

White Earth Oshki Manidoo "New Spirit" Center

1741 15th Street NW • Bemidji, MN 56601 • Office: 218.751.6553 • Fax: 218.751.1846

YOUTH DEMOGRAPHICS

Personal Information

Admit Date: _____ **Discharge Date:** _____

First Name: _____ Last: _____ MI: _____

SS#: _____ DOB: _____

Phone Number: _____ Message at this # ok? Yes / No

Message/Cell Phone #: _____ Message at this # ok? Yes / No

Mailing Address: _____

Physical Address: _____

Father's Name: _____

Mother's Name: _____

Other/Legal Guardian Name: _____

Agency Affiliation: _____

Health Insurance Information

Do you have any medical concerns: Yes / No If so, what?: _____

Do you have any allergies? Yes / No If so, what?: _____

Do you take any medications?: Yes / No If so, what?: _____

Do you have Medical Assistance?: Yes / No If so, policy #: _____

Insurance Policyholder Full Name: _____

Do you have other insurance?: _____

If yes, name of insurance: _____

Insurance Policyholder Full Name: _____

Other Information

Are you an enrolled member of a Federally Recognized Tribe?: Yes / No

If yes, please list Tribal enrollment #: _____

Name of Tribe/Band: _____

Emergency Contacts:

Full Name: _____

Relationship to you: _____

Phone #: _____

Address: _____

Full Name: _____

Relationship to you: _____

Phone #: _____

Address: _____

All information is protected under the Privacy Act of 1994 PL-93-359 and will not be shared with anyone without written consent of the patient.



EMERGENCY ACTION PLAN

Client Name: _____ DOB: _____ Admit Date: _____

Home Address/Phone	Parent/Family Name/Address/ Phone	Placing Authority Contact Info
Social Worker Contact Info	Probation Contact Info	Other Contact Info
Diagnosis(es)	Medications	Medical Conditions
Insurance Information	Allergies	Physical Description
Other Vulnerabilities/Identified Safety Risks	Type of Restrictive Techniques Approved in Healthy Living Plan	Effective Interventions for Crisis

Emergency Action Protocol

1. Call 911 for medical emergency.
2. Inform all contacts listed above as soon as possible of the emergency even including emergency service personnel.
3. Follow policy/protocol for emergency even (medical emergency, run/missing, psychiatric crisis).
4. Complete incident report within 24 hour and forward to Assistant Director.
5. Make follow-up contacts listed above after emergency has been handled.
- 6.
- 7.
- 8.

Prior Arrangements (emergency alternative placement or other pre-planned response)

- 1.
- 2.
- 3.
- 4.

ADMISSION FACE SHEET
YOUTH AND FAMILY INFORMATION

check if release of information obtained

Full Name: _____ Nickname (s): _____

Age: _____ Gender: M or F Date of Birth: _____ Place of Birth: _____

Race or Cultural Heritage: _____ Tribal Affiliation: _____

Enrolled Descendant Recognized as a member of the community

Languages the resident speaks and writes: Ojibwe English Other: _____

Spiritual or religious affiliation of the resident and the resident's family: _____

Last Known Address: _____

Permanent Address: _____

Name, address, and telephone number of parents, legal guardian, caregiver and advocate:

Parents: _____

Phone #: _____ Phone #: _____

Legal Guardian: _____

Phone #: _____ Phone #: _____

Advocate: _____

Phone #: _____ Phone #: _____

Current/Most recent diagnosis (es) (Substance Use Disorder and Mental Health): _____

Description of presenting problems, including medical problems: _____

Physical conditions/Special medical care Needed: _____

Medications: _____

Circumstances leading to admission: _____

PREVIOUS SERVICES/PLACEMENT HISTORY (community based & residential)

Name of Facility/Agency	Type of Service:	Dates of Service:	Progress/Benefits to Youth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental health concerns: _____

Safety concerns including assaultive behavior and victimization concerns: _____

ADMISSION FACE SHEET

Educational Program (last attended): _____ **Date:** _____

Contact Name: _____

Address: _____

Phone #1: _____ **Fax#:** _____

Home School District : _____

Phone #1: _____ **Fax#:** _____

- Assessment IEP 504 Plan LD DD
- Alternative Learning Environment EBD SED FASD ASD
- Currently attending school Not attending school GED Graduated
- Release obtained** IEP requested *Service minutes on IEP:* _____ min

YOUTH AND FAMILY STRENGTHS AND ASSETS:

Description of assets/strengths/talents/gifts of the youth and, if available, related information from the youth, youth's family, and concerned persons in the youth's life: _____

Family Strengths: _____

IDENTIFIED GOALS/SERVICES/IMMEDIATE NEEDS:

