of alcohol usage? :

Frequency?:

B. Does the youth have a history of drug usage? :

Frequency?:

C. Does the youth have a history of inhalant abuse? :

Frequency?:

**X. Comments -**

# HOME ON THE RANGE

## Education Data Form

1. Youth's Name:

Date of Birth:

Current Grade Level:

Permanent Address:

City/State/Zip:

Telephone:

Home School/ District:

Address:

City/State/Zip:

Telephone:

Please attach a current class schedule, most recent grade report, achievement test scores and immunization record. All permanent transcripts should be forwarded upon acceptance and prior to placement and will be requested by the HOTR education coordinator or the receiving school district.

2. Has the youth been identified to receive any Special Education services?

Yes

No

**If yes, attach a copy of the most recent Individual Education Plan (IEP).**

Parental consent is required at times in the development and implementation of special education services. If for some reason (i.e. termination of parental rights) a parent cannot provide this consent, who should be contacted to provide it?



**Home On The Range Medical Interview**  
**16351 I-94, Sentinel Butte, ND 58654**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Interview: \_\_\_\_\_

**ALLERGIES:**  Penicillin  Sulfonamide  Serum  Food  Other

**Check blanks that apply for above named individual:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Chronic Cough             | <input type="checkbox"/> Frequent Depression     |
| <input type="checkbox"/> Infect. Mono.      | <input type="checkbox"/> Epilepsy, Convulsions     | <input type="checkbox"/> Frequent Anxiety        |
| <input type="checkbox"/> Viral Hepatitis    | <input type="checkbox"/> Gum or Tooth Trouble      | <input type="checkbox"/> Insomnia                |
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Eye Trouble               | <input type="checkbox"/> Head Injury or          |
| <input type="checkbox"/> Measles            | <input type="checkbox"/> Ear, Nose, Throat Trouble | <input type="checkbox"/> Unconsciousness         |
| <input type="checkbox"/> German Measles     | <b>SURGERY:</b>                                    | <input type="checkbox"/> Back Problems           |
| <input type="checkbox"/> Mumps              | <input type="checkbox"/> Appendectomy              | <input type="checkbox"/> Other Illness or Injury |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Tonsillectomy             | <b>FEMALES ONLY:</b>                             |
| <input type="checkbox"/> Malaria            | <input type="checkbox"/> Hernia Repair             | <input type="checkbox"/> Irregular Periods       |
| <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Other                     | <input type="checkbox"/> Severe Cramps           |
| <input type="checkbox"/> Recurrent Headache | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Excessive Flow          |
| <input type="checkbox"/> Recurrent Colds    | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Last Menstrual Period   |
|   | <input type="checkbox"/> Sexually Trans. Disease   | <input type="checkbox"/> Pregnancy               |

Have you been physically abused?  Yes  No

Have you ever used any of the following? (Check if Yes)

- |                                    |                                      |  |  |
|------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Alcohol   | <input type="checkbox"/> Marijuana   | <input type="checkbox"/> Inhalants                   | <input type="checkbox"/> Amylnitrate (poppers) |
| <input type="checkbox"/> Crack     | <input type="checkbox"/> Barbituates | <input type="checkbox"/> Cocaine                     | <input type="checkbox"/> LSD                   |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> I.V. Drugs  | <input type="checkbox"/> Other Nonprescription Drugs |  |

Have you ever had a blood transfusion?  Yes  No

Have you ever had a tattoo?  Yes  No

Have you ever had acupuncture?  Yes  No

Have you ever been sexually abused?  Yes  No

Have you ever been sexually active?  Yes  No

If yes to sexually active, have you been active with any of the following?