Anticipated living arrangement after discharge: _____

Assessment needs/Questions/Concerns to be addressed by assessment:

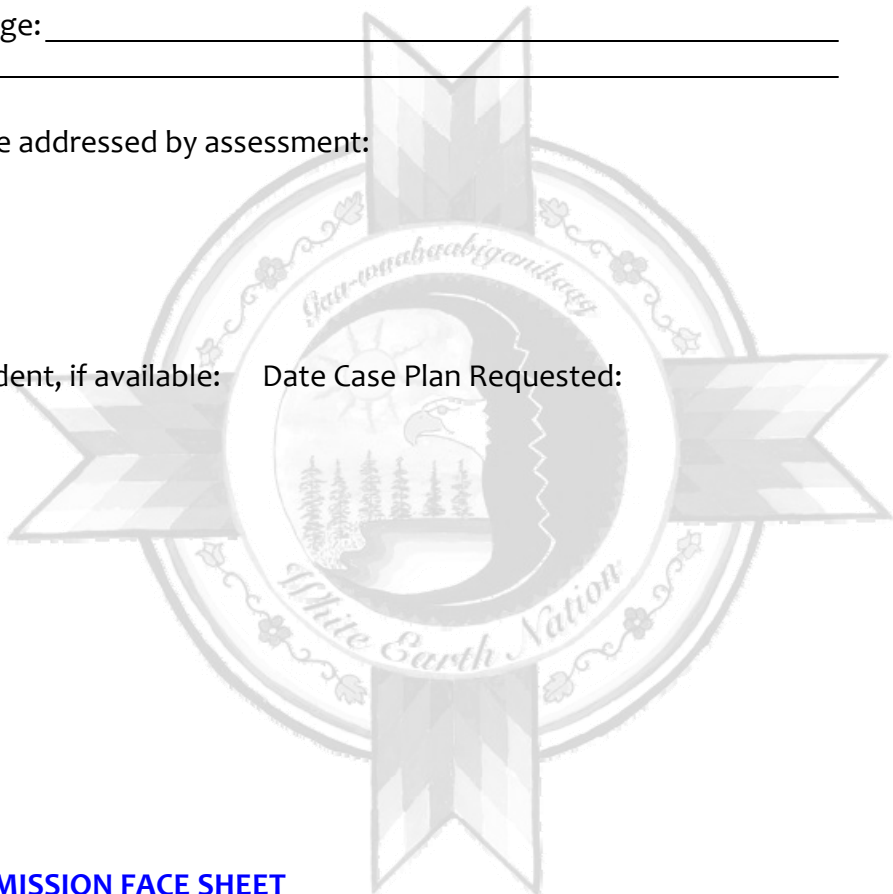
- 1.
- 2.
- 3.

Placing agency's case plan goals for the resident, if available: **Date Case Plan Requested:**

- 1.
- 2.
- 3.

Family goals/Family support needs:

- 1.
- 2.
- 3.



ADMISSION FACE SHEET

This Youth's Medical, Mental , Emotional, Substance Use, Cultural and Educational needs as identified in the assessments and screenings can be addressed at the Oshki Manidoo Center. The Youth's Initial Treatment Plan will address the Youth's Safety, Substance Use, Education, Recreational and Cultural needs:

Legal Guardian/Authorized Representative Signature

Date



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PRIVACY STATEMENT FOR PATIENTS AND RELATIVES

Federal Regulations CGR42, Part 2, Confidentiality of Alcohol and Drug Abuse Records and Minnesota Data Privacy Act MS 15-1653 require the program to keep all information about you strictly private.

Information we request or maintain will be used to:

1. Evaluate your services need.
2. Collect payment for your treatment from you, a private or government organization.
3. To meet county, state or federal statistical requirements. (Your name is not used when reports are filed.)
4. To share necessary information with a service provider with whom we have a qualified services agreements.
5. Information about the type, amount, dates, costs, outcome and evaluation will be shared with program staff who need to keep records or provide services.

Exceptions to Disclosure

Please be aware that the following disclosure may be made without your consent. We are required to report to:

1. Child Protection/law enforcement if we have reason to believe that you have abused or neglected a child. If you are pregnant and have exposed an unborn child to alcohol or controlled substances.
2. A judge who issues a court order to release your record.
3. Qualified medical personnel in a medical emergency.
4. Law Enforcement if you commit a crime on the premises or against staff.
5. Adult Protection/law enforcement if you consent in writing to reporting abuse. Staff will help you with a plan for your protection.

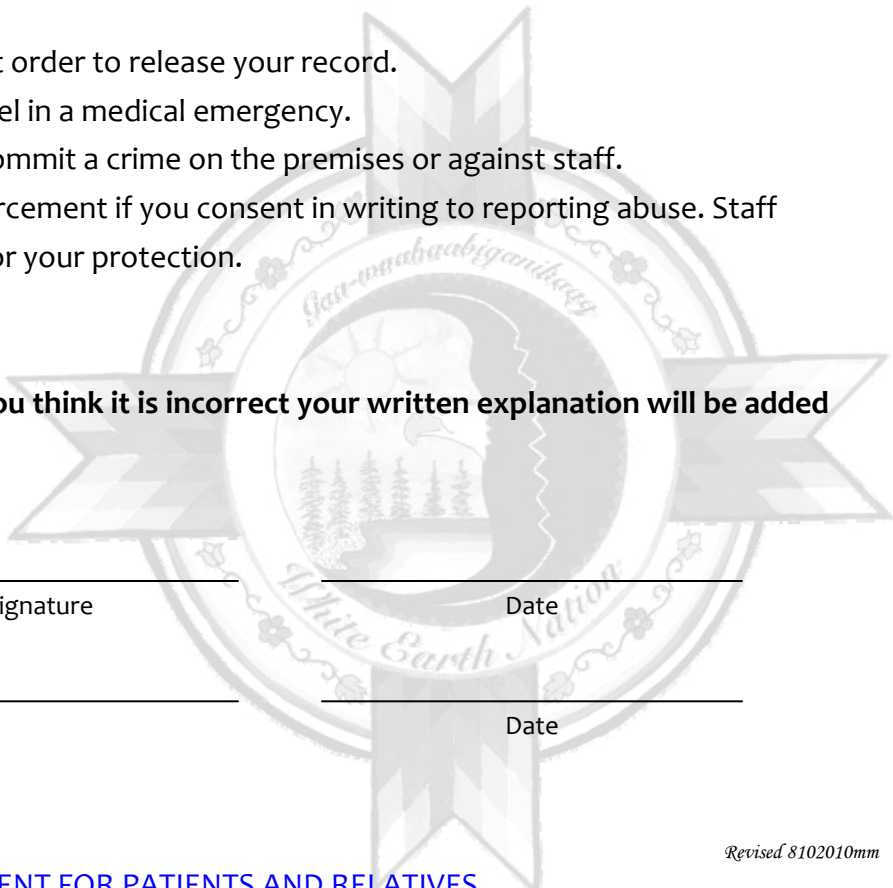
You may see all information about you. If you think it is incorrect your written explanation will be added to your record.

Legal Guardian/Authorized Representative Signature

Date

OMC Staff Signature

Date



CONFIDENTIALITY AGREEMENT

The Oshki Manidoo Center is a culturally specific treatment program for Native and non Native American Youth addressing substance use and mental health struggles. Access to sensitive and confidential information regarding youth, Oshki Manidoo & White Earth Reservation Tribal Council practices, and policies & procedures is apparent. Identification of youth, activities, written and verbal communication is strictly **confidential**. Under no circumstances is confidential information to be discussed or shared with others.

As a family member, friend, visitor or guest of the Oshki Manidoo Center and in accordance with the White Earth Reservation Tribal Council Confidentiality Agreement, I understand that it is my responsibility to understand and comply with these guidelines.