- |  |   |
|--|---|
| <input type="checkbox"/> Person with AIDS          | <input type="checkbox"/> IV Drug User           |
| <input type="checkbox"/> Multiple/Unknown Partners | <input type="checkbox"/> Male/Female Prostitute |
| <input type="checkbox"/> Homosexual/Bisexual Male  | <input type="checkbox"/> Hemophiliac            |
| <input type="checkbox"/> ARC                       | <input type="checkbox"/> Positive HIV           |

Have any of your relatives had any of the following? (Give relationship)

- |  |   |
|--|---|
| <input type="checkbox"/> Tuberculosis _____                  | <input type="checkbox"/> Diabetes _____             |
| <input type="checkbox"/> Heart Disease _____                 | <input type="checkbox"/> Kidney Disease _____       |
| <input type="checkbox"/> Asthma, Hayfever _____              | <input type="checkbox"/> Epilepsy/Convulsions _____ |
| <input type="checkbox"/> Alcohol/Drug Related Problems _____ |   |

Have you had difficulty with school studies or teachers? (Give details) \_\_\_\_\_

Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problems, alcohol or other drug related problems? \_\_\_\_\_

Scars or tattoos: \_\_\_\_\_

Date of: Last Eye Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_ Last Tetanus: \_\_\_\_\_

\_\_\_\_\_ was instructed on the medical routine at Home On The Range. He/she was advised to report any illness or injury to staff.

NOTES: \_\_\_\_\_

\_\_\_\_\_  
Signature

# HOME ON THE RANGE

## MEDICAL RELEASE

### TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_  
(Child's Name)  
for the mutual conditions of covenant and terms herein do hereby grant permission to Home On The  
Range (hereinafter referred to as HOTR) and/or its administrative authorities to provide any medical  
care it deems necessary for the well-being of \_\_\_\_\_.  
(Child's Name)

**FURTHER**, should \_\_\_\_\_ develop any illness or sustain an  
(Child's Name)  
emergency injury requiring immediate medical care and/or hospitalization, in the judgment of HOTR  
and/or its administrative authorities, permission is herewith granted by me \_\_\_\_\_  
(Parent/Guardian)  
for any necessary medical care.

### I (we) further consent to:

1. All medical tests and immunizations deemed advisable by HOTR's medical advisors and/or consultants.
2. All medical and dental care deemed necessary by HOTR's medical advisors and/or consultants.
3. The usage of anesthesia and/or furnishing any surgical treatment by the medical advisors and/or consultants of HOTR, if in the opinion of said advisors and/or consultants such an emergency exists or may unexpectedly arise. In keeping with the concept of the importance of parental and agency awareness, every effort will be made by HOTR to secure such surgical releases when in the opinion of said advisors and/or consultants no emergency exists or may unexpectedly arise.
4. To sign all medical forms deemed necessary to obtain medical attention. These forms include but are not limited to medical treatment forms, procedural consent forms, financial responsibility, HIPAA, health insurance forms, or mental health forms.

Further, in consideration of the aforesaid payment and the added consideration of medical care granted by HOTR, its administrative authorities and/or its medical advisors or consultants, I hereby covenant that I will forever refrain for any reason from instituting, or in any way pressing any claim of any kind against HOTR, Sentinel Butte, ND, its administrative authorities and/or its medical advisors or consultants.

Furthermore, I hereby expressly stipulate and agree in consideration of the aforesaid payment in the event any claim is pressed by, or on behalf of, said minor, the undersigned will forever "stand in the shoes" and hold forever harmless HOTR, its administrative authorities and/or its medical advisors or consultants.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referring Agency Rep.

\_\_\_\_\_  
Date

**HOME ON THE RANGE**  
**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Home On The Range may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Home On The Range's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Home On The Range reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HOTR Privacy Officer at 16351 I94, Sentinel Butte, ND 58654.

With my consent, Home On The Range may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as messages, permission slips, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Home On The Range may mail to my home or other designated location any items that assist in carrying out TPO, such as progress reports, permission slips, and patient statements, as long as they are marked Personal and Confidential.