Print Name

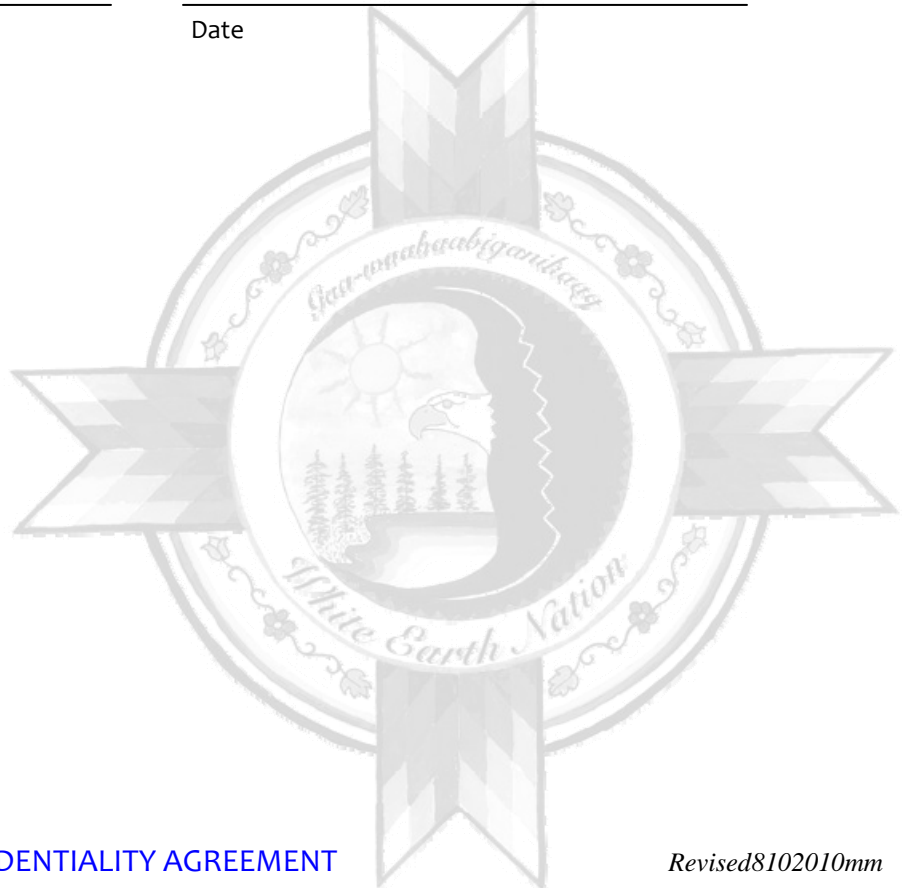
Title

Signature

Date

OMC Staff Signature

Date



Purpose of agreement (i.e. event, speaker, cultural)

CONSENT TO TREAT FOR DRUG & ALCOHOL COUNSELING

Client Name: _____ DOB: _____ Admit Date: _____

Phone numbers where you authorize us to contact you:

Phone 1: _____ Phone 2: _____

By signing below, I consent to treatment and counseling provided by the Oshki Manidoo Center counselor/s. I understand that anything I say will be kept in strict confidentiality and will not be shared to anyone outside the treatment center without my signed consent. Information may be share with other members of the treatment team to assist in your therapy and/or treatment when necessary. I understand that my counselor is a mandated reported and is required to report any suspicion of child abuse, elder abuse.

I understand that I have a right to participate in planning the goals, methods and estimated length of the my treatment and will be asked to be involved in the duration of my plan.

Client Signature

Date

Legal Guardian/Authorized Representative Signature

Date

INFORMED CONSENT FOR DRUG TESTING

I , as legal guardian/authorized representative of _____

Give my consent to complete UA/saliva drug testing on this youth if warranted per OMC Drug Policy. Positive screens will be validated by Redwood Biotech.

Client Signature

Date

Legal Guardian/Authorized Representative Signature

Date

CONSENT TO PROVIDE TRANSPORTATION

I , as legal guardian/authorized representative of _____

Give my consent to for Oshki Manidoo Center to provide transportation for my child/legal dependant.

Legal Guardian/Authorized Representative Signature

Date

Staff Signature

Date

MEDICAL CONSENT

Client Name: _____ DOB: _____ Admit Date: _____

I hereby authorize and give my consent to any dental, optical, medical care or surgical procedures to be performed on my child, _____ while at the Oshki Manidoo Center (OMC) when in the opinion of an attending, duly qualified physician or nurse practitioner, said services deemed necessary or advisable. I consent to administration of whatever anesthetics are advisable or deemed necessary. I also authorize and give my consent to administration of meds prescribed by a licensed physician or nurse practitioner to my child at OMC if deemed necessary or advisable. In addition, I authorize for the administrations of any vaccines needed for my child required by the MN Legislation Statute 121A.15. I have received written information on these vaccines.

It is my understanding that OMC staff will informed me as soon as possible if a medical emergency occurs and attempt to obtain my permission for any surgical procedures.

Legal Guardian/Authorized Representative Signature

Date

I further authorize the above approved Medical, Dental or Optical care provider to release information regarding this care of my child to OMC following completing of these care services.

Legal Guardian/Authorized Representative Signature

Date

I hereby authorize the Respond Personnel for the until in which my child resides, to provide authorizing signature when I am unable to be reached and emergency hospital care is warranted.

Legal Guardian/Authorized Representative Signature

Date

I hereby authorize the above approved medical, dental or optical care provider to file claims to our health Insurance, payments made directly to the provider and any balance owed after insurance has processed to be billed directly to the parents for payment.

Legal Guardian/Authorized Representative Signature

Date

I also authorize and give my consent to administer over the counter medications for minor illness to my child at OMC is deemed necessary.

Legal Guardian/Authorized Representative Signature

Date

Part I: OMC cannot accept financial responsibility for children in our care who need medical services. To ensure that our vendors receive payment, please sign off on the following statement: "When a child is placed without adequate medical insurance (or whose medical insurance is canceled/terminated while at OMC and who has no Medical Assistance as back-up, our vendors will be instructed to directly bill the financially responsible agency/county/parent."

Legal Guardian/Authorized Representative Signature

Date

Part II: The parent and/or financially responsible agency/county has the option to arrange for all medical, dental or vision services and provide transportation to and from appointments while the child is a resident of OMC.

Legal Guardian/Authorized Representative Signature

Date

RELEASE OF INFORMATION

Client Name: _____ DOB: _____ Admit Date: _____

I authorize Oshki Manidoo Center to: exchange with: disclose to: obtain from:

Name of Individual and/or Agency: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

To: Oshki Manidoo Center
1741 15th Street NW • Bemidji, MN 56601 • Office: 218.751.6553 • Fax: 218.751.1846

This is necessary for the following purpose(s):

- Assessment and services Personal Education Insurance/financial/billing Legal Per client Request
 Disability determination Evaluation Per family request: Name & relationship to family: _____

Information to be released: check yes or no

Y N

- Dates of Service
- Social service Agency Information
- Physical exam, Chemical/drug dependency history
- Medical Records: medical history, admit summary, SC summary, progress notes, blood/lab tests,
- Psychiatric intake, diagnostic assessment & Treatment plans, Interim and progress notes, Psychiatric/Psychological testing, Mental Health Assessment, Mental Health Treatment Plan
- Correction/probation/Court info.
- Education information (academic, IEP, transcripts)
- Other

I authorize the release of all records pertaining to Mental Health, Alcohol and/or Drug Abuse and/or HIV Testing/AIDS/ AIDS related illness.

I understand that :

- I have the right to revoke this authorization at any time giving written notice to Oshki Manidoo Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I need not sign this authorization to receive services unless the services are court ordered.
- Oshki Manidoo Center cannot prevent the re-disclose of records release as a result of this request and that after release from Oshki Manidoo Center the records may not be subject to privacy rule protections.
- This authorization will permit two-way telephone communication and exchange of information by electronic methods.
- I am entitle to a copy of this authorization once I have signed and I may review/request copies of information disclosed.
- A photograph or facsimile of this authorization is as effective as the original
- This authorization shall remain in effect until this date: _____ (one year maximum)

 Client Signature

 Date

 Legal Guardian/Authorized Representative Signature

 Date

 Witness Signature

 Date

I, _____ revoke the ROI consent signed on : _____ by which I authorize Oshki Manidoo Treatment Center to release/receive certain specified information.

DISCLOSURE OF THIS MATIERIAL IS PROHIBITED BY LAW: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. General authorization for the release of medical or other information is not sufficient for this purpose.: Please note that a copy is considered an equivalent of the original.

RELEASE OF INFORMATION

Client Name: _____ DOB: _____ Admit Date: _____

I authorize Oshki Manidoo Center to: exchange with: disclose to: obtain from:

Name of Individual and/or Agency: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

To: Oshki Manidoo Center
1741 15th Street NW • Bemidji, MN 56601 • Office: 218.751.6553 • Fax: 218.751.1846

This is necessary for the following purpose(s):

- Assessment and services Personal Education Insurance/financial/billing Legal Per client Request
 Disability determination Evaluation Per family request: Name & relationship to family: _____

Information to be released: check yes or no

Y N

- Dates of Service
- Social service Agency Information
- Physical exam, Chemical/drug dependency history
- Medical Records: medical history, admit summary, SC summary, progress notes, blood/lab tests,
- Psychiatric intake, diagnostic assessment & Treatment plans, Interim and progress notes, Psychiatric/Psychological testing, Mental Health Assessment, Mental Health Treatment Plan
- Correction/probation/Court info.
- Education information (academic, IEP, transcripts)
- Other

I authorize the release of all records pertaining to Mental Health, Alcohol and/or Drug Abuse and/or HIV Testing/AIDS/ AIDS related illness.

I understand that :

- I have the right to revoke this authorization at any time giving written notice to Oshki Manidoo Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I need not sign this authorization to receive services unless the services are court ordered.
- Oshki Manidoo Center cannot prevent the re-disclose of records release as a result of this request and that after release from Oshki Manidoo Center the records may not be subject to privacy rule protections.
- This authorization will permit two-way telephone communication and exchange of information by electronic methods.
- I am entitle to a copy of this authorization once I have signed and I may review/request copies of information disclosed.
- A photograph or facsimile of this authorization is as effective as the original
- This authorization shall remain in effect until this date: _____ (one year maximum)

 Client Signature

 Date

 Legal Guardian/Authorized Representative Signature

 Date

 Witness Signature

 Date

I, _____ revoke the ROI consent signed on : _____ by which I authorize Oshki Manidoo Treatment Center to release/receive certain specified information.