With my consent, Home On The Range may email to my home or other designated location any items that assist the practice in carrying out TPO, such as progress reports, permission slips, and patient statements. I have the right to request that Home On The Range restrict how it uses or discloses my PHI to carry out TPO. However, the facility is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Home On The Range, use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the facility has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Home On The Range may decline to provide treatment to me.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

## HOTR Church Preference Form

**Resident's Name:** \_\_\_\_\_

It is the belief of HOTR that healing is aided when we address physical, psychological, social, and spiritual needs. Our founder, Fr. Elwood Cassedy, maintained that the key element of healthy human living is a moral/spiritual component. Thus our program offers this spiritual element. HOTR accepts children of all denominations as well as children that are non-denominational. No particular religion is ever imposed on anyone, but information about religion and spirituality is shared with all under our care. As the parent/guardian, please mark your preference for:

---

**A) Select one:**

I choose the designated community church for my child.

\_\_\_\_\_ Catholic

\_\_\_\_\_ Evangelical

\_\_\_\_\_ Lutheran

\_\_\_\_\_ My child may choose for himself/herself which of these three to attend.

---

**B) Select one:**

\_\_\_\_\_ I require that I be contacted to grant permission for my child to change churches.

**OR**

\_\_\_\_\_ I authorize my child to change churches without my approval.

---

**C) Select one:**

\_\_\_\_\_ I desire that my child attend church.

**OR**

\_\_\_\_\_ My child has my permission to decide for himself/herself if they want to attend church.

**OR**

\_\_\_\_\_ My child has my permission to NOT attend any religious activities. Required attendance at Moral Development group is therefore understood.

---

**D) Add your comments:**

---

***SIGN AND DATE:***

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**HOME ON THE RANGE  
MEDICAL DATA AND HEALTH HISTORY  
QUESTIONNAIRE**

In order to facilitate quality medical care for youth placed at Home On The Range, the following information **must** be provided. Please answer all questions as accurately and completely as possible. This questionnaire should be completed by either a parent or legal guardian that is familiar with the youth's medical and physical status. **Youth will not be admitted without the following information.**

<b>I. APPLICANT DATA:</b>	
_____ Youth's Name	_____ Date Of Birth
_____ Name Of Person Completing This Form	_____ Relationship To Youth

**II. INSURANCE DATA:**

**A. Medicaid/Medical Assistance**

1. Is Medicaid/Medical Assistance the primary insurance coverage for the youth?  
 Yes                       No

Medicaid/Medical Assistance # : \_\_\_\_\_

\*\*Note – All North Dakota Medical Assistance numbers should be verified prior to placement. Current Montana Medicaid certificates are required upon placement. Montana residents will be exempted from the Montana Medicaid Passport Provider program if possible.

**Private Insurance**

1. Is a parent/guardian's private insurance the primary or secondary coverage for this youth?  
 Primary                       Secondary                       Not Applicable

2. Company Name -  
Address -  
City/State/Zip -  
Telephone # -

3. Name Of Policyholder -  
Date Of Birth -  
Social Security # -  
Policy Number -  
Group Number -
4. Are pre-authorizations required?  Yes  No  
If "Yes", attach a copy of the authorization procedure.
5. Does the private insurance include coverage for (check those applicable):
- |   |  |
|---|--|
| <input type="checkbox"/> Medical            | <input type="checkbox"/> Prescription Medication |
| <input type="checkbox"/> Dental/Orthodontal | <input type="checkbox"/> Vision                  |
| <input type="checkbox"/> Mental Health      |  |

**III. CURRENT HEALTH CARE DATA:**

- A. Does the youth have existing medical conditions that require immediate or ongoing care?  Yes  No  
(List):
- B. Medications currently prescribed:

\*\*Note – Home On The Range requires a written physician’s order to dispense prescribed medications. All youth must also have a physical examination within thirty days prior to the date of placement. All female youth must have an up-to-date gynecological examination and pregnancy test prior to placement.