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RESTRICTIVE PROCEDURES NOTIFICATION

Client Name: _____ DOB: _____ Admit Date: _____

I understand that the Oshki Manidoo Center utilizes with Handle With Care (HWC) Crisis Intervention and Behavior Management System. The Handle With Care core philosophy is premised upon the belief that there is no dignity in allowing a child or adult to hurt him/herself or someone else. Physical intervention is the last resort and is limited to emergency situations involving the likelihood that the child will physically harm or is physically harming self and/or others.

In the even that the Oshki Manidoo Center must initiate restrictive techniques as a last report for the safety of my child or someone else.

- I wish to be notified **each time** of the use of restrictive techniques with my child.
- I wish to be notified **weekly** of the use of restrictive techniques with my child.

Legal Guardian/Authorized Representative Signature Date

CUTURAL / SPRITUAL ACTIVITIES CONSENT

I, as legal guardian/authorized representative of _____
residing in: Giizhiik/ Wiigwaasigamig Lodge, give my consent to attend and participate
in Cultural/Spiritual Activities of the Oshki Manidoo Center.

Legal Guardian/Authorized Representative Signature Date

MEDIA RELEASE

Please check **one** of the following:

- I am giving Oshki Manidoo Center permission to take my photograph for identification use within this program. I understand my photo will not be shared with any other programs or used outside of this program for any reason.
- I am giving Oshki Manidoo Center permission to take photographs for identification use within this program. I am also giving Oshki Manidoo Center permission to use photos taken of me for purposed of representing youth participation in groups or activities at the Oshki Manidoo Center. These photos may be placed in advertisements or brochures that represent Oshki Manidoo Center. I understand that persons in the greater community may recognize my participation in substance use disorder treatment.

Legal Guardian/Authorized Representative Signature Date

Staff Signature Date

CONSENT: ADMINISTER INFLUENZA/H1N1 VACCINE

Client Name: _____ DOB: _____ Admit Date: _____

Authorization for Administering Influenza Vaccine

I, _____, parent/guardian authorize Oshki Manidoo Center to have:
_____ vaccinated for Influenza.

Legal Guardian/Authorized Representative Signature

Date

Telephone Authorization given to

Date

Authorization for Administering H1N1 Vaccine

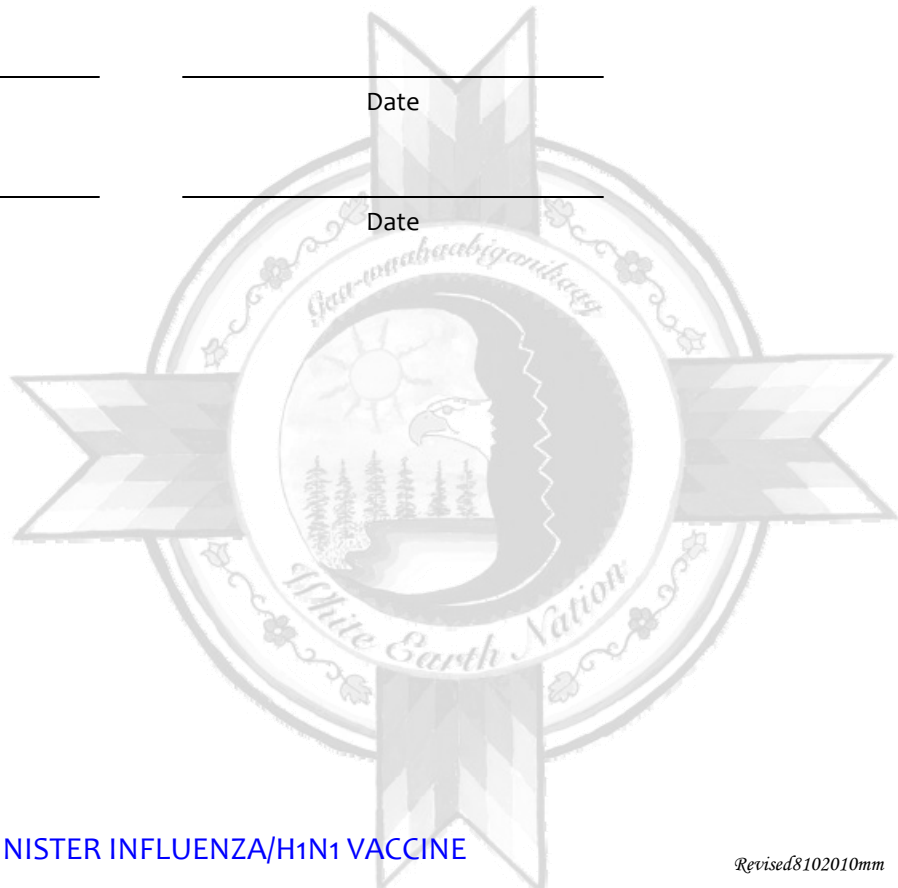
I, _____, parent/guardian authorize Oshki Manidoo Center to have:
_____ vaccinated for Influenza.