- C. Non-prescription medications taken regularly:
- D. Recent Exams/Medical Care:
1. Dental –  
Date of exam/care:  
Provider:  
Address:  
City/State/Zip:  
Telephone:

2. Vision –  
Date of exam/care:  
Provider:  
Address:  
City/State/Zip:  
Telephone:

3. Medical –  
Date of exam/care:  
Provider:  
Address:  
City/State/Zip:  
Telephone:

4. Mental Health –  
Date of exam/care:  
Provider:  
Address:  
City/State/Zip:  
Telephone:

#### IV. HEALTH HISTORY:

A. Please check any applicable and list the year:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> chicken pox _____           | <input type="checkbox"/> measles _____           | <input type="checkbox"/> rubella _____          |
| <input type="checkbox"/> scarlet fever _____         | <input type="checkbox"/> whooping cough _____    |   |
| <input type="checkbox"/> mumps _____                 | <input type="checkbox"/> frequent colds _____    |   |
| <input type="checkbox"/> ear infections _____        | <input type="checkbox"/> eczema _____            | <input type="checkbox"/> kidney infection _____ |
| <input type="checkbox"/> rheumatic fever _____       | <input type="checkbox"/> epilepsy/seizures _____ |   |
| <input type="checkbox"/> convulsions _____           | <input type="checkbox"/> diabetes _____          | <input type="checkbox"/> heart disease _____    |
| <input type="checkbox"/> congenital conditions _____ |  |   |
| <input type="checkbox"/> enuresis (bedwetting) _____ |  |   |
| <input type="checkbox"/> other: _____                |  |   |

B. Any history of surgery, serious accident/illness, or head injury?

C. Any pertinent family medical history (e.g. cancer, diabetes, heart disease) that can be predisposing to the youth?

D. Allergies:

1. Medications –
2. Foods -
3. Insect stings, etc. -
4. Respiratory conditions (asthma, hay fever, etc.) -

**V. IMMUNIZATION:**

- A. Please attach a copy of the youth's immunization record and EPSDT screening.

**VI. RESTRICTIONS:**

- A. Please list any activity restrictions, etc. that are indicated due to medical concerns:

**VII. COMMENTS:**

**VIII. SIGNATURE:**

\_\_\_\_\_  
Signature Of Person Completing Form

\_\_\_\_\_  
Date



## HOTR Emergency Evacuation Plan

Resident in care: \_\_\_\_\_

Facility Location: 16351 I 94, Sentinel Butte, ND 58654 Ph.: 701-872-3745  
Ph.: 701-872-3745 Cell #: 701-872-6396 (executive director)

In the event of an **emergency evacuation** of the facility, Home On The Range will use the following locations **within the same community:**

*First Option:*

St. John's Catholic Church

142 2<sup>nd</sup> Ave N

Beach, ND 58621 Ph.: 701-872-4153

*Second Option:*

Beach High School

600 N Central Ave

Beach, ND 58621 Ph.: 701-872-4161

In the event we would need to relocate **outside the region:**

*First option:*

St. Patrick's Church

310 2<sup>nd</sup> St. W

Dickinson, ND 58601 Ph.: 701-483-6700

*Second option:*

St. Bernard's Church

404 3<sup>rd</sup> Ave NE

Belfield, ND 58622 Ph.: 701-575-4295

These locations will be utilized until a full assessment of the emergency is made and housing needs determined.

Please furnish contact information for the person(s) in which HOTR needs to contact in case of an emergency. Please provide work, home, and cell phone numbers. (Note: The phone numbers will only be contacted in a real emergency and will be kept confidential).

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Work #: \_\_\_\_\_

Work #: \_\_\_\_\_

Home #: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Cell #: \_\_\_\_\_

HOTR understands that there are critical items we are urged to take with the resident when we evacuate. These may include:

- A copy of this form for each resident.
- Resident's information (e.g. prescriptions, recent medical reports, physicians name and contact information, immunization history.)

HOTR understands that in the event that we must evacuate the facility, we are required to report each resident's location to their legal custodian, licensing agent or the NDDHS.

HOTR requests that if any of the information included in this plan changes, we be updated by the legal custodian within 14 days of the change.

Legal Custodian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Copies: \_\_\_\_ Legal Custodian \_\_\_\_ HOTR On-call Book