Legal Guardian/Authorized Representative Signature

Date

Telephone Authorization given to

Date



DENTAL HEALTH QUESTIONNAIRE
(continued)

	Yes	No		Yes	No
Sensitive teeth			Do you brush?		
Toothache			Do you use fluoride toothpaste?		
Pain or clicking on opening			Do you floss?		
Clenching/grinding teeth			Do you use a fluoride rinse?		
Frequent headaches			Do you have city water?		
Injury to face or jaws			Do you want to save your teeth?		
Dry mouth					
Bleeding gums			Do you drink pop, Kool-Aid, juice, sports drinks or sweetened drinks more than once/day?		
Have you had orthodontics (braces)			Do you snack, chew gum, use hard candy, or use cough drops often?		
Gum treatment / periodontal surgery			Do other family members have poor teeth?		
Do you have VA benefits?			CHILDREN ONLY: Does your child drink from a bottle?		
Do you have MA Insurance?			Have mouth habits (thumb sucking, etc.)?		

When was your last dental checkup, cleaning and x-rays? _____

Have you been satisfied with your previous dental care? _____

Dental insurance company _____

If you have VA benefits, please list name and phone # of your case worker: _____

Tribal Affiliation _____

If under the age of 18, what are the names of your mother and father or guardian(s): _____

Please state reason you are here today _____

These answers I have given are true to the best of my knowledge.

Signature (Patient or guardian if under 18)

Date

AUTHORIZATION TO USE OR DISCLOSE CONFIDENTIAL HEALTH CARE INFORMATION

This authorization cannot be honored unless completely filled out. To ensure prompt processing, read carefully, fill in all appropriate spaces, and sign only if you believe it is in your best interest to do so.

PATIENT NAME _____ DATE OF BIRTH _____

I authorize _____

Clinician Name
1526 30th Street NW, Bemidji, MN 56601
phone: 218-751-0887 fax: 218-759-4807

_____ To GIVE information to _____ To RECEIVE information from

Name: _____

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

NOTE: A SEPARATE AUTHORIZATION FORM IS REQUIRED FOR EACH INDIVIDUAL OR OUTSIDE AGENCY

The use/disclosure of the following health care information:

_____ My health care information for the following dates: _____
_____ Other: _____

The purpose(s) of this use or disclosure are:

_____ Specify purpose: _____ _____ At my request

I understand that my clinical record may include information relating to infectious disease, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I do not have to sign this authorization. My refusal to sign will not affect my ability to get treatment except when the purpose of treatment is solely to create health care information for a third party and this authorization is for disclosure to that third party.

I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by my health care provider based on this authorization.

I understand that, once my health care provider has disclosed health care information I have authorized to be disclosed, my health care provider has no control over the information. The person or organization that I authorized to receive the information might re-disclose it. It may no longer be protected by Minnesota or federal privacy laws.

I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization, may deny the release of protected health information, if it has reason to believe this authorization has been altered or is not a true and accurate authorization initiated by the patient.

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE BELOW OR ON _____.

Print name

Date

Signature of client

Signature of parent/guardian

Description of legal authority

Signature of witness

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of it 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.

WHITE EARTH TRIBAL MENTAL HEALTH
PO Box 300, WHITE EARTH, MN 56591
218-983-3286

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

NAME OF CLIENT (PLEASE PRINT): _____

This is to acknowledge receipt of a copy of White Earth Tribal Mental Health's Notice of Privacy Practice with an effective date of ____/____/____ (mm/dd/yy).

Client's (or Legal Representative's) Name: _____

Client's (or Legal Representative's) Signature:** _____

Date: _____

Capacity or Authorization of Legal Representative (if applicable)*: _____

* May be requested to provide verification of representative status.

* Note: Client is unable to give consent because: _____

WEMHP Worker's Signature: _____

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (please print):

White Earth Tribal Mental Health Program

Authorization / Consent to Service / Confidentiality

1. I, _____, knowing that I want Mental Health Counseling for myself and/or my child, do hereby consent to receiving services from White Earth Tribal Mental Health Program.
2. I have been informed of professional standards for trained mental health personnel strictly limit releases from client records. I understand that all information in my file is kept in accordance with strictest rules of confidentiality and may not be shared outside the facility without my written consent.
3. A treatment plan will be created with my Counselor.
4. I further consent and authorize the Counselor to meet with and transport my child for mental health sessions, either during or after school.
5. If I cannot make an appointment, I will call as soon as possible before the scheduled meeting.
6. If I have two or more no shows, I will be sent a letter asking me to reschedule within two weeks or services will be discontinued.
7. I authorize payment of any Medical insurance or Medical Assistance due to White Earth Tribal Mental Health Program.
8. This form and its meaning has been discussed and explained to me by the Counselor.

Signature of Client

Date

Parent/Guardian Signature

Date

Counselor Signature

Date

White Earth Tribal Mental Health Program

Authorization / Consent to Service / Confidentiality

1. I, _____, knowing that I want **Mental Health Case Management** for myself and/or my child, do hereby consent to receiving services from White Earth Tribal Mental Health Program.
2. I have been informed of professional standards for trained mental health personnel strictly limit release of client records. I understand that all information in my file is kept in accordance with strictest rules of confidentiality and may not be shared outside the facility without my written consent.
3. Individual Family Community Support Plan (IFCSP) will be created with my Case Manager.
4. I further consent and authorize the Case Manager to meet with and transport my child for mental health purposes. **As parent(s) or legal guardian of the child receiving services I (we) hereby release, waive, discharge White Earth Tribal Mental Health Program and their agents, employees or other representatives, from all responsibility and damages regarding injury or harm to my child.**
5. If I cannot make an appointment, I will call as soon as possible before the scheduled meeting.
6. If I have two or more no shows, I will be sent a letter asking me to reschedule within two weeks or services may be discontinued.
7. I authorize payment of any Medical insurance or Medical Assistance due to White Earth Tribal Mental Health Program.
8. This form and its meaning has been discussed and explained to me by the Case Manager.

Signature of Client

Date

Parent/Guardian Signature

Date

Case Manager Signature

Date



White Earth Tribal Mental Health Program

Telephone: (218) 983-3286 Fax: (218) 983-4236

Authorization For Use And Disclosure Of Information

Name of Client _____ Chart No. _____

Date of Birth: _____ Phone # _____ Social Security # _____
(optional)

I authorize: _____ To release or exchange with: _____

Specific Dates of information to be disclosed: From _____ To _____

- Diagnosis
- Diagnostic Assessment
- Psychiatric Evaluation
- Psychological Assessment and Testing Results
- Substance Abuse Assessment
- Admit/Discharge Dates & Reports
- Progress Reports
- Medications
- Recommendations
- Treatment Plans
- Family Involvement Information
- School Reports / IEP
- Verbal Only
- Other (Specify) _____

The information is necessary for:

- Diagnosis & Treatment
- Acknowledge Referral
- Other (Specify) _____
- Coordination & Follow-Up
- Insurance Purposes
- Client Record
- Family Involvement
- Education Purposes
- Emergency Notification
- Update Record
- On-site Chart Review

PLEASE NOTE THE FOLLOWING:

1. You may refuse to sign this authorization. Your refusal will not effect your ability to obtain treatment or payment, but may effect the quality of services White Earth Tribal Mental Health Program is able to provide.
2. If the persons or entities authorized to receive the information are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws will no longer protect the disclosed health information.
3. I agree a photocopy or facsimile of this release be accepted with the same authority as the original.
4. This authorization will be effective for the above stated dates or until you revoke it. You may revoke this authorization by delivering a dated and signed letter to our program:
White Earth Tribal Mental Health Program, P.O. Box 300, White Earth, MN 56591

Client Signature: _____

Client is unable to give consent because: _____ Date _____

Parent/Guardian (Print) _____ Signature: _____ Date _____

Witness Signature: _____ Date _____

If the client is unable to sign, the person signing the authorization may be required to show proof of guardianship, or authority, and relationship to client, allowing him/her to authorize this release of information.

White Earth Tribal Mental Health Program

Mandatory Reporting Information

There are instances where we may be unable to protect your privacy. Staff is required by law to report suspected child abuse or vulnerable adult abuse or neglect even if the information was received in confidence. We may have to notify authorities if there is substantial risk of you doing harm to yourself or others, or if you intend to commit a crime. We may have to notify authorities if we become aware of a previously unreported incidents', which resulted in harm to self or others. If you are involved in court action, your records may be subpoenaed.

I have read and understand the above rules of confidentiality.

Client

Date

Parent/Guardian

Date

Agency Worker/Title

Date

YOUTH APPROVED CONTACT LIST: PER PARENT/GUARDIAN / EMERGENCY CONTACT LIST

Client Name: _____ DOB: _____

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

NO CONTACT LIST: are there contacts that are NOT okay?:

Name: _____ Phone #: _____

Relationship to Youth: _____

Is there a legal no contact order in place?: Yes/ No

Name: _____ Phone #: _____

Relationship to Youth: _____

Is there a legal no contact order in place?: Yes/ No

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No

Name: _____ Phone #: _____

Relationship to Youth: _____ Mail Ok?: Yes/No